Migration Yorkshire
supporting local migration services

Children and Families
Wellbeing Support

EVALUATION REPORT JULY 2020

THE CHILDREN AND FAMILIES WELLBEING PROJECT

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Children and Families Wellbeing Project

Foreword

Charlotte Cooke, Yorkshire and Humber Syrian Resettlement Project Manager, Migration Yorkshire

Yorkshire and Humber were unique in coming together as local authorities and forming a partnership agreement for the Syrian Resettlement Programme in 2016. Migration Yorkshire provides the project management and co-ordination for the partnership. This model has enabled us to have flexibility around arrivals, increasing the diversity of refugee cases that we can accept. It has helped local authorities that had no experience of supporting refugees to be part of the programme. Additionally, it has facilitated our strategic role in identifying issues associated with refugee resettlement and to commission apposite regional support.

While we have learnt a lot along the way, this model of sharing experiences of resettlement across different geographical areas has led to a recognition of gaps in provision. At the same time, it has given us the ability to come together and provide funds to commission services regionally. Working closely with voluntary sector partners who have refugee expertise has allowed us to have innovative and responsive solutions.

By 2017, we were beginning to pick up reports of individual children and schools struggling to cope. Sometimes this was children being seen as behaving badly or inappropriately and teachers unable to manage a child that simply couldn't cope with the structured school environment. We saw primary school children being referred to Prevent, other children being excluded or isolated. The pattern emerging pointed to traumatised children unable to 'fit in' with expectations of schools and of teachers being unable to provide the support these children needed. On the rare occasion where children were referred to mainstream services such as CAMHS, they often didn't meet the threshold, faced long waiting lists or the services just weren't appropriate.

In the majority of cases, we saw children settling into the school structure, thriving and the whole family benefitting from having a supportive safe environment. Where this was going wrong, it had the potential to destabilise integration for the family.

Having established that these weren't isolated incidents but a pattern emerging across the region, we decided to try and address the specific issue and began the Children and Families Wellbeing Project.

We were lucky to have very experienced specialist voluntary sector refugee mental health providers in our region already, in SOLACE, HAVEN and Refugee Council Therapeutic Services. We worked with them to look at how we might provide support wherever it was needed across the region, from a city like Sheffield, a rural town like Skipton, through to a seaside town such as Scarborough. We wanted to have a pilot project that could test out and adapt to need, whether that be with supporting the child, the whole family or the school – or a combination of all three.

While we've seen real impact from the project, which you'll discover reading this evaluation, we are still struggling to establish more long-term funding. It is truly heartening to hear a child, a parent or a teacher say what a difference this project has made. Alongside housing, access to benefits, ESOL and other standard support, my aim is to have this support as an integral part of the 'resettlement package' offered to all our families that need it, to help them to settle and thrive in Yorkshire and Humber.

Introduction

This report presents the findings of the evaluation of the Children and Families Wellbeing Project (hereafter referred to as the project). The project was established as a pilot by Migration Yorkshire in October 2018[1] as a way of addressing the mental health and wellbeing needs of refugee families who have been resettled in Yorkshire and Humber. Migration Yorkshire manage and coordinate the project and it has been delivered through a collaborative partnership with three voluntary sector organisations: Solace, the Refugee Council and Haven, hereafter referred to as the partners. Under the auspices of the project the partners have provided therapeutic support to the resettled refugee children and their families as well as training and other help for schools. The evaluation covered the work of the project for the period of October 2018 until the end of March 2020.

The independent evaluation of the project was commissioned by Migration Yorkshire and conducted by Scott-Flynn Consulting Limited between January 2019 and April 2020. The evaluation has drawn upon material gathered through the course of the project and feedback from 29 external and 27 internal stakeholders[2] who have provided their perspectives on the work. Additionally, 44 refugees shared, in evaluation interviews, their experiences of the support that they received from the project.

[1] The project technically began in the summer of 2018 but operational aspects, such as the provision of therapy, started later as the early months saw the partners and Migration Yorkshire establishing the infrastructure for the work. We use the operational date of October as the starting point.
[2] A list of internal and external stakeholders consulted is included in the appendices.

In the closing stages of the evaluation the Covid-19 pandemic happened and as a result some of the planned consultations with external stakeholders were not able to take place. More details about the project and the evaluation methodology are included within the report.

The evaluators would like to thank everyone who has contributed to the evaluation and we have sought to reflect their perspectives in these findings. It was inspiring to witness the dedication and skill demonstrated by everyone involved in delivering the project and we would echo the view of one stakeholder who said: *'The staff delivering the project are committed and dedicated and have improved the lives of all of those taking part.'*

We hope that the report does justice to the many achievements of this important work and that it will contribute to the development of good practice in refugee resettlement work.

Glossary

CFWP – The Children and Families Wellbeing Project – mostly referred to as the **project.**
Case studies – in the case studies, names, gender, nationalities, locations and other details have been adjusted to ensure anonymity. They are written from the perspective of the practitioners.
Caseworker – this is the resettlement integration caseworker that all resettled refugees are allocated under the resettlement scheme. They are referred to either as a resettlement caseworker, a refugee organisation caseworker or just as a caseworker. It is a different role from that of the therapists who are part of the project.
C**lient, service-user, refugee family or refugee** are used to refer to the refugees who have been supported by the project.
Family therapy – the branch of psychotherapy that works with families to nurture change and development in terms of systems of interaction between family members. More definitions of therapy are included in the appendices.
Migration Yorkshire is the Regional Strategic Migration Partnership and coordinates the resettlement schemes in Yorkshire and Humber and provides direct project management to the Children and Families Wellbeing project.
Partners - unless singled out, this covers Solace, the Refugee Council and Haven, the delivery partners for the project.
Practitioners – sometimes used to describe the therapists who delivered the therapy.
Quotes - the quotes from stakeholders, including the refugees who received support from the project, have been anonymised and are categorised as either: External stakeholder, School

stakeholder, Refugee, Refugee supported by the project, Refugee child supported by the project or Internal stakeholder. The quotes used are representative of the perspectives that were expressed in all the stakeholder feedback and are only a small fraction of the many that could have been used.

Region – refers to Yorkshire and Humber.

Resettlement schemes refers to the Syrian Vulnerable Persons Resettlement Scheme (SVPRS) and Vulnerable Children's Resettlement Scheme (VCRS). Sometimes the term refugee resettlement is used. In some cases, these are referred to as resettlement programmes rather than schemes. The terminology has changed over the last five years. Background information about the schemes can be found on the government website: https://www.gov.uk/government/publications/syrian-vulnerable-person-resettlement-programme-fact-sheet#history

Schools or school stakeholder – covers teachers and other roles within the educational system.

Syrian Refugee Resettlement Programme Team - a joint unit between the Home Office, DfID and the Ministry of Housing, Communities and Local Government.

Therapy – this is sometimes referred to as family therapy, trauma-related therapy or just therapy.

Wellbeing – unless otherwise specified this generic term of wellbeing covers a range of terminologies associated with wellbeing and mental health.

Young people / children – both terms are used to refer to refugee children under 19 years of age.

Executive Summary

'It is very important that everyone coming from our country should receive this support. Even if they think they are okay we all have things inside us after the war. All of them need the help [of the project] even though they might not know it.' (Refugee supported by the project)

The Children and Families Wellbeing Project has been successful in helping vulnerable refugees to resettle in Yorkshire and Humber. It has done so by providing therapy to the refugee families, supporting the schools that refugee children attend and engaging with the networks of organisations that are working with refugees in Yorkshire and Humber. The evidence gathered for the evaluation, such as clinical outcomes and feedback from schools and the refugees themselves, demonstrates that the project has been successful in:

- Enabling refugee children to better manage their feelings, to be more self-aware and resilient.
- Increasing the confidence of the refugees' parents and carers to understand and address their children's emotional and developmental needs.
- Improving the understanding of schools about the impact of forced migration on children and helping those schools to respond to that impact for the benefit of the child.
- Enhancing the knowledge amongst service-providers about support available to this client group and consequently improving referral pathways and targeting of appropriate help for clients.[3]

In the context of refugee resettlement in the UK the project is unique in its model of service delivery, funding and coordination. Migration Yorkshire used the expertise and geographical coverage of voluntary sector organisations to provide much-needed specialist support to refugees in a most effective way. Combined with the efficient use of funding and a strategically supportive role to local authorities and the Home Office, this pilot project has been an innovative success. The views about the project that were shared with the evaluators were overwhelmingly positive. These perspectives have, along with the few critical points made, informed the recommendations about the future of this work.

The main factors that contributed to the project achieving its outcomes include:

[3] These are the four outcomes the project set out to achieve.

- The needs of refugees that the project sought to address were understood by Migration Yorkshire and the partners because of their experience of working with this client group and their knowledge of the local context.
- The project was well-designed with clear outputs and outcomes established at the beginning.
- Offering family-based therapy that was both structured and flexible enough to respond to the variety of needs presented by the refugees.
- The project adopted a dual approach to supporting families: early interventions and crisis management. Both were needed in order to respond to the different ways and timelines that the families manifested the impact of trauma.
- Specialist interpreters being an integral part of the therapeutic process.
- Adopting a holistic approach to working with the refugees that recognised other factors impacting on their lives, such as housing. This approach involved good referral mechanisms to other sources of support, including those within the same organisation that was providing the therapy.
- The partners using different approaches to implement the project and then shared with each other the learning gained from the different styles. The pilot allowed for different approaches and increased the opportunities to learn and develop good practice.
- Adapting the activities as informed by the good practice identified in the learning gathered during the course of the project.
- Good communication between the partners, Migration Yorkshire and other providers, including schools.
- Complementing the work of other refugee support organisations and roles, including resettlement integration caseworkers within the partner organisations and other providers.
- Having the knowledge and local connections to be able to refer refugees to other sources of support for help with practical issues, such as housing.
- Having a joined-up approach across Yorkshire and Humber with a strategic overview held by Migration Yorkshire.
- The cost effective and strategic use of funding available for the project.
- Ensuring good geographical coverage of the service that was locally tailored (a place-based approach).
- The expertise and commitment of the staff and volunteers of the partner organisations delivering the project.

The staff were the most important factor in the success of the project and their pivotal role cannot be overstated - the specialised skills of the therapists and the schools liaison worker were fundamental to the work as were the other support roles within the partner organisations. The therapists used their expertise to create a safe and trusting environment. Within a professional framework they delivered therapy with flexibility and creativity in order to be appropriate to the varied needs of the individual families. There was an enormous appreciation expressed by the refugees for the support that they had received in this way.

'The therapy service is really amazing. It has helped us to work day-by-day with our dilemmas.' (Refugee)

'When I started the therapy, I felt very small. Now I feel grown up.' (Refugee child supported by the project)

'They [the project] helped with communication between the school, me and my family. They helped my son get back on track and helped him to understand what the school were wanting from him.' (Refugee supported by the project)

The expertise of the therapists and the impact that they achieved was also appreciated by schools who had referred children and families to the project.

'The understanding, expertise, skills and professionalism of the therapists and staff of the project all facilitate holistic work and sessions with the refugees [in which] they are able to discuss and unpick often deep-seated hidden trauma that may not be evident to those supporting clients in a more practical manner.' (External stakeholder)

'We have been given valuable insight and information to help us support a very vulnerable child. We have noticed that the child is becoming more settled and is able to access some learning.' (School stakeholder)

The project provided support to 103 refugee families[4], which included 221 children and as such supported almost a quarter of the all the families and children resettled in the region. The case studies, clinical outcomes and the direct feedback from the refugees show overwhelmingly that the impact of the project was positive, albeit with a recognition that there were still struggles that the refugees faced. Given the terrible experiences that the refugees had gone through before coming to the UK, it

[4] The number of people in a family ranged from single parent with one child to larger extended families including three generations.

would be naïve to think that all of their problems could all be somehow 'fixed' by therapy. However, it is clear that the project has helped nearly all of these families to progress with their lives in the UK. The quotes below are typical of the feedback from refugees describing the difference the project has made to their lives.

'At the beginning our children were shy and not engaged, but, the [therapy] sessions as a family helped them to talk. They became confident and free to talk about what was inside them.' (Refugee supported by the project)

'The support has been helpful to me and my family. Through talks and discussions with the therapist, the support enabled me to understand my children's needs and concerns. It [the support] has enhanced my self-confidence.' (Refugee supported by the project)

There was a positive impact on the work of the 49 schools that were supported by the project, through the provision of training to staff and therapy to children who had been referred by the school. It was not surprising that many schools struggled to cope with some of the needs presented by traumatised refugee children. In many instances schools had no awareness or experience of teaching refugee children and where schools did engage with the project, they found the specialised support enormously helpful.

'We see parents feeling more confident in their role as parents and the children being able to concentrate more in class.' (School stakeholder)

'The awareness-raising sessions in schools and collaborative working [of the project] with teachers works well in being able to address issues [with the refugee children] when they arise, as opposed to them remaining unaddressed and deteriorating. (School stakeholder)

There was unanimous agreement that there is a need for the services provided by the project and that the support offered by the partner organisations is valued enormously by external stakeholders (such as schools) and clients alike. There was a consensus amongst stakeholders that the vast majority, if not all, of this client group has very specific needs relating to their experiences as refugees compounded with additional vulnerabilities, such as health problems. The criteria[5] for refugees to be referred to the Vulnerable Persons Resettlement Scheme (VPRS) includes targeting people requiring

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730643/Resettlement_Policy_document_.pdf

urgent medical assistance, survivors of violence and torture, and women and children at risk. The project saw evidence of all of these elements amongst the refugees who have come to Yorkshire and Humber.

The project is addressing these needs using an effective service-delivery model that is enabling many refugee families to flourish in what can often seem like a bewildering and challenging environment. In doing so the project is also helping schools to provide education to this client group. Furthermore, the project is taking pressure off mainstream health providers by making timely interventions in the lives of these vulnerable clients - undoubtedly helping to avert the clients experiencing a health related crisis later. All of the fifty-six internal and external stakeholders consulted and the forty-four service users interviewed for the evaluation[6], believe that it will be 'very important' for other young refugees and their families to be able to get this type of help and support in future.

Although the project is not a solution for every problem that refugees face, for the vast majority of refugees supported it was clear that the project had achieved its aims of helping them to cope with the effects of the trauma and the refugee experience and to be better equipped to move on with their lives.

> *'I am much more confident and can do everything on my own. I have just started volunteering as a receptionist.' (Refugee)*

> *'My son was struggling at school. He was fighting and bullying. She [the family therapist] helped us to meet with teachers to talk about this and he is doing much better now.' (Refugee)*

The project cannot do it all on its own but it can go a long way to achieving the successful resettlement and integration of refugees who have an opportunity to rebuild their lives here after the horrors they have faced. It would be a waste to lose the momentum of the work and to not build upon the excellent services provided in the pilot and to use the learning and good practice captured by the partners. Ideally the model of the project should become part of the standard practice of supporting refugees coming to the UK on the resettlement programmes.

[6] The statistical Likert scale responses from service users were harder to calculate than those of other stakeholders as sometimes the interviews were done in the family group but, they reflect the positive responses given where recorded.

'I think the project is an absolute Godsend - without it our pupils and their family would still be living on a knife edge and living day to day. Now they are beginning to look to the future and are being more open and honest about their shared experiences – this would not have happened without the help the project provided.' (School stakeholder)

'I believe it would be essential that other refugee families had access to this service.' (External stakeholder)

'The project gave a voice to the refugee children coming to the resettle in Yorkshire and Humber.' (Internal stakeholder)

'We had stopped listening to each other as things had been very bad for us.' (Refugee)

'I really hope this partnership continues; it has been invaluable for some of the students and teachers.' (School stakeholder)

The following cases study is a good illustration of the work of the project.

Miriam (aged 14)

Background: Miriam is a 14 year old young woman who moved to the UK with her family one year ago. Her mother reported that Miriam has been refusing to go to school and that they often engage in arguments about it. Miriam's mother was also concerned that Miriam was making no progress in learning any English and that the school wasn't helping her sufficiently. The school learning manager reported that Miriam doesn't like studying, unlike her brother. Miriam speaks very little English and was placed in Year 10 at school, which is perceived as a critical stage in young people's further development. The school was hoping that Miriam would learn English by socialising with other young people, however Miriam's low confidence and shyness in addition to her basic English, meant that she isolated herself – and subsequently felt trapped in a vicious circle.

Action taken by the project and the difference made: The initial therapy sessions focused on providing space for the family to have fun together, as opposed to arguments. We also discussed Miriam's experiences in the education systems across different countries, which helped remove the guilt and blame with regards to her dislike of school. A school meeting was arranged with Miriam, her mother, the family therapist and the learning manager: this provided an opportunity for the school staff to appreciate Miriam's obstacles in learning. Miriam actively participated in the planning of her education going forward. Miriam's mother reported a change in Miriam's attitude about going to school. Their arguments around this have since minimised. Miriam also reported having made a friend

in school, which has enabled her participation in a number of activities. The school have arranged a follow up meeting in order to discuss any further difficulties and/or opportunities for Miriam. They have also arranged for Miriam and her mother to meet a staff member from their Career Advice service in order to discuss the different pathways available for her.

Recommendations

Overarching recommendations

- Building on the success of the pilot, continue with the project and embed it into the standard package of support that goes with resettlement.
- Increase the capacity of the project in order to be able to support more resettled refugees and for longer periods of time.
- Increase the resources available for the coordination of the project. Coordination was undertaken well by Migration Yorkshire and valued by the partners, but there was a considerable amount of work involved. The coordination function should be increased and may benefit from supporting one of the partner organisations to undertake some of the coordination tasks, such as organising practitioners' meetings.
- Develop a communications strategy for the project that includes a programme of raising the profile of the service to schools and other stakeholders. Broader audiences could be reached using events such as the Yorkshire Integration Festival. The strategy could also involve more awareness raising with local communities on refugees (similar to the work that Migration Yorkshire does already in this respect).
- Consider whether there are other ways to feed back to local authorities on progress of the work that would enhance their sense of ownership of the project. This could involve establishing a specific steering group or advisory board that includes representatives from education departments. Or, it could involve expanding the membership of the current project board to include a CCG or educational representative.
- Consider how the service could be offered to refugees with similar needs who have not come on the resettlement schemes. This could include allowing for a system of spot purchases for referrals to the service for non-resettlement cases.
- Develop an explicit good practice resource (on mental health and wellbeing) for organisations working in resettlement throughout the UK.
- Continue to integrate the project with the other work of Migration Yorkshire.

- Develop the capacity to train other health professionals to be better equipped to work with refugee clients. However, do so while acknowledging that mainstream health provision will struggle to provide bespoke services or respond to the mental health and wellbeing needs of refugees. There will always be a need for specialised support to be provided by voluntary sector organisations.
- Provide, as far as possible, more security for the funding of the project to militate against the detrimental effects of short-term funding on voluntary sector organisations, such as the difficulty of retaining staff.
- Organise a conference about working with refugee children in this context to share the learning from delivering the project.
- Use the evidence gained by the partners to inform advocacy on policy and practice at a regional and national level.

Service delivery recommendations relating to the therapy

- Make therapeutic interventions earlier in the resettlement process.
- Maintain the flexible approach to the way that the therapy is delivered but be clearer about some of the parameters of the role of the therapists, for example, the dividing line between therapy and resettlement casework.
- Ensure adequate capacity to build on the good practice of treating interpreters as an integral part of the therapy process.
- Develop a culturally appropriate clinical outcome assessment tool for this work building upon that which was devised by Solace during the course of the project. Additionally, develop a tool that does not take as long to complete as some of the current clinical assessment tools.
- Hold regular practitioners' skill-sharing meetings – every six months.
- Deliver an awareness raising session on the service to new refugee families in order to give them a clear idea about the service and dispel any distorted ideas that they may have about mental health services.
- Have a check-in appointment with clients six months after the support provided by the project had ended.

Recommendations relating to the work with schools

- Have school liaison or link worker roles as part of the project in order to enhance the relationship with schools. This would enhance the flow of information between the schools, Migration Yorkshire and the project.

- Establish better protocols for communication and the sharing of information between schools and the project. This could include appropriate mechanisms to feedback to schools on the progress of therapeutic interventions, without jeopardising client confidentiality.
- Encourage schools to have a policy on working with refugee children, either as a standalone policy or as a section of their Special Educational Needs (SEN) policy. This could include a recommendation that school staff receive refugee-awareness training and where they could find further support for refugee children.
- Develop a resource for school staff to better equip them to understand wellbeing issues affecting refugee children and how to address them. Brand this with the project identity and share with other organisations working with resettlement. Similarly, slightly repackage the current training offered by the partners to emphasise the link with the project.
- Book training for schools well in advance as the training offered by the project is competing with others who are offering training to teachers on a variety of topics – they only have so much time to spare.
- Consider holding a regional or sub-regional training event for several schools at the same time, rather than individually. This would ideally take place on one of the multi-school INSET day training sessions which many LEAs arrange during each academic year, so would need to be organised well in advance.

Other recommendations

- Involve refugees and refugee communities in developing the project. For example, providing peer support, conducting awareness-raising, attending the project board and delivering training to other organisations.
- Hold a multi-agency meeting on the commencement of placement or referral for therapy.
- Deliver parenting skills sessions for new refugees and consider combining these with ESOL provision.
- Run more therapeutic support groups for specific groups within the cohort, such as men or single parents.
- Connect more actively with other agencies working in local schools and in the community, for example, Barca in Leeds.

The following sections provide more detail about the project and the learning gained from its implementation.

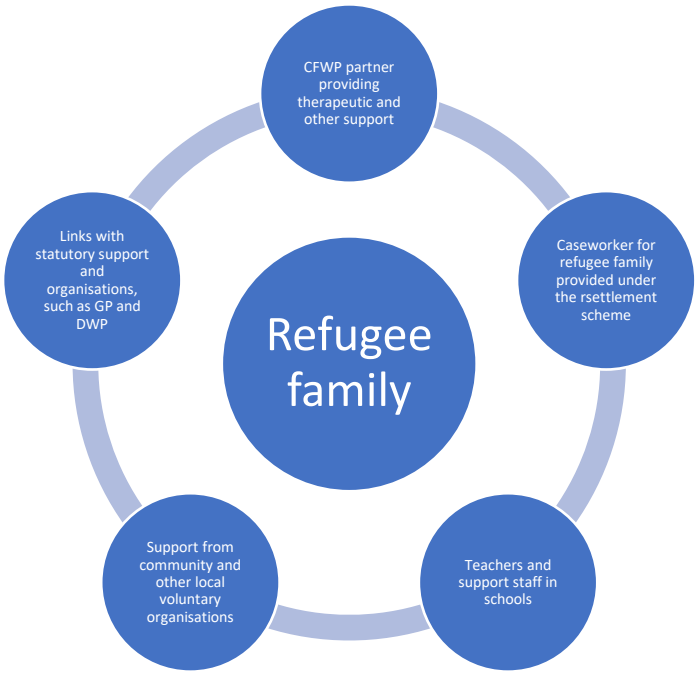
Description of the project

Under the auspices of the project the partners each provided specialised trauma-related family therapy for refugees who had been resettled in Yorkshire and Humber. They also provided support to the schools that refugee children attended. Each partner had a geographical focus: Solace worked mainly in North and West Yorkshire covering approximately 60% of the caseload, Refugee Council in South Yorkshire with 20% of the caseload, and Haven in the Humber Region with the remaining 20%. The partners also provided other services to refugees and asylum seekers outside the remit of the project.

The specialist provision of the project supplemented the casework support that is provided to refugees through the resettlement scheme. That casework involves each resettled family (or individual if arriving on their own) being assigned a named caseworker by the Refugee Council (the sub-contracted organisation)[7] in the majority of local authority areas. The caseworker assists the family with initial reception, social orientation, advice, signposting to other services and other help. This casework support aims to increase the independence of the refugee and does not include specific mental health and wellbeing support, although it does include referral to support for those needs where possible. Also, the casework support tends to be front-loaded into the early stages of a refugee's arrival in the UK and, as the project found, many of the mental health and wellbeing needs of the refugees do not manifest themselves fully until the person has been in the country for some time.

Amongst the partners, the Refugee Council provided this casework along with the wellbeing support of the project. Solace and Haven provided the wellbeing support only as part of the project and referred to other organisations (often the Refugee Council) for the casework support.

[7] Bradford City Council, North and North East Lincolnshire, Calderdale and Kirklees have a slightly different model of resettlement casework provision to that of other local authorities in Yorkshire and Humber.



The work of the project was coordinated by Migration Yorkshire to whom the partners reported every quarter and was overseen by a project board that met every three months (see the governance section below).

The Impact of the project – the outcomes

The impact of the project is described below in relation to the four outcomes that the work of the partners sought to achieve. It is illustrated with feedback from the stakeholders, service users and the use of case studies. During the evaluation, stakeholders were asked to assess the impact of the project's work in relation to the four outcomes.

Children are better able to manage their feelings and are more resilient and self-aware (Outcome one)

The evidence from the clinical measures[8] that the partners used to record their therapeutic work demonstrate that this outcome was achieved with the majority of clients who received therapy. For example, 75% of the clients Solace worked with attained improvement in the clinical measures.[9] The indications of the success of this outcome included the children showing an ability to:

[8] For example, YP-Core – see section on recording and monitoring for more details.
[9] Internal Solace report on the work of the project, April 2020.

- manage difficult feelings and behaviour safely
- form positive relationships
- engage constructively with everyday routines and setbacks
- express own needs and aspirations

In addition to the clinical measures, narrative assessments by the practitioners along with feedback from the refugees and the schools confirm that significant progress was made with each child the project supported. Ninety-five per cent of the stakeholders who contributed to the evaluation 'strongly agreed' or 'agreed' that CFWP support helps children to be better able to manage their feelings and to be more resilient and self-aware. (Three external stakeholders 'didn't know' or did not comment on this aspect).

Parents/Carers are more confident to meet their children's emotional health and development needs in new socio-cultural context (Outcome two)

The project placed great emphasis on the importance of working with the family and not just the child, although the initial referral for support was often of the latter. It was more complicated to measure this outcome with the assessment tools originally used but, there is evidence to show that the majority of parents and carers experienced positive changes in their ability to parent as a result of the support of the project. Manifestations of this included the ability of the parent to:

- recognise signs of trauma/distress in child
- respond sensitively and appropriately
- ask for help from relevant services
- recognise and manage their own emotional needs

This is backed-up by feedback from the refugees and narrative assessments by the practitioners along with feedback from the refugees, the schools and other stakeholders. Ninety-one per cent of the stakeholders who contributed to the evaluation 'strongly agreed' or 'agreed' that CFWP support helps parents to be more confident to meet their children's emotional health and development needs in a new socio-cultural context. (Five external stakeholders 'didn't know' or did not comment on this aspect).

Although the project made a positive impact on the lives of the children and their families in respect to the two outcomes above, the partners also recognised the limitations of their work given the many challenges their clients face. As one partner put it:

> *'Not all of these [problems] can be resolved by therapy, and as a result a key theme of our work has been exploring what our role really is.' (Internal stakeholder)*

The refugees' perspective on first two outcomes

Service users were asked (43 service users were interviewed for the evaluation) a set of questions to provide further indications of the impact of the project. The questions and the percentage responses were as follows.[10]

- Over 90% either 'strongly agreed' or 'agreed' that the support of the project had helped them or their children to manage or cope with difficult feelings and experiences.
- Over 90% either 'strongly agreed' or 'agreed' that the support of the project had helped them or their children to make positive relationships with other people, such as friends, family, schoolteachers, other pupils.
- Over 85% either 'strongly agreed' or 'agreed' that the support of the project had helped them or their children to cope with daily routines and deal with problems that arise.
- Over 90% either 'strongly agreed' or 'agreed' that the support of the project had helped them or their children to let other people know what it was that they needed or wanted to do or to achieve.
- Over 95% of parents said that the support of the project had helped them to recognise signs of trauma and distress in their children.
- Over 90% of parents said that the support of the project had helped them to recognise and manage their own emotional needs better.
- Over 90% of parents said that the support of the project had helped them to ask for help from relevant services.

[10] The statistical Likert scale responses from service users were harder to calculate than those of other stakeholders as sometimes the interviews were done in the family group but, they reflect the positive responses given where recorded.

Schools have improved understanding of, and response to, the impact of forced migration on children and families (Outcome three)

In total 49 schools were supported by the project, by a mixture of training, being able to refer children for therapy and in receiving advice and support about working with refugee children. Overall, the schools that had engaged with the project were very appreciative of the support they had received.

The majority of school stakeholders who contributed to the evaluation felt that this outcome had largely been achieved. Eighty-six per cent 'strongly agreed' or 'agreed' that the project support helps schools to have an improved understanding of, and response to, the impact of forced migration on children and families. (Eight external stakeholders 'didn't know' or did not comment on this aspect).

Partners and stakeholders benefit from clearer referral and communication pathways (Outcome four)

Referral pathways and communication between the partners was enhanced by working together on the project. Similarly, links within organisations worked well and more contacts were made with other organisations who could provide support to clients or have clients referred to them.

The majority of stakeholders who contributed to the evaluation felt that this outcome had been achieved. Eighty-two per cent 'strongly agreed' or 'agreed' that the project support helped partners and stakeholders to benefit from clearer referral and communication pathways. (One external stakeholder disagreed and nine external stakeholders 'didn't know' or did not comment on this aspect).

There was an appetite to build upon this aspect of the project and as with the schools outcome it was felt that there is scope to enhance this element of the project.

The numbers of children and families supported – the outputs of the project

The table below shows the numbers of families and children that the project provided direct support to in the form of therapy. The therapeutic element of the project was provided for different lengths of time depending on the needs of the refugee and the practice of the partner organisation. For example, the Refugee Council worked from a model that provided therapy for an average of twelve sessions for a client, although they did provide more sessions for some families whose needs were particularly complex. The Solace model tended to have a greater variation between clients in the number of sessions that they provided. Whatever their basic model, all of the partners exercised

flexibility in the timeframes as the therapists responded appropriately to differing levels of need amongst the client group. In addition to the distinct therapy offered to children and families, some group therapy has also been conducted as part of project.

The numbers of refugees supported by the project from October 2018 to 31 March 2020 broken down by local authority		
Local authority	**Families**[11]	**Children**
Sheffield	21	40
Rotherham	2	4
Doncaster	3	12
Barnsley	2	5
North Lincolnshire	8	22
North East Lincolnshire	0	0
Hull	8	19
East Riding of Yorkshire	7	20
Scarborough	1	4
Calderdale	1	4
Kirklees	6	10
Leeds	19	46
North Yorkshire (Excluding Scarborough)	7	8
Wakefield	12	19
York	0	0
Bradford	6	8
Total	**103**	**221**

The shadings are to differentiate between which partner organisation provided the service.

The project is continuing to provide a service after 31 March 2020 to some of the people covered by the figures above.

[11] All of the work done with children is with those in families, including single parent families. As such, the benefits of the project apply to all the members of the family, even if only directed at one or two people in it.

Refugee families resettled in Yorkshire and Humber (excluding Bradford) under the resettlement schemes (covers families or households that include children aged between 4 and 19 years old) as at 31 March 2020		
Local authority	**Family unit**	**Children**
Barnsley	3	6
Calderdale	15	34
Doncaster	6	16
East Riding of Yorkshire	32	77
Hull	26	62
Kirklees	33	76
Leeds	72	187
North East Lincolnshire	7	16
North Lincolnshire	10	26
North Yorkshire[12]	43	108
Rotherham	4	10
Sheffield	69	156
Wakefield	28	66
York	17	40
Total	**365**	**880**

The number of schools and other organisations supported

Forty-nine schools and thirty other organisations working with resettled refugees, such as housing providers, received support from the project. The support included the provision of training and awareness-raising sessions with staff and teachers. More schools were approached by the partners but have not taken-up the offer of the support that the project provides.

Context of the work of the project

The resettlement programmes - Vulnerable Persons Resettlement Scheme (VPRS) and the Vulnerable Children's Resettlement Scheme (VCRS) - were launched by the UK government in 2015 and 2016 respectively to provide sanctuary to vulnerable refugees fleeing the conflict in Syria and to other refugees in the Middle East and North Africa (MENA) region. VPRS and VCRS resettles those identified as in greatest need, including people requiring urgent medical treatment, survivors of violence and torture, and women and children at risk. The National Audit Office found that approximately two

[12] The North Yorkshire figures are a consolidation of the numbers in Craven, Hambleton, Harrogate, Richmondshire, Ryedale, Scarborough and Selby.

thirds of the refugees who arrived under the VPRS before September 2016 were resettled under the 'survivor of violence and torture' or on specific medical needs grounds.[13]

As the Regional Strategic Migration Partnership, Migration Yorkshire coordinates the resettlement schemes in the Yorkshire and Humber region. Fourteen local authorities signed-up to the Resettlement Partnership: Barnsley, Calderdale, Doncaster, East Riding, Hull, Kirklees, Leeds, North East Lincolnshire, North Lincolnshire, North Yorkshire, Rotherham, Sheffield, Wakefield and York. As at 31 March 2020, 365 refugee families with children between 4-19 years of age[14] have been resettled in this partnership arrangement.[15] These families include 880 children between 4 and 19-years of age.[16]

Working with local authorities, the Migration Partnership identified a number of issues affecting resettled refugees coming to the region on the schemes. These included the impact of complex trauma on refugee children who had been exposed to a range of factors associated with war, including family separation, death, loss of home, complex and exacerbated health issues, the stress of flight, being victims of torture, experiencing relocation and resettlement in unfamiliar environments. The resultant impact on children's emotional health resulted in strained family relationships, poor school attendance and behaviour and failure to fully integrate. Those schools which had little or no experience of providing support strategies for children resettled from areas of conflict, struggled to understand and respond appropriately.

Additionally, Migration Yorkshire and partners have found that while there is funding to cover health costs within the CCG Tariff[17], the capacity of NHS services to support refugee families with complex psycho-social and mental health needs, both those that are known and those that are likely to emerge, is limited. This was further evidenced by the number of critical incident reports that Migration Yorkshire was receiving about children and families who had arrived on the resettlement scheme. It

[13] The National Audit Office report - The Syrian Vulnerable Persons Resettlement Programme, September 2016. https://www.nao.org.uk/wp-content/uploads/2016/09/The-Syrian-Vulnerable-Persons-Resettlement-programme.pdf

[14] These numbers do not include anyone who arrived but then moved out of the region during the period, but it does include everyone who moved into the region during the period.

[15] Bradford is covered by the Children and Families Wellbeing project but is not part of the regional Resettlement Partnership that is managed by Migration Yorkshire.

[16] Another government scheme, the Gateway Protection Programme (GPP), also resettles refugees in Yorkshire and Humber.

[17] The funding provided by central government to support the resettlement of refugees is referred to as the Tariff and is calculated per refugee.

was clear that further support was needed, for the refugees, the schools and other bodies working with this client group.

Consequently, Migration Yorkshire established the project as a way of addressing some of the challenges that resettled refugees face in the above context. It was seen as a way of complementing the casework support provided to refugees through the resettlement scheme (this is covered further in the description of the project section below).

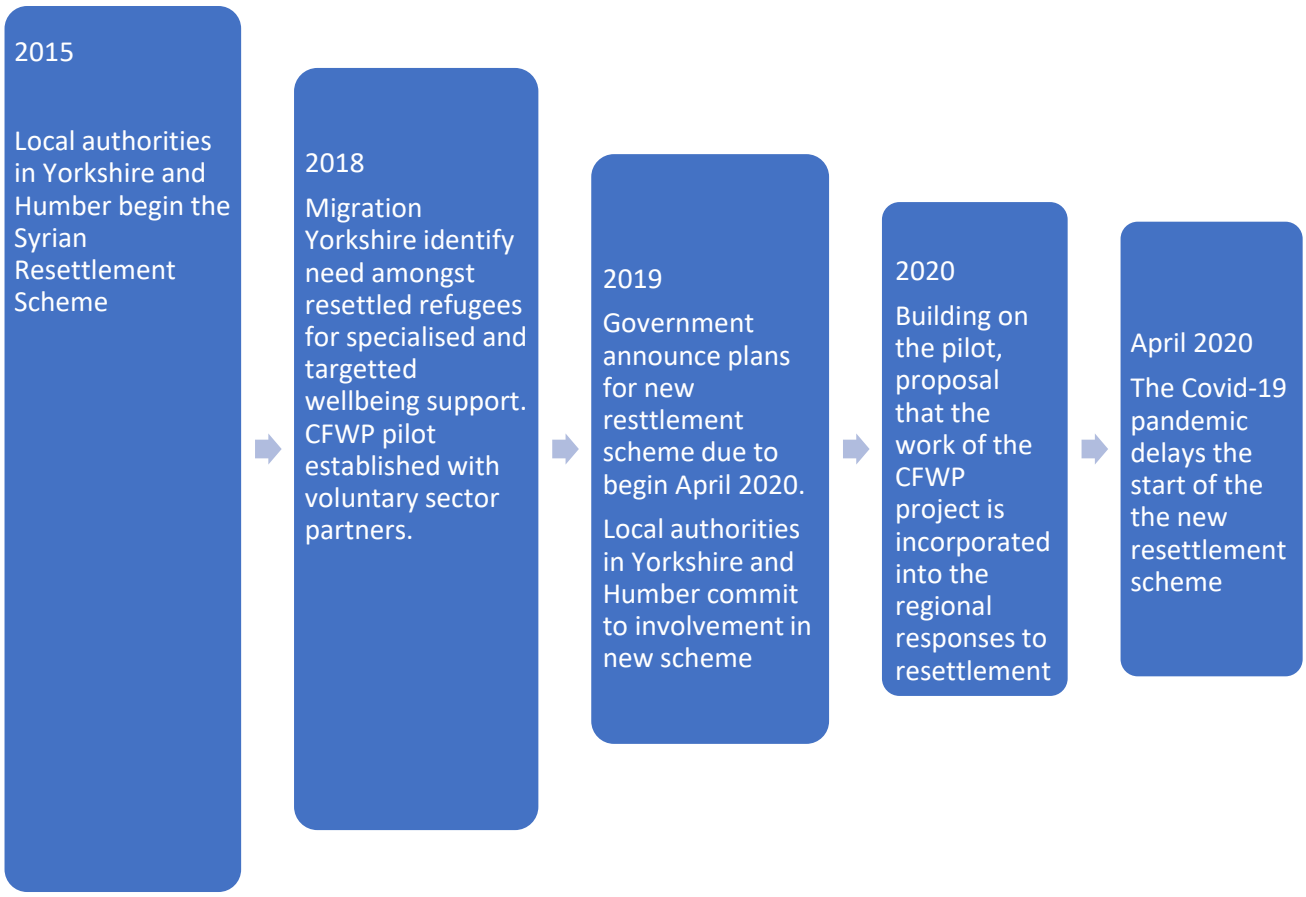
The future of resettlement

In 2019 the government reviewed the refugee resettlement schemes and as a result it is committed to continuing with refugee resettlement beyond the lifetime of the VPRS and VCRS – originally the end of March 2020. The plan is to combine all of the resettlement schemes into one programme that will operate along similar lines to the current schemes. As such it is envisaged that refugee resettlement will continue in Yorkshire and Humber. Accordingly, the needs which the project seeks to address will continue to manifest themselves in the refugees who will come to the region.

The current schemes have been completed in Yorkshire and Humber[18] but, the Covid-19 pandemic has caused a delay in the implementation of the new scheme. At the time of writing this report Migration Yorkshire and the local authorities are planning for refugee resettlement arrivals but, these are suspended until September 2020 at the earliest because of the pandemic. In the meantime, any continuing therapeutic support to refugees that is being provided by the project is being done so remotely.[19]

[18] The target to resettle 20,000 refugees under the VPRS by the end of March 2020 was about to be achieved when the Covid-19 pandemic occurred and arrivals were suspended. At that point 19,768 refugees had been resettled in the country. While some local authorities elsewhere in the UK had not fulfilled the quotas that they had committed to at the onset of the schemes, Yorkshire and Humber reached their quota before this deadline. The latest figures on resettlement and other immigration statistics can be found on the government website at: https://www.gov.uk/government/publications/immigration-statistics-year-ending-march-2020/summary-of-latest-statistics

[19] An experience of providing therapy for refugees remotely can be found on the blog of the Jude Boyles, the Project Manager of the Resettlement Therapeutic Services at the Refugee Council: https://www.pesi.co.uk/Blog/2020/April/Virtual-Therapy-With-Resettled-Syrian-Refugees



Other refugees and asylum seekers in the region

There are also refugees and asylum seekers who have come to the Yorkshire and Humber region through the asylum system. The relevance of this to the project is that many of the refugees who come through the asylum route also have mental health and wellbeing needs as they have suffered similar experiences to the resettled refugees. Although the majority of refugees who come through the asylum system are adults and single, there are children who come either as part of a family or unaccompanied. Several stakeholders, including schools, highlighted the wellbeing needs of these children and families. They recommended that wellbeing support should be available for them also.

Currently there are 6,007 dispersed asylum seekers in Yorkshire and Humber who receive support through the asylum system.[20]

Indicators of integration

The government have developed a framework of Indicators of Integration to help inform how local government and others work with refugees and migrants. The framework stresses the importance of refugees and migrants having good 'self-rated health and wellbeing'[21]. Several of the indicators relate to there being access to mental health support, including being able to be 'seen by therapists for trauma-informed care provided by voluntary, community and social (VCS) organisations.' [22] The project is an excellent example of supporting integration within the terms of the Indicators of Integration.

The need for the project

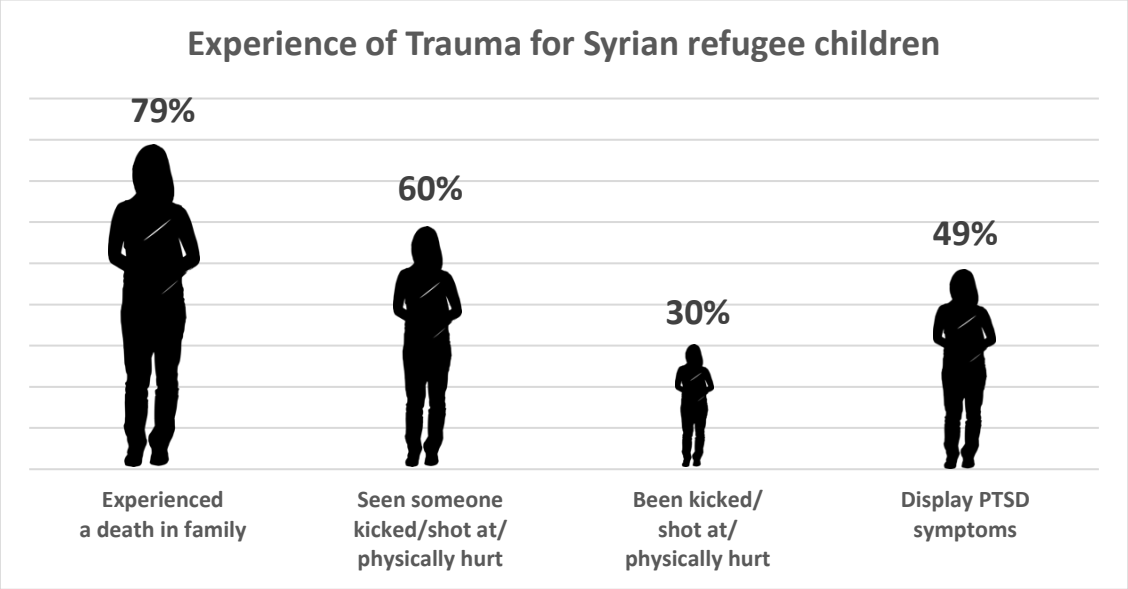
There is an appreciation that this client group has very specific needs relating to their experiences as refugees coupled with additional vulnerabilities, such as health problems. There is a vast amount of evidence and research that confirms the negative impact on mental health and wellbeing of the refugee experience, [23] some extracts are below.

> *'Children and adolescents, who account for most of the world's refugees, have an increased prevalence of psychological disorders.'*[24]

> *'Syrian refugee children are at risk for a range of mental health issues, having experienced very high levels of trauma: 79% had experienced a death in the family; 60% had seen someone get kicked, shot at, or physically hurt; and 30 % had themselves been*

[20] The latest figures including a break down by local authority can be found on the government website: https://www.gov.uk/government/statistical-data-sets/immigration-statistics-data-tables-year-ending-december-2019
[21] Home Office Indicators of Integration Framework 2019 available from the government website: https://www.gov.uk/government/publications/home-office-indicators-of-integration-framework-2019
[22] Home Office Indicators of Integration Framework 2019
[23] Other references to relevant research are included in the list of background document in the appendices, for example the material produced by the Centres for Disease Control and Prevention: https://www.cdc.gov/immigrantrefugeehealth/profiles/syrian/health-information/mental-health/index.html
[24] Lancet article published 2018 - https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30051-3/fulltext

kicked, shot at, or physically hurt. Almost half displayed symptoms of post-traumatic stress disorder (PTSD) — ten times the prevalence among children around the world.'[25]



Research carried out by the University of Oxford in 2018 found that people who came to the UK as refugees or to seek asylum have worse health outcomes than other migrants or the host population.[26] These research findings were attested to by the partners and other stakeholders who had witnessed the manifestation of PTSD amongst the refugees who had come to Yorkshire and Humber.

Many of the refugees who have been supported by the project had, before their arrival in the UK, experienced torture, witnessed the killing of family members, suffered bereavement, child abuse, rape, other sexual abuse or physical assault. The impact of these experiences was often compounded by a range of health problems, some of which are chronic.[27] Troublingly, the partners and other stakeholders also saw evidence that the refugees were experiencing further trauma by challenges they faced in the UK, including racism and bullying.

Other issues or challenges that the refugees faced or presented with once in the UK included:

[25] Migration Policy Institute report 2015 - https://www.migrationpolicy.org/research/educational-and-mental-health-needs-syrian-refugee-children
[26] https://migrationobservatory.ox.ac.uk/resources/briefings/the-health-of-migrants-in-the-uk/

[27] The criteria for a person to be referred to the resettlement schemes includes a range of health vulnerabilities.

- Couples and families facing reunification after extended periods of separation.
- Couples faced with the need to separate, but not knowing how to.
- Complex and dysfunctional family relationships.
- Domestic violence.
- Isolation.
- Language barriers, faced unevenly, but resulting in isolation, lack of self-worth, frustration, bullying at school and underachievement.
- Lack of knowledge, understanding and support from schools and colleges.
- Uneven and inadequate English language provision for adults and ESOL provision in schools/colleges.
- Loss of extended family and fragmented communities resulting in isolation and marginalisation.
- Poverty, poor housing and budgeting difficulties, especially for larger, less literate families.
- Re-employment difficulties and pressure from benefit agencies to find work with inadequate English.
- Being illiterate in their own language or having learning difficulties.

Some of the issues that are presented by resettled refugees in Yorkshire and Humber included the following (some are presented only by adult refugees):

- Symptoms of PTSD; intrusions associated with traumatic events (dissociative reactions, nightmares).
- Describing previous suicide attempts.
- A persistent negative emotional state with marked alterations in arousal (anger outbursts, crying and sleeping difficulties).
- Persistent negative beliefs and expectations.
- Avoidance (feeling detached, avoiding reminders of traumas).
- Anxiety, panic attacks.
- Disruptive behaviour in school.
- Aggressive behaviour towards family members.
- Inappropriate sexualised behaviour.
- A struggle to learn English due to the impairment of short-term memory loss, which is common in cases where people have been traumatised and/or tortured, particularly over extended periods of time.

- Finding it difficult to cope with the normal demands of family but being quickly left behind by their children who adapt to their new environment more quickly if they are in school and making new friends.
- Despite support from a caseworker, some refugees find it difficult to deal with providers and access services if they cannot speak the language or are suffering from PTSD.

Alongside refugee-related issues, clients also had a range of needs that were not directly connected to their refugee experience, such as being illiterate in their own language. Additionally, some of the experiences the refugees faced in Yorkshire and Humber, such as racism, created new trauma and impacted very negatively on their ability to resettle and on the efficacy of therapy.

Not every resettled family displayed these symptoms or faced the same challenges. In the judgement of some of the stakeholders, they estimated that 75% of resettled refugees would benefit from the support of the project, though some stakeholders felt that all of the resettled families could benefit from the project:

> *'Ideally, I would like all the families to engage with the service – I think it would benefit all of the families that I see coming through the resettlement scheme.' (External stakeholder)*

Most of the support provided to resettled refugees under the Resettlement schemes tends to be front-end loaded and tapers down after the refugee has been in the UK a year. Sadly, many of the mental health needs of the client group do not manifest themselves in the early days of their arrival in Yorkshire and Humber – sometimes it can take years for the need to become apparent. The refugees often need to have been here for some time to feel confident and safe enough to seek support.

In terms of addressing these needs, there are very few, if any, other providers that the client group can be referred to for the type of services offered by the project. There is also very little coordination amongst other providers or someone who has a holistic overview of the client's needs. Consequently, it is hard for clients to have their needs met in other ways. For example, in most areas there are long waiting lists for referral of children to Child and Adolescent Mental Health Services (CAMHS) and often the services offered by CAMHS are not flexible enough to adequately address the needs of these children.

Refugees who are not on the resettlement schemes

Refugee families who have come to Yorkshire and Humber by routes other than the resettlement schemes, for example though the asylum dispersal process, have similar needs to resettled refugees in respect of the service that the project provides. As such they would also benefit from having access to mental health and wellbeing support. Many stakeholders felt that the support of the project should be available to all refugees, regardless of how they came to the region.

The therapeutic interventions

> *'It was important that we were flexible in our approach to the therapy, while remaining within the professional norms.'*
>
> *'Family therapy for refugee families can look quite different from therapy with non-refugee families.'*
>
> *'I sometimes felt constrained in what I could achieve with the therapy as there were other factors impinging on the refugee that got in the way. Also, there were limitations in the amount of time I had to work with people - I could have used more [time].'*

Therapeutic support to refugee children and their families was the core work of the project. Although the partners used different approaches in delivering therapeutic interventions, they were all successful in achieving positive outcomes for the refugees that they supported. The different approaches also provided fertile ground for learning and identifying good practice, something that the partners did throughout, adapting their services appropriately as they learnt what worked well and what did not. The overarching approach of all the partners in relation to the therapy was to support the refugees in a holistic way and to exercise appropriate flexibility in order to ensure individual needs could be catered for.

There was a wide range of types of therapeutic support offered by the partners, reflecting the skills and training backgrounds of the therapists. The approach was multi modal and included the following types: systemic and relational, psychodynamic and person-centred, behavioural and psychoeducational, play therapy and trauma informed therapy, including EMDR. There was an integrative holistic approach operating within a stated systemic frame and distinctions were made between family therapy and family work, as well as individual and child focussed work. There were

also distinctions between psychosocial support groups and psychotherapeutic support groups.[28] For example, the men's group (described elsewhere in the report) falls into the first category, and the school groups were in one case psychosocial support groups and in another psychotherapeutic.

Therapeutic support using all of these approaches[29] was provided to families, individual adults, children and groups of clients. The main points to make are, that between them, the partners offered a wide range and rich array of therapeutic interventions that were appropriate to the needs of the clients. The variety of approaches and skills of the therapists were a key strength of the project and the most notable factor contributing to its success.

Some of the experiences and the learning captured by the partners in delivering the therapy include the following.

- Key to the successful methods used by the project was the ability to work with the whole family – if the family is more functional then the children tend to be more able to improve their wellbeing, participate in school and get on with their education. Correspondingly, when the children are functioning well as a result of the therapeutic support of the project then the parents' mental health and wellbeing improves.
- It is important to be able to respond flexibly to the needs of the client group. Every family is different and what works with some clients has to be adapted in order to work for others. For example, some families require a longer period of therapeutic support and don't fit into the framework of having a fixed number of sessions of therapy. Similarly, some families respond to art therapy, others prefer a more formal approach, and some children would rather have support on an ad-hoc basis rather than in regular sessions.
- The timing of therapeutic intervention is key. For most clients early therapeutic interventions are most efficacious and help prevent problems reaching crisis points, such as school exclusions and medical emergencies. However, some clients do not recognise or request help with their traumatic experiences until they have been here for some time. They need to feel safe and secure enough and to have built up trust with the therapist before they open-up. Consequently, the project needed to have the capacity and capability to work with refugees at different points in their time in the region. Therapeutic interventions were made at crisis points and as early interventions prior to a crisis arising - both had value and should be on offer in a future project.

[28] Examples of the play therapy and group work with children are included in the section on supporting schools.
[29] Basic descriptions of some of the types of therapy are included in the appendices.

- A western approach to mental health and wellbeing is not always understood or shared by refugees. However, this is not a simplistic issue as many refugees are familiar with the concepts of therapy and mental health needs. It is a more complicated matter, for example, where refugee men are reluctant to acknowledge that they have a mental health or wellbeing problem as they perceive it as a weakness. In some cases, refugees (often the male members of the family) feel shame in talking to someone outside of the family about their problems.

'It was my husband and son who have had the most problems being here.' (Refugee)

- The therapists understood that there is a link between mental health and other needs, such as access to support in obtaining employment. Accordingly, the therapists adopted an approach that sought to address the holistic needs of the client group. This involved working with and referring refugees to resettlement caseworkers and other providers who could help clients to address non-therapeutic needs. Such an approach was essential if the therapy was to achieve the outcomes sought. Some challenges identified in this respect were the intractability of some of their practical problems, such as poor housing.
- The therapy could be about strengthening relationships within the family, less than directly addressing trauma. 'We have also been responsive and flexible and, whilst not a crisis service, we have responded to crises.' (Internal stakeholder)
- Families who are well educated seemed to be doing better and being more resourced are more likely to respond well to therapy, and the children thrive in schools.
- There is a negative impact on some families of their experiences in the UK. These experiences also negatively impact on the therapy.
- The geographical scope of the project is very large which has resource implications for the partners and clients - there is a lot of ground to cover meaning less time to provide the therapy.
- Refugee teenagers were of particular concern to the therapists as they faced some challenges to adjusting to being in the UK that were less prominent for younger children.
- Most parents were trying to come to terms with the loss of their 'normal' way of life, the changes in personal ties and the struggle to construct new social networks. This had a direct bearing on their wellbeing.
- The role of interpreters who worked with the therapists was key. It was important that they were trained in and familiar with the needs of the client group and the context of therapeutic work. It was also important for the interpreters to be an intrinsic part of the therapeutic team – being so was shown to have enormous benefits for the clients and the delivery of the service. Using the same interpreter throughout the course of therapy with a family had the advantage of providing

consistency, but it was sometimes not possible to arrange and there was some ambiguity amongst partners about how desirable it was to use the same interpreter each time.

- The support of the project, its dependability and regularity has offered families a rare sense of consistency and an opportunity to trust.
- The location where the therapy was delivered in some instances varied between partners. One partner offered home visits as well as in office-based locations, this flexibility partly being a response to difficulties some clients had in travelling long distances to the partner's offices. Another partner did not provide therapy in the homes of refugees but used only office or school-based locations. All of the partners provided therapeutic interventions within schools.
- The partners were open to exploring new ways of delivering the therapy, for example providing therapy in the client's home as opposed to an office. These methods have been expanded to adapt to the Covid-19 pandemic, with all of the therapy now happening remotely. One method was not necessarily better than another; they had different consequences, such as the need to devise remote working protocols, but the commonality was that they sought to provide the service in a way that was most accessible to the refugees.
- It was important that therapists had access to their own support as they were hearing some very difficult disclosures from the clients. This support took the form of professional supervision.
- Although the project focussed on providing family therapy, there was enough flexibility to provide individual one-to-one sessions and larger group therapy when appropriate (see example below). However, the partners felt that the main value of the project was in being able to conduct family therapy, even if the route into that was initially through supporting the child.

'The therapeutic work started off mostly with children and through them more of the work shifted to being with the family [including the child].' (Internal stakeholder)

'It is not always clear who the client is. Often it is the child who is referred, but it is the family that needs therapy.' (Internal stakeholder)

Group therapy work with adults

In the group therapy, one or more therapists worked with a small group of clients together. Group therapy is not based on many rather than one single psychotherapeutic theory, often revolves around talking and may also include other approaches. An example of the group work that the project conducted with adult refugees was that of the **'Men's Group'** that was delivered jointly by Solace and the Refugee Council. The overall aim of it was to encourage engagement of the men with social activities, such as arts and sports. In doing so, the group also provided a place for the men to talk

about cultural differences, challenges and learnings and to ask practical questions. Solace led on addressing the distinctly therapeutic aspects of the group while the Refugee Council led on the practical issues that arose. This combination was particularly effective as it helped address the needs of the men in a holistic way.

The group sessions with the men included the involvement of outside organisations. For example, one session included a worker from the local Job Centre who answered questions regarding self-employment, how to find a job, Universal Credit and benefits. Members of the group took on representative roles, leading the discussion with outside organisations on behalf of the others. In doing so the confidence and English language skills of the participants increased. A WhatsApp group was established for the members to communicate in their own language.

In delivering the group work, the partners learnt that it was important to be flexible regarding attendance in order to allow the men to access the support at their own pace. This flexibility meant that attendance of the group each time included different people though a core group of men attended most sessions.

The partners felt that the group work was an important element of the project and should be sustained in the future delivery of the service.

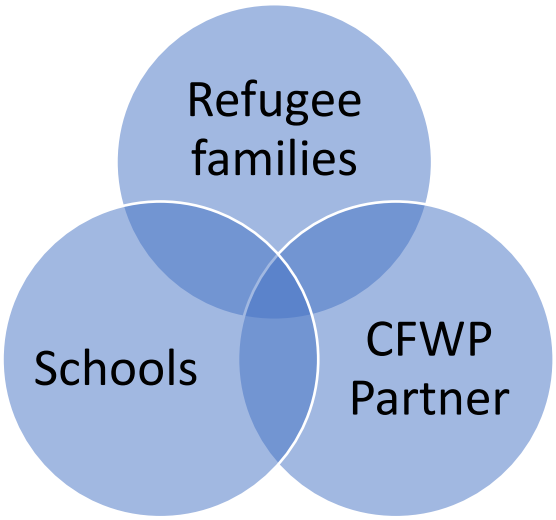
Supporting schools

> *'The project has up-skilled our staff. The training has helped them to support the children in their new settings and to understand cultural differences.' (School stakeholder)*

The reporting of incidents involving refugee children struggling to settle in school was one of the main factors that gave rise to the project. It was clear that some refugee children were struggling to adapt to being in the UK, which was unsurprising given their experiences before coming. At the same time some schools were ill-prepared to work with refugee children, especially when those children displayed challenging behaviour or were being bullied. In the worst instances refugee children were excluded by the school, thereby compounding the difficulties that the children were already experiencing.

'How do we expect children to excel and develop their full potential if they are bullied.' (External stakeholder)

The project supported schools in two ways: by providing therapy to the children and by training teachers and other school staff (an example of the material used in the training is included in the appendices). The vision for the project was one of working together with a school and a family, to act as something of a bridge.



Where a good relationship was established with a school the support that the project offered was effectively utilised to the benefit of the child and the school. Evidence of this was provided by those schools and the refugee families and children, as illustrated by the following quote:

'Families need help to communicate with the school so that everyone understands what is going on with the family circumstances.' (Refugee)

Refugee children who suffered from stress, anxiety, sleep and eating disorders often struggled to make friends in school partly because of cultural differences but equally due to language barriers, particularly in the early months after arrival. In some cases, children isolated themselves to survive. Others missed out on key experiences such as school residentials and became 'invisible children'. In some instances, children were erroneously referred to Prevent. To help mitigate these problems, the therapists worked in schools to provide flexible targeted provision designed to support traumatised children to address their anxiety issues and to help the school support that child. The following case study is a good example of how this aspect of the project worked.

Case study - Mahi (aged 10)

Background: Mahi was referred to us by his school due to concerns about him disclosing traumatic events sometimes in an excited way, sometimes very sad. The school felt overwhelmed by this and was not sure how to support him. Mahi had an older sister aged 12 who was transitioning to high school. Mahi's teacher was concerned about the impact of this on him as they are very close and he relied on his sister for many things in school. The school felt there was a lack of information about the family's background, medical record and access to interpreters which affected communication between parents and school. The school also was not aware of available funding and help that agencies could provide.

Action taken and difference made: We provided family therapy sessions to explore the effects of traumatic events on the family life and the responses of parents to the needs of children. Sometimes we also included school staff to establish clearer communication between the school and parents and we met with school staff to offer guidance and support. Finally, we also worked with the family's resettlement caseworker to create a clear and consistent plan.

Through the process of therapy both children gained confidence and progressed in school. The family improved their communication skills, acknowledging the difficulties for the children and validating the experiences of family members. The family said that they felt listened to and helped when making sense of their past, present and plans for the future in a way that generated agency and motivation. The school also gained confidence in supporting the children and promoting more communication with the parents. Mahi was empowered to manage the start of the year without his older sister. He progressed onto making friends and asking for help when needed. Relationships between the children and school staff were strengthened as well as between parents and school.

Some schools were very open to receiving training from the project as they recognised the need to develop or to better use existing skills to help them in their work with refugee children. Other schools were resistant to receiving any outside help (assuming that they were aware it was on offer). The project encountered three types of school:

- Schools who actively engaged with the project, seeing it as an asset.
- Schools who had experience of working with refugees and didn't want support from the project.
- Schools who knew little about working with refugees but didn't want support from the project or did not know about it or did not have the time to engage.

The project worked with 49 schools and the partners felt that the number could have been higher if more schools had engaged. The key factor that helped in terms of school engagement was the ability to broker a relationship between the project and the school. The following are two illustrations of what made this work.

One of the partners employed a **Schools Liaison Worker** as part of the project and this role had enhanced the ability of the partner to develop and maintain effective links with schools. It was felt that having this capacity within the project was a key factor in successfully working with schools.

Sheffield City Council have a **Gateway[30]/VPRS Education Team** based within the local authority that works in partnership with other key stakeholders, such as the Refugee Council, Health and Housing. The team provides a 12-month comprehensive support package to help settle refugee children into education settings (schools, nursery, college, etc.) in the city. Their role includes the following activities, which can be seen as a model for good practice in education support for refugee families.

- Helping families to apply for schools.
- Providing an education briefing for newly arrived refugee families.
- Accompanying families to Admission Appointments.
- Provide an interpreter (where required) for the Admission Appointments and for the child's first day at school.
- Help with obtaining school uniform, bus passes and language resources.
- Supporting children to settle-in to their new educational setting.
- Enabling wider integration of the families in the local community.
- Ensuring that the voice of the refugee family and child is heard within the school.
- Offering weekly drop-in sessions for parents.
- Arranging and attending TAF and parent review meetings.
- Offer services through the local authority English as an Additional Language (EAL)/New Arrivals Team. These services could for example, include language assessments and helping schools to create personalised material for refugee children to access the curriculum.

[30] The Gateway Protection Programme is another refugee resettlement scheme – see the glossary and context sections for more details.

- Where appropriate, supporting referrals to specialist services, such as the SEN team, Educational Psychology, The Children with Disabilities team, Children Missing from Education team or the Family Therapy Service.
- Delivering summer programmes tailored to the needs of the particular cohort, for example, Internet Safety, or Education Pathways.

The work with schools presented challenges to the partners – the take-up of the services of the project by schools has been mixed – in that some welcomed the project and the support it offered, others not. It is not clear why some schools did not access the project; there may be a mixture of reasons, including a lack of time to engage. The Academy set-up complicated school engagement in some cases. The inconsistency in the approach of schools was identified as major challenge for the project. The partners did not think that the lack of take-up by some schools reflected a lack of need, rather the opposite. It was felt that much more needed to be done engaging schools and working together for the benefit of the refugee children.

Other learning from supporting schools included the following:

- Some schools knew very little about refugees and were not familiar with the impact of the refugee experience on mental health and wellbeing. The teachers could misunderstand why some children behaved as they did and consequently struggled to find an appropriate way to respond.
- The project helped promote the dialogue between the refugee parents and the school that their children were attending. This helped iron out misunderstanding and contribute to resolving problems that the child was experiencing at school.

'The project is an invaluable link between home and school. The families trust their link workers as do we and the support and guidance from the team has been fantastic.'
(School stakeholder)

- It can be problematic when class placements in schools for refugee children are based on their age, as often they have missed years of schooling and may struggle to keep up with their peer age group. In some instances, the project saw that this led to isolation and bullying. Additionally, in this context teenage refugees were of particular concern to the partners.
- Refugee children reported not feeling safe sometimes in some schools.
- The onus to 'integrate' is often placed by schools on to the refugee child, rather than seeing integration as a two-way exercise with the school playing an equal part.

- The behaviour management systems in schools can be too rigid to adapt to the situation of a young refugee.
- Schools aren't always aware of student's history/resettlement status and do not always use the English language grant to support the children.
- Schools have to adapt to completely varied levels of English language ability amongst the refugee group.
- English as an Additional Language (EAL) staff and other support staff can be isolated within schools.
- A lack of resources or time in the school to engage with the training offered by the project.
- Some schools feel ambivalent about children being taken out of class for therapy sessions and would rather such sessions take place outside of classroom time.
- Some schools were reluctant, because of understandable concerns about confidentiality, to share information about the children that the project was working with. Similarly, it would not always have been appropriate for the therapists to share information with schools. In one example, the school was frustrated that they had not known the child was receiving therapy. A more joined-up approach between the school and therapist would have been helpful for the child.
- Some schools did not have adequate facilities to provide space for therapy.
- Some stakeholders, including schools, found it confusing and unfair that pupils who have arrived on the resettlement scheme could be offered support by the project while others who had similar mental health and wellbeing needs but had arrived via a different route, such as the asylum process, could not access the service.

Feedback from schools

The following quotes are illustrative of the feedback received from schools about the project:

> *'The therapeutic element has continued and is very much valued by my team of support workers who have made many referrals.'*
>
> *'I have found the communication [with the project] very easy and extremely accessible with regards to the pupils.' (School stakeholder)*
>
> *'The main value of the service is assisting/reassuring the refugee pupils with their concerns or any issues they may have. This is vital in helping with their emotional health and needs. I believe this service to be invaluable to both the pupils and their families.' (School stakeholder)*

'The difference the [project] therapists have made to refugees in my area has been invaluable. Families who have experienced significant trauma with subsequent mental health difficulties have quick access to specialist support which is invaluable in their recovery.' (School stakeholder)

'The main impact [of the project] has been to support the child with his emotional well-being.' (School stakeholder)

'In my experience of working with the project the most noticeable strength is that there is a dedicated therapist assigned to the family, they are not experiencing changes in worker which promotes that working relationship. The therapists are extremely knowledgeable and share skills and advice pertinent to supporting the families. I have always found it easy to contact the therapist and she has always attended meetings and shared information promptly.' (School stakeholder)

'The work done by the play therapist was invaluable to help this individual child to speak through play about his emotions and well-being.' (School stakeholder)

'Parents have a significant challenge settling into the ways of this country, children become very empowered very quickly as they learn the language so much quicker, this in turn disempowers parents and unbalances the family dynamics. This service helps parents understand and empowers them to support their family accordingly.' (School stakeholder)

'The therapist is always warmly welcomed into our school and her manner is equally warm, open and inviting. She is always very willing to listen to any concerns we may have and act upon these concerns wherever deemed necessary. Obviously, her work is extremely confidential however she has been able to offer an element of reassurance to us regarding our recent concerns over a pupil.' (School stakeholder)

'We had a very professional and excellent partnership working with the project worker. The work done with the child was excellent and needed at the time.' (School stakeholder)

Group work in schools

The following example is of group work conducted by the project with secondary school students. It is illustrative of the wellbeing issues concerning refugee children. The group work included children

who had come on the resettlement scheme as well as through the asylum system. As such it highlights the similarity of needs amongst the two groups as well as the different challenges that they face.

A learning point from the group work is the recognition that these Secondary School-age pupils may have missed out on primary school activities designed to encourage social engagement and teamwork. While some of the activities in the group work may seem unsophisticated, they are compensating to some extent for the gaps in a more normal childhood experience. To provide a space to do this was extremely important and effective for the refugee children involved. This and other learning points are captured in the case study below.

Case study of group work with children

Referrers concerns and the presenting issues. The CFWP team was made aware of a school in Leeds where a high proportion of students were young refugees and asylum seekers. We contacted the school to provide information about our role and to offer support, training and consultation if needed. The school described concerns relating to the wellbeing and academic progress of several students from refugee backgrounds in Syria, Afghanistan and Kurdistan. School staff felt that these students were, in different ways, struggling emotionally, academically and socially at the school, possibly at least partly because of their prior experiences in their countries of origin and becoming an asylum seeker or refugee in the UK. Some of the young people had arrived in the UK on the Vulnerable Person Resettlement Scheme whilst others had arrived as asylum seekers or on a different resettlement programme. The concerns about and perceived challenges for the young people included isolation, withdrawal, excessive deference and rule following, experiences of bullying and distracting or unsettled behaviours in class. Some students had experienced extreme anger or distress in reaction to seemingly small incidents or slights. It was agreed that a group of nine students (five males and four females) aged between eleven and fifteen years-old could potentially benefit from the support of the project.

Group sessions - delivery and value for participants. The establishment of a 'friendship group' was agreed with the young people. The group was facilitated by the project therapist with support provided by a member of staff from the school. In total ten whole group sessions took place along with four more small group sessions. After the initial sequence of ten group sessions, individual assessment sessions were also completed with two of the group members. The group facilitator (the therapist) also met with parents and carers at a school-based meeting in the final session. The value

and benefit of the sessions were observed by the project therapist and confirmed by students themselves in subsequent feedback and evaluation conversations. Examples included:

- The development of shared experiences and a sense of identity, of belonging or togetherness. Some members had not known that there were several other Syrians in the school and were pleased to speak to them for the first time.
- Being able to share commonalities and experiences of exile - and sometimes experiences of and responses to trauma.
- Developing social skills and confidence, through new friendships and healthy rivalry. At the end of the sessions, group members felt that they had grown in resilience through surviving challenging behaviour of other members, by making alliances and becoming more assertive.
- Enjoying the creative, expressive, sensory and 'play' aspects of sand tray work, 'slime making' and other creative activities. Many have missed out on these types of play opportunities and developmental experiences during childhoods that have been disrupted by conflict and upheaval.
- Exploring issues around difference, diversity, tolerance and gender.
- Having fun that isn't always possible in a school setting (or at home) through enjoying messy, sensory activities or in presenting puppet shows depicting humorous and risky themes about scandalous relationships, pregnancy and drama.
- Exploring boundaries, consent, fairness, negotiation, tolerance, rejection, hurt and the impact of their own behaviour.

After the initial sessions. As the series of group sessions approached conclusion, alternative ideas for further support and activities were not initially received positively. However, with further encouragement, some members did move into follow-on activities and support. These included:

Four of the quieter members of the group were offered a series of small group sessions in a quieter setting to explore both positive and difficult experiences in their lives and share poignant memories of their childhoods. They shared fears, hopes and barriers, gave each other validation and support, gained in confidence and self-esteem through shared humour, fun and solidarity.

The project therapist also worked with the group to help them develop strategies to support their emotional, social and academic welfare. They (and a non-group member friend) were successfully introduced to a local community girls' group and signposted to a young person's counselling project for further support if needed. This smaller group was made up of children who had come on the resettlement scheme.

Subsequent to this second group, one member, her sister and their parent have been offered further support from project. This work is ongoing and includes individual work with the girls in school, as well as occasional family sessions. This family had previously declined support from the project but, through one of the daughters taking part in the group, they opted to engage with the service.

Similarly, the project was able to offer further support to one group member and went on to work with his wider family due to his involvement with the initial group and the contact this gave his parent with the therapist. One group member was supported in gaining a place on a Community Art course at Leeds University of Arts.

We were unable to offer some of the group members further support, despite them sharing common refugee experiences of conflict, trauma and loss, as they had not come to the UK as part of the resettlement scheme. They were asylum seekers or had been granted refugee status through another process). These included:

- A member who became noticeably sadder and withdrawn in the final group sessions was encouraged to access a young person's counselling service as an alternative to support from the project. Sadly, this was not supported by the foster carer and declined by the student.
- Another member who we suspected of suffering from Post-Traumatic Stress Disorder (PTSD) was referred to a counselling service. Unfortunately, they were not able to complete the assessment process due to his parent's lack of English and understanding or support for the counselling process.

Learning points and issues relevant for future planning, service development and delivery.

- The group took place in an inclusive school environment in which some, but not all, staff demonstrated a committed and informed approach to their very diverse student community. Due to this, collaboration with the project, including the running of the group and staff training, was both easier to achieve and welcomed by the school.
- The liaison work between the project, students, school staff, parents and carers during the establishment and delivery of group sessions helped develop a shared understanding of the needs of the children and the support available from the project. This helped pave the way for further project work with young people and families who might not otherwise have engaged with or whose needs might not have been recognised by the school.

- The group sessions increased the engagement between the parents and carers of the children and the school.
- The project's restorative, trauma and attachment-informed therapeutic approach to challenging behaviour is often at odds with school behaviour policy. Group work gives members an experience of unconditional acceptance, respect and understanding within school, regardless of behaviour. It can also be an alternative model (relational rather than punitive) for school staff to consider in their responses to students.
- The group highlighted the importance of facilitating opportunities for informal social contact between refugee students with shared or similar backgrounds/experiences of dislocation.
- At times, some group members found it hard to listen, focus and cooperate with others in the session. Incidents of low-level aggression were responded to by the therapist with a restorative, trauma-informed approach. This involved not excluding members at any time and giving the group the opportunity to restore cohesiveness and individual regulation by giving all members a second chance to be part of the group activity.
- Children who arrive by the resettlement schemes and those that come by the asylum route have similar wellbeing needs. However, the support that is available to them differs, with the latter having additional barriers to accessing appropriate support due to their immigration status.
- Mainstream therapeutic services are often inaccessible to or inappropriate for refugee children who have come by either route.

The professionalism of the staff and volunteers

A key factor that contributed to the success of the project were the skills and professionalism of the staff and volunteers. The therapists and the managers of the services provided by the project are leaders in their field, many of them contributing to professional therapeutic journals and the development of good practice worldwide in the field of wellbeing and mental health support to refugees. The project was fortunate in being able to draw upon their expertise which contributed to making this a pioneering project that can inform others who work with refugees in the UK and beyond.

The value of working with skilled interpreters

The importance of using trained interpreters who have experience of working with refugees in the therapeutic setting cannot be overstated. Many of the refugees were not able to speak English to an extent that would have been suitable for therapy so it was essential that interpreting was available. The partners found that using interpreters with a knowledge of the project was more efficacious than

using a 'mainstream' interpreter. There was also a value in making the interpreter feel part of the team, while still maintaining appropriate boundaries and clarity of roles.

One partner used the same interpreter for each session with a particular client as they found that this provided more consistency as the client and interpreter got used to each other. Another partner was worried that using the same interpreter each time might create a dependency dynamic. Both approaches worked well and did not detract from the importance of using trained interpreters used to working with refugees.

That the partners were comfortable in delivering therapy through an interpreter was another manifestation of the skills of the therapists. In the broader therapy sector some practitioners struggle to work through interpreters. It would be good if there were an opportunity for the partners to share with others their expertise in providing therapeutic support through an interpreter.

One concern raised by the partners was that refugee children were sometimes used in other settings to interpret for their parents, including health appointments. It was strongly felt that this was not good practice and that other organisations should use trained interpreters.

Recording and monitoring systems - measuring the outcomes

The partners were assiduous in recording and measuring the work of the project and the elements that they focused on fall into two categories: the clinical outcomes achieved with clients and the other activities of project, such as recording the work with schools.

Measuring clinical outcomes

The partners used industry-standard clinical outcomes measurement tools, including: YP Core, SCORE 15, ORS, CORS and Core 10.[31] These were able to provide a lot of information about the impact of the therapy on clients, but they did have their limitations. For example, some of the language used in them was not always culturally appropriate or easily translatable into Arabic. Consequently, the partners also developed their own tools, such as the Bio-psychological Assessment form used by the Refugee

[31] There are many references on the internet to these types of tools, such as that at the Child Outcomes Research Consortium website: https://www.corc.uk.net/outcome-experience-measures/core-measurement-tools/

Council or the Outcomes Measures form used by Solace (the first page of the form is below – a full copy can be obtained from Solace).

Solace CFWS Outcome Measure V 9/19			
Date		**Client identifier**	
Reading No.			

Please tick the face that <u>best</u> shows your viewpoint at this time.

A How I am doing and feeling now?

1. **I think that my thoughts and emotions are….**

Very negative — Very positive

0 1 2 3 4 5

2. **I feel my health is…**

Very poor — Very good

0 1 2 3 4 5

3. **I feel that my progress at school, work or learning new things is going ….**

Very badly — Very well

0 1 2 3 4 5

4. **I feel that I am making new friends ….**

Very badly — Very well

0 1 2 3 4 5

1

The partners enhanced their ability to measure the impact of their work by a variety of means, including:

- Writing-up case studies and narratives of each of the families that they worked with.
- Conducting internal case reviews.
- Internal self-evaluation meetings.
- Devising spreadsheets to collate outcomes measured from other tools.
- Seeking feedback from others who were working with the families, for example the resettlement caseworkers and the schools.
- Obtaining feedback from 44 refugees who were interviewed specifically for this evaluation.

The combination of methods used enabled the partners to measure the outcomes of their therapeutic work to a satisfactory level for the purposes of the project, albeit that there were limitations to the tools.

Reporting on activities

Migration Yorkshire designed a format for the reports that the partners provided each quarter (see the appendices for a copy). This created a consistent framework for the partners and enabled Migration Yorkshire to maintain an overview of the progress of the project.

Although overall the reporting mechanisms for the project worked, there are some key learning points or issues that the project should consider in any future iteration of the work:

- The partners used slightly different methods from each other in measuring and recording some aspects of their work. For example, how to count up the number of refugees who were receiving therapeutic support. These differences were reconciled over the lifetime of the project but, in the future, there would be a benefit from the partners adopting a more common approach from the beginning.
- It may not be possible to forego using the industry-standard clinical outcomes measurement tools but there may be a value in investing to develop a more bespoke tool for this project.
- There was no standard way of collecting feedback from schools that had been supported.
- Whatever method partners use to capture and measure their work, it has to be proportionate to the resources that they have available. It is important to get the balance right between delivering a service and filling-in forms. This balance seemed to be appropriate for this project.

Working as a partnership – collaboration and coordination

Delivering the project as a partnership of three organisations worked well. The partners were chosen because of their expertise and their knowledge of the context of refugee work in the areas of Yorkshire and Humber that they were based. The partnership approach enabled the project to reach all of the region and to experiment with a wide range of methods and styles as each organisation approached the work differently.

It was clear that the partners were very supportive of each other, very willing to learn together, to share good practice and identify challenges. The therapists particularly found great value in sharing their experiences and skills in order to inform their work and to develop good practice. This was manifested clearly in the two practitioners' meetings held during the project (June 2019 and January 2020) which brought together the therapists for detailed discussions about their work. Solace hosted the practitioners' meetings and they were logistically supported by Migration Yorkshire. The learning from them was captured and utilised by each partner as they developed their services during the lifetime of the project. It was important that like-minded professionals were able to develop their skills in a collaborative way – the feedback from these events was very positive.[32]

The partnership approach enabled the strategic development of the project, with partners working towards common approaches to aspects of the work, such as the marketing of the services (see section on communications).

There was a challenge to the partnership approach as each partner had different ways of recording and reporting on their work which sometimes led to it being difficult to compare like with like. However, this challenge was mitigated to by the opportunity to learn more from the different approaches of each partner.

Going forward, a partnership approach would continue to be the most effective way to deliver the project. There would be a benefit from having a greater number of practitioners' meetings, perhaps one every six months. However, given that many of the therapists work part-time and that any meeting in the region will involve travel, that may be unrealistic.

[32] Notes were taken at each of the practitioners' meetings and were used for the evaluation of the project.

There would also be a benefit from more of a differentiation between the practitioners' meeting and the project board meeting.

The coordination by Migration Yorkshire

The project would not have existed without the overarching role of Migration Yorkshire, whose coordination function was a key factor in the success of the work. The role included identifying the need for and initiating the project, which also entailed designing it and securing the funding. Once the project was operational Migration Yorkshire supported the partners in several ways, that included:

- Developing reporting formats.
- Producing marketing material.
- Facilitating the learning processes, including commissioning the evaluation and support for the practitioners' meetings.
- Maintaining an overview of the context of the work and keeping partners informed of any changes to the resettlement schemes or local statutory provision that would affect the project.
- Enabling links between the partners and key stakeholders, such as local authority contacts.
- Adopting an appropriate amount of flexibility towards the partners and the way in which the project was implemented – this reflected the spirit of the project being a pilot.

In their strategic role Migration Yorkshire maintained a commitment to supporting local authorities and the partners to deal with and benefit from the resettlement of refugees in Yorkshire and Humber.

Links with other providers

> *'We found the service to be excellent and wish to pass on our thanks to the staff involved.' (External stakeholder from a referring organisation)*

A strength of the project was the holistic or multidisciplinary approach that the partners took towards their work with refugee families. The partners stressed the need to address the variety of challenges that refugees faced in adjusting to life in the UK – not just their therapeutic needs. While the therapeutic interventions were at the heart of the project, it could be hard to enact these when refugees were distracted by problems such as poor housing or hate crime.

> *'I still feel stressed, everything is distressing me [even after therapy] including my housing which is dirty and mouldy but I can't do anything about it.' (Refugee)*

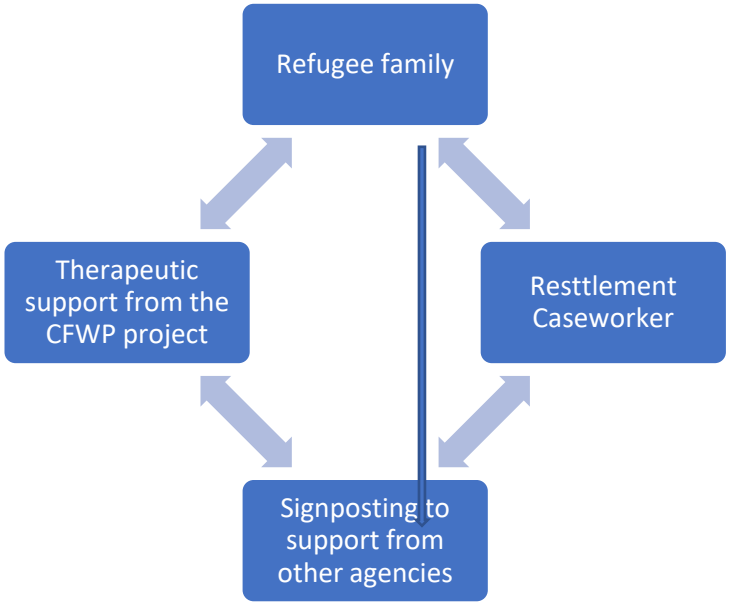
'Adopting a holistic approach and knowing where to refer clients for other types of support was key to allowing us the space to conduct the therapy.' (Internal stakeholder)

From the beginning the project established links with other providers, including the resettlement caseworkers and support organisations, both statutory and voluntary.

'We would often involve other organisations in supporting the families, for example their resettlement caseworker. Working in coordination with others enabled us be more effective and provide a more holistic service.' (Internal stakeholder)

Being locally embedded, the partners had good knowledge of other support available and were able to make appropriate referrals of refugees for help with issues such as domestic violence and anger management.

Every resettled refugee is assigned a caseworker[33] as part of the resettlement scheme and in the first instance that role was the pivotal contact for the therapists working for the project. The resettlement caseworkers would refer refugees to the project for therapeutic support. In turn, the therapists would liaise with the caseworkers about practical issues concerning the refugee.



[33] The role of the caseworker is described in more detail in the description of the project section.

In South Yorkshire the Refugee Council provide both resettlement casework and the therapeutic services and this aided the flow of information between the two. The staff though were very stringent about maintaining professional boundaries and acknowledged the different roles that they each played in their relationship with the refugee.

> *'I have witnessed the positive impact that the Children and Families Project has had on VPRS families and the complementary way in which the therapy team and the resettlement team work together.' (Resettlement Caseworker)*

The resettlement caseworkers also noted that many refugees who arrived under other resettlement schemes would benefit from the service.[34]

> *'It is an excellent project that is joined-up and brings together different providers to use their different roles to complement one another for the benefit of the client.' (External stakeholder)*

In the Humber a partnership was developed between Statutory Mental Health Services and Haven, which enabled a clear pathway of referrals between the two agencies. In addition, the excellent relationship with General Practitioners (GPs) saw the latter referring clients for support and acting upon psychological assessments from Haven Therapists. GPs also referred to Haven if other care treatments (usually medication) had not had the desired impact.

External organisations got to know about the project directly from the partners, or by the Newsletter[35] and through networks facilitated by Migration Yorkshire and the voluntary sector.

Challenges and learning about links with other providers

- Across the project, boundaries were not crossed but sometimes the therapists could get drawn into the practical aspects of a family's case more than they would have wished.

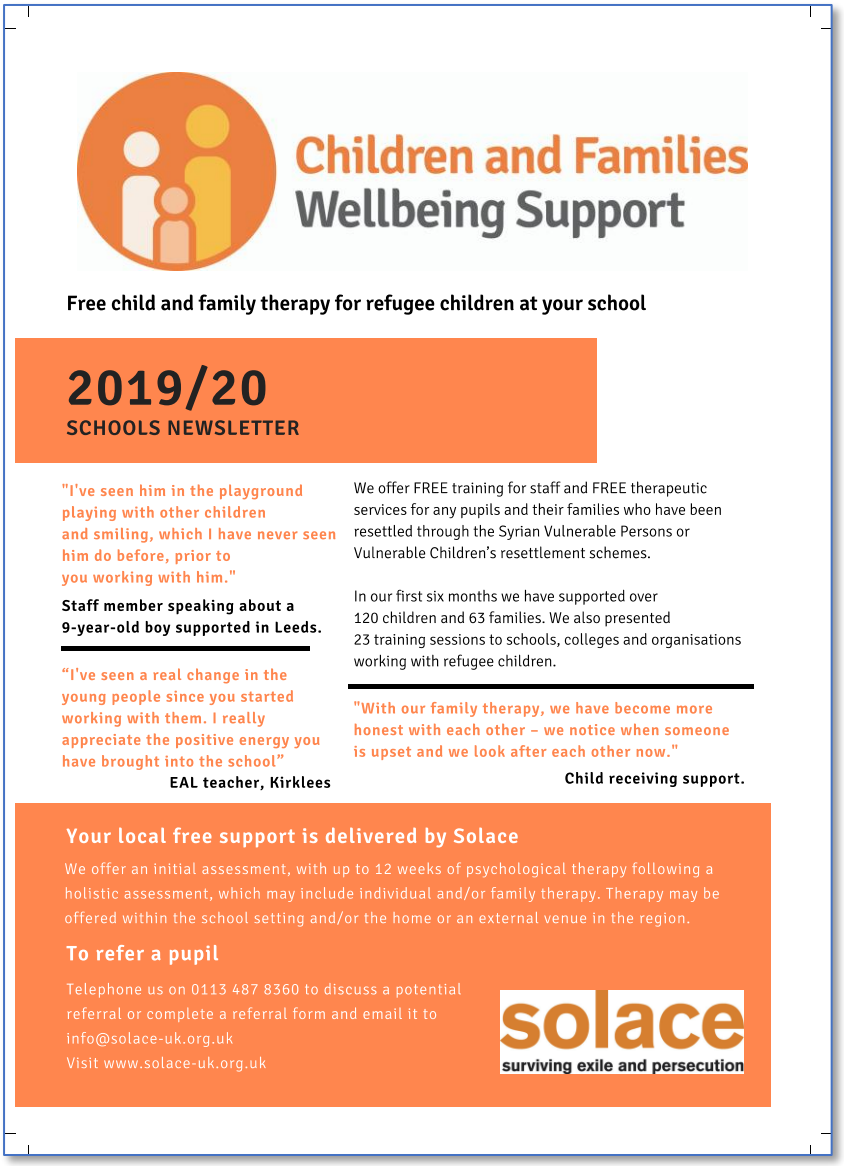
[34] The new resettlement scheme (see the Context section) will be an opportunity to harmonise the different support regimes for resettled refugees as all of the schemes will become one.
[35] More information about the newsletter is covered in the Communications section.

- With the exception of the School's Liaison Worker, there were not specific roles in the project that focussed solely on the task of developing links with other providers (a typical development worker role). However, everyone involved in the project, including Migration Yorkshire, had a role in raising awareness about the services offered by the project. Going forward it may be worth considering incorporating a development role (see also the section on Communications) to enhance the links with other providers.

Communications and information material about the project

Migration Yorkshire developed a newsletter that they and the partners used to inform local authorities and schools about the project and the support that it offered.

Example of extract from project newsletter (this was adapted for Solace's use)



Children and Families Wellbeing Support

Free child and family therapy for refugee children at your school

2019/20
SCHOOLS NEWSLETTER

"I've seen him in the playground playing with other children and smiling, which I have never seen him do before, prior to you working with him."

Staff member speaking about a 9-year-old boy supported in Leeds.

"I've seen a real change in the young people since you started working with them. I really appreciate the positive energy you have brought into the school"

EAL teacher, Kirklees

We offer FREE training for staff and FREE therapeutic services for any pupils and their families who have been resettled through the Syrian Vulnerable Persons or Vulnerable Children's resettlement schemes.

In our first six months we have supported over 120 children and 63 families. We also presented 23 training sessions to schools, colleges and organisations working with refugee children.

"With our family therapy, we have become more honest with each other – we notice when someone is upset and we look after each other now."

Child receiving support.

Your local free support is delivered by Solace

We offer an initial assessment, with up to 12 weeks of psychological therapy following a holistic assessment, which may include individual and/or family therapy. Therapy may be offered within the school setting and/or the home or an external venue in the region.

To refer a pupil

Telephone us on 0113 487 8360 to discuss a potential referral or complete a referral form and email it to info@solace-uk.org.uk
Visit www.solace-uk.org.uk

solace
surviving exile and persecution

The newsletter was updated during the course of the project and was a succinct and effective marketing tool. For example, the partners used it as a handout when providing training or awareness-raising sessions with schools or when attending networking meetings and events.

Migration Yorkshire also shared information with local authorities and other stakeholders through networking events, such as the Yorkshire Integration Festival in Leeds in September 2019. A workshop at the event was run by some of the partners and was attended by a large number of organisations that work with refugees in Yorkshire and Humber. The description of the workshop is below.

Description of the Workshop on the project at the Yorkshire Integration Festival September 2019

Wellbeing: exploring impact

Do you want to listen to a variety of different perspectives on refugee/migrant mental health and well-being? Do you want to discover and explore the impact this specialist support can have? This session will hear from the Children and Families Wellbeing Support Service (Project), which works with schools and families to help resettled children by addressing trauma issues through early intervention; a Solace Therapist together with a refugee on their journey, who has accessed Connecting Opportunities; Touchstone on their experiences in integrating well-being into a group setting and ESOL provision and about the City of Sanctuary mental health resource pack.

This session will be chaired by Kathryn Ashworth (SOLACE). Other speakers/participants include Kath Allert (Touchstone); Julie Angelidou (Refugee Council Child and Family Wellbeing Service); Andrew Hawkins and Gill Martin (SOLACE).

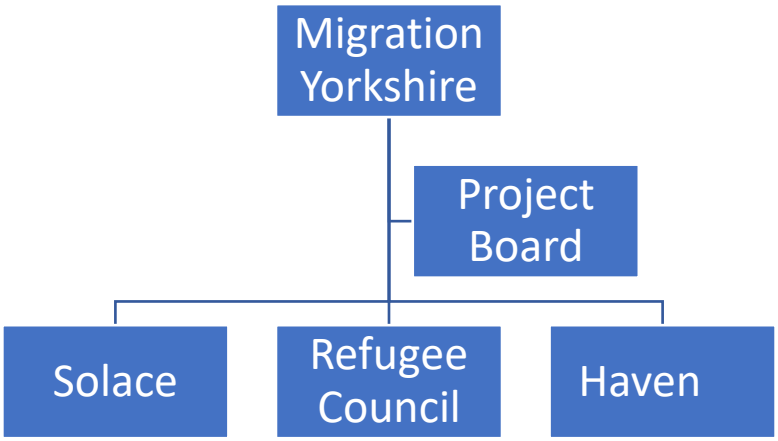
Challenges and learning points about communications

- The partners came across local organisations and schools that had not heard about the project, even though the newsletter and other methods had been used to market it.
- A couple of external stakeholders who contributed to this evaluation said that they didn't know enough about the project and would have liked to have known more and to have received more frequent updates.
- There were challenges about how best to distribute the information about the project to ensure that it got to the people most likely to use it to refer refugees for support.
- The evaluation identified a need for more advocacy and awareness-raising about refugee issues amongst external bodies, including schools. It was felt that this would encourage the use of the project by schools that had been resistant or simply unaware of the support on offer.

Despite the above challenges, Migration Yorkshire and the partners were effective in informing a lot of schools and other organisations about the project – this was reflected in the numbers of referrals to the project. Given the limited resources available for marketing the project it is understandable if not every school or relevant organisation was reached. In the future, if resources allow, it would be helpful to develop a comprehensive communications strategy for the project. This strategy could include marketing material, mechanisms for updating external organisations and a schedule of awareness raising events.

Structure of the project

Having a project board that met every three months was useful as it helped maintain a continuity for the work, provided a platform for sharing learning and it enhanced communications between the partners and Migration Yorkshire. The board included representatives from each of the partners (managers and therapists), Migration Yorkshire and the Refugee Resettlement Programme team (the Home Office). The discussions at the board meetings were about a mixture of operational and strategic items and were conducted in an open and constructive way. The board was part of the mechanism by which partners accounted for their work and as such complemented the written reports provided quarterly by each partner to Migration Yorkshire.



The board functioned well but sometimes the discussions about operational issues overlapped with similar ones that took place at the practitioners' meetings (see the working as a partnership section above). Similarly, the participants from the partner organisations at the board meeting were largely the same people who attended the practitioners' meetings.

It would be helpful in the future to make the distinction between the two meetings clearer. It may also be useful to expand the membership of the board to include representatives from local authorities, particularly schools or an education department, and CCGs. Their expertise would inform the work of the project and they could help champion the work in the region.

Funding the project - the cost effectiveness

The project has been funded through:

- A proportion of the grant that local authorities receive from the Home Office for their participation in the VPRS and VCRS resettlement schemes (referred to as the tariff).
- Matching contributions from central government through the Syrian Refugee Resettlement Programme.

In the 18-months of operation[36] the project has cost approximately £600,000 to implement. A study in 2016 concluded that the mental health-related costs associated with young people averaged £1,778 per child per year rising to £2,780 per year for 12-15 year olds. Ninety per cent of these costs fall to the education sector.[37] If these costs are compared with the current average referral rates to the project (90 per quarter), this equates to mental health related costs of over £1 million that would have otherwise fallen on the local education sector. Whilst it cannot be shown that all of these costs are saved by the intervention of the project, it is safe to assume that a substantial saving is made to a wide range of services, especially schools and CAHMS.

As such the project delivers very good value for money with the partners providing specialised trauma-informed therapy at considerably less cost than the equivalent provision (even if it were available – see the section on gaps in this report) in the statutory sector. In addition, within the same budget, the partners provide support to schools in the form of training to help them develop tools and techniques to support children and families.

[36] The expenditure period covers a slightly longer period than just 18-months but we have used this period as operational frame to refer to.
[37] Youth Mental Health: New Economic Evidence 2016 by the LSE, Young Minds and PSSRU https://www.pssru.ac.uk/pub/5160.pdf

There is one note of caution regarding the cost-effectiveness. The therapists and others involved in delivering the project are professionals working in an insecure environment. The remuneration that they receive for providing the service should reflect both of those factors.

Other learning identified from the project delivery

There was other learning identified by the project, including challenges that the partners sought to overcome. These provide a useful checklist to inform some of the recommendations and the future iterations of the project.

- There were some very complicated family dynamics amongst the client group which could have been pre-existing before the refugee experience but which were certainly complicated by the latter.
- More women than men accessed the project initially, although there is clearly a high need for support amongst the male cohort of the client group.
- There was not enough capacity in the project in terms of the numbers of clients the project was able to support and the amount of time therapists could spend with them. It was estimated that at least 75% of the overall client group (refugees coming on the VPRS and VCRS resettlement schemes) would benefit from the therapeutic support offered by the project. As it was, the project was able to support approximately 25% of the refugees coming to Yorkshire and Humber.
- Linked to the resource limitation was the challenge of trying to provide the service over a large geographical area - there was a lot of ground to cover which involved a lot of travel time for clients and the partners.
- In a similar vein, because of resource limitations there were not as many opportunities for the practitioners to meet up as would have been desirable.
- The therapeutic support of the project did not work or was not appropriate for everyone who was referred.
- There are very few if any other sources of this type of specialist support for refugees in Yorkshire and Humber. In the experience of stakeholders, it was very hard to obtain an appointment with the Children and Adolescent Mental Health Service (CAMHS). Also, the service provided by the project was seen as being more specialised and cost-effective than those of the statutory provider.

- Several refugees described a range of problems that they faced in the UK, including the lack of access to appropriate ESOL[38] provision and feeling socially isolated.[39] These problems were pertinent because the ability to communicate in English and socialise has a direct bearing on integration and on the ability of the refugee to participate in the community, which in turn has an impact on mental health and wellbeing.
- Although there was good information material about the project[40] that was produced in order to raise awareness of the service, it was not clear that this reached some of the schools and other organisations which could have benefitted from knowing about the project.
- There were some difficulties in communication between schools and the project that were partly down to there not being an established set of protocols for sharing information about pupils.
- Some of the challenges faced by the clients and the schools that impacted upon the refugees' mental health and wellbeing were rooted in aspects of the community, such as racism. The project did not have the capacity to raise awareness about refugee and child-related wellbeing issues to a broader audience. The impact of the project could have been increased if there had been more of a development or awareness-raising element that could help combat some of the problems that the clients face here.
- While local authorities were kept informed about the progress of the project, it may be helpful to find a more specific updating mechanism that increases their sense of ownership of the work. *'If I was asked to fund the project, I would need more information, I haven't heard more since the beginning and would like an update.' (External stakeholder)*
- There is a need for more mentoring opportunities for young refugees, particularly the older teens.

Case studies

In the case studies, the names, gender, nationalities, locations and other details have been adjusted to ensure anonymity. They are written from the perspective of the practitioners.

[38] English for Speakers on Other Languages.
[39] Other initiatives of Migration Yorkshire are supporting ESOL work in the region. Further details can be found on the Migration Yorkshire website and at: www.learningenglish.org.uk
[40] See the example of a newsletter for schools in the section on communications.

Case study - Fatima, Yama and Rima (aged 11, 14 and 15)

Background: Fatima (11), Yama (14) and Rima (15) were referred to us to by their family's refugee resettlement caseworker. The refugee organisation caseworker and parents were concerned for their mental wellbeing as they were receiving no support at their school and were effectively isolated. The two older sisters had been there for a year, much of which they had spent in the school's pastoral support area, crying. The youngest sister had received more support, having joined primary school in year six, but she was now isolated in the secondary school. The refugee organisation caseworker secured a meeting with the school which helped to resolve communication difficulties with the parents and established the need for a referral to our organisation (for therapeutic support). The main issue identified was that the people who were supporting these girls had very little support in the school themselves: the year learning managers were responsible for 350 children. Pushing the issue up to the SENCO helped. The family were initially reluctant to consider transfer to another school, which had a higher number of refugee children from the same country, due to their concerns about other community members. The three girls were also understandably reluctant to move given their history of upheaval and bad treatment at a school in Jordan prior to coming to the UK.

Action taken and difference made: We met with the family and the learning manager and contracted to see each girl fortnightly. They had each presented differently: the eldest sister seethed with rage and had a tendency to violent outbursts, but was otherwise shy, the second sister seemed very depressed, and the youngest suffered high levels of anxiety and excess sweating (palms, armpits, feet). They all expressed relief and delight at the opportunity to talk. Alongside the sessions we also persisted in asking the school about providing support for learning English for the sisters. Eventually they had sent them to the neighbouring school (part of the same academy Trust) for an EAL assessment. A few weeks after this the family were offered the opportunity to transfer to this school. A meeting with the family helped all voices to be heard and a decision made to move. Sessions continued in the new school until it was closed due to the Covid-19 pandemic. The girls' symptoms started reducing as soon as sessions started. However, once they transferred to the new school, the change was dramatic. They were no longer isolated, they had friends, they had some English support and they all blossomed. Their Core 10 scores all dropped to sub clinical levels. Fatima and Yara, the two younger sisters both subsequently described themselves as too busy to come to sessions anymore. Rima, the oldest sister has more to work through and she made good use of our final session together. We will follow up the family to see how they are coping with home study. There may well be underlying issues that will emerge later but for now it was wonderful to see the effect that a supportive school environment can create. As Rima said: "*everyone talks to us – staff, pupils, not just those who speak Arabic. Everyone! I don't have to eat my lunch by myself anymore*"

Case study - Dina (aged 8)

Background: Dina, aged 8, was referred to us by her teacher due to concerns about her not speaking at all in school. She was also clearly fearful, seemed generally sad and had very little social interaction with other students. Dina's brother was also socially isolated and experiencing bullying at high school but he did not feel able to share this with school staff when incidents occurred. Their parents had significant physical disabilities and post-traumatic stress symptoms. These related to their experiences whilst fleeing their country of origin and subsequent difficulties prior to and during resettlement in the UK. These issues impacted on the support that they could offer their children. In addition, whilst we were working with them, the family also experienced a medical emergency in the home which was very distressing for all the family members. Sadly, the trauma caused by this event was also compounded by medical negligence, which appeared to have a racist element.

Action taken and difference made: We initially offered the family individual, school based therapeutic sessions with each child. We also provided assistance in communicating about concerns with school staff, and family sessions to support positive relationships, communication and effective parenting. As the work progressed, additional advocacy work, sign posting and individual therapeutic adult sessions were conducted. During the period of work with the older children, improvements were noticed in their confidence, assertiveness, self-esteem and mood. Both became more appropriately engaged in educational and social activities at school, made friends and spoke English more freely and competently in all settings. Incidents of bullying in the older child lessened and the student became confident in reporting incidents and also in coping creatively with their impact. The parents made good use of individual sessions to begin to address their past and recent experiences of trauma and share significant fears which they felt unable to explore elsewhere. The therapist was experienced as a 'friend' to the family in the absence of close relations and provided a bridging role in helping the family address their emotional needs, in time being trusted to both support and challenge members in dealing with difficult issues and events. Supporting their individual and family resilience though strengthening relationships and promoting greater openness was felt to enable members to take more risks outside the family and to reduce the family's sense of isolation.

Case study Amina - a single mother

Background: Amina is a widowed mother of four children who was resettled in the UK with her mother. Amina, her mother and the four children share the same accomodation. Amina is finding it very difficult to raise her children in this context and feels she is co-parenting with her mother. She also feels she has completely failed to be a good parent and blames herself for over-compensating for past losses and experiences by buying her children material things. Amina' two oldest children have been refusing to go to school and are playing video games, doing online dating throughout the night and sleeping during the day. Amina blames social media for making her children dislike school and her mother for trying to use her strict parenting ways on her children (which they are resisting). The two youngest children are struggling to cope with their past traumas and the current issues at home. The second child and eldest daughter has been involved in drugs and the police have been involved. The eldest child, the only son, had been trying to discipline his sister in their usual cultural ways (probably as he thinks his father would have done). Unfortunatelly this resulted in him being taken into custody by the police. Amina is torn between her children and struggles to find ways to support the eldest and to restore their lost relationship. All the children were referred to us by their different schools for therapy whilst Amina and her mother were also referrred to us for therapy by their resettlement support caseworker.

Action taken and difference made: Amina has needed a lot of support with her past trauma, on how to manage appropriate boundaries and in coming to terms with her own losses and feelings. There were many issues and needs and it was very difficult to engage the family in therapy without dealing with the practical issues first. The school tried to ensure the eldest children's attendance by sending a bus to their home to collect them but without success. The welfare of the youngest two children was felt to be at risk due to the constant arguing and police invovement with the two eldest childern. There was also shared concern for the safety and welfare of their grandmother who has heart problem. Consequently it was agreed that the family be referred to Social Services which resulted in child protection measures being put in place. Whilst we did not provide therapeutic support for the family we were effective in helping the family access statutory support and ensure safeguarding protections by working effectively to bring schools and other agencies together in a multi agency approach. We remain able to provide further assistance if needed and requested in future.

Case study Ahmad - (aged 12)

Background: Ahmad is a 12 year old boy who came to the UK with his two parents and one brother on the VCRS programme in summer 2019. The family was referred to the family therapy service by their refugee organisation project worker due to concerns about Ahmad's low mood. Ahmad suffers from cerebral palsy which affects his mobility and ability to speak. His additional needs have delayed his school allocation significantly which means that Ahmad is at home at all times, except when he has to attend multiple medical appointments. Ahmad cannot walk far, so the family need to use public transport or a taxi every time they need/want to go out.

Action taken and difference made: The family therapy sessions focused on introducing play time between family members, while also slowly exploring their feelings about Ahmad's condition. This allowed Ahmad to share his feelings of sadness and guilt about his condition and his parents to share stories of strength and resilience. Similarly to other refugee families, Ahmad's family needed time to feel able to share negative feelings within sessions and to utilise family therapy in a way that they find helpful. The sessions have recently started focusing on Ahmad's anxiety and on ways to actively address it.

Case study - Abdel (aged 9)

Background: Abdel is a 9 yr old boy who lives with his dad. His dad describes him as "nervous", he gets easily irritated and shouts, and he can't sleep alone. At school he responds strongly to other childrens' teasing, at times using violence. Abdel's family resettled to the UK three years ago but they have been through a number of significant difficulties since arrival. The family have also had historic traumatic experiences in their country of origin. Domestic abuse led his mother and brothers to relocate to a different part of the country after they came to the UK. Abdel's previous school did not see his behaviour as a sign of stress or trauma and responded punitively by excluding him. Abdel moved houses and schools a number of times in a short period of time and then his family experienced hate crime in the community where they were accomodated.

Action taken and difference made: As it became clear that Abdel did not feel safe anywhere and was finding it hard to trust people, it was important to tailor the support to his needs and extend it beyond the traditional clinical setting. We contacted Abdel's new school in advance of his admission and offered clinical consultation to staff. This led to regular contact with the school's safeguarding lead, and progressively with Abdel's teacher and headteacher. We also offered family therapy and 1-1 therapy to Abdel's father, in order to discuss his worries. We also jointly explored how to recognise

Abdel's triggers, how to avoid them and how to respond to him when he has been triggered. Finally we also set up regular TAF meetings with Abdel's dad, the school staff and Early Help.

As Abdel's family dynamics remain unpredictable, it is still difficult for him to feel safe. However some progress can be identified: Abdel's new school has been become the positive constant in his life which offers structure and consistency. School staff are invested in offering Abdel a different experience: a safe educational setting which can contain his anger when he's been triggered. They are also being supported to explore the reasons behind Abdel's behaviour - including how the staff contribute to it - and to recognise small signs of progress. Unfortunately Abdel's life has again changed unpredictably as a result of COVID-19 and therefore not being able to attend school.

Perspectives from the refugees

The following are further examples of feedback provided by the refugees who have been supported by the project. These were obtained from interviews with 44 refugees that were conducted by volunteers or staff who had not been directly involved in delivering the project. Some refugees were interviewed individually, others as a family. As the beneficiaries of the project their views are the most important and as can be seen from the quotes below, their experiences are an affirmation of the value of the work of the project. There were many more examples of the positive feedback that could have been included in the report.

'The help [of the project] is excellent. I am so different now from when I came. I know how to speak and who to speak to.'

'She [the therapist] taught us to look to the future in a better way.'

'I discovered things with my children that I didn't know before, like how and why they are thinking some things and what they feel.'

'Me and my children have gone through a very hard time. Now I will hold meetings with my children to discuss things together. Our family relationship is getting better.'

'The most helpful support that I got from anywhere in this [difficult] time has been from the project.'

'It [the therapy] was very helpful for me and my children – it has helped us to go a step forward.'

'When I started therapy, I was very small - after therapy I feel more grown-up.'

'The therapist knows how to reach a child, a young person and me as an adult and talk to us all together in the right way, with respect.'

'At school, there were a couple of issues and the therapist helped the children settle at the school, the children loved the sessions and it was their favourite day when the therapist came.'

'Our child always finds it difficult to talk to people, but he liked the therapist so much that he talked to her.'

'There were lots of things I didn't know. The therapist helped me emotionally and with my children. My son feels more settled in school now. '

'I feel happier than I was before.'

'The therapist helped me to understand the impact of trauma and how my children are different because of that.'

'The therapist helped me understand my children's behaviours. Now my son is making positive relationships and is going to the gym. He never used to go anywhere, but now he is more open and has friends.'

'It [the therapy] has helped reduce the pressure on me as a mother.'

'I was given ways of dealing with my son's behaviour.'

'The schoolteachers understand my children more and they understand our circumstances.'

'The therapist helped me see how distressed they [my children] really were and the problems they had and helped me understand them and help them more.'

'The therapist helped me to relax and think about my own emotions so that I could express them. I feel true to myself and I know my emotions better.'

'Everything about the service [therapy] was brilliant. The way we were accepted and welcomed has been so good.'

'We really needed the service as we felt lost - we are different now.'

'It's an excellent service, I recommend it for other families.'

'Every family should get this therapy – it should be compulsory.'

'I am better emotionally and getting what I want from life.'

'I had wanted to change school but after the [therapy] sessions I am okay to stay – for my own good'.

'She [the family therapist] gave me the confidence and advice to communicate better and to help my daughter feel better. Now my daughter has lots of friends.'

Appendix 1 - methodology of the evaluation

The evaluators conducted a range of activities for the evaluation, including:

- Desk top research (see separate list of background materials referred to).
- Consultation with internal and external stakeholders by a variety of methods, including interviews, online surveys and obtaining written feedback (see separate list of stakeholders who contributed).
- Participation in two practitioners' meetings.
- Attending the project board meetings.
- Visiting the partners to enhance their understanding of the context within which the project was being delivered.

The evaluators devised a framework of questions that was used for all of the consultations with stakeholders. Sometimes the questions were modified depending on the category of stakeholder.
In addition to client input (see below) a total of 58 stakeholders contributed to the evaluation as shown in the following table.

CFWP Project stakeholder groups	Numbers consulted
External stakeholders (based in local authorities and other organisations)	13
Schools	17
Internal stakeholders (based in CFWP partner organisations)	28
Total	**58**

There were challenges in obtaining the input of some external stakeholders – more had been approached to contribute but did not reply to the request.

Service user input into the evaluation

The partners conducted evaluation-specific interviews with service-users (sometimes referred to as clients) to obtain their perspective. The interviews were conducted by staff and volunteers from within the partner organisations who were not themselves providing the therapy. These client evaluation interviews differed from interviews that the therapists had with clients as part of the therapeutic support that they provide, for example the clinical assessment interviews conducted at different stages in the therapy.

The evaluators provided 'client interview preparation sessions' for the staff and volunteers at Haven, Solace and Refugee Council who conducted the client evaluation interviews. These sessions provided guidance on good practice involved with interviewing clients and how these interviews fitted into the project evaluation. All the partners used a similar framework of questions in the client interviews. In total 44 refugees contributed to the evaluation interviews.

Appendix 2 – stakeholders consulted for the evaluation

	Stakeholder	Role	Organisation
1.	Joanne Peel	Team Manager Children's Social Care	Bradford Council
2.	Salwa Abdelrehim	Refugee Support Worker	Horton Housing
3.	Matthew Broadly	Year 10 Pastoral Manager	
4.	Helen Butler	Learning Support Manager	Beverly High School
5.	Gurdeep Kaur	Family Link Worker	Bradford Academy
6.	Jenny Long	Administrative Assistant	Le Cateau Community Primary School
7.	Rehan Majeed	Resettlement Project Worker	Refugee Council (Leeds)
8.	John Craig	Forward Planning, Housing Strategy and Development Manager	East Riding of Yorkshire Council
9.	Natalya Shepherd-Cutler	Migration Services Team Leader	Calderdale Council
10.	Sarah Rollin	Area Manager North Yorkshire &Wakefield	Refugee Council (Wakefield)
11.	Tim Woodhouse	Community Development Worker	Refugee Council (Leeds)
12.	Sarah Addis	Designated Safeguarding Lead, Pupil Engagement Worker	Broom Valley Primary, Rotherham
13.	Claire Gurnell	Head of Centre	St. Patrick's, Hull

14.	Debbie Robinson	Designated Safeguarding Lead	Wheeler Primary School Hull
15.	Francis Console	Children & Families Worker	North Yorkshire Children and Family Early Help Team
16.	Gemma Fletcher	SENCO Year 6 Teacher	Burley St. Matthias CoE Primary School
17.	Janet Peacock	Pastoral Leader	Hookstone Chase Primary
18.	Kim Davis	Lead teacher of the Deaf (Secondary)	Leeds Inclusion Service - DAHIT
19.	Lynn Dove	Learning Manager	Bramley Park Academy
20.	Sharon Wardell	Emotional Wellbeing lead	Wheeler Primary School Hull
21.	Stacie Eriksson	EAL coordinator and English teacher	Outwood City Fields Wakefield
22.	Viv Watson	Head teacher	Hookstone Chase Primary
23.	Kissi Wilde	SENCO	Belle Vue Girls Academy
24.	Kimberley Brundell	Tenancy Support Officer	Ongo (North Lincolnshire)
25.	Debbie Hammond	Syrian Resettlement Programme Manager	Hull City Council
26.	Lynda Lo	Resettlement Education Manager	Hull City Council
27.	Reem Katrameez	Project Worker Resettlement Team	Refugee Council (Leeds)
28.	Agnes Ndebele	Counsellor /Family Psychotherapist	Haven
29.	Anne Burghgraef	Clinical Director	SOLACE
30.	Chandraa Bhattacharya	Resettlement, Asylum Support & Integration	Home Office

31.	Hernan Sosa-Canal	Therapist	SOLACE
32.	Jude Boyles	Project Manager VPRS Therapeutic Services	Refugee Council
33.	Kathryn Ashworth	Chief Executive	SOLACE
34.	Paula Boston	Clinical Supervisor	SOLACE
35.	Stella Munthali-Armstrong	Liaison Case Worker	Haven
36.	Stuart Murray-Borbjerg	Part of AMIF project	Haven
37.	Amy Smith	Education Coordinator	Sheffield Council
38.	Sue Shelley	Housing Service Development Manager	Rotherham Council
39.	Akoi Bazzie	Community Development & Volunteering Co-ordinator	Refugee Council
40.	Annemarie Morsch	Project Worker Gateway Resettlement Team	Refugee Council
41.	Gutema Kussa	Resettlement Project Worker	Refugee Council
42.	Hannah Wellington	Resettlement Project Worker	Refugee Council
43.	Jack Owen	VPRS Community Development Worker	Refugee Council
44.	Julie Angelidou	Child and Family Therapist	Refugee Council
45.	Kat Bradford	Administrator	Refugee Council
46.	Rafa Qaid	Interpreter	Refugee Council
47.	Shaimaa Khattab	Interpreter	Solace

48.	Helen Crook	Co-founder	Freedom School, Wakefield
49.	Dianne Hamilton	Head of CYP & Wellbeing	Goodwin Trust (Haven)
50.	Jackie Wright	Manager	Haven
51.	Gayle Clark	Part of AMIF project	Haven
52.	Kate Graham	Therapist	SOLACE
53.	Mo Theodusius	Therapist	SOLACE
54.	Philippa Kempe	Therapist	SOLACE
55.	Jessica Ross	Senior Resettlement Worker	Refugee Council
56.	Katie Mumba	Employment and Training Adviser	Refugee Council
57.	Mahmoud Abdalla Ibrahim	Resettlement Project Worker	Refugee Council
58.	Myriam Trabelsi	Resettlement Project Worker	Refugee Council

Appendix 3 – the quarterly reporting template

Quarter Report for October 2019 – January 2020 ORGANISATION NAME -

Key staff engaged in delivering the project and their roles	
Name(s):	Role(s):

Information/Briefing/Training Sessions held during the quarter:	
Organisation	Brief description of intervention

Brief description of your referral process:

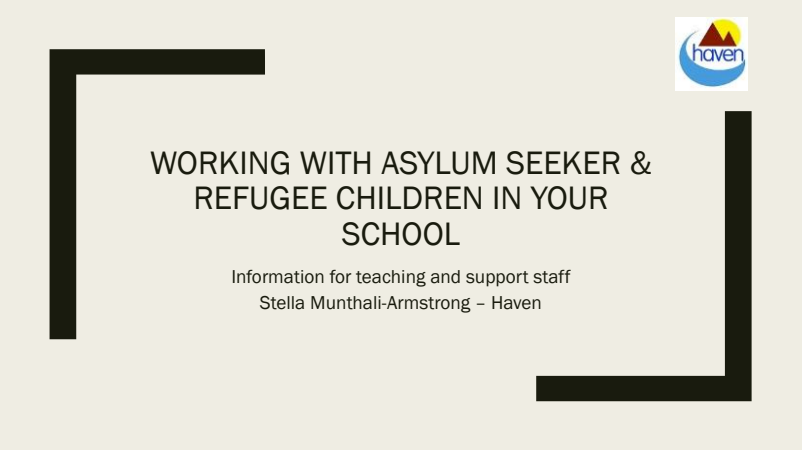
Referrals IN to service	**Total for Qtr.**
From School	
From GP	
From Family	
From Refugee Council Project Worker	
From Local Authority Project Worker	
From Other Sources (please use additional rows):	

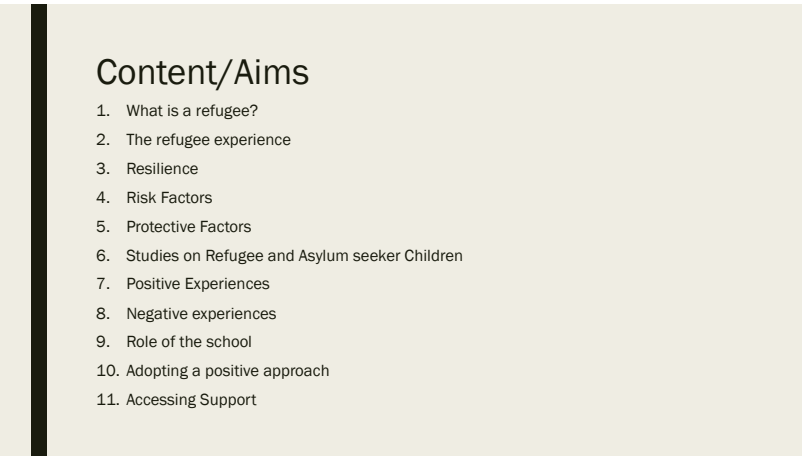
No. individual children who have received support in quarter			
No. families who have received support in quarter			
Current case load (individual children)			
Current case load (families)			
	By Therapist/Liaison caseworker	**By client**	**Referred to other services**
No. children's cases closed in Qtr.			
No. family cases closed in Qtr.			

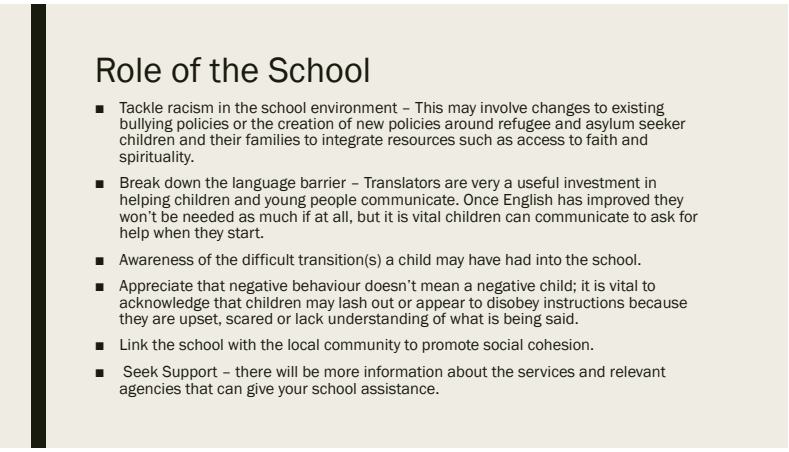
Case Study (please be brief):

Issues (difficulties/gaps in service/good practice etc):

Appendix 4 – example of the training material used by the project when raising awareness with schools – extract from the presentation used by Haven







Appendix 5 – descriptions of therapeutic methods

The following are brief and basic descriptions of some of the therapeutic methods used in the project. They are not definitive and there may be different ways that others in the field of therapy would describe them. They are intended to provide the lay reader with a sense of what is involved in some of the different therapeutic approaches.

Eye Movement Desensitisation and Reprocessing (EMDR) therapy involves the identification of unprocessed traumatic or other distressing experiences that are continuing to drive an individual's psychological disturbance. It is an evidence-based therapy used to help with the symptoms of mental health disorders and in particular PTSD (Post Traumatic Stress Disorder).

When a traumatic or distressing experience occurs, it can overwhelm normal coping mechanisms. As a result, these unprocessed memories and the accompanying sights, sounds, thoughts and feelings are stored in the brain in 'raw' form, where they can be accessed each time we experience something that triggers a recollection of the original event.

The goal of EMDR is to reduce the long-lasting effects of distressing memories by engaging the brain's natural adaptive information processing mechanisms, thereby relieving present symptoms. The therapy uses an eight-phase approach that includes having the client recall distressing images while receiving one of several types of bilateral sensory input, such as side to side eye movements.

Today, the therapy is used to treat a wide range of psychological difficulties that typically originate in trauma, such as direct or indirect experiences of violence, accidents or natural disaster. EMDR therapy is also used to treat more prolonged, low-grade distress that originates in shock or loss in adult life and/or issues experienced during childhood. The experiences outlined above often lead to a post-traumatic stress disorder diagnosis, for which EMDR has been recommended by the National Institute of Health and Care Excellence (NICE).

Play therapy combines talking therapy with creative exploration through play. In sand-play, for example, clients choose toys to represent people, animals and buildings and arrange them in the controlled space of the sandbox. The therapist is trained to have a comprehensive psychological understanding of the inter-relationship between the toys chosen and how they are placed and described to reveal elements of the client's perceived reality.

Play therapy can be particularly effective for clients who have difficulties verbally expressing themselves. Play therapy can also be useful for people who have experienced trauma, such as refugees, and for people with learning difficulties.

Family therapy is a branch of psychotherapy focusing specifically on family relationships. It works from the premise that a problem lies within the family as a whole, rather than with a single person within the family unit.

Family therapy encourages change and development, and the combined resolution of family conflicts and problems. The focus is on how families interact together, emphasising the importance of a functioning family unit for psychological health and wellbeing. Regardless of the origin of an issue, or whom the problem lies with, the therapist's aim is to engage the family in beneficial solutions, seeking constructive ways for family members to support each other through direct participation. A skilled family therapist will have the ability to influence conversations in such a way as to harness the strength and the wisdom of the family unit as a whole, taking into consideration the wider economic, social, cultural, political and religious context in which the family lives, and respecting each individual's different perspectives, beliefs, views and stories.

Group psychotherapy is a branch of psychotherapy intended to help people who would like to improve their ability to cope with life's difficulties and problems but in a group situation.

In group therapy, one or more therapists work with a small group of clients together. Group therapy is not based on one single psychotherapeutic theory, but many, often revolves around talking and may also include other approaches.

The aim of group psychotherapy is to support the solving of emotional difficulties and encourage the personal development of the participants in the group. The combination of past experiences and experiences outside the therapeutic group, with the interactions between group members and the therapist's, becomes the material through which the therapy is conducted. These interactions might not be perceived as entirely positive, as the issues that the client has in daily life, will inevitably be reflected in his or her interactions within the group setting. However, this allows for valuable opportunities for such problems to be worked through in a therapeutic setting, generating experiences, which may then be translated into "real life."

Appendix 6 – background documents referred to for the evaluation

External documents

- How Schools are Integrating new Migrant pupils and their families
- Transcending Educational Boundaries – challenges to the educational inclusion of refugees in Europe's two seas area
- Wellbeing toolkit
- Home Office Indicators of Integration Framework 2019
- Sussex University report on the integration of resettled refugees Dec 2018
- Health of Migrants in the UK (July 2019) Migration Observatory (Oxford University)
- How to Support Young people (asylum seekers) - GMIAU guide for LAs July 2019
- Asylum Statistics up to June 2019
- BAME Positive Practice Guidance for Improving Access to Psychological Therapies - see https://www.babcp.com/Default.aspx.

- Directory of Mental Health and well-being resources for refugees in England.
- Northern Schools IPPR Research paper summary May 2016
- Syrian refugees in Oxford research (COMPAS University of Oxford 2019)
- Education and mental health IPPR North research paper 2016
- NHS Mental Health Implementation Plan 2019-2020
- Systems Changes in Mental Health work with UASC
- Improving Access to Psychological Therapies (IAPT) – BAME service user positive practice guide
- Anti-Bullying Week newsletter
- A Health needs assessment for asylum seekers and other vulnerable migrants in Southampton and Portsmouth
- An exploration of asylum seekers' mental health needs versus services provided within Brighton & Hove 2018
- Lancet article published 2018 - https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30051-3/fulltext
- Migration Policy Institute report 2015 - https://www.migrationpolicy.org/research/educational-and-mental-health-needs-syrian-refugee-children
- Migration Observatory research into migrant health
- https://migrationobservatory.ox.ac.uk/resources/briefings/the-health-of-migrants-in-the-uk/

Internal documents

- Information sheet for clients
- Therapeutic Services Assessment forms and Clinical outcomes measuring tools
- Confidentiality form for clients
- Referral forms
- Children and Families Wellbeing Support Information Leaflet
- Supporting Refugee Children in schools – presentations used in training for schools
- Project plan
- Newsletter for the project
- Consent form for interviewing clients
- Business Case for the CFWP Sept 2019
- Quarterly outputs reports
- Guide for local authorities on Syrian refugee resettlement
- Self-evaluation reports from the partners, narrative case studies and O
- output and outcomes summaries.

Appendix 7 – flier for learning event

Because of the Covid-19 pandemic the event was postponed and will be held either virtually or in person when possible.

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