Baobab Centre for Young Survivors in Exile

Monitoring and Evaluation Report 2024

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

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Introduction

Children and young people make up a significant portion of those affected by forced displacement, with around 40% of the world's displaced population being under 18 (UNHCR, 2023b). While most forcibly displaced people reside in low- and middle-income countries (UNHCR, 2024), numbers in Europe and the UK have been rising annually (UK Parliament, 2023; UNHCR, 2023a). Between March 2022 and March 2023, the UK saw a 33% increase in asylum applications, the highest number in 2 decades (Home Office, 2023). The number of Unaccompanied Asylum-Seeking Children (UASC) or Unaccompanied Refugee Minors (URMs) is also growing, representing a significant share of applications (Department for Education, 2023).

Forced migration, including pre-migration trauma and post-migration resettlement challenges, has long-term negative effects on mental health (Bogic et al., 2015; Jannesari et al., 2020; Porter & Haslam, 2005). Children are particularly vulnerable due to exposure to violence and instability during critical stages of cognitive and emotional development. Indeed, studies have reported that asylum-seeking and refugee children have higher rates of post-traumatic stress disorder (PTSD), anxiety and depression than the general population (Blackmore et al., 2020; Kien et al., 2019; Reed et al., 2012). UASC and URMs have been shown to be especially vulnerable, being more likely to experience multiple traumas, such as abuse and parental loss (Fazel et al., 2015), and suffer from severe mental health difficulties compared to children who are accompanied by caregivers (Bean et al., 2007; Höhne et al., 2023). Despite greater challenges and mental health needs, most of the UASC and URMs residing in Europe are not in contact with mental health services (Mitra & Hodes, 2019), which offers cause for concern and highlights UASC and URMs as an underserved group. There are known challenges deterring UASC and URMs 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). It is important to understand UASC and URMs' experience of receiving services to ensure accessibility and increase the value of support.

Research on the specific needs and experiences of UASC and URMs remains scarce (Groark et al., 2011). There is a limited understanding of the needs and characteristics of this population, which makes it challenging for services to develop informed support strategies. This issue is further complicated by the constantly shifting landscape in which these services operate—both due to the ever-changing composition of asylum-seeking populations, influenced by global conflicts and crises, and the continuous evolution of policies and services designed to accommodate them in the UK. Evaluations and monitoring play a crucial role in enhancing service quality, measuring impact, and ensuring services align with the needs of clients. They generate evidence that informs decision-

making, fosters innovation, and contributes to a strong evidence base for effective practices by assessing outcomes and incorporating feedback from service users (Gibbard et al., 2022). To ensure services are reaching the populations that would benefit from their support and that 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 understand how they may experience the service offered and draw from their views and feedback to inform service development and improvement.

Project Context and Aims

The Baobab Centre for Young Survivors in Exile (the Baobab Centre hereafter) is a UK-based non-residential community providing holistic, multidisciplinary support to UASC and URMs, offering a variety of services, including practical support, therapeutic work, social activities, and legal counselling. All young people within the service have faced child-specific human rights abuses, such as violence, forced recruitment, trafficking, and exploitation, and have arrived in the UK suffering significant mental health and developmental difficulties. Whilst all service users will have entered the UK as unaccompanied minors, 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 the needs and service experiences of its community. The present report details the findings of the monitoring and evaluation project conducted in 2024. The evaluation questions are as follows:

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

2. How is the service experienced by of service users of the Baobab Centre, and what are their recommendations for improvement?

Methods

Participants and Recruitment

Participants were current service users of the Centre, recruited using non-probability sampling between 11/04/2024 and 18/08/2024. Service users were eligible for inclusion in the evaluation if they were aged 16 or above, had been in contact with the 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 and offered the opportunity to ask questions. Written consent was obtained before service users participated in the questionnaire. Participants did not receive compensation for their time, but travel expenses were reimbursed.

Procedure

After providing informed consent, participants completed a questionnaire including clinical measures of mental health with an external research assistant to ensure anonymity. Participants then completed a second questionnaire about their experience of service online. Routinely collected data was provided alongside the questionnaire data to allow for triangulation data from multiple sources. This was to reduce the burden on participants and reduce duplicating data collection. For example, data was provided on how many years each participant had been in contact with the Centre.

Materials

The questionnaire included both standardised psychometric measures and bespoke questions using Likert-scale responses, as well as open ended questions. The questionnaire collected information on participant demographics, psychosocial wellbeing, and their service experience.

Demographics

Demographic data held by the service was linked to participants' data prior to anonymisation by Centre staff to allow for triangulation. These data points included country of origin, age, gender, length of contact with the service, number of years in the UK, and asylum status.

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, affect regulation, and resilience.

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).

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 complex PTSD. 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).

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 five-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).

Resilience. The Child and Youth Resilience Measure Revised (CYRM-R; Jefferies et al., 2019) and the Adult Resilience Measure Revised (ARM-R; Resilience Research Centre, 2022) were used to measure resilience, developed from the perspective that resilience is a social-ecological construct. The CYRM-R was used for participants under 23 years old, and the ARM-R for participants 23 and over. The CYRM-R and ARM-R are 17-item measures with personal (intrapersonal and interpersonal) and caregiver/relational resilience subscales, rated on a five-point scale from "*Not at all*" to "*A lot*".

The minimum score is 17 and the maximum score is 85, with higher scores indicating greater resilience. Prior research has used an interpretation of the total score can be evaluated as < 63 low resilience, 63 - 70 moderate resilience, 71 – 76 high resilience and ≥ 77 exceptional resilience (McEwen et al., 2022; Uysal et al., 2022). This interpretation will be adopted, as well as

recommendations by the Resilience Research Centre (2022) to split the sample into two groups between relative higher and lower resilience, in recognition that resilience and thresholds may vary between contexts.

Experience of service

The Experience of Service Questionnaire (ESQ; Brown et al., 2014) was employed to capture participants views and experience of the service. The ESQ consists of 12 items and three free text sections measuring the perceived satisfaction level of the respondent receiving mental health services, exploring what was liked about the service, what was felt needed improving, and any other comments. Items are scored on a three-point Likert scale with 'Don't know' option (0 = Not true; 1 = Partially true; 2 = Certainly true; ? = Don't Know), with higher scores indicate higher satisfaction with care. Although designed for and validated among those under 18 years of age, it was employed in this survey due to its simplicity. The three free text section were omitted and replaced with 8 bespoke open-ended questions capturing perceived impact of the service across different domains and feedback on how the service could be improved. Example questions included: "*How do you think Baobab has helped you?*", "*Is there anything you don't like at Baobab or anything that needs improving?*" and "*What do you think of the group activities and community activities?*".

Ethical considerations

Participants gave informed consent before taking part in the study. Eligible service users were assured that participation was voluntary and would not impact their care at the Baobab Centre. They were also informed about confidentiality and its limitations. Staff received training to address risk issues in line with local safeguarding procedures. While no participants withdrew, all were made aware of their right to withdraw at any time until data anonymisation was complete.

Identifiable 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. Anonymised data was accessed by the first author for analysis purposes.

All interviewers held honorary contracts with the Baobab Centre and had received enhanced DBS checks. Interpreters involved had non-disclosure agreements in place.

Analysis plan

Data cleaning in preparation for analysis was supported by Excel and Stata (StataCorp, 2021). Missing data was omitted from any analyses (i.e. Listwise Deletion) and all quantitative 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 the measures. Quantitative comparative descriptive analyses were performed to explore group differences where possible. Values of measures of central tendency and percentages were reported to two decimal places. Qualitative data was analysed using content analysis, a systematic method used to quantify and analyse within text-based data by identifying patterns, themes, and clusters within the data (Crowe et al., 2015), using Elo and Kyngäs' (2008) three-phase process of Preparation, Organising and Reporting.

Results

Demographics

In 2024, the Centre supported 77 young people, with 9 new young people joining the service. Thirty-three participants completed the questionnaire (90.91% male (n = 30); mean age = 23.45 years, SD = 4.4, range: 16-33). At time of data collection, participants had been in the UK for 2-22 years (mean = 6.85 years, SD = 4.8). Approximately half of the sample (n = 17) came into contact with the service the same year or the year after entering the UK.

The country of origin of approximately a third of the sample was Afghanistan (30.30%, n = 10). Other countries of origin included Albania (n = 1), Algeria (n = 1), Bangladesh (n = 1), China (n = 2), Egypt (n =1), Eritrea (n = 3), Ethiopia (n = 3), Guinea (n = 1), Iraq (n = 1), Mali (n = 1), Niger (n = 1), Pakistan (n = 1), Sierra Leone (n = 1), Somalia (n = 1), Sri Lanka (n = 1), Sudan (n = 2), and Syria (n = 1). The majority of participants were granted Refugee Protection status (60.61%, n = 20). A fifth of the sample (21.21%, n = 7) had been granted Indefinite Leave to Remain. For four participants, their asylum claim was 'pending'. One participant had been granted Discretionary Leave to Remain for two and a half years, and one participant was a British citizen. The majority of participants (75.76%, n = 25) reported not having a family of their own here in the UK (e.g., a partner or children).

Mental Health and Wellbeing

Depression and Generalised Anxiety

Mean PHQ-9 score was 12.76 (SD = 6.24, range: 2-25). Most participants scored between the moderate and severe range for depression (69.69%, n = 23), see Table 1. Mean GAD-7 score was 9.61 (SD = 5.53, range: 0-21). Almost half the sample's scores indicated moderate or severe anxiety (48.48%, n = 16), see Table 1.

Participants who had been in the UK for 4-7 years had lower PHQ-9 and GAD-7 scores compared with those who had been in the UK for less (0-3 years) or more time (8+ years), with the highest scoring group being in the UK for over eight years (PHQ-9: mean 0-3 years = 12.3, SD = 2.13; mean 4-7 years = 10.67, SD = 2.08; mean 8+ years = 14.43, SD = 1.56; GAD-7: mean 0-3 years = 8.6, SD = 2.02; mean 4-7 years = 8.56, SD = 1.49; mean 8+ years = 11, SD = 1.49).

Participants who came into contact with the service either the year they entered the UK or the following year had lower PHQ-9 and GAD-7 scores compared with those who came in contact with the service later (PHQ-9: mean = 11.82, SD = 1.32 vs. mean = 13.75, SD = 1.75; GAD-7: mean = 8.71, SD = 1.16 vs. mean = 10.56, SD = 1.56).

Table 1

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

Measure	n	%
Depression (PHQ-9)		
None (0-4)	4	12.12
Mild (5-9)	6	18.18
Moderate (10-14)	12	36.36
Moderately severe (15-19)	5	15.15
Severe (20-27)	6	18.18
Generalised Anxiety (GAD-7)		
Minimal (0-4)	7	21.21
Mild (5-9)	10	30.30
Moderate (10-14)	11	33.33
Severe (>15)	5	15.15

PTSD and Complex PTSD

The ITQ was completed by a subsample of eight participants. Examples of trauma provided included experiences relating to childhood abuse, being detained or imprisoned, and seeking asylum.

Of these eight participants, all endorsed at least one of the two symptoms of re-experiencing in the here and now, and of avoidance. Most (n = 6) endorsed at least one of the two symptoms of

sense of current threat. All endorsed that 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). Most (n = 6) met criteria for diagnosis of PTSD.

All participants (n = 8) endorsed at least one of the two symptoms of affective dysregulation. Most (n = 6) endorsed at least one of the two items describing relationship difficulties and at least one of the two symptoms of negative self-concept. For seven of the eight 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). Six of the eight participants 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, suggesting Disturbances in Self-Organization.

Five of the eight participants met criteria for Complex PTSD, having met criteria for both PTSD and Disturbances in Self-Organization.

Affect regulation

Mean scores for each ARC subscale were: 2.71 for affect dysregulation (SD = 0.99, range: 1-4.75), 3.37 for reflection (SD = 0 .95, range: 1.5-5) and 3.37 for suppression (SD = 1.02, range: 1-5).

Resilience

Among those completing the CYRM-R (aged below 23, n = 13), the mean score was 59.30 (SD 9.85, range: 40-73). 69.23% of the respondents of the CYRM-R (N = 9) scored in the 'low resilience' range, 2 (15.38%) in the 'moderate resilience' range and 2 (15.38%) in the 'high resilience' range. The mean score for the personal resilience subscale was 36.08 (SD = 5.72, range: 23-44) out of maximum total of 50. The mean score for the caregiver subscale was 23.23 (SD = 5.02, range: 15-31) out of maximum total of 35. When asked about which family were held in mind whilst responding to certain items, most participants referenced family or parents 'back home' or siblings or friends in the UK. One participant spoke about semi-independent housing care, two spoke of having no family and two spoke about having community at Baobab.

Among those completing the ARM-R (above 23, n = 20), the mean score was 62 (SD = 11.64, range: 41 – 81). 50% of the over 23 respondents (N = 10) scored in the 'low resilience' range, 6 (30%) scored in the 'moderate resilience' range and 4 (20%) in the 'exceptional resilence' range. The mean score for the personal resilience subscale was 37.8 (SD = 5.82, range: 26-47) out of maximum total of 50. The mean score for the relational resilience subscale was 24.2 (SD = 6.46, range: 13-35) out of maximum total of 35. Some participants stated the family they held in mind whilst responding to the

questions were family (e.g., parents, siblings, children) or friends, either in the UK or abroad. Three referenced staff at the Baobab Centre when thinking about family. One participant made reference to a deceased grandmother, one shared having no family at home and another shared they had no family in the UK.

Looking at the whole cohort, the mean score was 60.94 (SD = 10.89, range: 40-81), with a mean score of 37.12 (SD = 5.75; range: 23-47) for the personal subscale and 23.82 (SD = 5.87; range: 13-35) for the caregiver/relational subscale. Scores were relatively similar among those over or under 23 years old (i.e., completing the CYRM-R vs the ARM-R), except more of those under 23 are represented in the 'low resilience' category. Of the whole sample, 57.58% scored within the category of 'low resilience' (N = 19), 24.24% in the 'moderate resilience' category (N = 8), 6.06% in the 'high resilience' category (N = 2) and 12.12% scoring in the 'exceptional resilience' category (N = 4).

Participants with family in the UK had higher mean resilience scores compared to those who did not (M = 66.88 vs. 59.04). This effect was observed across both personal and caregiver/relational subscales (M= 41.13 vs. 35.84 and M = 25.75 vs. 23.2). Although a minority within the sample, female respondents had higher resilience scores compared to male respondents (M = 80 vs. 59.03). As resilience tends to vary between contexts and thresholds would similarly vary (Resilience Research Centre, 2022), the sample was split into two groups between relative higher (≥ 61, N = 17, 51.52%) and lower resilience (≤ 60, N = 16, 48.48%) to explore group differences. No notable groups differences were observed according to anxiety and depression scores, age, or years of contact with the service and years in the UK.

Service experience

The mean ESQ total score was 22.58 (SD = 1.75). With a maximum total score of 24, this suggests high satisfaction with care and the environment. The items which scored the highest, with all participants selecting 'Certainly True' were "*I feel that the people who see me at Baobab listen to me*" and "*Overall, the help I have received here is good*. The lowest scoring item was "*The facilities here are comfortable (for example: reception area, therapy rooms, group rooms...)*" (mean = 1.70, SD = 0.59).

Qualitative findings

The qualitative findings are thematically summarised below. Three overarching themes were identified, speaking to different aspects of the service and its impact: "*Psychotherapy and mental health*", "*Baobab as a community space*", and "*Supporting to independence*". Whilst most participants did not identify any areas of improvement (n = 22, 66.66%), the constructive feedback from those who did is threaded throughout the findings.

Theme one: Psychotherapy and mental health

A need for support

Participants expressed that upon accessing the service they really needed help, with a few specifying for their mental health and speaking of overcoming trauma, depression and anxiety. Participants shared how psychotherapy and belonging to the Baobab community more generally has helped tackle feelings of shame and guilt and difficulties with trust and self-compassion. The service is perceived to have helped them develop feelings of acceptance and safety: "*When I came here, I really needed to help, coming here helped me discover a lot of things about myself and my trauma and helped me learn to live with and accept it*."

"*Baobab changed me. I was very bad before- mentally. I could not go to sleep, I had a lot of stress, depression. I got a lot of mental help here. With their services I am better now, I look back at myself three years ago and see a 100% change. I care about myself now and look after myself. Baobab showed me the ways how to come out of the depression.*"

"I was experiencing PTSD, I was not really stable but now I am pretty much okay. From my childhood memories of being abused and tortured, so I hold onto those memories for a very long time until I managed to overcome them"

The value of psychotherapy

When asked about how useful participants have found psychotherapy (individual and/or group), all but one participant (96.96%) described their experience of psychotherapy with Baobab to be useful. The one person who expressed that psychotherapy wasn't helpful, shared "*For some people the group and individual psychotherapy would work but for me I prefer to do actions rather than talking about my feelings or my life in general*". Psychotherapy was described to have a significant impact on some of the participants lives. For example, one spoke of being taught skills to calm themselves down and stopping to self-harm, improved sleep, and working towards building trusting relationships. For some, this translated into less reliance on avoidance as a coping strategy: "*I only did the individual therapy and it helped me to accept my grief and process it and live with it before I use to run away from these things but now I can handle it much better".* Participants shared they feel able to express feelings better, process memories and have fewer nightmares because of psychotherapy. One participant shared: *"[individual psychotherapy is] very useful, it has kept me alive"*.

"Individual Psychotherapy: helped with nightmares; helped with confidence; lost a lot of myself and thinking a lot about my past; focus on the future; this made me who I am today; do not know how I would have managed without psychotherapy. I learned things that help me a lot to

become stronger and realize that my past is not going to affect me and to just go forward in life. Helped with trust issues."

Some attended group psychotherapy, describing it to be really helpful to hear others share and feel understood by and relate to others: "*In group I see lots of people in a similar condition to me and helps me to deal with what I'm going through and the individual one helps me to relieve my stress and open up*". Others expressed that they do not enjoy the group psychotherapy, for example as it can be challenging to be sitting with so many people and share: "*I am a private person, I did not feel comfortable to share, it was hard."*

> *"I like when others share and talk about their problems; it helps me too and encourages me to talk about my problems too […] When I hear that others have somewhat similar problems to what I have it makes me feel that I am not the only one and certain things they share resonate with me too."*

> *"It takes me some time to get used to people around me even if they have gone through the same path and situation. I learned how to open and share with them. It took me time to be able to ask them about their own experiences, how they handled difficulties, how they faced them. Now I am comfortable sharing about many different topics in my life and I Know that it will remain confidential. We can talk about relationships, family, people, relationships with neighbours, things that happened in my life, difficulties. We talk about changes and sadness. Also because everyone is so open and everyone has got their own experiences, we are able to learn from each other and benefit each other."*

The therapeutic process

A process of change was observed in participants descriptions of the impact of psychotherapy. This was observed to link to the experience of learning to expressing difficulties and talk about problems, traumas and emotions, being heard and listened to and feeling cared for: "*Being able to openly talk about it and express yourself, I couldn't before. I had someone I could talk to and I could trust".* The therapeutic relationship and space was highly valued, particularly establishing trust, building confidence and experiencing psychological safety.

> *"Individual Psychotherapy helps me a lot. For me, it takes me time to trust somebody and for me to speak to somebody about myself/what is going o for me/my feelings, I am not an easy person so it takes a long time to connect to someone and empty my chest to that person. The way they talk to me makes me feel like I am important, as worthy as anyone else, make me feel like whatever we tell them and share with them is going to be kept secured and won't be shared so you don't worry about yourself when you leave."*

"They have been very helpful for me, both group and individual. The individual therapy gave me more confidence to build myself up and the group therapy helped me feel like I belonged to a group and my voice is heard"

One participant shared how the therapeutic relationship could offer challenges, for example if unable to attend a session and feeling that they have to explain themself. However, another shared that this therapeutic contract and the expectations and warmth associated with it enabled them to re-engage when they stopped attending.

"When I can't come to sessions, they always ask a lot of questions and explanations that can be overwhelming. Sometimes I don't want to go into it or feel that it's helpful. Feels like a police investigation. I don't want to be forced to me do something."

"[individual psychotherapy] helped with depression. I can say that it has been a really big change, last year I was really down and a bit more drinking. Talking with [my therapist] helped me stop many things, stopped drinking, go outside and be a part of the community, I stopped going to Baobab and stayed home, they pushed me to come back and welcomed me back."

Theme 2: Baobab as a community space

"it's like going with my family"

Participants often spoke about the feeling of being taken care of, and a few compared the support they receive and the relationships they have to being with family: "*it's like a family, my caseworker was like a mother and held my hand and helped me in this country*". They described a process of being supported to socialise and not feel alone: "*When I talk to the people at baobab they make me feel strong and I don't have anyone else in England, and I only have baobab to talk to*". Community spaces and group activities being facilitative of this for some.

"I attend some of the group activities and I think they are great. For example the retreat or maybe going out together makes you feel like you are with your family, and also especially for someone who is by himself all the time, it is a good experience to get used to being around with people. I enjoy them."

Shared activities

Participants were asked about their views and experiences of group activities at Baobab. Ten participants (30.30%) reported not taking part in the community activities at the Centre. One shared he attended when he was younger, and another stated that the length of time it takes to get to the Centre is a big barrier. Most feedback for the group activities from those who attend was very

positive, e.g., "*I enjoy the group activities it helps to share my experiences and meet new people*" and "*Being part of the community and attending the groups gives me a very good feeling*". These were described to be "*fun*" and "*helped me to gain new skills and meet others*".

> *"It's very great because community and activities is where we are together and we have food and long chats and you can share what you feel and what you need and what support you might need / and also how you can support other YP if they need help / I like when they do (mentoring) so how we can as a community help another"*

While one person sharing they thought the community meetings were "*a bit of a waste of time*", other participants explained these were helpful and enjoyable spaces: "*it was really nice, wonderful to be honest, people are together laughing eating and making fun and enjoying*".

> *"The community meeting is good, I think it is a great way of getting used to speaking [in front] of people, opening up topics, listening to them, hearing different questions and answers. They give you an opportunity to talk about anything you want to talk if you have got anything to say and people are respectful which makes you feel welcome."*

The retreats and trips around or outside London received positive feedback: e.g., "*It's very good, the little holidays are really nice as a refugee we can't leave the country it's nice to have a little holiday*".

One participant was ambivalent about an upcoming trip, explaining they are relatively new to the service and the prospect of going away with many people and not knowing sleeping arrangements makes them uncertain. A few participants shared feedback that they would value if more trips were organised at other times of the year and that they would like to spend more time outdoors. One participant reflected that it would be a good experience to also travel internationally together, like a family holiday.

Music, drama and art were also valued among those who attended, e.g., "*I really enjoy the music and art, nothing bad to say about baobab*". Other activities and clubs were suggested by one participant: "*If they had a gym here I would probably go /gym activities / outdoor gym. If they had a rugby team […] sporty activities/outdoor activities I would probably go […]. Something to do with computers or cyber security activities. Maths.*"

Building and environment

Participants provided feedback on the therapeutic space and accessibility. One participant reflected that removing referrals could improve access: "*I think everything is alright and the way things are going it is the best- I hope everybody could come to Baobab without needing a referral*".

Adding to the ESQ responses, participants shared that the building could be more accessible, noting that the stairs can be challenging. The halls and reception spaces were described as small and could be crowded, leading to a lack of privacy: "*The reception area: too crowded, too small, not much privacy. The hallway as well*.". One participant expressed it is not practical moving between buildings, whilst another suggested upgrading the therapy rooms (e.g. by adding candles). For a few, the location could be more convenient as travel time can be long. One participant queried whether the Centre could be larger and/or could move to more green space.

A few participants shared that to it would be helpful to have more information about staff roles and working patterns, which can make it challenging to know who to address queries to: "*it's harder to communicate with the whole of baobab as different people are on duty different days so it's hard to know who to communicate with"*. This was suggested to improve sense of community. One participant proposed creating badges for staff to help differentiate staff and service users.

> *"It is not organised in terms of structure, there are so many people who work here I don't know who does what, there should be something that tells is this"*

One participant reflected on a positive culture change they have perceived: "*In the past few years they have improved a lot, previously I felt like we didn't have a voice and we count express our opinions freely without repercussions but now this is a lot better and we are more free to talk*"

Theme three: Supporting to independence

Advocacy, support and companionship: the perception and impact of casework

The Baobab Centre was described to have helped with a wide variety of difficulties beyond mental health challenges. These included helping with education and legal issues, housing, asylum applications, health (e.g., accessing GP, physio), financial challenges (e.g., debts or accessing benefits) and being allocated a social worker. Further support included reminding of appointments, providing food and transport when needed, and helping to write emails or letters. Caseworkers were described to escalated issues where needed, providing advocacy on matters such as housing for participants: "*It is good, he put pressure on the council and social service and called them to get me support*". Some participants spoke about Baobab staff accompanying them to important meetings, for example for their health or asylum claim, and how helpful this is for their wellbeing and comprehension: "[*my caseworker] comes to most appointments and explains things to me and makes me feel, better as I understand more*". Participants expressed a lot of gratitude to this part of the service: "*It changed my life one of the most useful services provided*". One participant highlighted the value of Baobab having links with a wider network of services: "*Appreciating link with Red Cross to find my family back home*".

"They helped get my brothers to the uk / they put me in contact with a lawyer/ they funded this lawyer/ they came to court with me I feel much comfortable and much happier because they recognise my disability and get me disability benefits / when I physically can't go back home they book me a cab"

Three participants did not access casework at Baobab and another expressed they do not ask much from their caseworker. Among those who did, this was described as 'great', 'very good', and a 'very big help', with participants expressing that caseworkers are there for them: "*They have been very useful and they are proactive in supporting me and they respond quickly if have any problems*", "*he calls me every week to ask if I have any problems"* and "*anytime I need to ask for help or have a question [my caseworker] is there for me*".

Education and employment

Participants were asked about their experience of support towards accessing education and employment. Twenty-four participants perceived that Baobab supported them with their education (72.72%), including supporting to understand options and learn about courses, enrol into college, fund University or proofread work: "*I went to college with Baobab's help, they helped register me at college, helped me with problems, sometimes come with me to the college, talk to the service desk at college. They kept track of my progress at college*". Baobab also provided tuition to some, e.g. "*They also help me with me English and maths, they brought a laptop for me*". Eight participants (24.24%) shared they are not using this part of the service, with four expressing that if they did they are sure that they would receive the support they need: "*There hasn't been an opportunity for them to help me with my education yet but I know that if I want to go to college I know I can ask for their help and they will help me*".

"They did help me get a one-to-one tutor and also tried to get me into college but because of my ongoing mental health issues I struggle to concentrate and decided not to start yet. When I did decide not to start yet the centre was supportive of my decision."

One participant (3.03%) expressed that they didn't believe Baobab was doing enough to support them enough with their education but did not elaborate on why or what could be done to improve.

Eleven participants shared they are not currently in work or allowed to work (27.27%), with three expressing they have received support to access benefits, advice on approaching beginning work, sending applications or receiving references should they pursue employment or education. Six participants found employment on their own and did not need support from the Centre, however

some expressed they would come to Baobab for support should they need in the future and that Baobab do offer support and advice for work or benefits related difficulties.

> *"My work was introduced through my friend, no they did not help me with this one. Baobab centre helped with interrelationships at work. Baobab is helping with issues with benefits; I was penalized by the benefits agency so Baobab centre is helping negotiate/clear the benefits penalization which was an error of my boss."*

For some, Baobab helped with work related matters, for example showing them how to find a job or professional course and other relevant resources, reminding them when to go to work, how to manage if interpersonal difficulties arise at work, and ensuring not to be taken advantage of.

> *"BAOBAB centre helped with work; helped show me how to find a job, give me advice on how to work. I used to forget when you had to go to work, BAOBAB centre would remind me. Helped me type my CV."*

Three participants expressed they do not feel that Baobab do enough to support with job and work situations, although some also expressed they were believe that "*they do their best*". Similarly to education, two participants spoke about not receiving help but knowing it is there: "*They kind of help, they are not really involved in that area, but if f I would ask them they would surely help me*".

Socialisation and transition

Some participants spoke about how support from the Baobab Centre has supported them with socialisation to the UK, learning about new systems and a new language: *They have helped me navigate the new UK system which is unfamiliar and intimidating at times*". Others spoke about how Baobab helped them with entering adulthood and becoming independent, learning about 'life': "*They are doing a pretty good job helping people like me. From being a boy to being a man that is a huge achievement*" and *"I could talk to [my therapist] about everything, she taught me how to live, even about brushing my teeth and what to eat, and how to dress".*

> *"my social worker does not just obviously support me legally, she has helped me learn to be independent and reliant on myself to deal with things for example my housing situation and sorting my issues on myself and finding the solutions instead of just coming to BAOBAB or making phone calls."*

For some, group work was important within this process, by learning with and from others and developing a sense of belonging and community.

> *"The group therapy is also very helpful because I can improve me English and learn about different people and different cultures."*

Discussion

Key findings and recommendations

UASC and URMs are an especially vulnerable group of refugees (Bean et al., 2007; Fazel et al., 2015; Höhne et al., 2023), and services working with this group must hold up-to-date understandings of their needs and experiences to ensure adequate support and promote positive service experiences. The present service evaluation used a questionnaire capturing different aspects of service users' psychological wellbeing and their experience and perceptions of the service, a third sector organisation operating a non-residential, holistic therapeutic community model to support UASC and URMs. Just under half of service users completed the service evaluation questionnaire.

Consistent with findings from previous years and with the broader literature (Bean et al., 2007; Höhne et al., 2023), the present evaluation indicate a high level of vulnerability and suffering among service users of the Centre. Levels of anxiety and depression, as measured by the PHQ-9 (Kroenke et al., 2001) and GAD-7 (Spitzer et al., 2006), were found to be high. Of concern, the group reporting on average the most severe anxiety and depression symptoms were those who had been in the UK for 8 years or more. This is not an entirely novel finding, with previous longitudinal research highlighting that URMs can experience long-term, persistent mental health difficulties (Vervliet et al., 2014). There is also evidence that poor social support, insufficient language proficiency, detention and the experience of discrimination influence mental health outcomes for URMs (Bamford et al., 2021), which may continue years into resettlement. It is recommended that the experiences of this group of service users are explored in more depth to understand their needs and challenges.

Many participants came into contact with the service (approximately half) within a year of entering the UK, which is positive given wider findings of separated children having low levels of contact with mental health services despite high prevalence of mental health difficulties (Bean et al., 2007; Sanchez-Cao et al., 2013). Although caution must be used to interpret the present findings due to a small sample size, lack of confounder analysis and the cross-sectional design employed, figures might suggest a protective effect of coming into contact with mental health support services shortly after arrival to the UK on depression and anxiety symptoms.

Although only measured within a subset of the present sample (n = 8), most met criteria for PTSD and/or Complex PTSD. PTSD has been systematically found to be the most prevalent mental health problem among asylum-seeking and refugee children (Blackmore et al., 2020; Kien et al.,

2019). In addition to the trauma-focussed and -informed therapeutic support provided at the Centre, the service could also consider facilitating evidence-based group interventions for PTSD, e.g., as that developed by Children and War Foundation (Yule et al., 2013) and adapted for unaccompanied refugee minors (Sarkadi et al., 2018). Given the significant levels of trauma, PTSD and Complex PTSD within the population, the service might also want to draw from applications of Compassion Focused Therapy (CFT) adapted for trauma survivors (Lee, 2022).

Emotional regulation challenges were described in free text responses and captured by the ARC (Moretti, 2003). 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: 1-5), more difficulties with emotional suppression (M = 2.93, SD = .96, range: 1-5) and greater reflection (M = 2.26, SD = 1.03, range: 1-5). In terms of resilience, more than half the sample scored within a 'low resilience' category, although higher resilience is noted among participants with family in the UK and the few female participants. Resilience scores on the personal subscale are comparable to those reported in a study of war-affected Ukrainian Children displaced to Poland (Urbański et al., 2023), however scores on the caregiver/relational resilience subscale were lower. This is perhaps unsurprising given participants' shared experience of separation with and/or loss of key attachment figures, but nevertheless endorses the application of systemic approaches to support as employed by the Centre.

Overall, participants provided very positive feedback about the support they received. Participants described the significant impact and change experienced as a result of engaging in psychotherapy and describing the wide and flexible support offered by the service more broadly, covering different aspects of needs from financial, to health, educational and legal. Participants spoke about being accompanied by staff to appointments and emotional held, providing a scaffold towards independence in the UK. The provision of care and support described by participants aligns with the practice guidelines developed for clinical psychologists supporting UASC and URMs in the UK produced by Foundation 63 (King & Said, 2024), which, within a biopsychosocial framework, advocates for a phased model of mental health, legal, social and physical health support for separated children. The primary area of constructive criticism provided by participants spoke to the facilities and physical environment. Some participants expressed in their qualitative responses that the accessibility to the building could be improved (due to steep stairs and narrow hallways) and that the reception area can be crowded and lack the privacy needed. Some participants also suggested expanding the community offer of activities and trips, for these to be more frequent and diverse and be tailored to different interests (for example, sport).

Strengths and limitations

The data presented provide a meaningful contribution to the existing literature, where research on the needs of UASC and URMs remains limited (Groark et al., 2011). The report uses rich mixed-methods data to capture the mental health difficulties and service experience of service users. The design employed aimed to reduce social desirability bias and increase psychological safety, with questionnaires relating to participants psychological wellbeing and service feedback component completed with researchers independent to the service, and ITQ survey completed with participant clinicians.

Although the data presented speaks to a relatively small sample size (n = 33), this represents approximately 42.86% of the services users of the Centre in 2024. Furthermore, only 3 of the 33 participants were female. However, in 2024 in the UK there were only 286 applications from female UASC compared to 3,818 males (Home Office, 2025), so the limited representation of female participants in the sample is in keeping with trends captured through government figures. Due to the limited sample size, the analysis employed quantitative descriptive comparisons, which limits any group differences and conclusions that can be made. A larger sample would enable more robust statistical analyses to identify significant differences. In addition, ethical considerations in recruitment and selection bias/non-participation bias may have led to an underreporting of mental health challenges and negative feedback within the sample. For example, service users for whom there were significant concerns about their wellbeing were not approached to take part. Furthermore, it might be that service users who are more psychologically well and who have a more positive service experience are more likely to participate. All findings must therefore be interpreted with some consideration to these factors.

Conclusions

The present report sheds light on the mental health and psychosocial challenges experienced by service users of the Centre and the variety of ways that the service works with and supports them. Participant accounts emphasise the importance of holistic and phased models of care for this vulnerable group, and the value of community building.

References

Asgary, R., & Segar, N. (2011). Barriers to health care access among refugee asylum seekers. *Journal of health care for the poor and underserved*, *22*(2), 506-522.

Bamford, J., Fletcher, M., & Leavey, G. (2021). Mental health outcomes of unaccompanied refugee minors: a rapid review of recent research. *Current psychiatry reports*, *23*, 1-11.

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E., & Spinhoven, P. (2007). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *The Journal of Nervous and Mental Disease*, *195*(4), 288-297.

Blackmore, R., Gray, K. M., Boyle, J. A., Fazel, M., Ranasinha, S., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). Systematic review and meta-analysis: the prevalence of mental illness in child and adolescent refugees and asylum seekers. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(6), 705-714.

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: a systematic literature review. *BMC international health and human rights*, *15*(1), 1-41.

Brown, A., Ford, T., Deighton, J., & Wolpert, M. (2014). Satisfaction in child and adolescent mental health services: translating users' feedback into measurement. *Administration and policy in mental health and mental health services research*, *41*, 434-446.

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical psychology review*, *75*, 101812.

Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., Karatzias, T., & Hyland, P. (2018). The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatrica Scandinavica*, *138*(6), 536-546.

Crowe, M., Inder, M., & Porter, R. (2015). Conducting qualitative research in mental health: Thematic and content analyses. *Australian & New Zealand Journal of Psychiatry*, *49*(7), 616-623.

Department for Education. (2023). *Children looked after in England including adoptions*. https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions#releaseHeadlines-summary

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing*, *62*(1), 107-115.

Fazel, M., Reed, R., & Stein, A. (2015). Refugee, asylum-seeking and internally displaced children and adolescents. *Rutter's child and adolescent psychiatry*, 573-585.

Franks, W., Gawn, N., & Bowden, G. (2007). Barriers to access to mental health services for migrant workers, refugees and asylum seekers. *Journal of Public Mental Health*, *6*(1), 33-41.

Gibbard, E., Brandling, J., & Harding, T. (2022). Best practice in the ethics and governance of service evaluation: Guidelines for evaluators and commissioners of evaluation in health and social care. England: National Institute for Health and Care Research Applied Research Collaboration West; 2017. In.

Goulter, N., Balanji, S., Davis, B. A., James, T., McIntyre, C. L., Smith, E., Thornton, E. M., Craig, S. G., & Moretti, M. M. (2023). Psychometric evaluation of the affect regulation checklist: Clinical and community samples, parent-reports and youth self-reports. *Journal of Research on Adolescence*, *33*(1), 344-360.

Groark, C., Sclare, I., & Raval, H. (2011). Understanding the experiences and emotional needs of unaccompanied asylum-seeking adolescents in the UK. *Clinical Child Psychology and Psychiatry*, *16*(3), 421-442.

Haselgruber, A., Sölva, K., & Lueger-Schuster, B. (2020). Validation of ICD-11 PTSD and complex PTSD in foster children using the International Trauma Questionnaire. *Acta Psychiatrica Scandinavica*, *141*(1), 60-73.

Höhne, E., Banaschewski, T., Bajbouj, M., Böge, K., Sukale, T., & Kamp-Becker, I. (2023). Prevalences of mental distress and its associated factors in unaccompanied refugee minors in Germany. *European child & adolescent psychiatry*, *32*(7), 1211-1217.

Home Office. (2023). *Immigration system statistics, year ending June 2023: Summary of latest statistics*. https://www.gov.uk/government/statistics/immigration-system-statistics-year-ending-march-2023/summary-of-latest-statistics

Home Office. (2025). *Immigration system statistics data tables: Asylum applications, initial decisions and resettlement detailed datasets, year ending December 2024*. https://www.gov.uk/government/statistical-data-sets/immigration-system-statistics-data-tables#asylum-applications-decisions-and-resettlement

Hyland, P., Shevlin, M., Brewin, C. R., Cloitre, M., Downes, A., Jumbe, S., Karatzias, T., Bisson, J. I., & Roberts, N. P. (2017). Validation of post-traumatic stress disorder (PTSD) and complex PTSD using the International Trauma Questionnaire. *Acta Psychiatrica Scandinavica*, *136*(3), 313-322.

Jannesari, S., Hatch, S., Prina, M., & Oram, S. (2020). Post-migration social–environmental factors associated with mental health problems among asylum seekers: A systematic review. *Journal of immigrant and minority health*, *22*, 1055-1064.

Jefferies, P., McGarrigle, L., & Ungar, M. (2019). The CYRM-R: A Rasch-validated revision of the child and youth resilience measure. *Journal of Evidence-Based Social Work*, *16*(1), 70-92.

Kien, C., Sommer, I., Faustmann, A., Gibson, L., Schneider, M., Krczal, E., Jank, R., Klerings, I., Szelag, M., & Kerschner, B. (2019). Prevalence of mental disorders in young refugees and asylum seekers in European Countries: a systematic review. *European child & adolescent psychiatry*, *28*, 1295-1310.

King, D., & Said, G. (2024). Practical recommendations for addressing the psychological needs of unaccompanied asylum-seeking children in England: a literature and service review. *Clinical Child Psychology and Psychiatry*, 13591045241252858.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, *16*(9), 606-613.

Lee, D. (2022). Using compassion focused therapy to work with complex PTSD. In *Compassion Focused Therapy* (pp. 565-583). Routledge.

McEwen, C., Alisic, E., & Jobson, L. (2022). Moderating role of moral injury in the mental health of adolescent refugees. *Journal of Clinical Psychology*, *78*(7), 1478-1490.

Mitra, R., & Hodes, M. (2019). Prevention of psychological distress and promotion of resilience amongst unaccompanied refugee minors in resettlement countries. *Child: care, health and development*, *45*(2), 198-215.

Moretti, M. M. (2003). Affect regulation checklist. *Unpublished measure and data. British Columbia, Canada: Simon Fraser University*.

Penney, S. R., & Moretti, M. M. (2010). The roles of affect dysregulation and deficient affect in youth violence. *Criminal Justice and Behavior*, *37*(6), 709-731.

Pollard, T., & Howard, N. (2021). Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. *International journal of mental health systems*, *15*(1), 60.

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *Jama*, *294*(5), 602-612.

Reed, R. V., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *The lancet*, *379*(9812), 250-265.

Resilience Research Centre. (2022). CYRM and ARM user manual. In (pp. 3–27). Halifax, NS: Resilience Research Centre, Dalhousie University.

Sanchez-Cao, E., Kramer, T., & Hodes, M. (2013). Psychological distress and mental health service contact of unaccompanied asylum-seeking children. *Child: care, health and development*, *39*(5), 651-659.

Sarkadi, A., Ådahl, K., Stenvall, E., Ssegonja, R., Batti, H., Gavra, P., Fängström, K., & Salari, R. (2018). Teaching recovery techniques: evaluation of a group intervention for unaccompanied refugee minors with symptoms of PTSD in Sweden. *European child & adolescent psychiatry*, *27*, 467-479.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine*, *166*(10), 1092-1097.

StataCorp. (2021). Stata Statistical Software: Release 17. In. College Station, TX: StataCorp LLC.

UK Parliament. (2023). *House of Commons library: Asylum statistics* https://commonslibrary.parliament.uk/research-briefings/sn01403/

UNHCR. (2023a). *Europe: GLOBAL REPORT 2022*. https://reporting.unhcr.org/europe

UNHCR. (2023b). *Refugee Statistics.* https://www.unhcr.org/refugee-statistics/

UNHCR. (2024). *Data and Statistics: Mid-Year Trends 2023*. https://www.unhcr.org/mid-year-trends

Urbański, P. K., Schroeder, K., Nadolska, A., & Wilski, M. (2023). Symptoms of depression and anxiety among Ukrainian children displaced to Poland following the outbreak of the Russo-Ukrainian war: Associations with coping strategies and resilience. *Applied Psychology: Health and Well-Being*.

Uysal, B., Yanik, M., Tastekne, F., Tuzgen, E., Altinisik, E., & Acarturk, C. (2022). Psychological problems and resilience among Syrian adolescents exposed to war. *European Journal of Trauma & Dissociation*, *6*(3), 100258.

Vervliet, M., Lammertyn, J., Broekaert, E., & Derluyn, I. (2014). Longitudinal follow-up of the mental health of unaccompanied refugee minors. *European child & adolescent psychiatry*, *23*, 337-346.

Yule, W., Dyregrov, A., Raundalen, M., & Smith, P. (2013). Children and war: the work of the Children and War Foundation. *European journal of psychotraumatology*, *4*(1), 18424.