DEVELOPING A SUSTAINABLE PROGRAMME: DESIGN AND EVALUATION

by

REBECCA ANNE TYRER

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THESIS OVERVIEW

This thesis is comprised of three projects which are related to programme development and evaluation. In the process of undertaking the various projects, I have learned how to apply the most appropriate research methodologies and professional standards to acquire data which is reliable, valid, and credible in order to address questions regarding the performance and potential implementation of programmes. While all projects were related to programme development and evaluation, the methods applied to each were different. I was fortunate enough to work in two contrasting environments: Oxford University Psychiatry Department, whose focus is on research; and split NHS sites in Coventry, Longford Community Mental Health Team (CMHT) and the Caludon Centre (the mental health department at the Walsgrave hospital) where the focus is on diagnosis and treatment.

The following three sections will reflect upon the experiences I had in conducting research in these settings.

School and Community Based Interventions for Refugee and Asylum-seeking Children: A Systematic Review

The first project involved conducting a systematic literature review to examine existing evidence on mental health interventions for refugee and asylum-seeking children.

Having never previously conducted a systematic review, I felt it important to follow the most appropriate guidelines. COCHRANE and PRISMA present highly effective protocols which increased my confidence to perform the task to a good standard.

The working environment at Oxford University is highly academic. I had the opportunity to discuss the varying projects being carried out within the department, providing me with an insight into the workings of a research department. As a result of this experience I have become aware of the challenges surrounding communication within research teams while also ensuring information that could bias assessors' judgments be kept anonymous.

Supervision provided me with an opportunity to learn and reflect upon the review process. My supervisor has published numerous papers in this field which helped me feel reassured in my own research; I felt confident to submit this review for publication in PLOS ONE. I had never submitted a paper for publication before and I learned a lot about the importance of selecting the most appropriate journal for the research area. Furthermore, my supervisor and I felt that we needed a journal with a high impact factor and which offered open access. I found the support I received in weighing up all this information both valuable and insightful.

Evaluation of a Training and Supervision Programme in Cognitive Behavioural Approaches

During my second placement I was asked to evaluate a training and supervision programme in cognitive and behavioural approaches. This was achieved by way of

interviews within a CMHT in Coventry, which were then analysed using Template Analysis (TA).

It was interesting that this placement took place at a time when a new government initiative was about to be rolled out; the introduction of a system of care clusters and the ensuing payment by results policy. This was reflected during the interviews providing me with an insight into the resistance and challenges this new approach could bring. I was also surprised to discover that given the large psychological component of clinicians' work within CMHT, the allocated Clinical Psychologist was only available one day a week, indicating inadequate funding within the NHS for this role. Conducting research in the NHS was challenging given the time and financial pressures which staff are under. However, I have gained a valuable insight into the workings of the NHS.

This placement gave me an appreciation of the complex workings of multi-disciplinary mental health teams which bring the benefit of holistic care and also the challenges of daily working relations between people from various disciplines.

An IPA Study Exploring the Experiences of School Staff Working to Promote Mental Health Among Refugee and Asylum-seeking Children

My final project followed on from the systematic literature review in placement one. This involved the on-going development towards creating an effectiveand sustainable approach used to facilitate the mental wellbeing of refugee and asylum-seeking children in schools.The second phase of research involved gaining the

views of relevant school staff; uncovering their perspective of what is currently happening in schools and the support they feel is needed.

As my second project taught me the importance of using a “bottom-up” approach to ensure programme take up and sustainability, I therefore understood the importance in gaining the views of school staff who work closely with these children. I used Interpretative Phenomenological Analysis (IPA) in order to understand the ‘lived experience’ of the staff recruited.

While the knowledge gained from undertaking the systematic literature review enabled me to ask new and insightful questions, this may have influenced the development of my themes, especially given the personal subjectivity associated with IPA. Supervision offered me the chance to check the validity of my themes and also discuss ideas about how to broach potentially sensitive topics. Furthermore, the theoretical knowledge I gained from the literature meant that while the topic was theoretically and psychologically salient to me, some participants found it hard to identify with. Consequently, I had to consider my use of language to extract the data that would allow me to answer my research question without shaping the topic.

In summary

During the course of this MRes I have expanded my research knowledge greatly; I have learnt to conduct systematic literature reviews and use qualitative methodology, namely TA and IPA in order to answer questions concerning policy and health care interventions. I feel this has encouraged me to develop skills in critically appraising

research as well as ensuring that research is relevant in order to further psychological knowledge and understanding.

I have enjoyed collaborative working with my supervisors during the three placements and believe the supervision I received has improved my critical and analytical skills, in particular my ability to synthesise material and keep recommendations for future practice grounded in the data.

ACKNOWLEDGMENTS

I would like to thank my academic supervisors at the University of Birmingham, Dr Gary Urquhart Law and Dr Michael Larkin. Dr Gary Urquhart Law offered a great deal of supervisionduring my final research project which enabled me to reflect and develop the most appropriate themes to match the data.Dr Michael Larkin provided me with support during my second placement offering time to help me develop a template for analysis; furthermore, he always had time to discuss any problems that arose during the course of the year.I would also like to thank the supervisors I worked with while on placement, Dr Mina Fazel dedicated a great deal of time and energy to help me fulfil the ambitious aims of my first placement and has been encouraging throughout the year. Susan MacPherson who I worked with during my second placement was instrumental in helping me understand how NHS Trusts operate in Coventry and Warwickshire.

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CHAPTER ONE: SCHOOL AND COMMUNITY BASED INTERVENTIONS FOR REFUGEE AND ASYLUM-SEEKING CHILDREN: A SYSTEMATIC REVIEW

Abstract

Background

The need for interventions in environments more easily accessed by children and families is especially relevant for newly arrived populations. This paper reviews the literature on school and community-based interventions aimed at reducing psychological disorders in refugee and asylum-seeking children.

Methods and Findings

Searches were conducted in seven databases and further information was obtained through searching reference lists, grey literature, and contacting experts in the field. Studies were included if they reported the efficacy of a school or community-based mental health intervention for refugee or asylum-seeking children. Twenty studies met inclusion criteria,reporting on interventions for over 1600 refugee children.Thirteen studies were carried out in high-income countries in either school (*n*=11) or community (*n*=2) settings andseven studies were carried out in refugee camps.Interventionswere either primarily focusedon the verbal processing of past experiences (*n*=8), orcreative art techniques (*n*=7) and others used a combination of these (*n*=5). While both intervention types reported significant changes in symptomatology, effect sizes could only be calculated for thosefocusing on the verbal processing of past experiences, these having effect sizes ranging from 0.31 to 0.93.

Conclusions

Only a small number of studies fulfilled inclusion criteria and the majority were in the school setting. Findings suggest that interventions within this setting can be successful in helping children overcome difficulties associated with forced migration.

Introduction

The stressful experiences of many refugees and asylum-seekers during forcedmigration,make them vulnerable to a range of psychosocial problems(Reed, Fazel, Jones, Panter-Brick, & Stein, 2012). As more is understood about the rangeof potential psychological sequelae of traumatic events experienced by refugees, research for effective interventionshas intensified (Basoglu, 2006). These interventions can be delivered to individuals, families or groups in either clinical or non-clinical/community settings. The focus can be either primarily on potentially traumatic events ormulti-modalin design, concurrently addressing various issues in the child's environment and social networks including psychological needsas well as past experiences (Miller & Rasmussen, 2010; Nickerson, Bryant, Silove, &Steel, 2011). Potential interventions can therefore be limitless so developing a coherent evidence-base is crucial to ensure that effective interventions can be replicated and ineffective onesdiscontinued.

The UNHCR estimated that at the end of 2011 there were 10.4 millionrefugees worldwide, of whom approximately half were under 18. Only a small proportion of refugees reach high-income countries (less than half a million in 2011) (UNHCR,

2011b). Under the UN Refugee convention, the term ‘refugee’ is defined as someone who has fled their country of origin due to a well-founded fear of persecution because of race, religion, nationality, membership of a particular social group or political opinion (UNHCR, 1992). An ‘asylum-seeker’ is waiting for refugee status.

Mental Health Issues in Refugee Populations

The prevalence of psychological disorders varies amongst refugees across studies, although high rates of post-traumatic stress disorder (PTSD) appears to be a common theme. A study which compared rates of psychological problems among 300 school-children living in the UKshowed that refugee children scored significantly higher than two control groups on the teacher-rated Strengths and Difficulties Questionnaire with one quarter of refugee children showing serious difficulties. The refugee children, compared tonon-refugee children from ethnic minorities and indigenous white children, had significantly more total difficulties ($p < .01$) (Fazel&Stein, 2003).

When refugee and asylum-seeking children arrive in a resettlement country, they might have experienced potentially traumatic events with unaccompanied children particularly at increased risk of significant psychological difficulty (Hodes, Jagdev, Chandra, &Cunniff, 2008) Post-migration events, such as stringent border controls, discrimination and social isolation can expose children to further risk of developing psychological disorders(Fazel, Reed, Panter-Brick, & Stein, 2011; Porter &Haslam, 2005). Furthermore, children have to negotiate many new challenges in

resettlement,such as learning a new language and understanding the educational and cultural environments of a new school (Ehntholt, Smith, & Yule, 2005).

Refugee Camps

The 2011 UNHCR Global Report highlighted that one third of all refugees are living in camps (UNHCR, 2011a). These present challenging living conditions where basic survival can become the overriding focus for families, delaying restoration of the community and social milieu needed for healthy development(Andemicael, 2011). It is estimated that vast numbers of children living in camps have significant psychological difficulties, exacerbated by the numerous potential adversities, such as insecurity, malnutrition, limited access to education, lack of parental work, poor health and exposure toviolence and abuse(Crisp, 2000).Artistic activities in refugee camps have been used to engage recipients into ‘constructive action’(Andemicael, 2011).

Challenges Accessing Mental Health Services

Despite a need for mental health interventions forrefugee ad asylum-seeking children, accessingservices can beproblematicfor linguistic, social, and historical reasons(Folkes, 2002). Cultural and family beliefs about psychological difficulties can also prevent families seeking professional help (O'Shea, Hodes, Down, &Bramley, 2000).Past experiences can also make it difficult to establish a sense of trust necessary for a therapeutic relationship (Henley & Robinson, 2011). Using school and community-based mental health interventions could be an effective means of

accessing newly arrived young people as well asreducing stigma (Hodes, 2000; Rousseau &Guzder, 2008).

The School Context for Mental Health Interventions

Schools could provide an ideal setting to implement interventions to address the mental health needs of refugee children. School staff can identify difficulties as they observe children's behaviour in structured and unstructured settings(Masia-Warner, Nangle, &Hansen, 2006).School-based interventions delivered in a safe and informal setting potentially offer non-stigmatizing services which families may be more likely to accept given the interaction with school staff and the relatively easy access to children in school (Beehler, Birman, & Campbell, 2012).

Researchers have noted acculturation develops in the school context and therefore providing support either on an individual basis or using a multimodal approach may serve to enhance socialization and support psychological adjustment and development(Birman, Weinstein, Chan, &Beehler, 2007; Rousseau, Singh, Lacroix, Bagilishya, &Measham, 2004).Working with groups of children who have come together naturally in the school context can strengthen the child's relationship to the group through shared responsibilities and team work while simultaneously providing practical support (Ehntholt,*et al.,* 2005).

Drawing on the Literature

Investigation into successful mental health interventions for this population is necessaryas little is known about which theoretical models or implementation

strategies are most appropriate (Hodes, 2000). Creative activities in the classroom that allow children to construct personal accounts of their lives, interact with others and express emotion have consistently been found to have a beneficial effect on self-esteem, conflict resolution and problem solving (Schaefer, 1993; Torbert, 1990). A reviewof mental health interventions for children affected by war reported that creative-expressive, psycho-educational and recreational activities were most studied.

Aims of the Study

To conduct a systematic review of mental health interventions thathad been evaluated in school or community-settings for refugee and asylum-seeking children.

Method

Search Strategy

Seven databases were systematically searched: CINAHL; Embase; ERIC; PsycINFO; Scopus; Sociological Abstracts and Web of Science withsearches of similar terms combined (See appendix 1A for search strategy for PsycINFO). Studies of mental health interventions in school and community-settings for refugee and asylum-seeking children from January 1987 to December 2012 were identified. The search was completed in January 2013. Grey literature was searched (WHO database), article reference lists and authors of significant papers were checked for other relevant articles and experts in the field were consulted. There were no language restrictions.

Inclusion Criteria:

Selected articles were based on the following criteria:

(1) Evaluation of a mental health intervention programme that addressed emotional, social or behavioural difficulties of the sample using a controlled or within-subjects experimental design

(2) The population was inclusive ofinternally displaced persons (IDPs), refugees and asylum-seekers

(3) Age between 2 to 17 inclusive

(4) Intervention delivered inschools, refugee camps or the community as opposed to clinic and hospital-based settings

(5) Intervention outcome was evaluated with a clinical psychometric measure

Exclusion Criteria:

(1) Interventions that primarilyevaluated educational performance or language acquisition

(2) Interventions that aimed to change the overall school environment without specific measures for refugee and asylum-seeking children

(3) Non-displaced children and adolescents in areas of on-going conflict

(4) Single case studies

Quality of Ratings Scale

Following a broad review of quality rating scales (Olivo*et al.,* 2008), the Yates Scale was chosen to evaluate the quality of studiesas it was comprehensive and has been used in similar reviews(Yates, Morley, Eccleston, &Williams, 2005). The Yatesscale focuses on treatment quality and quality of design and methods. The quality rating of each study was assessed independently by tworaters and any discrepancies discussed (See appendix 2A).

In the Yates Scale, theevaluation of quality design and methodsincludesstudy sampling, minimisation of bias, outcome measures, control groups and statistical analyses. Scores range from 0 to 26 (0-8: 'not fulfilled'; 9-17: 'partially fulfilled'; 18-26: 'fulfilled').The evaluation of treatment quality includesthe rationale and explanation of the treatment, whether it is manualised, therapist training or patient engagement. Scoresrange from 0 to 9 (0-3: 'not fulfilled'; 4–6: 'partially fulfilled'; 7-9:'fulfilled').

Effect Size

Effect sizes of the study interventions were obtained frompublications where provided or calculated using a procedure outlined byThalheimer andCook (2002). Cohen's *d* effect sizes were computed for symptom change to present data in a manner that could be compared across studies, given the high clinical heterogeneity of the sample(Cohen, 1988). Cohen proposed $d = 0.2$ as a small effect size, $d = 0.5$ as a moderate effect size, and $d = 0.8$ as a large effect size(Cohen, 1988). As limited

follow-up data were available, the effect sizes were calculated from end of treatment scores.

Results

The database search identified 2,237 potentially relevant papers, of which 22 met the inclusion criteria, reporting on 20 studies(Refer to Figure1 for process of study selection).The studies were undertaken in ten different countries on either specific refugee populations or mixed groups of migrant children, including refugees.Through searching article reference lists one further unpublished study was identified which could not be obtained(Paardekooper, 2002).

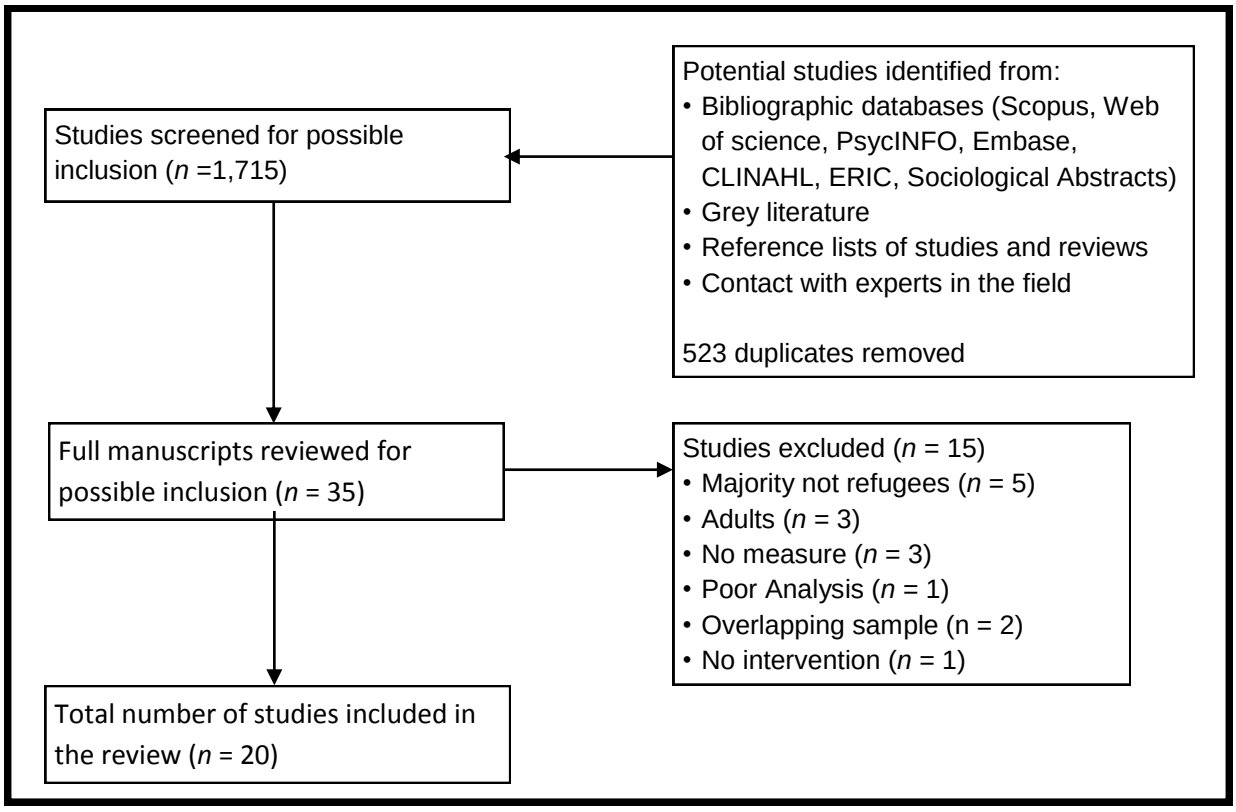


Figure 1 - Flow Diagram to Show the Process of Study Selection

Intervention Features

All twenty studies meeting inclusion criteria were published since 2000 and included data from over 1,600 children.These reported school and community-based interventionsaimed at the mental health, psychosocial development and functioning of refugee and asylum-seeking children. Table 1 presents a summary of the studies included with information on the intervention used, the population targeted and the assessment of study quality. Given the marked difference of refugee camp settings, the interventions that were provided for these are presented separately.

Due to the considerable variation in the types of intervention being delivered and the populations targeted by each intervention, a meta-analysis could not be conducted. Two broad classes of intervention were identified, interventions based primarily on the verbal processing of past experiences (*n* = 8) and creative art techniques (*n* = 7) with 5 further studies using a combination of both. The verbal processing approaches included Cognitive Behavioural Therapy (CBT),Trauma Focused-CBT (TF-CBT); Narrative Exposure Therapy (NET) and Eye-Movement Desensitization and Reprocessing (EMDR). The creative art techniques drew on different therapies including music therapy, creative play, drama and drawing. The range of different mental health interventions utilised in the included studies is shown in Figure 2. Services were delivered either in the school (*n* = 11), community (*n* = 2) or refugee camps (*n* = 7 of which 2 were in camp schools). Of these, three studies included consultation meetings with professionals working in other agencies (Birman*et*

*al.,*2008; Durà-Vilà, Klasen, Makatini, Rahimi, &Hodes, 2012; Fazel, Doll, & Stein, 2009).

Table 1. Summary of Included Studies

First Author	Setting	Country	Intervention focus	Intervention	Study type	Target population	Selection criteria	Sample size*	Age yrs	Outcome measures	Quality: Experimental design	Quality: Treatment procedure
STUDIES from High-income settings												
Baker 2006	School	Australia	Creative arts	Group	CCT: Cross-over design	Newly arrived refugees	Present at school for following two terms	31	11-16	Emotional, behavioural & cognitive	Partially fulfilled	Not fulfilled
Barrett 2003	School	Australia	CBT (FRIENDS)	Group	Case-control study: classes grouped together	Mixed migrant population, approx. half refugees	EAL class	166	6-19	Emotional	Partially fulfilled	Fulfilled
Beehler 2012	School	USA	CBT, TF-CBT, supportive therapy, case management (CATS)	Group and individual	Cohort study: two school districts	Mixed migrant population, small proportion refugees	Those referred by staff, nurses or parents	1043 /149	6-21	Emotional, behavioural, cognitive & physiological	Not fulfilled	Partially fulfilled
Birman 2008	Community	USA	Counselling, therapy, case management, creative arts (FACES)	Group, family and individual	Cohort study: attending specialist service	57% Refugees and asylum seekers, 43% other types of migrant	Those referred to staff	97 (68)	6-18	Emotional, behavioural & cognitive	Not fulfilled	Not fulfilled

Dura-Vila 2012	School	UK	Individual, family & supportive therapy.	Individual and Family	Cohort study: referred to specialist service	Refugees and asylum seekers	Referred by teachers & social workers	102 (35)	3-17	Emotional & behavioural	Not fulfilled	Not fulfilled
Ehntholt 2005	School	UK	CBT	Group	CCT	Asylum-seekers	Referred by teachers	15	11-15	Emotional, behavioural, cognitive & physiological	Not fulfilled	Fulfilled
Fazel 2009	School	UK	Supportive therapy and creative arts	Individual, Family and Group	Cohort study: referred to specialist service	Refugees and asylum seekers	Referred by teachers	69 (47)	5-17	Emotional, behavioural & cognitive	Partially fulfilled	Not fulfilled
Fox 2005	School	USA	CBT	Group	Cohort Study	South-East Asian refugees	All those attending a school	58	6-15	Emotional	Not fulfilled	Not fulfilled
Kalantari 2012	School	Iran	Exposure through writing	Group	RCT	Afghan refugees	High score on traumatic grief measure	29 (29)	12-18	Emotional	Partially fulfilled	Partially fulfilled
Möhlen 2005	Community	Germany	Creative arts	Group	Cohort study	Kosovo-Albanian refugees	In refugee accommodation.	10 (10)	10-16	Emotional, behavioural & cognitive	Not fulfilled	Partially fulfilled
Rousseau 2005	School	Canada	Creative arts	Group	RCT: whole classes	Mixed migrant, mainly	All students in special	73 (73)	7-13	Emotional & behavioural	Partially fulfilled	Not fulfilled

					randomly assigned	Asian & South American	integration classes					
Rousseau 2009	School	Canada	Creative arts	Pairs or individual	RCT: whole classes randomly assigned	Predominantly South Asian (28% refugees)	All students in special integration classes	52	4-6	Emotional, behavioural & social	Fulfilled	Partially fulfilled
Schottelkorb 2012	School	USA	TF-CBT vs. creative arts	Individual vs. group	RCT	Refugees	Referred by teachers	31 (26)	6-13	Emotional, behavioural, cognitive & physiological	Partially fulfilled	Fulfilled
STUDIES from REFUGEE and IDP CAMPS												
Ager 2011	School in IDP camp area	Uganda	Creative arts, community service and parental meetings	Family, Group & Classroom	RCT: schools randomly assigned	Ugandan IDPs	Referred by teachers	203 (180)	7-12	Emotional & behavioural	Partially fulfilled	Partially fulfilled
Bolton 2007	Camp	Uganda	IPT vs. creative arts	Group	RCT	Ugandan IDPs	Those with depression features	210 (210)	14-17	Emotional & behavioural	Partially fulfilled	Fulfilled
Catani 2009	Camp	Sri Lanka	KIDNET vs. meditation relaxation	Individual vs. group	RCT	Sri Lankan IDPs	Diagnosis of PTSD	31 (31)	8-14	Emotional, behavioural, cognitive & physiological	Partially fulfilled	Fulfilled
Ertl 2011	Camps	Uganda	NET vs. supportive counselling	Individual vs. group	RCT	Ugandan former child soldiers	Those with PTSD	57 (57)	12-25	Emotional, behavioural, physiological & cognitive	Fulfilled	Fulfilled

Gupta 2008	Camp	Sierra Leone	Creative arts	Group	Cohort study	Sierra Leonean IDPs	Randomly selected from school registration lists	315 (306)	8-17	Emotional	Not fulfilled	Partially fulfilled
Onyut 2005	Camp	Uganda	KIDNET	Individual	Cohort study (pilot)	Somali	Those with PTSD	6	13-17	Emotional, behavioural, physiological & cognitive	Partially fulfilled	Fulfilled
Thabet 2005	Schools in camp area	Gaza	Creative arts vs. teacher education training	Group	CCT	Palestinian	Those with PTSD	69	9-15	Emotional, behavioural, physiological & cognitive	Fulfilled	Partially fulfilled

* Sample size calculated excluding non-active controls; brackets indicate final number used in evaluation, if reported
CATS: Cultural Adjustment and Trauma Services; CBT: Cognitive Behaviour Therapy; CCT: Controlled Clinical Trial; ESL: English as a Second Language; FACES: Family, Adult and Child Enhancement Services; IDP: Internally displaced person; IPT: Interpersonal therapy; KIDNET: Narrative Exposure Therapy adapted for children; NET: Narrative Exposure Therapy; RCT: Randomised Clinical Trial; TF-CBT: Trauma-Focused Cognitive Behaviour Therapy

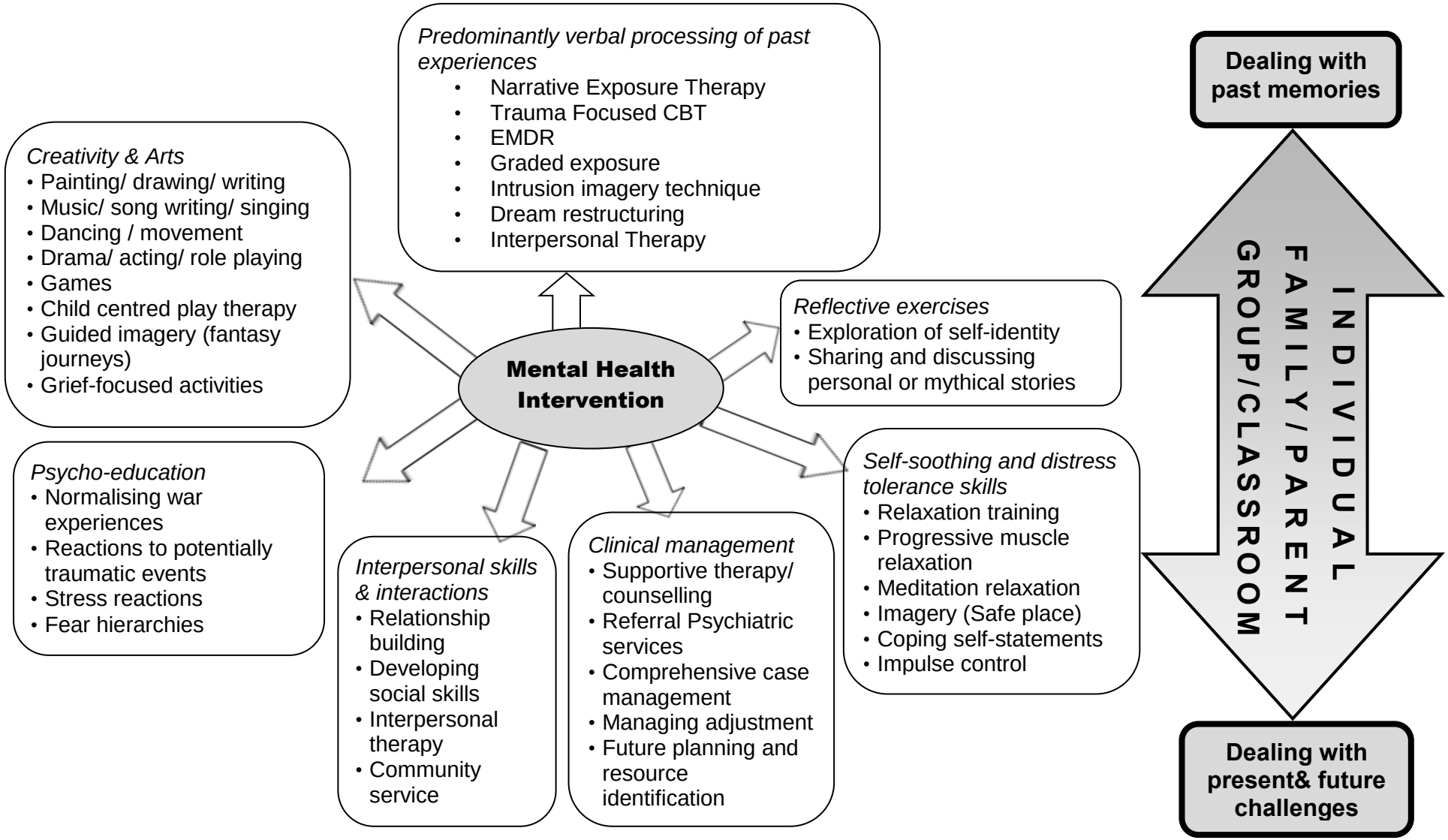


Figure 2: Diagram to show the range of mental health interventions included in the selected studies

Study Quality

Quality of Design and Method

In assessing overall quality of design and method three studies scored ‘fulfilled’; ten ‘partially fulfilled’ and seven ‘not fulfilled’. All20studies fulfilled the criteria for statistical reporting.

The sample sizes of included studies ranged from 6 (Onyut*et al.,* 2005) to 1043 participants (although the data reported from this study was on a sub-sample of 149)(Beehler, *et al.,* 2012). Eight studies used random allocation to determine groups (Ager, Akesson, Stark, Flouri, &Okot, 2011; Bolton *et al.,* 2007; Catani *et al.,* 2009; Ertl, Pfeiffer, Schauer, Elbert, &Neuner, 2011; Kalantari, Yule, Dyregrov, Neshatdoost, &Ahmadi, 2012; Rousseau, Benoit, Lacroix, & Gauthier, 2009; Rousseau, Drapeau, Lacrois, Bagilishya, &Heusch, 2005; Schottelkorb, Doumas, & Garcia, 2012). Three studies were controlled clinical trials (Baker & Jones, 2006; Ehntholt, *et al.,* 2005; Thabet, Vostanis, &Karim, 2005), eight were cohort designs (Beehler, *et al.,* 2012; Birman *et al.,* 2008; Durà-Vilà, *et al.,* 2012; Fazel, *et al.,* 2009; Fox, Rossetti, Burns, &Popovich, 2005; Gupta & Zimmer, 2008; Möhlen, Parzer, Resch, & Brunner, 2005; Onyut*et al.,* 2005)andone was a case control study (Barrett, Sonderegger, &Xenos, 2003).

Recruitment strategies differed across papers; in six studies children were selected to receive an intervention based on meeting specific criteria (Bolton *et al.,* 2007; Catani *et al.,* 2009; Ertl, *et al.,* 2011; Kalantari, *et al.,* 2012; Onyut*et al.,* 2005; Thabet, *et al.,* 2005). In four studies a whole class received the intervention(Barrett, *et al.,* 2003; Fox, *et al.,* 2005; Rousseau, *et al.,* 2009; Rousseau, *et al.,* 2005). Seven studies used referrals from school staff (Ager, *et al.,* 2011; Beehler, *et al.,* 2012;

Birman*et al.,* 2008; Durà-Vilà, *et al.,* 2012; Ehntholt, *et al.,* 2005; Fazel, *et al.,* 2009; Schottelkorb, *et al.,* 2012). In three studies children were either selected on the basis of their refugee status (Baker & Jones, 2006), their residence in refugee accommodation (Möhlen, *et al.,*2005), or randomly selected from a school register (Gupta & Zimmer, 2008).

Treatment Quality

In assessing the treatment quality seven studies scored ‘fulfilled', seven ‘partially fulfilled’ and six ‘not fulfilled’. The least fulfilled quality component was patient engagement with only five papers reporting on active engagement in treatment. Treatment duration was the most fulfilled criteria with only 3 studies failing to report treatment length. The measures used in the studies varied measuring emotional, behavioural, cognitive and physiological domains. Measures also varied across studies from child/adolescent self-assessment toparents/primary caregivers and teachers completing questionnaires and some studies using multiple raters.

Interventions typically lasted 10-12 weeks although there was a range from a fortnight (Catani *et al.,* 2009) to 16 weeks (Bolton *et al.,* 2007). The number of sessions varied between 6 and 17, most commonly lasting one hour. In two studies, interventions were conducted over the course of a school year (Fazel, *et al.,* 2009; Durà-Vilà, 2012). A further two studies enlisted a range of individual and group therapies and longitudinal data were collected and analysed (Beehler, *et al.,* 2012; Birman*et al.,* 2008). One study collected data over a 3 year period (the number of sessions cannot be inferred) (Beehler, *et al.,* 2012), and one study engaged participants in services for 1 month to 7 years (Birman*et al.,* 2008).

Parents were involved in six interventions (Ager, *et al.,* 2011; Beehler, *et al.,* 2012; Birman*et al.,* 2008; Durà-Vilà, *et al.,* 2012; Fazel, *et al.,*2009; Möhlen, *et al.,* 2005). Three studies involved family therapy sessions (Beehler, *et al.,* 2012; Birman *et al.,* 2008; Durà-Vilà, *et al.,* 2012), one involved individual parental support (Ager, *et al.,* 2011)and two incorporated both family and individual parental sessions (Fazel, *et al.,* 2009; Möhlen, *et al.,* 2005). In one study, school staff also received weekly consultation with mental health professionals at the schools(Fazel, *et al.,* 2009).

Effectiveness of the Interventions

The intervention programmes reviewed addressed arange of difficulties experienced by refugee and asylum-seeking children.Thestudies reporting significant changes in psychological symptoms are summarisedin Table 2.Cohen's *d* effect sizes are reported for the five studies that provided sufficient data for these to be calculated, all of which were for therapies based onverbal processing of previous traumatic events(Barrett, *et al.,* 2003; Bolton *et al.,* 2007; Ehntholt, *et al.,* 2005; Ertl, *et al.,* 2011; Kalantari, *et al.,* 2012). Four of these studies had effect sizes in the medium to large range.

Table 2: Summary of significant findings in studies

First author	Intervention	Significance	Effect size (if available)
Depression			
Barrett, 2003	CBT	Depression decreased following group based CBT (p<.01)*	0.93
Möhlen, 2005	Creative arts	Range of creative art techniques reduced depressive symptoms (p=.014)	
Bolton, 2007	IPT	Group IPT reduced depressive symptoms (p=.02)*	0.57
Fox, 2005	CBT	CBT reduced depressive symptoms (p<.001)	
Anxiety			
Barrett, 2003	CBT	Anxiety symptoms decreased following group based CBT for primary school (p<.001)* and high school students (p<.05)*.	0.65 (primary) 0.67 (high)
Ehntholt, 2005	CBT	Decrease in anxiety symptoms (p=.018)*	0.64
Möhlen, 2005	Creative arts	Range of creative art techniques reduced anxiety symptoms (p=.006)	
PTSD			
Beehler, 2012	CBT, TF-CBT, & supportive therapy	Decrease in PTSD symptoms with TF-CBT (p<.05), supportive therapy (p<.04) and a decreasing trend was found with CBT (p<.07).	

Barrett, 2003	CBT	Decrease in PTSD symptoms with group based CBT (p<.001)*	0.92
Catani, 2009	NET & meditation-relaxation	NET and meditation-relaxation reduced PTSD symptoms, sustained at follow-up (p<.001)	
Ehntholt, 2005	CBT	Decrease in PTSD symptoms (p=.011)*	0.88
Ertl, 2011	NET	Decrease in PTSD symptoms with NET compared to supportive counselling (p=.02) and waiting list controls (p=.02)*	0.31
Gupa, 2008	Creative arts	Decrease in PTSD symptoms in 96% of participants following intervention.	
Möhlen, 2005	Creative arts	Decrease in PTSD symptoms with a range of creative art techniques (p=.018)	
Onyut, 2005	KIDNET	Decrease in PTSD symptoms with KIDNET (p=0.039)	
Functional impairment			
Beehler, 2012	CBT, TF-CBT, & supportive therapy	Decrease in functional impairment with TF-CBT (p<.01), supportive therapy (p<.001) and CBT (p<.03).	
Birman, 2008	Counselling, therapy, case management & creative arts	Decrease in functional impairment following a mixed intervention of cognitive therapy and creative arts (p<.001).	

Catani, 2009	KIDNET & meditation-relaxation	Decrease in functional impairment sustained at follow-up with both KIDNET and meditation-relaxation (*p*<.001).	
Ertl, 2011	NET	Decrease in functional impairment with NET compared to supportive counselling (*p*=.008)* and waiting list controls (*p*<.001)	0.64
Other			
Barrett, 2003	CBT	Anger: Decrease in levels of anger (*p*<.001)	
Ehntholt, 2005	CBT	Behavioural problems: Decrease in behavioural problems (*p*=.027)**	
Durà-Vilà 2012	Individual, family & supportive therapy	Conduct problems: Decrease in parent-rated conduct problems (*p*=0.043)**	
Ehntholt, 2005	CBT	Emotional problems: Decrease in emotional problems (*p*=.010)**	
Rousseau, 2009	Sandplay	Emotional problems: Decrease in parent-rated emotional problems (*p*=.002)**	
Durà-Vilà 2012	Individual, family & supportive therapy	Hyperactivity: Decrease in teacher-rated (p=0.015)** and parent-rated (p=0.001)** hyperactivity	

Durà-Vilà 2012	Individual, family & supportive therapy	Peer Problems: Decrease in teacher-rated peer problems (p=0.017)**	
Fazel, 2009	Supportive therapy & creative arts	Peer Problems: Decrease in peer problems for both CBT and creative arts therapy (*p*=.005)**	
Rousseau, 2009	Sandplay	Relational problems: Decrease in parent-rated relational problems (*p*=.001)**	
Kalantari, 2012	Exposure through writing	Traumatic grief: Decrease in children's traumatic grief symptoms (*p*<.001)*.	0.67
Ager, 2011	Activities programme	Well-being: Improved well-being according to self-rated (*p*<.001), and parent-rated (*p*=.01) measures but not teacher ratings (*p*>.1)	

*Effect size calculated if data permitted
** Effect size not calculated for studies using the SDQ
Studies highlighted in blue indicate those conducted in refugee and IDP camps

Both the verbal processing-based and creative art-based interventions led to significant reductions in symptoms of depression, anxiety, PTSD,functional impairment and peer problems. Verbal processing therapies were also effective in treating anger (Barrett, *et al.,* 2003), traumatic grief (Kalantari, *et al.,* 2012), behavioural and emotional problems (Ehntholt, *et al.,* 2005),hyperactivity, peer and conduct problems (Durà-Vilà, *et al.,* 2012). Creative arts were also effective in treating well-being (Ager, *et al.,*2011), and emotional and relational problems (Rousseau,*et al.,* 2009).

All but one study conducted in refugee and IDP camps found significant findings *(Thabet, et al.,* 2005). Two of these studies reported a significant decrease in functional impairment following NET (Catani *et al.,* 2009; Ertl, *et al.,* 2011). Two studies found a decrease in PTSD symptoms following a creative arts intervention(Gupta & Zimmer, 2008) and KIDNET (an adapted version of NET for children and adolescents)(Onyut*et al.,* 2005). Bolton *et al.,*(2007)found interpersonal psychotherapy reduced symptoms of depression and *Ager, et al.,*(2011) found improvements in well-being following a psychosocial activities programme.

Four studies reported significant reductions in symptoms of depression(Barrett, *et al.,* 2003; Bolton *et al.,* 2007; Fox, *et al.,* 2005; Möhlen, *et al.,* 2005); twoof these studies usedCBT. Bolton,*et al.,*(2007) found CBT superior to an activity-based intervention in treating symptoms of depression (p=.02). Furthermore, the activity-based intervention was no more effective than waiting list controls in treating depression. Although these results point towards the importance of the cognitive behavioural approach in treating depression in refugee children it should be noted

thatMöhlen, *et al.,* (2005) found a range of creative art techniques significantly reduced symptoms (p=.014).

Three studies reported a significant improvement in symptoms of anxiety. Group-based CBT and a creative art-based intervention incorporating psycho-education, creative techniques and relaxation activities in individual, family and group sessions were found to decrease levels of anxiety(Barrett, *et al.,* 2003; Ehntholt, *et al.,* 2005; Möhlen, *et al.,* 2005).

Eight studies reported a decrease in symptoms of PTSD (Barrett, *et al.,* 2003; Beehler, *et al.,* 2012; Catani *et al.,* 2009; Ehntholt, *et al.,*2005; Ertl, *et al.,* 2011; Gupta & Zimmer, 2008; Möhlen,*et al.,* 2005; Onyut*et al.,* 2005). All but one of these treatments was grounded inthe verbal processing of past experiences. Four of the studieswere undertaken in low-income countries(Catani *et al.,* 2009; Ertl, *et al.,* 2011; Gupta & Zimmer, 2008; Onyut*et al.,* 2005).

Only four studies reported improvements in functional impairment(Beehler, *et al.,* 2012; Birman *et al.,* 2008; Catani *et al.,* 2009; Ertl, *et al.,* 2011). Improved functioning was found to be associated with several interventions (TF-CBT, NET, creative arts, and meditation relaxation). Catani *et al.,*(2009) found no significant difference in functional impairment following KIDNET or meditation-relaxation although at six month follow up recovery rates for KIDNET were higher at 81% as opposed to 71%. Ertl, *et al.,*(2011), however, found functional impairment improved significantly with NET compared to supportive counselling (p=.008) and waiting list controls (P<.001).

In the Birman*et al.,*(2008)study, participants received tailored services to meet their individual needs; it is therefore difficult to evaluate which elements of the intervention

had the greatest impact on improvements in functioning.Similarly, Beehler, *et al.,*(2012)utilised a variety of interventions including TF-CBT, supportive counselling and other CBT approaches.

Discussion

Overall 20 studies were identified, most conducted in schools with a variety of therapeutic tools and modalities utilised.Of the eight studies from low and middle income countries, seven were conducted in refugee camps. Many of the interventions focused on past traumatic events, using either verbal processing, for which there is the strongest evidence-base, or an array of creative arts techniques. Significant improvements were seen for depression, anxiety, PTSD, functional disturbances and peer problems in both types of interventions. Individual as well as group interventions were effective as were bothshort and long-term treatments. CBT or TF-CBT and NET both have evidence to support their use. Some services developed multimodal interventions, attempting to address the diverse difficulties faced by refugee children and their parents. Effect sizes calculated to compute symptom change in disorders were, however, only available for interventions based on the verbal processing of past experiences.

Six out of the seven studies conducted in refugee camps showed a significant reduction in psychological symptoms. The success of these interventions is noteworthy given that one third of refugees will spend some time in a refugee camp (UNHCR, 2011b).

Limitations

Of the twenty studies included, only seven monitored treatment fidelity and seven conducted a follow-up assessment. In combination with small sample sizes, lack of blind assessment, and inactive or no control groups the overall quality of studies reviewed was a limitation and highlights areas for further work. Participant eligibility varied across studies; in the majority of cases refugees and asylum-seekers were enrolled in treatment irrespective of whether they met clinically significant rates of psychological problems prior to the commencement of the intervention.

The studies were varied in their scope, environment and target population and so limited conclusions can be drawn on what is most effective. The interventions adopting the most multimodal approaches attempting to address both systemic and individual needs were those with the lower quality ratings. This could reflect the difficulty of evaluating more complex interventions trying to address potential difficulties incommunity, school and refugee camp settings *(Beehler, et al., 2012; Birman et al., 2008; Durà-Vilà, et al.,* 2012).

Studies of interventions for children living within current conflict conditions were excluded but could have provided some important examples of interventions. There have, however, been two recent comprehensive systematic reviews on mental health interventions for children living in conflict and post-conflict environments (Betancourt & Williams, 2008; Jordans,Tol, Komproe, & de Jong,2009).

Conclusion

The different contextual factors, environments and socio-cultural political contexts that refugees come from and find themselves in cannot be ignored (De Jong, *et*

*al.,*2001) and services need to address the heterogeneity of difficulties that refugees experience (Nickerson, *et al.,* 2011). This is the rationale for offering a broad range of services to refugee children (Durà-Vilà, *et al.,* 2012) yet the evidence-base remains weak to support this approach over individualised trauma-focused work.

An important development would be to make interventions more widely available and sustainable. Training local non-mental health professionals to deliver interventions could address this need (Tol*et al.,* 2012). Some studies utilised lay therapists successfully, a model that needs replication in other settings and with other therapeutic modalities. To this end, within schools, teachers could be trained to promote mental health by creating a supportive and caring environment and through implementation of preventative and efficacious psychological interventions (Ehntholt, *et al.,* 2005).

Reflection on Placement One

Aims:

- Conduct a systematic search of literature on global school and community-based interventions for refugee and asylum-seeking children.
- Determine hypotheses surrounding school-based mental health interventions.
- Attend workshops on therapeutic interventions used with refugee and asylum-seekers suffering from PTSD.
- Obtain University ethical approval for a second phase of research on school-based interventions.

I conducted a systematic search of the literature on school and community-based interventions for refugee children. Having familiarised myself with COCHRANE systematic reviews and protocols and PRISMA guidelines, I gained an awareness of the review process and issues relating to publication bias and quality assurance.

I identified and discussed good and bad examples of systematic literature reviews. Supervision allowed me to examine the review process and helped me understand the importance of careful planning, identifying the right research question and selecting the right databases and key terms.

Realising the importance of keeping good records and the need to work in a systematic way I created a RefWorks account that allowed me to organise and locate references and the Write-N-Cite tool enabled me to cite accurately. An excel

spread-sheet provided an efficient means to organise and synthesise informationextracted from included articles (See appendix 3A).

I gained an appreciation of the need to set exact criteria for the inclusion/exclusion of articles to give consistency when deciding on borderline articles. I began excluding displaced children still living in their country of origin, in line with the UNHCR definition of refugees, but this meant excluding children living in refugee camps within their home country, which led to the exclusion of significant studies. I decided to include studies conducted in refugee camps regardless of whether the participants had crossed international borders, but excluded children living at home in conflict situations.

It was necessary to identify articles that hadreported findings from the same participant population and, where necessary, contact relevant authors to confirm this and avoid bias. It also became evident that not all relevant studies are in English and I now understand the process involved in obtaining translations.

While critically appraising articles selected for inclusion, I gained insight into the methodological difficulties of carrying out high quality research in this field. Owing to the clinical heterogeneity, a meta-analysis could not be conducted. Effect sizes were calculated from end of treatment scores', although computing scores from follow-up may have provided more useful information, due to the limited follow-up studies this was not possible. Despite these constraints, it was possible to theorise that the strongest evidence base lies with verbal processing of past experiences for treating mental health problems commonly experienced by refugees, although both

interventions were found to be beneficial. Due to the limited number of studies conducted, however, no firm hypothesis could be drawn.

Attending training workshops on PTSD amongst refugees has given me a comprehensive understanding of the theoretical models used to explain symptoms resulting from potentially traumatic events and advanced my intervention skills. The theoretical background of the training helped me understand reasons for success or failure in different interventions. Although there is a huge evidence base for current interventions for PSTD, it is almost exclusively not used with refugees and this is an area I am eager to develop.

This placement gave me the opportunity to meet professionals working with refugees in a number of settings and has given me valuable insights into the important remit of working with this population in an integrated way.

The next phase of research is to gather the views of front-line workers in schools about their experiences in supporting refugee children. I have applied for ethical approval for this work and subsequently furthered my understanding of the importance of careful planning in order to meet timelines and putting safeguards in place to protect participants.

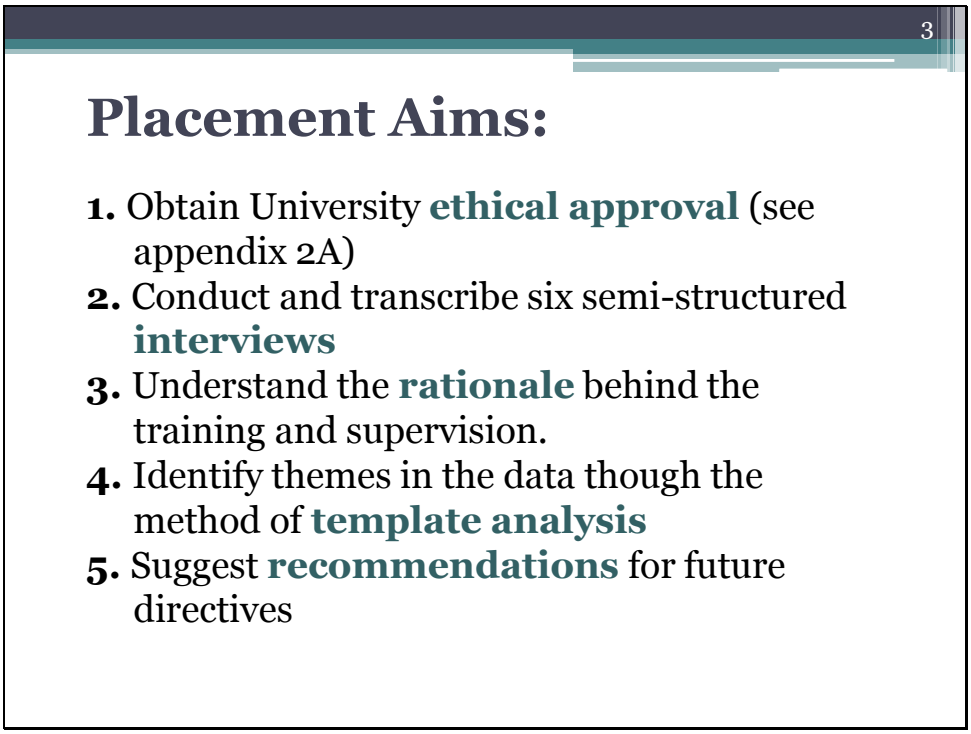
Conducting a systematic literature review to answer scientific questions concerning policy and health care interventions, enabled me to develop skills in critically appraising research and demonstrated the importance of ensuring research is relevant and furthers psychological knowledge and understanding.

CHAPTER TWO: EVALUATION OF A TRAINING AND SUPERVISION PROGRAMME IN COGNITIVE AND BEHAVIOURAL APPROACHES

It is essential that formative evaluations are made that discover what works and why, to inform adaptations which may be needed to improve the effectiveness of future programmes (Newcomer, Hatry, &Wholey, 2010). This placement evaluates a training programme that was received by clinicians in a community mental health team in Coventry. The training intended to equip clinicians with a range of cognitive and behavioural techniques.

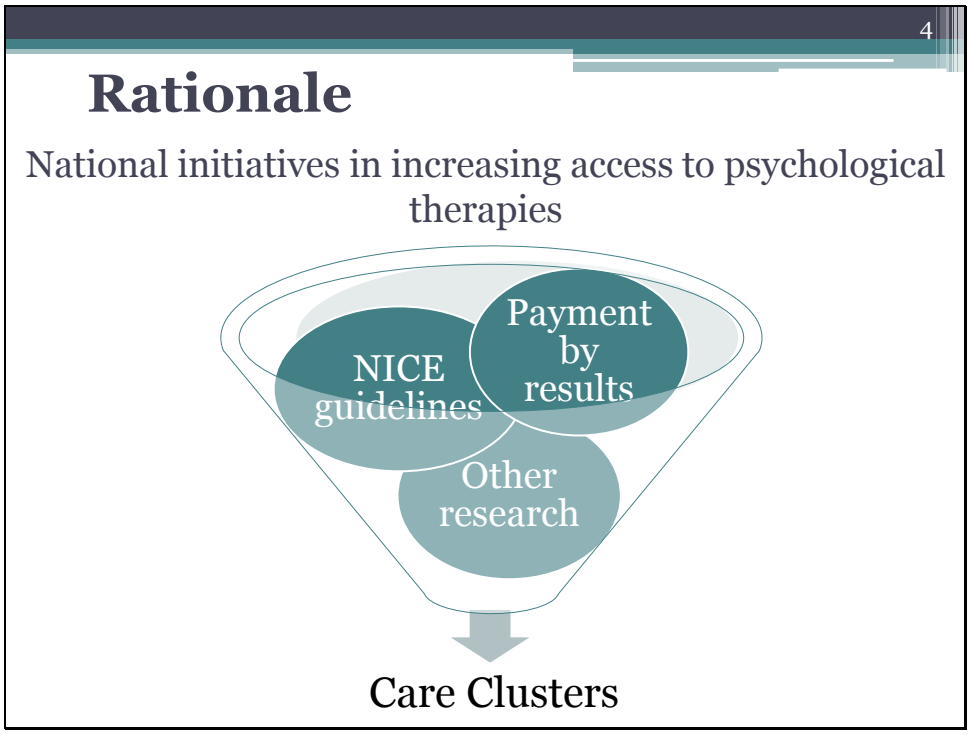
This presentation will cover:

- Placement Aims
- Rationale
- Context
- Method
- Analytic Strategy
- Findings / Recommendations
- Summary



Placement Aims

While all the elements were covered on placement, for the purposes of this presentation I focus on the last three points.



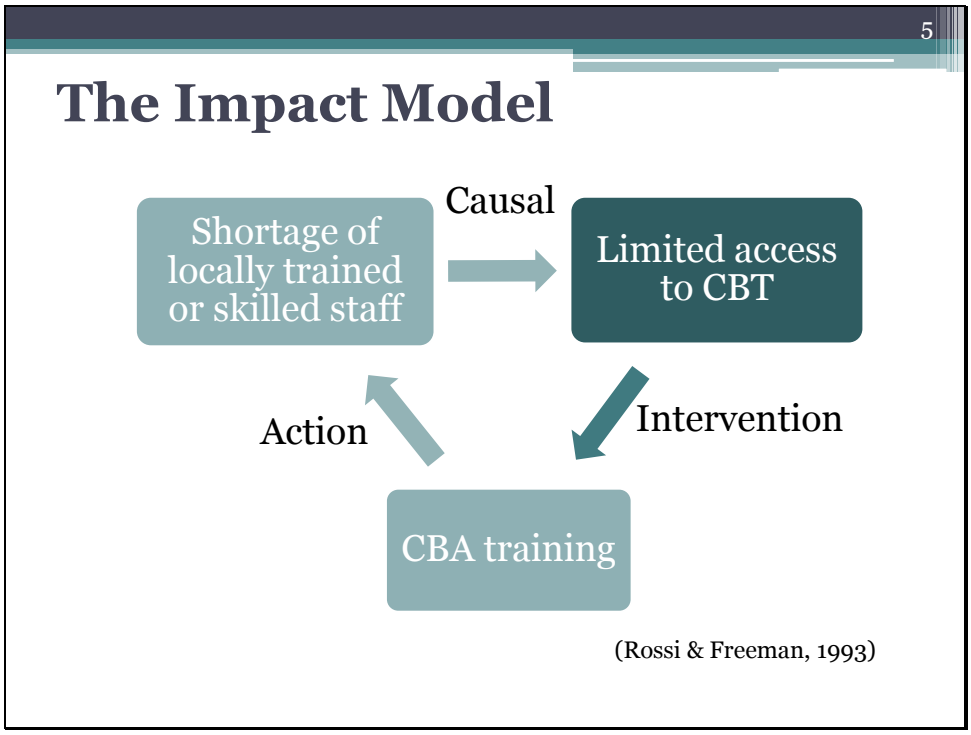
Rationale

As part of the Coalition Government's plans to increase access to psychological therapies, patients are allocated to one of twenty-one mental health care clusters based on their presenting problems and the intervention they are likely to require (Department of Health, 2012). In order to support efforts to deliver interventions in accordance with care clusters, the government has proposed a payment by results policy, whereby money is allocated to each care cluster depending on the nature of the intervention, number of patients allocated to that cluster and recovery outcomes. (HM Government, 2011).

National Institute for Health and Care Excellence (NICE) Guidelines and other research set out evidence based practice for specific clinical presentations which determine the care a person will receive based on their care cluster allocation. With many NICE approved guidelines for psychological interventions recommending

Cognitive Behavioural Therapy (NICE, 2013), the CBA training and on-going supervision was intended to be an empowering exercise that would increase skills in identifying and delivering appropriate intervention in accordance with care clusters.

Having never worked in the NHS, it was important that I familiarised myself with national and local policy guidelines that inform current practice. I reviewed current strategies outlined by the Department of Health, however, my understanding of how these were currently being implemented and received by clinicians was most developed through attending weekly psychological meetings and discussions with my supervisor.



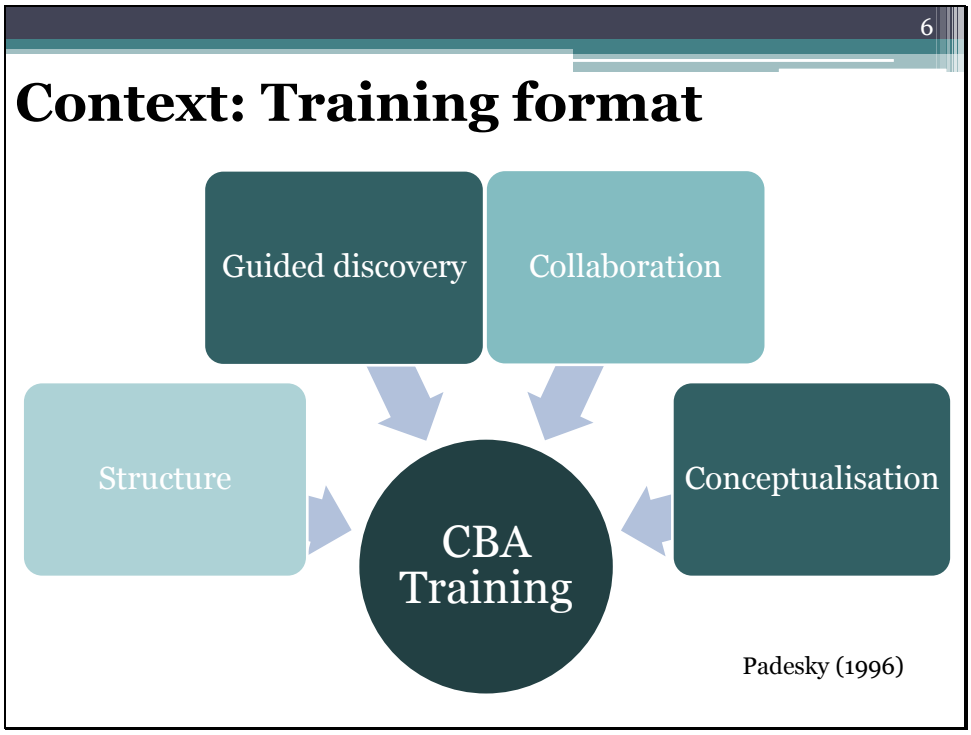
The theoretical basis from which the CBA training and supervision was derived can be implicitly depicted through three hypotheses of the impact model.

- *Causal hypothesis* –some service users who would benefit from cognitive behavioural work do not currently receive it because of a shortage of locally trained or skilled staff.

- *Intervention hypothesis* – training will increase the number of locally trained or skilled staff able to deliver CBA.

- A*ction hypothesis* – training more staff to deliver specific targeted interventions under supervision and being able to recognise when to refer onto psychology will increase access to cognitive behavioural interventions.

What's interesting about this model is that any one of these three components could be flawed and thus this model was useful when evaluating the impact of the programme/supervision and where adjustments need to take place.



Context

The training programme was built on Padesky's (1996) four principles:

- Structure (nineteen weekly, half day workshops enabled trainees to practice and develop skills)
- Guided discovery (delivering specific targeted interventions under supervision and reflecting on own practice)
- Collaboration
- Conceptualisation (through three cognitive formulation models)

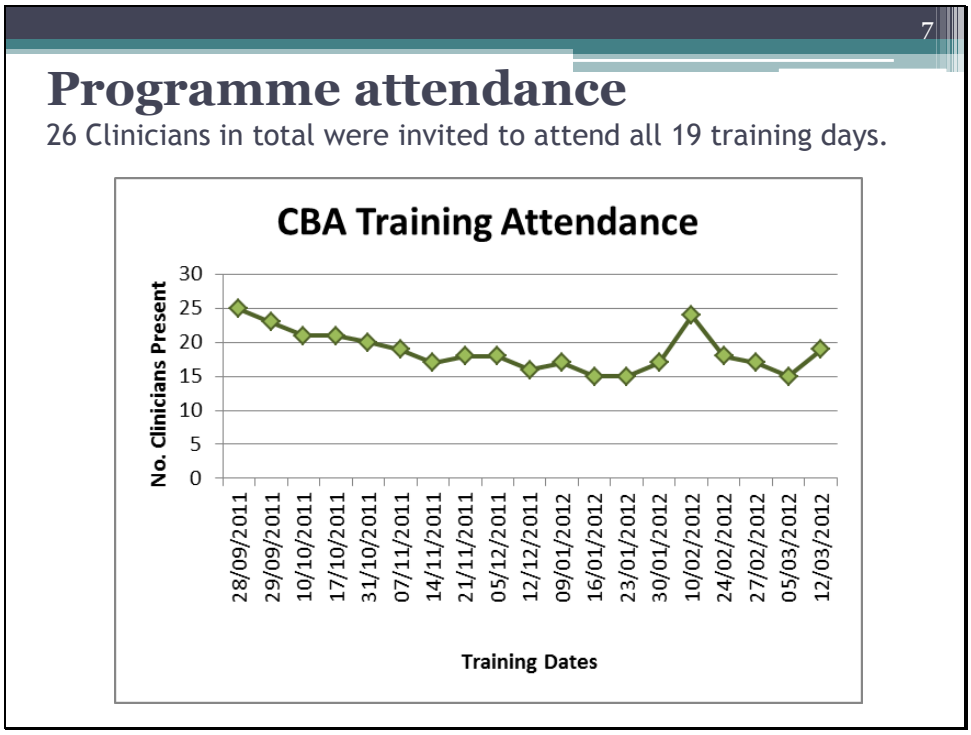
  - Five system model (Padesky& Greenberger, 1995)
  - Maintenance cycles for disorder specific problems (Vivyan, 2010)
  - Longitudinal formulation (Beck, 1995)

Used to assist clinicians' in:

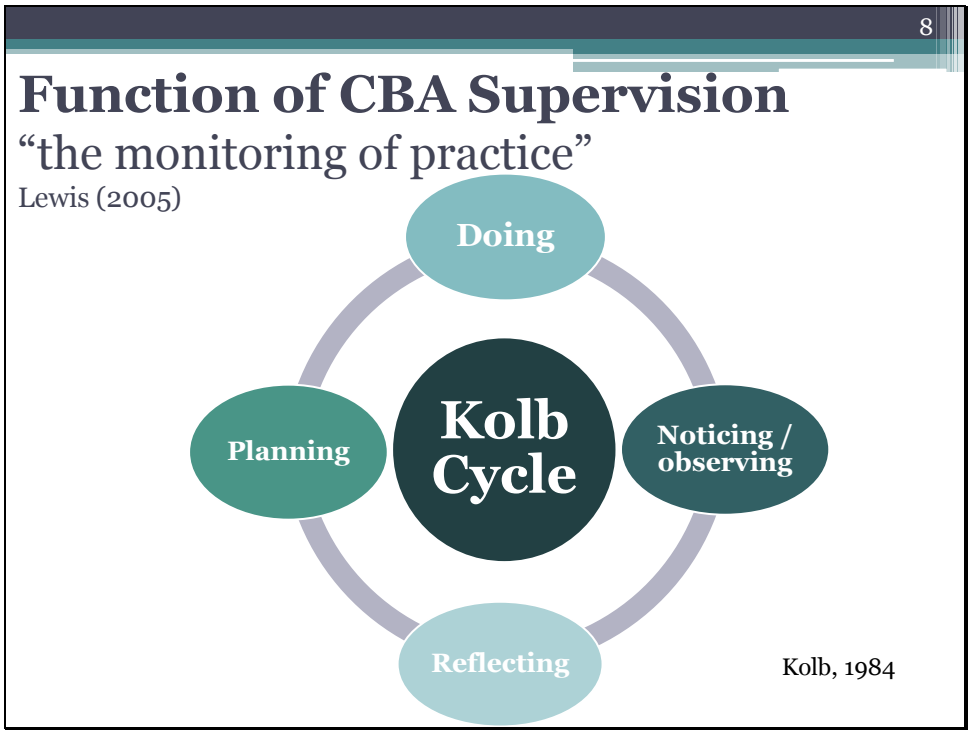
Making sense of presenting problems

Identifying points of treatment

When to refer on



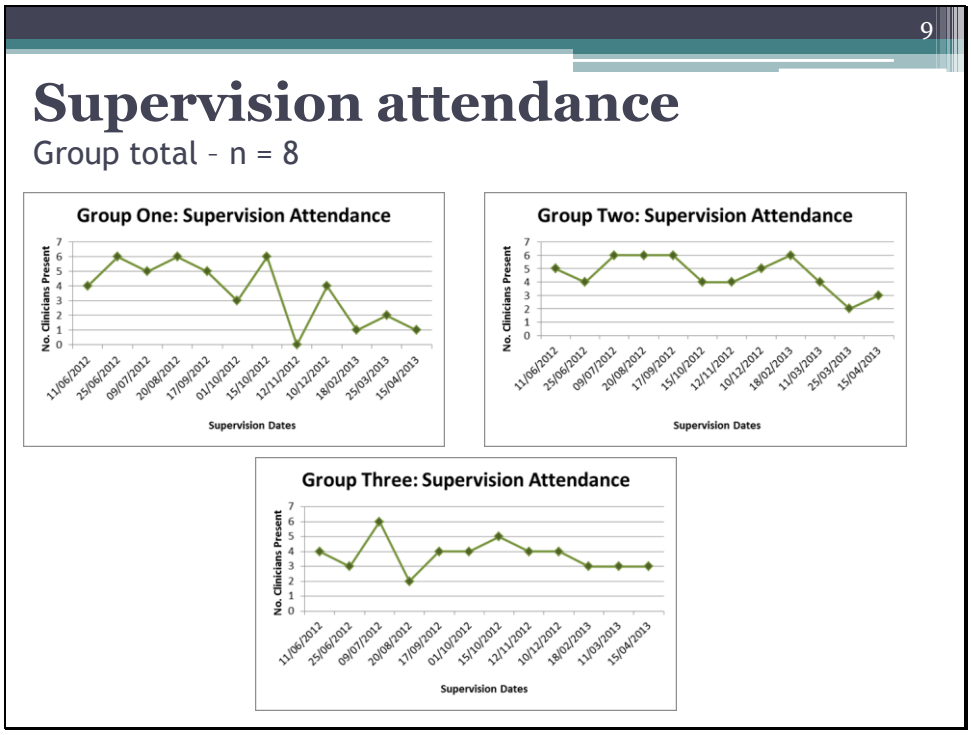
Attendance ranged from fifteen to twenty-six clinicians. Twenty clinicians attended at least fourteen out of nineteen training days.



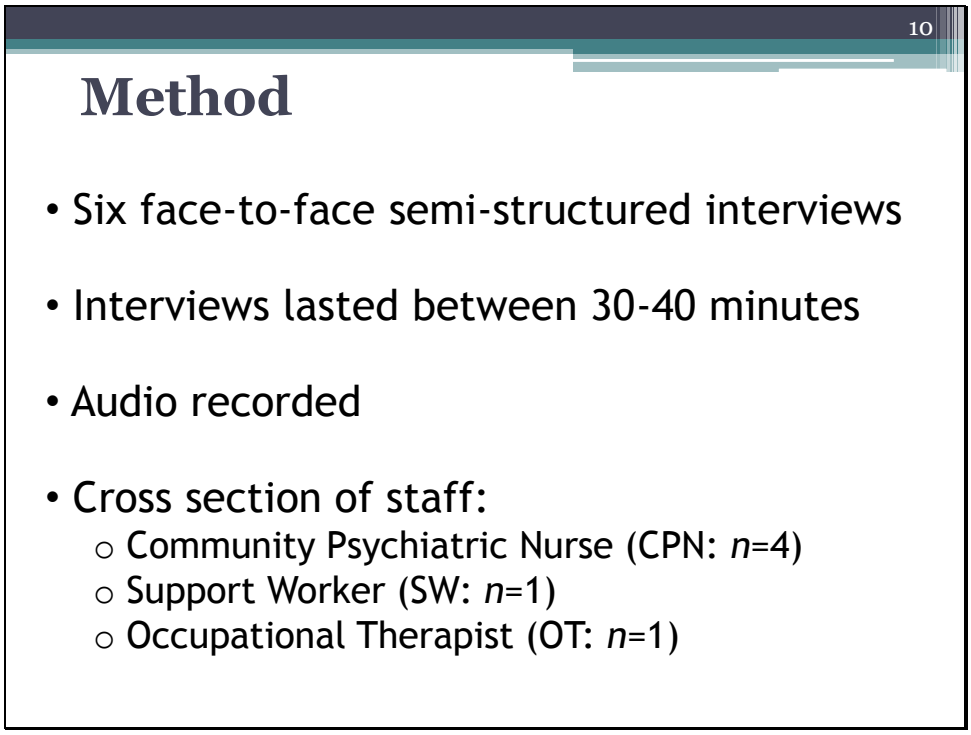
Following CBA training, participating clinicians received fortnightly supervision conducted in a group format.

The Kolb Cycle (Kolb, 1984) provided a framework for supervision and was used as a way of understanding what was happening not only at the client level but also at the level of practitioners own learning:

- Consolidate skills
- Facilitate further learning through reflective practice
- Encourage and support
- Provide opportunities to practise and master new techniques
- Formulate and case conceptualise



Since the training, clinicians were split into three groups for fortnightly group supervision, with eight clinicians in each group (three clinicians were not enrolled into any group). A total of 36 sessions have run, with attendance rates ranging from nil to six clinicians being present, the mean attendance was four.



Method

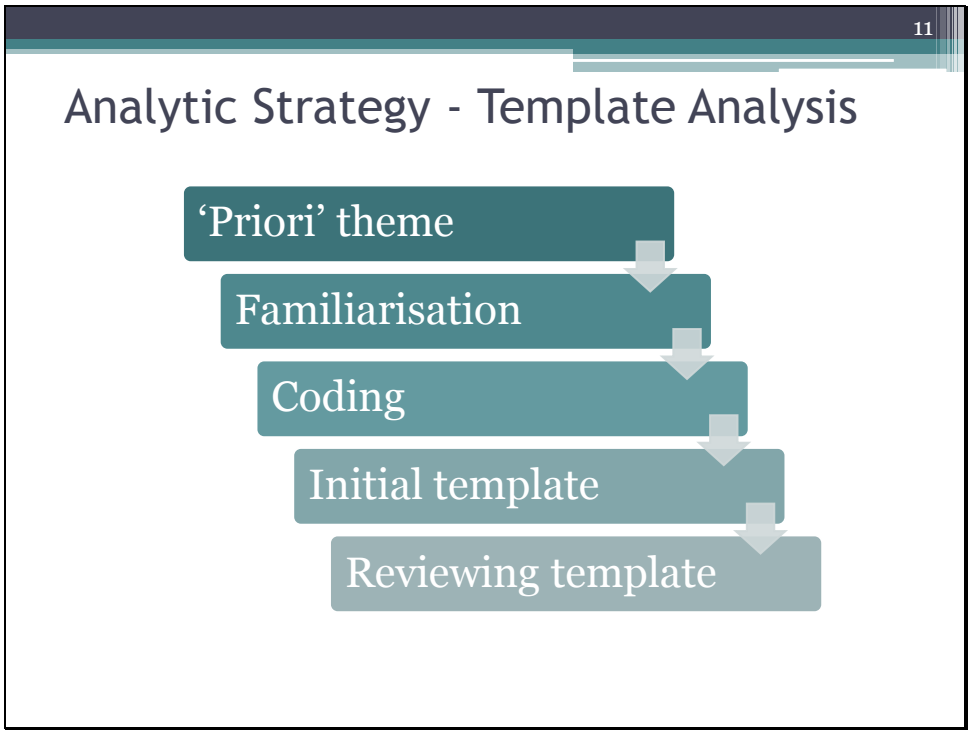
Participants were recruited through a method of purposive sampling (Silverman, 2000)

To obtain a more representative sample of the team, an equal number of staff from the 'old primary care team' and 'old case management team' which merged in 2010 to form North Coventry CMHT were recruited. Due to the pressures the team were under it was not possible to conduct an interview with a social worker.

Staff were sent an information sheet (see appendix 5B) and having been given the opportunity to discuss any issues, were asked to sign a consent form (see appendix 6B).

Before commencing staff interviews I conducted a mock interview with my placement supervisor, allowing me to reflect on my own interview skills. I believe my ability to prompt clinicians to reveal their thoughts and experiences of the training/supervision improved with time, as my own confidence and understanding of the training increased and I was better able to predict issues likely to arise. While finding it challenging to have limited knowledge about the training/supervision, I believe this made me more objective to the concerns being raised as I was less emotionally attached to the programme. I was also aware of some clinician's resistance to the training and I needed to ensure I was not dismissive about their comments.

Being a student working with one of the trainers, could have influenced what staff felt comfortable to reveal and their willingness to provide an honest reflection. I gained experience in getting the most out of people who were largely resistant and negative by ensuring they understood that I was not evaluating them and that there were no right or wrong answers to my questions. I've learnt how important it is to relate to individuals on a personal level and have gained self-confidence to interact professionally with other mental health professionals.



Analytic Strategy

Given the practical focus and specific areas of evaluation, Template Analysis (TA: King, 1999) was chosen, as it allows identification of themes relevant to the enquiry. It was also thought that specific questions would be most efficient in eliciting the information needed from busy professionals (see appendix 7B for interview schedule).

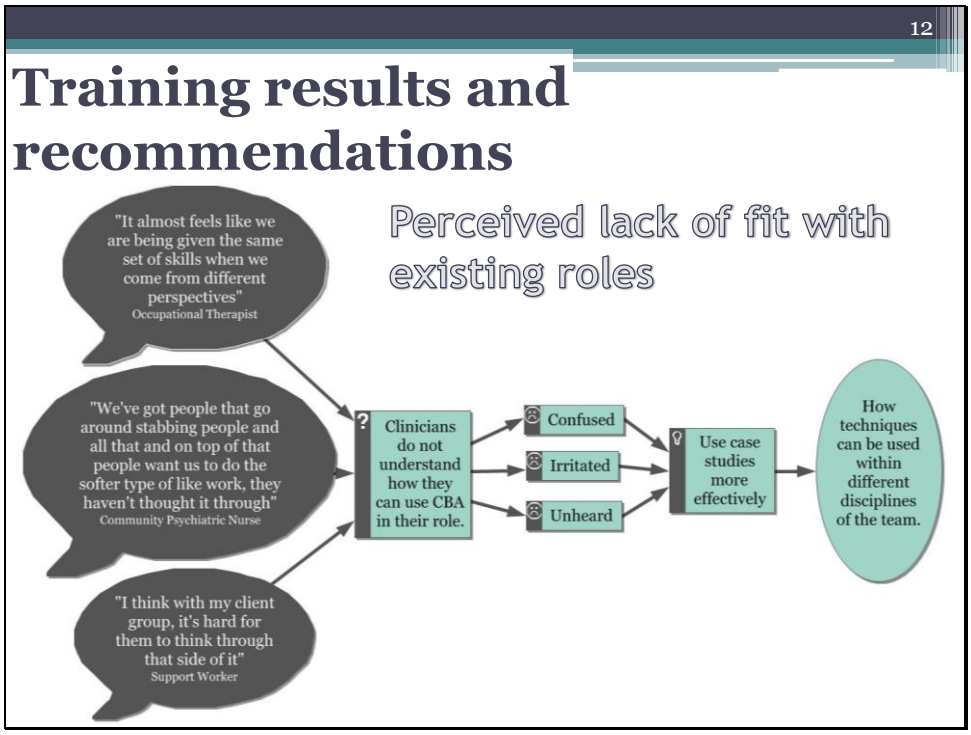
After a sub-set of transcripts was coded an initial template was produced (see appendix 8B). This template was applied to the full data set and modified in light of new features (see appendix 9B).

One shortcoming of TA, is that analysis fragments the data at a very early stage and might not capture the context of the overall interview. In order to overcome this and

place greater balance on ‘stand out’ quotes, I noted the context of the wider interview.

In order to aid interpretation and draw from all the participants, each transcript was coded in a different colour. This enabled me to make comparisons between participants and notice any differences across disciplines.

My supervisor and I worked collaboratively to adapt and shape the development of the template which helped limit a biased interpretation.



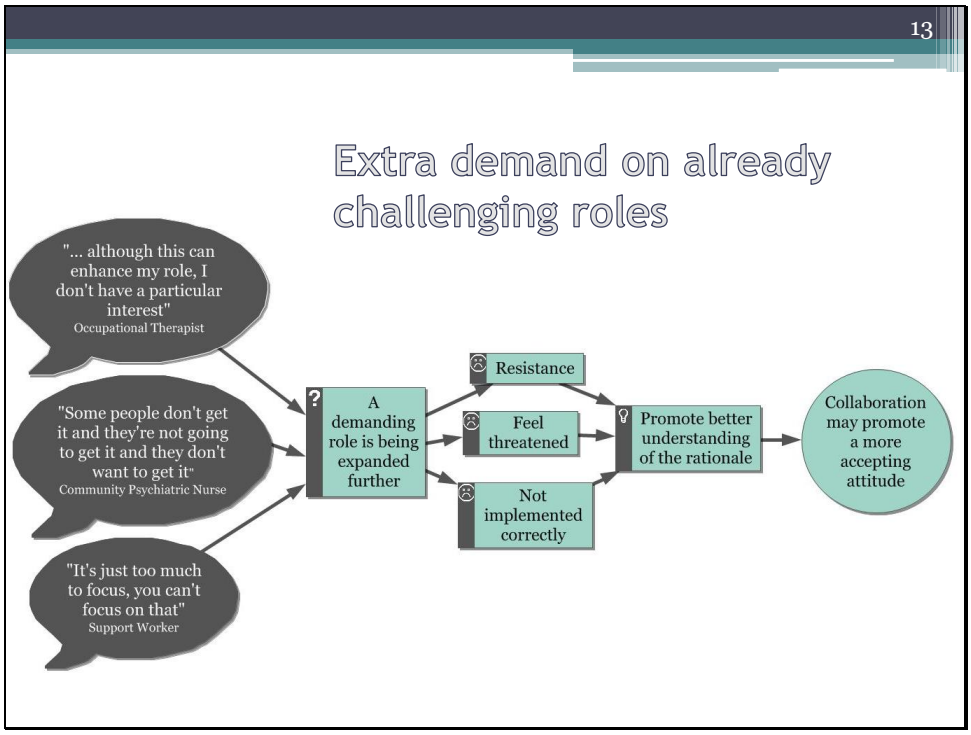
Results and Recommendations

Clinicians appeared very defensive and protective of their individual roles. Reference was frequently made to uncertainty about how CBA could fit existing roles which subsequently affected uptake of these new approaches.

There was an unwillingness to adapt and utilise tools that were dissimilar to existing ones, reinforcing the link between frequency of use and comfort and confidence in the approach.

There was a clear polarisation with some clinicians perceiving psychology and CBA as only suitable for ‘soft referrals’ and seeing their own roles focused in more practical areas, whilst at the same time, regarding the work of psychologists as more academic, scientific and complicated, with CBA being beyond the depth and competence required for their role.

It might be useful to incorporate more participation in suggesting relevant case studies and build on clinician's ideas of how best to work with particular patients, rather than superimposing new ideas.

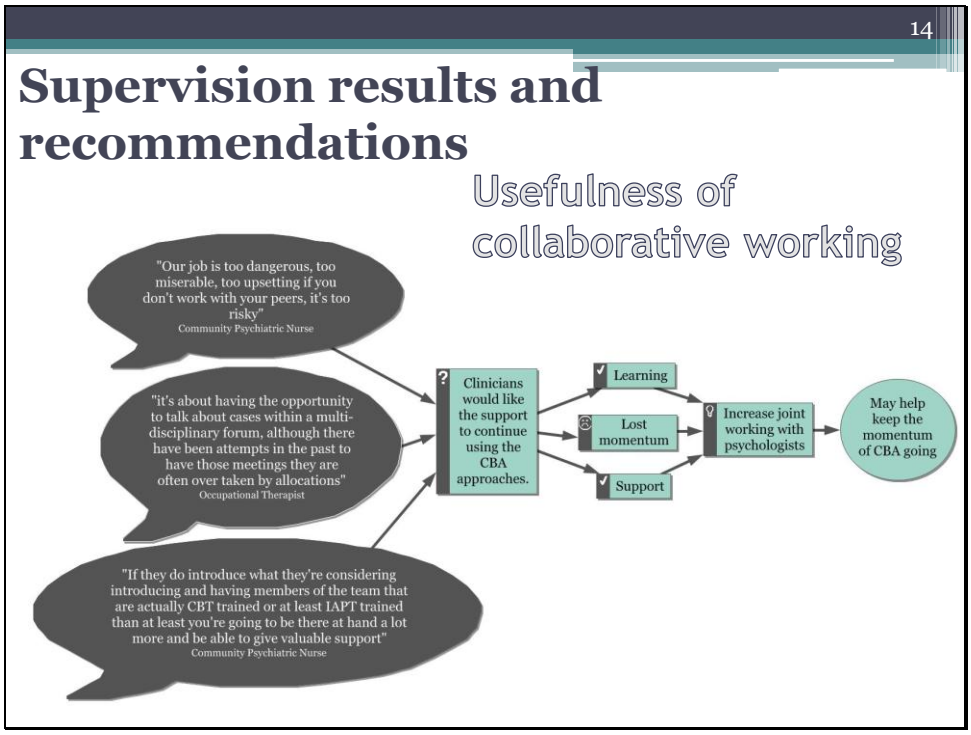


Although training was intended to equip clinicians with skills required to deliver interventions in accordance with care clusters policy, effective provision is still hindered by different priorities, heavy case loads, poor understanding of individual roles and the use of professional language. There was an overall perception that the new skills being introduced meant that an already demanding role was being expanded even further. This attitude resulted in resistance to attending and fully engaging in the training and was expressed explicitly during interviews.

This made me realise how difficult it is to introduce a new initiative in the NHS where staff perceive themselves to be overworked.

Training to implement change is inevitably threatening, therefore it is important to reach common agreement on how proposed policies might affect clinicians and to discuss the support they might need.

From a training perspective it is important for the “expert” to check the material is fully understood so participants are not demotivated and demoralised.



Supervision facilitates collaborative working, clinicians stated that their colleagues sometimes suggested relevant models and interventions they had not considered which were useful.

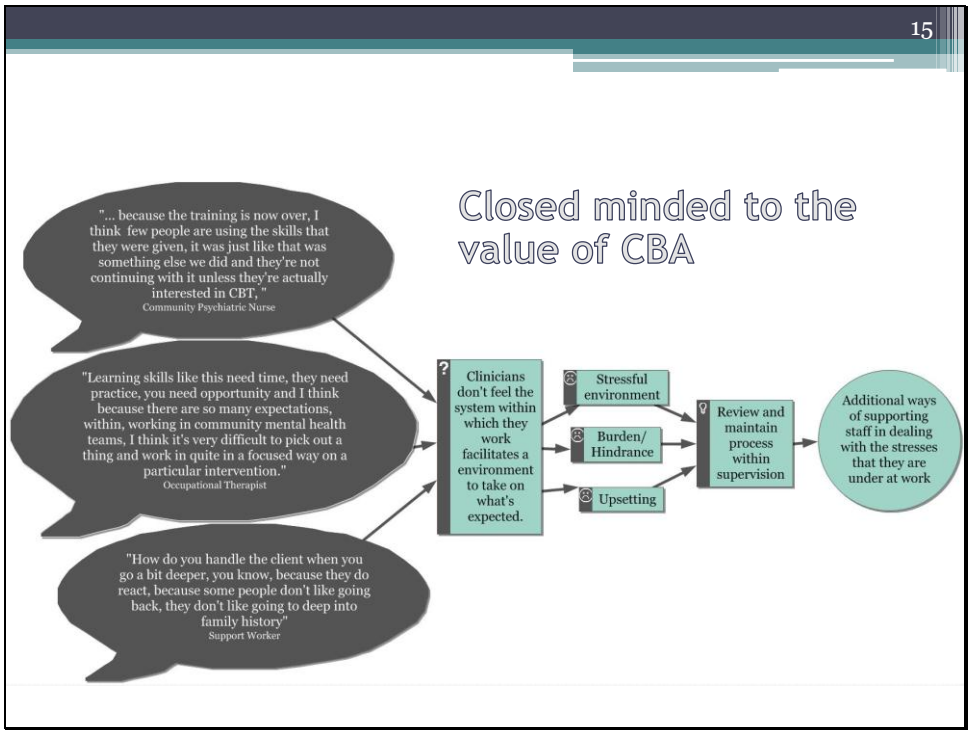
One clinician reflected on how isolating and emotionally draining the work could be and found supervision a source of support, a chance to debrief and discuss any concerns. In addition, it was acknowledged that during supervision safeguarding and negligence could be identified and discussed, protecting both clinicians and patients from potential harm.

Clinicians reported that being able to draw on knowledge from the team regarding various stages of a patient's care informed the assessment and prevented clinicians' own perceptions and biases about patients leading to an unhelpful intervention.

Many clinicians did not specifically identify CBA elements of supervision as being useful, rather valued the space and support supervision provided. However, it would be premature to draw the conclusion that these elements were unhelpful because the overall structure of supervision is informed by a cognitive behavioural supervisory process.

Although there was clear resistance to utilising the CBA as tools for intervention, opportunities to reflect on one's own practice and plan future care with colleagues was something many clinicians values.

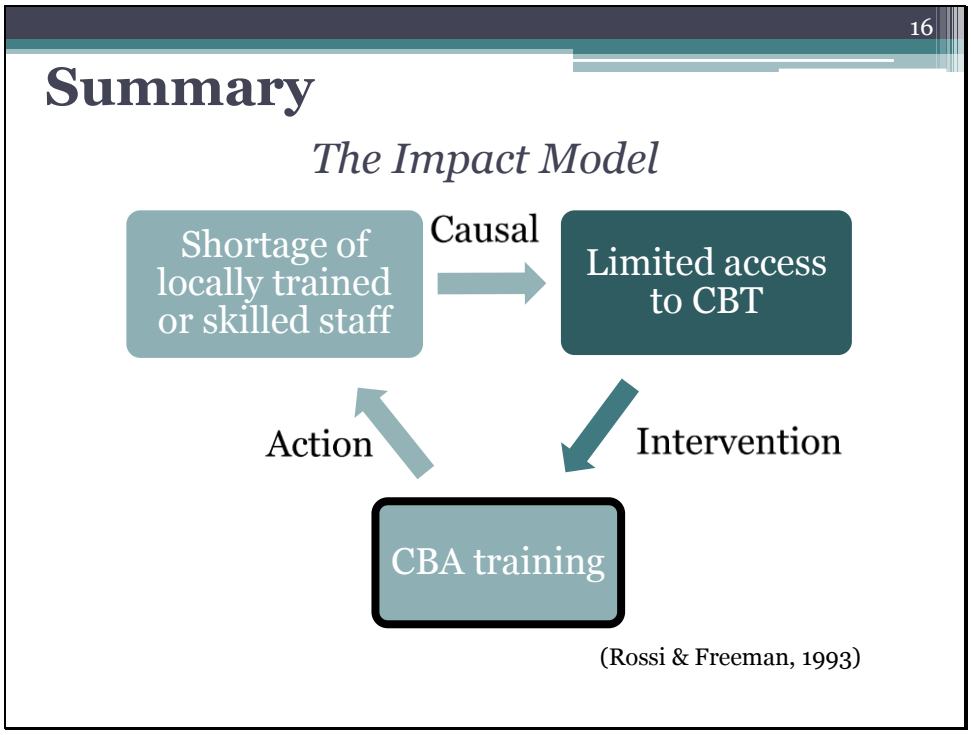
The way in which the role of a psychologist is set up in CMHTs could be changed to facilitate collaborative working.



Some clinicians did not feel the need for supervision, arguing that it did not enhance their understanding of patients or help them move forward with a patient's care.

Time constraints were a recurring theme with clinicians expressing that tight schedules meant they had little time to attend supervision or time to prepare for it.

There is a need to address wider issues such as supporting staff in dealing with stress and transference between clinicians and patients before they are able to take on new challenges.



Summary

Referring back to the impact model, the findings suggest barriers seem to arise at the intervention component, while clinicians have received the training they are unable or unwilling to implement it, the reasons for this being:

- Resistances or concern on taking on another professions role
- Limited time
- Inappropriate to patients needs

Such limited acceptability of CBA within the team raises concern regarding how the team will use the skills with clients.

1616I believe there is a fundamental need for therapeutic interventions, but believe these will be more effective if synchronised with people working in multiple levels of

the patients ecology. This belief is in line with Maslow's (1970) hierarchy of basic needs who proposed that until basic needs are met, people can’t engage with issues of general wellbeing.

CHAPTER THREE: AN IPA STUDY EXPLORING THE EXPERIENCES OF SCHOOL STAFF WORKING TO PROMOTE MENTAL HEALTH AMONG REFUGEE AND ASYLUM-SEEKING CHILDREN

Abstract

Background

The literature points towards the benefits of promoting the psychological wellbeing of refugee and asylum-seeking children in schools. Research suggests the school environment is most profitable in terms of targeting such children who don't readily access mental health services, although evaluation of such approaches is not well developed. This paper explores the experiences and views of secondary school staff about the difficulties faced by refugee and asylum-seeking children and their perceptions of future support.

Methods and Findings

In-depth interviews were conducted with six members of school staff across five secondary schools in Birmingham. Using Interpretative Phenomenological Analysis this paper gives an insight into the concerns of participants working with refugee and asylum-seeking children. Three themes emerged from the analysis conducted: demands of sense making and meeting needs; experience of meeting the needs; and positive partnerships. Participants discussed many approaches for creating a safe and secure environment for children. However, specific targeted interventions were seen to be the role of mental health professionals rather than school staff and hence collaboration with external agencies was considered important. The author interprets these findings to suggest a number of recommendations: training to improve staff mental health literacy; skills to enhance social and emotional wellbeing; group supervision and support; a strategy for information sharing; and a family link worker.

Conclusion

The findings suggest a need to develop a multi-layered approach in which schools promote an empathetic caring environment and designated staff receive adequate training to recognise when to refer children onto more specialised mental health services.

Introduction

Speaking for the Department for Children, Schools and Families at the All-Party Group Seminar on Wellbeing in the Classroom, Bartholomew (2007) argued that 'good evidence' is needed about interventions delivered in schools as a means of developing resilience in children's mental health. In 2008 the latest UK government initiative to promote mental health in schools was rolled out (Department for Children and Families, 2008). However, while school based programmes specifically promoting the psychological wellbeing of refugee and asylum-seeking children have been discussed few such examples exist, resulting in a lack of evaluation of the approach (Jordans*et al.,* 2010). This research seeks to develop a sustainable programme in schools, whereby teachers or other members of staff can promote the mental health of refugee and asylum-seeking children by creating supportive and caring environments.

By the end of 2011 roughly 10.4 million people worldwide were considered refugees, of whom approximately half were under the age of 18, with the number of refugees resettled in the United Kingdom making up less than 2% (193,510) (UNHCR, 2011). In this paper, the term 'refugee' is used to refer to people who have fled their country of origin due to a fear of persecution because of race, religion, nationality, membership of

a particular social group or political opinion (UNHCR, 1992). An ‘asylum-seeker’ is someone who has not yet been granted refugee status. The United Kingdom received 27,400 registered asylum claims in 2012, putting them fifth among the 44 industrialised countries for asylum applications per capita (UNHCR, 2013).

Current Mental Health Promotion in Schools

It could be argued that ‘the whole school approach’ advocating the need for a supportive and informed mental health environment, where children can establish a place of safety, would be more appropriate than singling out children with behavioural problems (Weare, 2000). In a similar vein, national legislation including Social and Emotional Aspects of Learning (Department for Children, Schools and Families, 2007; Department for Education and Skills, 2005, 2006) and Every Child Matters (Department for Education and Skills, 2003) suggest that holistic programmes, which seek to prevent mental health problems and promote psychological wellbeing, may be preferable to individualised therapy. Despite sound evidence for a wide range of educational and social benefits from promoting emotional and social wellbeing in schools, evaluation of such approaches is not well developed, (Vostanis, Humphrey, Fitzgerald, Deighton, &Wolpert, 2013).

Mental Health Statistics of Refugee Populations

The prevalence of mental health difficulties among refugee and asylum-seekers is varied across studies, although rates are usually higher among forcibly displaced children than host populations (Bronstein, Montgomery &Ott, 2013). Since exposure to life-threatening stressors can produce serious and often debilitating post-traumatic spectrum difficulties (March, Amaya-Jackson &Pynoos, 1996), it is no surprise that the

literature is biased towards Post Traumatic Stress Disorder symptomology among refugee populations who have often been exposed to adverse events (Jordans, Tol, Komproe, & De Jong, 2009). However, research has demonstrated that post conflict stressors such as unfamiliar language and culture are equal contributors to the levels of psychiatric symptomology as pre-migration war exposure (Steel, Silove, Bird, McGorry, & Mohan, 1999).

Barriers for Refugees in Accessing Mainstream Health Services

Due to budget and time constraints, lack of cultural awareness and understanding of refugee issues, the NHS has been unable to meet the mental health demands of refugee and asylum-seeking children (Mind, 2009). Therefore, alternative practical options need to be considered. It has been suggested that school based mental health interventions are the most effective in reaching the target population and forging links with the community (Beehler, Birman& Campbell, 2012). O'Shea, Hodes, Down &Bramley (2000) conclude that where refugee populations are restricted from access to clinic-based mental health services, much can be gained by working in collaboration with school staff.

School and Community Approaches to Promote Mental Health among Refugee and Asylum-seeking Children

A literature review by Tyrer&Fazel, (in press) explored interventions seeking to address the mental health problems of refugee and asylum-seeking children in school and community based settings. The review identified 20 studies, of which thirteen were delivered in high income countries in either the school context (*n*=11) or in the community (*n*=2), and seven in refugee camps located in areas of on-going conflict.

The interventions used were varied, including those primarily focused on the verbal processing of past experiences as well as creative art activities dealing with processing past events as well as present and future challenges. A few studies offered multimodal interventions to concurrently address a range of difficulties. While both verbal processing of past experiences and creative art techniques broadly led to reductions in symptomology, effect sizes could only be calculated for those that focused on the verbal processing of past experiences and ranged from 0.31 to 0.93. The literature review identified no evaluations of interventions delivered by school staff.

Multi-Modal Interventions for Refugee and Asylum-seeking Children

Research has begun to promote multi-faceted, multi-modal school based interventions that address social and environmental issues alongside more specific trauma related needs (Nickerson, Bryant, Silove, & Steel, 2011; Miller &Ramsussen, 2010). Although the efficacy of such programmes is difficult to measure (owing to substantial life challenges that can affect the mental health of forcibly displaced populations), it has been suggested that interventions that target the multiplicity of on-going challenges to the mental health of refugee and asylum-seeking children are most fitting (Reed, Fazel, Jones, Panter-Brick & Stein, 2012)

Current Research

With expressed concerns over the withdrawal of new initiatives by external agencies (Dutton, 2012; Weare& Murray, 2004), this research is intended to give an overview of the experiences of school staff working with asylum-seeking and refugee children in one city in the West Midlands whose council has received requests for more financial support and interventions in education and health for newly arrived children

(Hulusi&Oland, 2010). Although teachers often feel burdened by increasing demands due to new roles, changing curricula etc., good whole school mental health awareness supports academic learning (Weare, 2000). In order to prevent teachers feeling they are being required to take on the role of therapist or social worker, it is crucial that a 'bottom up' approach is taken, involving genuine consultation and shared goals Weare, 2010).

Aims of the Research

- To explore the experiences of secondary school staff in relation to the mental health difficulties faced by refugee and asylum-seeking children.
- To explore staff's experiences of current support for themselves and their children and to discover their perceptions of future need in the development of interventions targeting mental health difficulties for the above children.
- To suggest strategies needed to foster emotional and social wellbeing for refugee and asylum-seeking children.

Method

Design

This qualitative study employed interpretative phenomenological analysis (IPA: Smith, 1996; Smith, Jarman, & Osborn, 1999). IPA attempts to capture specific lived experience and is influenced by the work of Husserl (1927), who was interested in drawing upon the perception, awareness and consciousness of the individual. In this study, analysis involved asking phenomenological questions of the data from six participants in order to identify themes about their relationship to the world, people and events and the meaning it has for them (Brocki&Wearden, 2006). Heidegger

(1962/1927) claimed that individuals are indelibly in-context; thus, as the researcher seeks to understand other people's points of view, the pursuit necessarily becomes interpretative, automatically influenced by the researcher's experiences and perceptions (Brocki&Wearden, 2006; Hunt & Smith, 2004). (See appendix 10C for author's reflective statement).

Ethical Approval

Ethical approval for the study was granted by the University of Birmingham Human Research Ethics Committee (appendix 11C).

Context

The current research was undertaken in Birmingham, which has a population of around one million, of whom, approximately 26% are under the age of 18 (Birmingham City Council, 2012). Being the largest ethnically diverse city outside London, almost 30% of its residents belong to Pakistani, Indian, African Caribbean and mixed heritages; such minority ethnic communities make up for around 42% of students in schools with more than 50 spoken languages (Birmingham City Council, 2012). According to data collected for the 2011 census, the city is made up of 40 wards, of which 9 have over 60% non-white ethnic groups. These are Lozells& East Handsworth, Sparkbrook, Aston, Washwood Heath, Bordesley Green, Soho, Handsworth Wood, Springfield and Nechells (Office for National Statistics: ONS, 2013).

Due to on-going conflicts in Northern and West Africa, the Middle East and Asia, the year of 2011 was marked by a major increase of people seeking refuge (UNHCR,

2011). While newly arrived asylum-seekers are waiting for a decision on their application, families are dispersed outside London to designated accommodation. At the end of 2006, Birmingham was in the top three dispersal towns in England (Home Office, 2008).

Participants

Six participants, all front-line school staff, reported their experience of working with refugee and asylum-seeking children in the school context. Participants were recruited from five secondary schools across Birmingham through a method of purposive sampling so that a variety of experiences common to school staff was gleaned (Silverman, 2000). Three of the participants were English as an Additional Language (EAL) Co-ordinators, two were Pastoral Managers and one was a Teaching Assistant. Four of the participants were female. The length of time participants had been in the role ranged from three to twenty years. Details of the participants (names are given as pseudonyms) are presented in table 3.

Table 3: Participant Details

Pseudonym	**Position held**	**No. years in area of work**	**Gender**	**Ethnicity**
Aletea	EAL Co-ordinator	3	Female	White- European
Elizabeth	EAL Manager	10	Female	Black – British
Lavana	EAL Co-ordinator	N/A	Female	Asian – British
Omar	Pastoral & EAL work	15	Male	White - European
Mohsen	Pastoral Manager	20	Male	Middle Eastern
Harriett	Teaching Assistant	5	Female	White - British

Inclusion criteria:

1) School staff working directly with asylum-seeking and refugee children in schools
2) Secondary Schools, including academies, community schools, and free schools
3) EAL departments

Exclusion criteria:

1) Newly qualified teachers (up to one year)
2) Single sex schools
3) Grammar/Private/Voluntary Aided schools

In order to fulfil the aims of the project, secondary schools in Birmingham with an intake of refugee and asylum-seeking children needed to be identified. Birmingham

City Council was unable to supply this information, but suggested that head teachers of schools in areas of high ethnic diversity should be contacted. The 2011 census showed these to be in nine inner-city wards (ONS, 2013).

An invitation (appendix 12C) and participant information sheet (appendix 13C) was sent through email or post to the thirteen head teachers in the nine inner-city wards that met the inclusion criteria. From this only one school agreed to take part in the research. Due to the low response rate, some reliance was placed on personal recommendations from schools which had already agreed to participate. This strategy resulted in an approach to a further four schools in Birmingham outside the nine inner-city wards meeting the inclusion criteria, all of whom agreed to participate. The invitation letter asked head teachers if they would be happy to circulate the participant information sheet to teachers or support staff meeting the inclusion criteria. For those staff agreeing to participate, it was ensured that all had the information and consent was taken before interviews commenced (appendix 14C). The semi-structured interview schedule used was developed through reading the literature to identify areas pertinent to the subject. It was refined further through discussions in supervision (appendix 15C). The broad areas covered were staff's experience of working with refugee and asylum-seeking children, their perceptions of specific emotional and behavioural difficulties faced by the target children and their attitudes to support.

Interviews

Individual face-to-face semi-structured interviews were conducted with participants in schools during the summer of 2013. In line with the principles of IPA, a semi

structured interview was used to facilitate a ‘guided conversation’ and prevent a strict direction of the interview (Hunt & Smith, 2004). The semi-structured interview enabled participants to discuss events and issues of importance to them while the researcher ensured broad content areas were addressed. Data collection took place in a quiet/private location within the school and lasted approximately one hour. Interviews were audio recorded and transcribed in full; participants received a copy of their transcript and were given two weeks to notify the researcher of their withdrawal, any inaccurate information in the transcript or any sections they did not wish to be quoted directly. Participants were given two weeks to respond, otherwise it was automatically assumed they wished to remain in the study. No participant responded to the transcript.

Analysing the Text

Interview transcripts were used as the basis for analysis. In IPA the researcher is required to engage with the text in order to move from descriptive to interpretative features (Larkin, Watts, & Clifton, 2006; Smith *et al.,* 1999). As such, themes derived though IPA intend to capture both objects of concern to the person-in-context and, importantly, their interpreted meaning. While there are no set rules for analysing data using IPA, the current study employed a method set out in Smith, Flowers and Larkin (2009). Analysis began by reading and re-reading the transcript making detailed line-by-line notes of descriptive, linguistic and conceptual comments. Patterns emerging from initial codes where connected to form emergent themes (see appendix 16C for a worked example from Mohsen). Emergent themes from each transcript were then clustered together and re-occurring patterns were grouped to form sub themes. In order to ensure that derived themes were common across participants, a colour-

coding system was used to identify individual participant's data. For each thematic cluster, overarching super-ordinate themes emerged (see appendix 17C for a display of themes and appendix 18C for table ofemerging themes).

In order to ensure the analysis was plausible and coherent, a selection of un-annotated transcripts was independently examined and coding of emerging analysis evaluated. These were then discussed in supervision.

Results

Three main themes and six sub-themes emerged from the analysis (Table 4).The first main theme explores the need to understand the experiences faced by asylum-seeking and refugee children, creating an increased awareness resulting in an overwhelming sense of need to not only educate children but also support their emotional wellbeing. The second main theme looks at supporting the psychological wellbeing of refugee and asylum-seeking children within the remit of the school and the third explores relationships between the school and other factors that play a crucial role in enhancing children's mental health.

Table 4: Super-ordinate and Sub-themes

Super-ordinate Themes	Sub-themes
Demands of sensemaking and meeting needs	A need for sense making
	Wellbeing and education: the overwhelming sense of one and the other
Experience of meeting the needs	Whole school approaches in development
	Responsibility to provide and protect
Positive partnerships	Reaching out to others
	Importance of the family on wellbeing

Demands of Sense Making and Meeting Needs

A Need for Sense Making

The diversity of challenges faced by school staff was vast, ranging from disruptive to anxious and withdrawn behaviours in the children. All but one member of staff appeared to have tried hard to make sense of the children's presenting problems, attributing cause pre-migration, whilst travelling to a resettlement country and/or to the on-going stress children continue to face in resettlement. More specific examples participants gave included dealing with the loss or separation of loved ones,discrimination, the insecurity of a lengthy/confusing process to gain refugee statusand acclimatisation to the country, school and language.

R: I remember one particular child a few years ago, they were doing an experiment in science, it was a cover teacher, there were, it was a big pop, you know, and our student ended up under the table with the whole class laughing… and then obviously I went in and talked to the class, didn't give them specifics but I said, you know, this is the situation, you know, then you made it worse because you know the country he comes from, the types of things that we see on the news about this particular country.

(Aletea– EAL Co-ordinator)

R: … the training or the talking would need to have some kind of, this is what it's like, you know, you've got to put yourself in this person's shoes, you've got to understand when they're telling you 'yes Miss', 'yes Sir', that's not what they mean, you can't take it at face value.

(Harriett – Teaching Assistant)

The extracts above convey a sense of going beyond simple awareness to, instead, staff trying to put themselves in the shoes of refugee and asylum-seeking children. Three participants postulated that, in order to truly understand the experiences of these children, you have to have been through similar experiences yourself. It was expressed that enhanced empathy could lead to a realisation of how children's experiences might play out in terms of the here and now, subsequently leading to more appropriate responses. In the first excerpt, the participant believed that her decision to raise awareness among a class that had responded insensitively was an 'obvious' choice. In the second excerpt, it can be seen that refugee and asylum-

seeking children are potentially misunderstood and don't receive the support they need from teachers who are unable to put themselves in the children's shoes. It can be seen here that when there is knowledge and understanding of the experiences refugee and asylum-seeking children are often subjected to, this leads to increased empathy, acceptance, tolerance and consideration. This in turn leads to children who are likely to feel more connected to the school which previous research has suggested leads to positive mental health outcomes (Kia-Keating & Ellis, 2007; Sujoldžić, Peternel, Kulenović&Terzić, 2006).

While more knowledge seemed to increase enhanced empathy, participants also expressed the emotional impact and distress caused by moving beyond awareness to actively listening to some of the experiences children spoke about.

> R: Yeh, yeh, um that knocked me back that really (sigh).
>
> *I: Just hearing those stories?*
>
> R: It was just, you know, you hear it on the news, and then when you really come into contact with it, it's just different; I was numb, it was awful and I thought this young girl she's all what happened to her and then coming into school, into the environment, not understanding the language, that's frightening in itself 'cause you don't understand, you don't know what to expect.
>
> (Elizabeth – EAL Manager)

> R: We had supervision as mentors because yes we did hear a lot of horrible, you know, things that have happened to children and that kind of really affects

you, so we had regular supervisions we could go and talk and kind of talk about it, um yes I think there should be a supervision opportunity.

(Mohsen- Pastoral Manager)

Staff are a source of support by being there to listen to the harrowing stories of children's past. In the extracts above it is clear that hearing these stories can be emotionally upsetting and supervision is needed to contain staff in order to allow them to react appropriately without becoming overwhelmed.

Wellbeing and Education: the Overwhelming Sense of One and the Other

General teaching staff, not working so closely with asylum-seeking and refugee children were perceived to be far less tolerant and less able to cope with the demands of meeting the emotional needs of such children while simultaneously trying to cope with providing children with an education.

R: … they have to teach, they've got the pressures but it's hard when, you know, lots of them can't think well sort of,'What does that mean then to me? What does that mean? I haven't got time to be worried about their background and how things that I'm going to do in my class can really affect them.' Because they've got pressures obviously from the head, from league table, from Ofsted, from, you know, so they've got pressures to get on with their things as well but I do think that more awareness needs to be made.

(Aletea– EAL Co-ordinator)

R: I think that there's a lot of stigma as well on children from certain countries. Um that aren't sort of, you know, they seem to be kind of, 'a Gipsy, oh God do I have to have …' those sorts of things where it's kind of like, you know, that's training as well.

(Aletea– EAL Co-ordinator)

Although the participant clearly recognises that teachers are at times overwhelmed by the pressures they are under and their resistance to take on students with a range of complex needs, a clear position is taken regarding the need to train staff to make them more mindful, considerate and empathetic of children. In the second excerpt, we can see that the participant, although hesitant to say explicitly, recognises that children from different backgrounds are also stigmatised by teachers. Some teachers are perceived as considering children with complex needs as a burden and again the general belief of participants is that the solution is to provide training in order to increase awareness and reduce prejudice.

The pressures of working with refugee and asylum-seeking children are not restricted to general teaching staff. While acknowledging the importance of understanding children's individual circumstances, participants felt the extra work it creates for EAL and pastoral staff can sometimes feel like too much to take on.

R: No I think that we would, we're better off doing the support of the child's education. We don't want to go down that road; the role of the foster parent is the care and the wellbeing. We should have a clear line, that's how it should be. Because then we'll be taking on a lot of problems and resolving none.

(Elizabeth – EAL Manager)

Participants clearly felt a sense of competing and conflicting priorities over their roles. In one sense the majority of participants felt compelled to take on the emotional support and psychological wellbeing of children while on the other hand felt their focus of attention should lie in educating. Participants spoke both enthusiastically and reluctantly about taking on such positions, possibly because of the heavy demand such work created and three participants explicitly stated that there should be role boundaries put in place.

Experience of Meeting the Needs

Whole School Approaches in Development

There was a general sense of frustration in working within an education system that is so heavily driven and judged by results and a concern among some participants that if schools continue to be coerced along the results line it could be damaging. Such disapproval, and an active pursuit to fight against it, was explicitly stated by participants:

> R: … we've got pressures on us as well from the council to get them into mainstream, to get them producing so they're not draining resources but we refuse to be rushed.
>
> (Aletea – EAL co-ordinator)

R: I'm not afraid to hold them back until I know because his psychological side and emotional side is more important at that point.

(Aletea– EAL co-ordinator)

Faced by enforced procedures within the system, which places people working to support asylum-seeking and refugee children and teaching staff appraised by their results in opposing roles, opportunities for desired action are restricted and good staff relations are threatened.

R: Sometimes when I see teachers I know they're walking the other way 'cause they know I'm on their backs.

(Aletea– EAL Co-ordinator)

While interviewees expressed their difficulties in supporting the psychological wellbeing of children within the remit of the school through attempts to create a more nurturing and caring school environment, they were able to provide examples of small victories.

R: So how's it working? 'Cause it is working, it's praise, it's motivation, it's 'Miss, look I've worked well today' 'Oh my God, right I'm gonna ring your mum tonight, that's amazing', you know, telling people higher up.

(Aletea– EAL Co-ordinator)

Working against this backdrop, specialised support is starting to emerge, however at present no interventions within the school were in place to specifically support the

needs of asylum-seeking and refugee children. School staff alluded to the fact that specialised interventions to target common problems being presented by asylum-seeking and refugee children would be useful.

> R: … somebody say's something and if you have already emotional issues, and you have seen things back in your country as a refugee or an asylum-seeker, you will react to it. You see the kids that come from the other country um I think my personal view is they need training, you know, you need to train even emotionally and things like that.
>
> (Mohsen– Pastoral Manager)

While targeted interventions were seen to be important, all participants regarded specialised mental health support to be the role of mental health professionals and saw their role as creating an environment where such need for support could be identified. These constraints are thus an important part of the broad context in which teachers are seeking to work.

Responsibility to Provide and Protect

The majority of participants expressed a protective instinct towards the children, recognising the needs of the whole child. At one end of the spectrum one participant treated her EAL students as though they were family taking on a maternal role. For four interviewees this came across as an instinct to nurture and develop the wellbeing of the child. The extracts below show an understanding by the school staff

that children need a secure base in order to have the confidence to explore and progress.

> R: … honestly it's like a big family, it really really is. So although there's no need for them to come, they still come and, you know, and I'll make no excuses even to the Head. I'll never turn one of them away.
>
> (Aletea– EAL Co-ordinator)

> R: I mean a big part of what we do regardless of the academic side of it is to kind of act as a buffer between the world and these children. It takes a long time for them to become truly settled and some of them never really achieve that depending on obviously when they arrive.
>
> (Harriett – Teaching Assistant)

At the other end of the spectrum the perception was much more objective. While it was recognised that children had complex needs, it was felt that the responsibility should be simply to provide a safe learning environment within the school.

> R: We did computer work. She enjoyed it, was more to just sort of, it was more to see because of her behaviour and all her issues you see what she was interested in, and what would get her going really.
>
> (Lavana– EAL Co-ordinator)

R:What we tend to do is sort of do work on their country, so try and do something positive from that um that they can tell us something about their own country.

(Lavana– EAL Co-ordinator)

In practical terms a creative and flexible approach to curriculum delivery was one way in which participants provided support for the children. They tried to incorporate more holistic, nurturing and therapeutic skills and activities and advocated a whole school approach.

R: He loved sport so we incorporated um myself with the trainer outside of the class and on the difficult day we would go outside and we would do like maths via sports.

(Aletea– EAL Co-ordinator)

R: We had to watch a lot of the, you know, the um clips of the fighting, um to do with the first and second World War and he got upset and I had to take him out of the lesson. And he, I think he had to see a counsellor to express how he felt.

(Elizabeth – EAL Manager)

Strategies were also put in place to help children integrate smoothly into the school and to help them fit in with their peers, showing a recognition of the importance of relationships to a child's wellbeing.

R: We find somebody (buddy) that will match um them somebody who's very suppor- will be supportive and helpful who's in the same, we usually put them in the same class so that they can take them to the lessons and sit with them.

(Elizabeth – EAL Manager)

R: At the beginning when we have new student's starting eh they will probably, you know, be buddies with somebody going from lesson to lesson so that they know that they're not lost and usually we tell them if they do get lost or they need any support it's always very important that they know where to go for that support.

(Omar– Pastoral Manager)

Whilst disclosing children as refugees and asylum-seekers to teaching staff may enable teachers to act more appropriately, disclosure is a delicate and ethical issue; care has to be taken to ensure this doesn't come at the expense of protecting children's privacy and child protection issues. Opinions of participants differed greatly as to what information teaching staff should be given about their pupil's circumstances. In one school, staff were completely unaware which children were refugee or asylum-seekers and consequently the interviewee felt there was no clear framework on which to build her own practice. In contrast, for two schools, the EAL departments worked hard to source this information but specifics were not made available to general teaching staff. In the final two schools, all background information of each student was given to teaching staff.

> R: … you have all the CP [*Child Protection*] issues and you have all the, you know, other things that go on so I would say most of the staff aren't truly aware. I mean what we would tell them is that this child has had a very traumatic experience and, you know, um again because I think in this school we do have a lot of children that are on the CP register, so the staff are very used to getting information but not knowing anything and having to deal with that is just you need to be aware that this child is very sensitive today, we can't really necessarily tell you why. And they are very good with that. If the child is happy for it to be discussed than we might, but obviously most children they don't want that widely known.
>
> (Harriett – Teaching Assistant)

In this extract the participant demonstrates that she has acted correctly by not revealing too much information on a child listed in the Child Protection register. Information is usually sourced directly from the child after building a trusting and confident relationship in which children feel able to disclose. Therefore, support staff seemed to feel a sense of ownership of the information and feel proud at being able to have sourced it. However, the lack of coherent systems for disclosure and sharing of data was seen to have an impact on current practice.

Positive Partnerships

Reaching Out to Others

Staff relations within the school were sometimes problematic, and participants' enthusiasm for their work appeared to impinge on their relationship with general

teaching staff. However, co-operative working within the schools has also been illustrated.

> R: ‘Cause when they send out the lesson plans they will send us key words, and what they’re doing. So we would then do a lesson plan from that lesson plan to support that group or an individual pupil.
>
> (Elizabeth – EAL Manager)

Teaching staff supporting the mental wellbeing of refugee and asylum-seeking children take on a huge responsibility and some reported feeling isolated in their role. Some teachers felt out of there depth due to not receiving appropriate professional support from external agencies. Two participants mentioned support that was cut due to funding and it was implied that replacement professional help hadn’t been found.

> R: We for example maybe brought people from outside or we sent, for example counselling again it’s loads of things that were there before but now it’s gone because of cuts.
>
> (Mohsen– Pastoral Manager)

> R:… those boys did for a while have a learning mentor come in that was also from Afghanistan um and so they kind of had a connection a male role model um whereas, you know, that was a very temporary thing but he happened to be there at the right time when we had a lot of Afghani boys.
>
> *I: And how did that come about?*

> R: It was through BASS ‘Birmingham-Advisory-Support-Service’ which um they actually helped us a lot in setting up the EAL department anyway um but their whole funding situation changed a few years ago now and they basically withdrew their support in schools.
>
> (Harriett – Teaching Assistant)

One participant also discussed her active pursuit for more support with other EAL departments where information could be learnt and ideas shared.

> R: I’m trying to network with other schools, other schools that had EAL departments in their school and see what they’re doing with their pupils and see what programmes they’re doing that we can implement into ours and vice versa.
>
> (Elizabeth – EAL manager)

Again, the above extracts highlight that while hesitant to share personal details of their pupils’ circumstances, staff are eager to gain new ideas and learn new skills and thus ameliorate their feelings of isolation and concerns about limited knowledge.

Importance of the Family on Wellbeing

The relationships between the school and students families are bound to play an important role in multiple factors of the child’s development.Three participants believed that in order to help the child you have to help the family.

> R: … it was the case that sometimes the kid fainted here and the kid hadn't eaten because there was nothing at home so the parents couldn't, for example, they didn't know how to fill the forms and things like that, to apply for benefits that they are entitled too. So that's the thing that you have to have a very regular connection to the family.
>
> (Mohsen– Pastoral Manager)

Here the participant demonstrates the importance of a consistent and positive relationship with the family; working to help them understand the benefits they are entitled to and how to claim them will have a cascading effect on the child. In order for the school to be able to put in place appropriate interventions to help children a more holistic picture of the child needs to be drawn through transparency with the family.

> R: Yes we do call parents if we need to and then try and talk and see what's, you know, what's happening in the family and um what can be done and how the family can help. Oh yes we liaise with the family closely and I think that's very important too because the more you liaise with the people that deal with those children I think the better results will come out of it.
>
> (Omar– Pastoral Manager)

Consistency between the school and the family was also important for participants. In the above excerpt it can be seen that school staff try to make contact with families so as to reinforce what's being done in school. In this way the participants' view both themselves and the parent as responsible agents in educating children and that the

best results come out of working collaboratively to determine and put in place the most appropriate strategies.

Discussion

The study provided an insight into the reactions and emotions of staff working with refugee and asylum-seeking children. Pupils see more of EAL staff than others and sometimes form a particular attachment to them as maternal/paternal figures. Consequently, staff are more likely to be exposed to stories of difficulties and trauma that the children have endured. While not always expressed explicitly, there was a clear sense that staff members found it uncomfortable and distressing to hear some of the pupils' life stories and were anxious for a source of support.

There was a clear discrepancy between those interviewed regarding their commitment or reluctance to fostering psychological wellbeing in schools. While some staff regarded the support and wellbeing of children as a crucial part of their role, others appeared wary and anxious at the thought of taking on such a responsibility. This is surprising given that previous research has found school staff delivering universal interventions to be as effective as external specialists, although it should be noted that these were not received specifically by refugee and asylum-seeking children (Durlak, Weissberg, Dymnicki, Taylor &Schellinger, 2011; Wilson &Lipsey, 2007).

Opposing roles or different priorities was a concern for some staff, who felt the lack of support from colleagues within the school placed strains on staff relations. Staff

appeared frustrated and powerless against the barriers preventing them meeting the needs of refugee and asylum-seeking children and feeling their voice was lost in the school system, whose emphasis is on achieving academic targets. Despite these constraints, it was apparent that most staff persisted in taking on more than just a practical role and expressed a feeling of guilt that they were not able to do enough to support these children.

Feelings of isolation as a result of the school system and conflicting priorities created a certain amount of anxiety. Participants appeared enthusiastic to link with peers in other schools for support, and believed their understanding of problems could also be increased by consulting with pupils' families. Staff expressed a feeling of pride that they were able to build up a trusting relationship whereby children would confide in them.

The participants discussed many ideas of what school staff should be doing or putting in place to support, nurture and develop the mental wellbeing of all children, whether they have specific mental health difficulties or not. Results point towards a general desire to enhance all aspects of the child's psychological wellbeing, signifying a multi layered universal approach although more targeted interventions are emerging. This is consistent with the other literature which advocates the need for multi-modal interventions which aim to concurrently address the holistic needs of children (Nickerson, Bryant, Silove, & Steel, 2011). Alongside previous research (Durlak&DuPre, 2008; Greenberg, Domotrovich, Graczyk, &Zins 2005) the analysis reveals that many of the staff who took part in the study experienced a range of facilitators and obstacles in working effectively (or ineffectively) with asylum-seeking

and refugee children. The most salient factor in the data in terms of promoting the psychological wellbeing of the target children is the discrepancy between the will of staff and their perceived ability to effect change, time being a major contributor.

Clinical implications

Some teachers found it emotionally upsetting to hear the pupils' life stories. It is therefore important that continuing support and a forum for consultation is put in place to provide a facility for staff to debrief and better support these children. This has been found to be an effective tool in supporting school staff concerned with the mental wellbeing of children (Emanuel, 2005). It would be useful for appropriate staff from different local schools to meet together to discuss, support and share ideas. Ideally, it should be externally facilitated or joined by a clinician from a child and adolescent mental health service, who would be able to help teachers think about and formulate the children within the context of where they currently reside and where they have come from.

While the participants' perceptions were that general teaching staff and, to some extent, EAL staff are reluctant to improve their mental health literacy, it would seem a necessary requirement for those teachers who hold a special responsibility to support and work with these children more closely. It is recommended, therefore, that training is offered to such staff, not so they can provide therapy but so that they can respond appropriately and to be helped to process their own reactions to what might be very uncomfortable stories. If they are helped to contain their own feelings, they will, in turn, be better placed to help contain and respond to the feelings and behaviours of children. A training package needs to include ways of recognising

mental health difficulties, with particular reference to those that may be high risk for refugee and asylum-seeking children so that informed decisions can be made as to what comes under teachers' own remit and when referrals should be made.

It is desirable that a whole school approach to psychological wellbeing is adopted and should be primarily led by designated EAL and pastoral staff experienced in working with these children. One school mentioned it has taken on the Social and Emotional Aspects of Leaning (SEAL) programme designed to promote social and emotional skills with reference to the whole-school approach (Humphrey, Lendrum, &Wigelsworth, 2010); this would seem to be an appropriate model to use as a starting point for refugee and asylum-seeking children, and may help counter the aforementioned reluctance to change. Resources available in the SEAL package are envisaged to be used by schools to meet their own needs rather than as a structured one-size-fits-all package (Weare, 2010).

Increased understanding was regarded as an important predictor of appropriate practice and thus sharing information is crucial for improving outcomes. However, a balance needs to be struck between the benefits of sharing information with the view to improving practice and protecting the privacy of the individual. To aid multi-agency work in improving the wellbeing of children, HM Government (2008) have produced an Information Sharing: Guidance for Practitioners and Managers which outlines how information should be shared legally and professionally in accordance with Section 10 of the Data Protection Act of 1998. This guide clearly states that information can be shared with teachers as long as it is necessary, proportionate, relevant, accurate, timely and secure. It would seem to be appropriate, therefore, for all those who teach

refugee and asylum-seeking children in school to be informed of relevant issues concerning those children.

Teachers are primarily concerned with educating the child and there can be reluctance by some to take on what they see as a specialist mental health care role. One way to address this might be to bring an external professional into schools to carry out a formulation on these children and determine triggers for presenting problems. Teachers can then be advised of these triggers so they can make appropriate choices in their classroom without becoming overwhelmed at taking on a mental health role.

Congruent with the literature (Arnot& Pinson, 2005), the data highlights the importance of mutual understanding between the school and the family for raising educational achievement and understanding the social, emotional, and psychological needs of the child. One approach for establishing consistent links with parents is to use a family link worker. This would take some of the strain off busy teachers and facilitate a good understanding and working relationship between the school and the home.

Strengths and Limitations

Participants were eager and willing to describe and reflect upon their personal experiences of working in school to educate and support the needs of refugee and asylum-seeking children. On the whole, all appeared genuine and forthright in their answers and were not afraid to share the perceived strengths and weaknesses of the current system. The implications drawn from participants' accounts relate to five

secondary schools across Birmingham. Although analysis aimed to uncover the most powerful patterns of meaning it cannot be assumed sampled environments are representative. This is further complicated by the low response rate from initially contacted schools, resulting in only one of the five participating schools being located in the nine inner city wards. The fact that the study did not talk to general teaching staff may also be viewed as a limitation. However, this decision was made due to the restricted knowledge general teaching staff tended to hold; many of these were unaware of which of their pupils were refugee or asylum-seeking children.

Future Directions

The current research points towards a need to support schools in developing a multi-layered framework to support the psychological wellbeing of children. Providing training and supervision for designated EAL and pastoral staff to teach fundamental skills and identify when pupils may need to be referred externally would aid such practice. Although this research points to a multi-modal approach in schools, the efficacy of this is still largely unknown (Fazel, Reed, Panter-Brick & Stein, 2012) and a next step might be to run pilot schemes for purposes of evaluation.

Conclusion

The interpretative undertaking of the current research suggests the need for consultation and support, adequate training, mechanisms for sharing information and a family-school link worker in order to develop a multi-layered approach in schools. Understanding the perception of school staff and the conflicting challenges they face on a daily basis is vital in ensuring support is accepted and utilised effectively. It is suggested that while all staff should work to promote an empathetic caring

environment, in order to promote a sustainable approach, EAL and pastoral staff should receive the training, supervision and support to deliver preventative and effective interventions. These should include knowledge of when and how to refer on to specialist external agencies, in order to nurture the psychological wellbeing for refugee and asylum seeking children in schools.

APPENDICES

Appendix 1A: Search Strategy Used for PsychINFO

#	Searches	Results	Search Type
1	exp Immigration/ or exp Refugees/	13775	Advanced
2	exp Immigration/ or exp Refugees/	13775	Advanced
3	*migrant/	167	Advanced
4	exp Refugees/	3084	Advanced
5	1 or 2 or 3 or 4	13927	Advanced
6	(refugee* or "asylum seeker" or migrant* or immigrant* or displace*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	26611	Advanced
7	5 or 6	27892	Advanced
8	exp Junior High School Teachers/ or exp High School Students/ or exp School Counseling/ or exp Elementary School Teachers/ or exp Elementary School Students/ or exp Primary School Students/ or exp After School Programs/ or exp School Environment/ or exp Middle School Students/ or exp Nursery School Students/ or exp Intermediate School Students/ or exp Middle School Education/ or exp Public School Education/ or exp Middle School Teachers/ or exp High School Teachers/ or exp High School Education/ or exp School Based Intervention/ or exp Junior High School Students/ or exp Private School Education/	64104	Advanced
9	exp Community Mental Health Centers/ or exp Community Counseling/ or exp Community Mental Health/ or exp Community Mental Health Services/ or exp Community Mental Health Training/ or exp Community Psychology/ or exp Therapeutic Community/	9723	Advanced
10	(School* or Community*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	328019	Advanced
11	exp Group Intervention/ or exp School Based Intervention/ or exp Intervention/	46397	Advanced
12	exp Treatment/	424322	Advanced
13	(intervention* or treatment*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	499715	Advanced
14	8 or 9 or 10	328938	Advanced
15	11 or 12 or 13	676393	Advanced
16	7 and 14 and 15	1674	Advanced
17	limit 16 to (160 preschool age <age 2 to 5 yrs> or 180 school age <age 6 to 12 yrs> or 200 adolescence <age 13 to 17 yrs>)	373	Advanced

Appendix 2A: Quality Rating Scale

Treatment Quality

Item	Question	Item	Ager *et al.*	Baker & Jones	Barrett *et al.*	Beehler *et al.*	Birman *et al.*	Bolton et al.	Catani *et al.*	Durà-Vilà *et al.*	Ehntholt et al.	Ertl et al.	Fazel et al.	Fox *et al.*	Gupta & Zimmer	Kalantari *et al.*	Möhlen et al.	Onyut *et al.*	Rousseau *et al.*	Rousseau *et al.*	Schottelkorb et al.	Thabet *et al.*
			Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response
1	Has a clear rationale for the treatment been given and an adequate description of its content?	Treatment content/ setting	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	1 1 2	0 1 2	2 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
2	Has the total treatment duration been reported?	Treatment duration	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	1 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
3	Is there a treatment manual that describes the active components of treatment?	Manualisation	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
		Adherence to manual	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
4	Have the therapists been appropriately trained in the relavant procedures for this trial?	Therapist training	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
5	Is there evidence that the patients have actively engaged in the treatment?	Patient engagement	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Total score for section:	**5**	**2**	**8**	**5**	**3**	**8**	**8**	**3**	**8**	**9**	**2**	**3**	**6**	**4**	**4**	**8**	**3**	**6**	**7**	**4**

Quality of Study Design and Methods

Item	Question	Item	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response	Response
1	Are the inclusion and exclusion criteria clearly specified?	Sample Criteria	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Evidence criteria met	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
2	Is there evidence that CONSORT guidelines for reporting attribution have been followed	Attrition	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
		Rates of attrition	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
3	Is there a good description of the sample trial?	Sample characteristics	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Group equivalence	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
4	Have adequate steps been taken to minimise biases?	Randomisation	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
		Allocation Bias	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Measurement Bias	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Treatment expectations	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
5	Are the outcomes that have been chosen justified, valid and reliable?	Justification of outcomes	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
		Validity of outcomes for context	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
		Reliability and sensitivity to change	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2
6	Has there been a measure of any sustainable chance between the treatment and control groups	Follow up	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
7	Are the statistical analysis adequate for the trial?	Power calculation	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Sufficient sample size	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Planned data analysis	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Statistical reporting	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Intention to treat analysis	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
8	Has a good, well-matched alternative treatment group been used?	Control group	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1	0 1
		Total score for section:	**12**	**9**	**14**	**5**	**5**	**18**	**18**	**3**	**8**	**20**	**9**	**6**	**7**	**9**	**8**	**16**	**9**	**22**	**15**	**13**
		Total Score:	**17**	**11**	**22**	**10**	**8**	**26**	**26**	**6**	**16**	**29**	**11**	**9**	**13**	**13**	**12**	**24**	**12**	**28**	**22**	**17**

Appendix 3A: Information to Extract from Included Articles

Reference		Location		Population			Design				Findings		Further communication		
Author	Year	Location of study	Location of intervention	Ethnic group	Sample size	Age	Intervention	Questionnaire	Outcome Measures	Analysis	Results	effect size (If available)	comments	contacted (how. Whom and when)	Response
Ager *et al.*	2011	Uganda	Schools	African (Ugandan)	403	7 to 12	Psychsocial Structured Activities Programme	Self, parent & teacher ratings	Increase resilience & well-being	Fixed-effects linear model	Sig. group & time interaction for self & parent report but not teacher report. Pre and Post assessments self report(<.001), parent-report (p = .01) teacher report (p>.1)	Not available	Internally displaced		
Rousseau *et al.*	2005	Canada	School	Mostly Asian & South American	138	7 to 13	Creative expression programme	Achenbach's Teacher's Report Form & the Dominic (self report questionnaire) & the Piers-Harris Self-Concept Scale	Emotional & behavioral problems & self-esteem	Univariate generalized linear model t-tests	Pre-test & post test results revealed programme had a possitive effect on self-esteem and may decrease emotional & behavioural symptoms.Self report: Externalising (<.000), Internalising (.001), Popularity (<.008), & Satisfaction (<.000) Teacher's report: Externaliszing (.217), Internaliszing (0.21)	Not available	33% born in Canada		
Baker & Jones	2006	Australia	School	Sudanese (n = 20), Iranian (n = 5), Liberian (n = 2), Rwandan (n = 2), Ethiopian (n = 1), & Congolese (n = 1).	31	11 to 16	Music therapy	Behaviour Assessment System for Children	Hyperactivity, aggression, conduct problems, anxiety, depression, somatisation, attention problems, learning problems, atypicality, withdrawal, social skills, leadership & study skills	MANCOVA	Music therapy decreased externalising behaviours. Non sig. effects for music therapy on internalising, Behaviour Sympton Index, School problems and adaptive skills. Externalising behaviours (p = .01), Internalising behaviour (P = .86), Behaviour Symptom Index (p = .07), School Problems (p = .49) & Adaptive Skills (p = .71)	Not available	Provides little evidence that music therapy is a successful intervention		
Barrett *et al.*	2003	Australia	School	Former-Yugoslavian (n = 125), Chinese (n = 148), & non-English speaking backgrounds (n = 47)	320	6 to 19	Group-based cognitive-behavioural early intervention programme	Self-Esteem Inventory, Roesnberg Self Esteem Scale, Revised Children's Manifest Anxiety Scale, Trauma Symptom Checklist for Children, Hopelessness scale	Self-esteem, anxiety, future expectations	ANOVA & MANOVA	Elementary sig. improvement in self-esteem (p < .05), anxiety (p < .001), future outlook (p < .01) for FRIEDS group compared to waiting list. High school sig. improvement for anxiety (p < .05) for FRIENDS group, sig. improvement for self esteem (p < .05) in waiting list. Sig. improvement in trauma symptoms (Anxiety P < .001; Depression p < .001; Anger p < .001; PTSD P < .001; Dissociation p < .001) for FRIENDS group	PTSD (0.92), depression (0.93). Anxiety primary school (0.65), high school (0.67)	Might be worth buying the manual for FRIENDS.		

Beehler *et al.*	2012	USA	School	American, African, Asian.	149	6 to 21	Cultural Adjustment and Trauma Service	The Child and Adolescent Functional Assessment Scale & PTST Reaction Index	Functional impairment & PTSD symptoms	Random-effects regression	Functional impairment decreased as greater cumulative totals of supportive therapy (p <0.01), TF-CBT (p <0.01) & CBT services (p <0.03) increased. PTSD symptoms decreased as a result of greater cumulatice totals of TF-CBT (p <0.05) & coordinating services (p < 0.04). CBT services did not reveal a sig. improvment (p < 0.07).	Not available			
Birman *et al.*	2008	U.S	Community	African, Central/Eastern Europe, Latin American, Middle East/Central Asia & South Asia	68	unknown	Familly, Adult, Child Enhancement Services (FACES)	The Child and Adolescent Functional Assessment Scale (CAFAS) & Harvard Trauma Questionnaire	Children's functioning in the school, home, community, behaviour towards others, behaviour towards self, mood, substance abuse and thinking.	Random-effects regression	No sig. effect of amount of services on improvement	Not available		Emailed Dr Dina Birman, 12 Decemer 2012	Response from Dr Dina Birman, 24 December 2012
Catani *et al.*	2009	Sri Lanka	Refugee camp	Asian	31	8 to 14	KIDNET, meditation-relaxation	UCLA PTSD Index for DSM-IV (UPID), items for problems in functioning, Tsunami experience, & somatic complaints	PTSD symptoms, levels of functioning & physical health	ANOVA	PTSD & impairment in functioning sig reduced & remained stable over time (p <0.001). Difference between treatment groups was not sig.	Not available			
Ehntholt *et al.*	2005	England	school	Kosovon, Sierra Leone, Turkey, Afghanistan, & Somalia	26	11 to 15	CBT	Revised Impact of Events Scale, Depression Self-Rating Scale, Revised Childen's Manifest Anxiety Scale, War Trauma Questionnaire, & Teacher Strengths & Difficulties Questionnaire.	PTSD symptoms, behavioural difficulties & emotional symptoms	ANCOVA & paired *t*-tests	PTSD pre-post total PTSD decrease in CBT group (p = .011) & increase in control (p = 0.073) Anxiety pre-post anxiety decrease in CBT group (p = .136) & increase in control (p = .068). Behavioural difficulies pre-post behavioural difficulties (p = .027) & emotional symptoms (p = .010) decrease sig. in CBT group. no sig. difference in control.	PTSD (0.88), Anxiety (0.64)	All from war-affected countries		
Ertl *et al.*	2011	Uganda	Camps for internally displaced	Ugandan	85	12 to 25	NET, supportive counselling, or waiting list	Clinical-Administered PTSD scale, Mini international Neuropsychiatric Interview, a locally adapted scale for perceived stigmatisation	PTSD symptoms, depession & suicide, perceived stigmatisation	Mixed-effects model	NET vs. academic catch up (mean difference -14.06) NET vs. waiting-list (mean differnce - 13.04). NET vs. academic catch up over time (p = 0.02) NET vs. waiting list (p = .02)	PTSD (0.31), functional impairment (0.64)	Some particpants were over 18 years (aged 12 to 25 years)		
Fazel *et al.*	2009	England	Schools	Balkans, Asia, Africa Ethnic minority group - Pakistan, Bangladesh & elsewhere	141	5 to 17	Weekly consultation between mental health worker and teacher	Strengths & difficulties questionnaire	Emotional, conduct & peer problems, hyperactivity & prosocial behaviour	ANOVA	Children receiving both CBT and creative arts showed significant declines in peer problems (p=.005)	Not available			
Gupta & Zimmer	2008	Sierra Leone	Camps for internally displaced	African	306	8 to 17	Rapid-ED - structured trauma healing activities	Pre test - exposure to war events items & Impact of Events Scale post test - subjective assessment of child's feelings and Impact of Events Scale	Feelings	*t*-tests	PTSD symptoms (concentration, sleep, intrusion and arousal) decreased in 96% of participants following intervention.	Not available			

Möhlen *et al.*	2005	Germany	Refugee accommodation	Kosovan	10	10 to 16	Individual, family & group sessions, psycho-education, trauma & grief activities, creative techniques & relaxation	Harvard Trauma Questionnaire (HTQ), Kids Schedule for Affective Disorders and Schizophrenia (K-SADS), Diagnostic System for Psychologica Disorders (DYSIPS), Child Global Assessment Scale (CGAS)	Emotional distress & psychosocial functioning	*t*-tests & random effects regression	Sig. pre-post decline in PTSD (p = 0.018), depression (p = 0.014) & anxiety (p = 0.006). Sig. Increase in CGAS (p < 0.001)	Not available			
Rousseau et al.	2009	Canada	school	South Asian	52	4 to 6	creative expression workshop sandplay	Strenghts and difficulties questionnaire	reduce emotional & behavioral problems & improve social adjustment	t-tests & generalized linear models	Parents report - Sig. Pre-post reduction SDQ (p = .003), emotion symptoms (p = .002) & relared subscale (p = .001).		72% not refugees		
Schottelkorb *et al.*	2012	USA	School	African, Asian, European & Middle Eastern	26	6 to 13	Child-centered play therapy vs. TF-CBT	UCLA PTSD Index for DSM-IV, Parent Report of Posttraumatic Symptoms	PTSD	ANOVAs	Entire sample - child report - non sig difference for time (p = .35) or group (p = .85). Parent report - non sig. difference for time (p = .22) or group (p = .32). Clinical sample - child report sig. difference for time (p > .01) non sig. group difference (p = .68). Parent report sig. difference for time (p > .01) non sig group difference p = .40).	Not available			
Fox et al	2005	USA	School	Asian	58	6 to 15	Cognitive behavioural school based program	Childrens depression inventory	depression	not stated	Depression scores had sig. degreased between screening times before the intervention and half way though intervention (p = .003) and also one month following intervention (p=.000)	Not available			
Kalantari	2012	Iran	School	Afghani	29	12 to 18	Writing for recovery	Traumatic Grief Inventory for Children	Traumatic grief symptoms	not stated	Sig effect (p<.001)	Traumatic grief (0.67)			
Bolton *et al.*	2007	Uganda	Refugee camp	Ugandan	314	14 to 17	Interpersonal psychotherapy for groups (IPT-G), vs creative play (CP) vs. Waiting list control	Acholi psychosocial assessment instrument	Depression, anxiety, conduct problems	Random-effects regression	Sig. pre post improvement in IPT-G vs. CG for depression (p = 0.02). non sig. improvements in CP vs CG for depression (P = 0.58). Anxiety sig. (but small) pre-post decline on IPT-G vs. CG. Conduct non sig pre-post decline on IPT-G vs. CG. CP non sig. pre-post increase for anxiety & decrease for conduct problems.	Depression (0.57)			
Thabet *et al.*	2005	Palestine	Refugee camp	Palestinean	47	9 to 15	Group intervention (story telling, drawing, free play & role play) vs. education vs. no intervention	CPTSD-RI & CDI	PTSD & Depression	Wilcoxon test	The three groups did not differ sig. on any CPTSD-RI or CDI at time of first assessment and no sig. changes were estabilished.	not sig.	Still living in war zone.		

Durà-Vilà	2012	UK	Community	Middle East, African, European	102	3 to 17	theraputic work with children & families & consultations	SDQ (teacher or patent compleation or self)	hyperactivity/inattention,conduct, emotional & peer problems	t-tests	Pre-test & post test results reveiled treatment had a sig. improvement for teacher rated total problem scores p=0.010, hyperactivity p=0.015 & peer problems p=0.017 and parent rated total problems p=0.006, hyperactivity p =0.000 & conduct scores p=0.043.	Not available	data was only collected for 35 children, possible that it was the same childrena & intervention as O'shea study		
Onyut	2005	Uganda	Refugee camp	Somalian	6	13 to 17	KIDNET	Composite International Diagnostic Interview	PTSD & Depression	Mixed model ANOVA & a Friedman	significant reduction of symptoms of PTSD across time (p<0.039)	Not available			

Appendix 4B: Certificate of Ethical Approval

[redacted]

cc. Ms Rebecca Anne Tyrer

Appendix 5B: Participant Information Sheet

[redacted]

Participant Information Sheet

CBA Training and Group Supervision evaluation

You are invited to take part in a service evaluation interview. Before you agree to participate, it is important that you understand the purpose and nature of the interview.

What is the purpose of this evaluation?
This evaluation aims to see whether the CBA Training and on-going Group Supervision supports the use, and application of, CBA in day to day clinical practice for CMHT clients.

Why have I been chosen to take part?
You have been asked to take part as I am aiming to get a wide range of views from different practitioners who have attended the training and group supervision.

Do I have to take part and what will happen if I do?
No, participation is completely voluntary and if you decide not to take part this will not affect you in any way. If you do decide to take part, I will ask you to sign a consent form, but if you change your mind later, you are free to withdraw at any time during the interview. You are also free to withdraw you data up until Monday 25th March 2013.

What will happen to me if I take part?
You will be interviewed about your experiences of the CBA training and of the on-going CBA supervision Group that you are a part of. This will include questions on how the process of training and supervision works, what you find helpful about the process, and what you feel could be improved. Interviews will be carried out individually and will involve recording on an audio device. Recordings will be deleted after transcription and transcriptions will be disposed of after 10 years.

Will my taking part in the study be kept confidential?

If you join the study, the interview will be recorded and transcribed before recordings are deleted. When the interview is transcribed, you will be allocated a pseudonym so that you are not personally identifiable. Transcriptions will be kept confidential and stored in a password protected, encrypted database, and will only be accessible to the research team. Some quotes may be used in an internal presentation and report within the University, but no quotes will be used that could identify an individual.

What if there is a problem?

It is unlikely that taking part in this study will cause any problems, but if you have a complaint about any aspect of the way in which you have been approached or treated during the course of the study, you can either contact myself (Rebecca Tyrer) directly, my academic supervisor Michael Larkin, or Susan MacPherson.

What will happen to the results of the service evaluation?

The data will be used for research purposes, presented in an internal presentation within the University and in a written report to form part of a Masters thesis.

Who has reviewed the study?

This study has been reviewed by University of Birmingham Research Ethics Committee.

What happens next?

I will give you at least 24 hours to decide if you would like to take part in this research study, participants who are willing to take part will be asked to sign a consent from. If you would like any further information about this study, please contact Rebecca Tyrer, (contact details can be found on the top of the page).

Thank you for considering taking part in this research and taking the time to read this information sheet.

Appendix 6B: Consent Form

CONSENT FORM

CBA Training and Group Supervision evaluation

I confirm that I have read and understood the Information Sheet and have had theopportunity to consider the information and ask questions. ☐

I understand that participation is voluntary and that I will receive a copyof myTranscript. I have been asked to notify the researcher if I see anything which Ibelieve is inaccurate or any sections that I wish not to be quoted directly. I understand that I will be given until Monday 25th March 2013 to provide feedback to the researcherafter which it will be assumed that I wish to remainin the study. ☐

I understand that data collected during the study will be stored on the University Computer network (which is password protected). ☐

I understand that data will be used for research purposes, and that it will form part of an Masters in Research thesis. ☐

I agree to take part in this study. ☐

……	……	.....
YOUR NAME	Signature	Date
……	……	.....
RESEARCHER'S NAME	Signature	Date

When completed: 1 copy for participant, original copy to be retained in research file.

Appendix 7B: Interview Schedule

CBA Interview Schedule

Introduction:

Hello

Thank you for agreeing to meet with me.
This interview should take between **30 to 40 minutes**.
I'll be asking you to talk about **your experiences** of two things; the CBA training you received and the on-going CBA supervision that you're now part of.
I'm interested in finding out what you found **helpful** about both of those things; the **process** and any **changes** you feel could be made for either of them.

Opening questions:

Ok so let me start of by asking **how long** have you worked for the North Coventry Community Mental Health Team?

(Clarify – yes so including the time before case management and primary care teams merged)

Right, and what's your **job role** and what does it **involve**?

Service context:

Thinking though your caseload, what are the most common **diagnoses** that you work with?

What sorts of **problems** come up for your service users?

What are the main **interventions** that you use to tackle these issues?

CBA training:

Can you tell me a little bit about the **CBA training** that you attended?

What did you **learn** about in the training?

What did you find **helpful** about the training?

If the training were repeated, what would you suggest was done **differently**?

Impact on practice:

Before training did you use any CBA techniques? (If yes)

Which ones? (*Probe - can you give me some examples of the **techniques you've used**, **how** you've used them, **who** you've used them with (without breaking confidentiality) and **when**, so what stage of contact with the clients were you at when you brought the techniques in and for what **purpose** (i.e. was it to **educate** - make distinctions and links between the clients experiences, did you use techniques to **formulate** – make sense of the problem, or did you use techniques to **identify** points of treatment, or did you use a technique as part of an intervention?*)

Has training **impacted** on your understanding or use of the techniques that you were already using?

Have you used any CBA approaches with any of your clients **since the training**? (If yes)

How Many?

Which ones? (*Probe - can you give me some examples of the* ***techniquesyou've used****,* ***how*** *you've used them,* ***who*** *you've used them with (without breaching confidentiality) and* ***when****, so what stage of contact with the clients were you at when you brought the techniques in and for what* ***purpose*** *(i.e. was it to* ***educate*** *- make distinctions and links between the clients experiences, did you use techniques to* ***formulate*** *– make sense of the problem, or did you use techniques to* ***identify*** *points of treatment, or did you use a technique as a* ***framework*** *for an intervention?*)

How do you feel these interventions have gone?

-What has **gone well**?

- What has **been difficult**?

Has anything **got in the way** of you using CBA interventions? (If yes)

Is there anything that could be done to help you **overcome these obstacles**?

Supervision:

Have you **discussed any clients** in CBA supervision?

- What did you **talk about** during supervision?
- For you client work what did you **find helpful** about supervision?
- Can you give me a specific example of a client that you've taken to supervision without breaching confidentiality - **What** techniques you used, **how** you used them, **when** you used them, and for what **purpose**?
- Is there anything that you **did not find helpful** when talking about these clients?

Has supervision impacted on how you **view any of your clients** at all? (If yes)

In **what way**?

(*Probe – so that might not necessarily mean doing anything differently*)

Has supervision impacted on **what you do** with your clients?

(*Probe – has the supervision supported you using the CBA techniques with your clients?*)

Is there anything that you would have liked to have taken to supervision in hindsight, what was it & what stopped you?

Thinking generally, is there anything that you find **helpful** about supervision that we have not spoken about today?

Is there anything that you'd like to be **different** about supervision?

Future directions:

Aside from the things that you have mentioned so far, is they anything that you would like to see **happen next** in terms of training and supervision?

Thanks for your time. Do you have **any other comments** on your experiences of the CBA training and CBA Supervision?

Thanks again

Appendix 8B: Initial Template

1. CBA Training
    a. Main component learnt
        i. Subsequent use of CBA approaches
        ii. Impact on former practice
            - What went well
            - What was difficult
            - What were the obstacles
    b. What was helpful
    c. What could be done differently

2. CBA supervision
    a. What was done
    b. Clients discussed
        i. Change in perception of clients
        ii. Impact on what is done with clients
    c. What was helpful
    d. What was unhelpful
    e. What could be done differently
    f. Topics excluded form supervision
        i. Reasons why

Appendix 9B: Final Template

1. CBA Training
    a. Fit with existing toolkit
        i. Unwillingness to utilize new skills
        ii. Comparisons between old and new skills
    b. Subsequent use of CBA
        i. Dependent on client suitability
        ii. Formulation models
        iii. File of CBA material
        iv. What went well
    c. Difficulties and obstacles in utilising CBA
        i. Lack of fit to job role
        ii. Inappropriate clients
        iii. Systems issues
        iv. Not equip enough
    d. What was helpful
        i. Recap
        ii. New interventions
        iii. Better understanding of patients
        iv. Answered questions
    e. What could be done differently
        i. Choice to attend
        ii. Shorter
        iii. Stronger links to job roles
    f. Resistance and unease to CBA
        i. Lack understanding behind the training
        ii. Irrelevant to professional roles
        iii. Felt threatened

2. CBA Supervision
    a. What was helpful
        i. Recap
        ii. Clinical discussions
        iii. Case formulation
        iv. Support
        v. Safeguarding
    b. Change in perception of clients
        i. Limits bias
        ii. Impact on what is done with clients
        iii. More informative understanding of clients
    c. Lack of relevance/purpose
        i. What was unhelpful
    d. Extra burden
    e. Time constraints

Appendix 10C: Reflective Statement

The author of this paper has grown up in a family environment where her parents worked in the field directly supporting refugee and asylum-seekers in Bosnia, Rwanda and Uganda and subsequently this has impacted on her own desire to continue in this line of work. She has lived in Tanzania and worked in a hospital there where adults and children accessed mental health treatments, which has made her conscious of the limited knowledge and negative attitudes towards mental health difficulties held across East Africa and of the specific challenges this brings. Experience of living in an alien culture with a foreign language has given her an awareness of what life can be like for people living outside their normal environment. Furthermore, previous research she has undertaken in the area of school and community mental health interventions for refugee and asylum-seeking children has highlighted successes and failures in the models. This background may have shaped interpretation of the data to fit with her personal belief about the need to foster wellbeing of such children, and thus the writer's stance should be recognised.

Appendix 11C: Certificate of Ethical Approval

19th March 2013

Dear Dr Law and DrFazel

Re: "Developing a school-based support package for refugee and asylum-seeking children"
Application for Ethical Review ERN_13-0227

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Ethical Review Committee. The study was granted conditional ethical approval on 5th March 2013.

On behalf of the Committee, I can confirm the conditions of approval for the study have now been met and this study now has full ethical approval.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly bought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages(available athttps://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Yours Sincerely

Dr Jane Steele
Chair
Science, Technology, Engineering & Mathematics Ethical Review Committee

cc. Ms Rebecca Anne Tyrer

Appendix 12C: Letter of Invitation

Dear

[*Please circulate this letter to any of the teachers or supporting staff in your school who may like to participate in this study*].

I am a Master's student at the University of Birmingham and am writing to ask if you would be willing to take part in a research study that will inform the development of a school-based support package for refugee and asylum-seeking children.

Birmingham has seen an increase of newly arrived children and young people from oversees. Some of these children are seeking asylum and have experienced adversities before arriving in the UK and continue to face challenges after arrival including discrimination and insecurity. As a result these children have an increased risk of developing mental health difficulties and often benefit from individual support from a variety of school staff.

Birmingham Local Education Authority acknowledges that something needs to be done to support school staff with the skills needed to improve outcomes for these children in the school context and I would like to interview members of staff to find out what they do and what might be helpful for them in their attempts to best support these children.

If you are interested and considering participation, please read the participant information sheet.

Thank you for your time,

Rebecca Tyrer

Appendix 13C: Participant Information Sheet

[redacted]

[redacted]

Information Sheet

School Psychological Support Study

Developing a school-based support package for refugee and asylum-seeking children

Before you decide if you want to join in this study, it's important to understand why the research is being done and what it will involve for you. So please consider this information sheet carefully and ask us if anything is not clear or if you would like more information.

What is the purpose of the study and why have I been invited?
Birmingham local authorities have reported a growing number of requests from schools requiring support and intervention for children from minority ethnic communities (including asylum-seeking and refugee populations). The aim of this research is to gain information through interviews with school staff on the current strategies being used to support the mental health needs of refugee and asylum-seeking children in schools and the knowledge, support and assistance school staff would find helpful in furthering development into successful interventions forthese children. The information collected during interviews will be used to inform the development of a school-based intervention programme that can be implemented by teachers or other school staff to address the mental health needs of asylum-seeking and refugee children in their care.

Do I have to take part and what will happen if I do?
It is up to you to decide to take part in this study and if you decide not to, this will not affect you in any way. If you agree to take part, I'll ask you to sign a consent form, but if you change your mind later, you are free to withdraw at any time, without giving a reason. I will come and interview you at your school; the interview should take about half an hour and no longer than one hour. Interviews will be carried out individually and will involve recording on an audio device. Recordings will be deleted after transcription and transcripts will be disposed of after 10 years.

Will my taking part in the study be kept confidential?
If you join the study, the interview will be recorded and transcribed before recordings are deleted; your identity will remain anonymous when analysed. Transcriptions will be kept confidential and stored in a password protected, encrypted database, and will only be accessible to the research team. You will receive a copy of your transcript and be given two weeks to notify the researcher of your withdrawal from the research, any inaccurate information in the transcript or any sections you wish not to be quoted directly. After two weeks, if we have not heard from you, it will be assumed that you wish for your data to remain in the study.

What if there is a problem?
It is unlikely that taking part in this study will cause any problems, but if you have a complaint about any aspect of the way in which you have been approached or treated during the course of the study, you can either contact me directly, or contact Dr Gary Law, Senior Academic Lecturer, University of Birmingham. Contact details can be found at the top of the front page.

What will happen to the results of the research study?
A summary of the results from across all participating schools will be sent to each participating school to be made available for all staff. Nothing that could identify you will be included in any report or publication.

Who has reviewed the study?
This study has been reviewed by University of Birmingham Research Ethics Committee. The head teacher of the school you work at has also been given information about this study and agreed that staff within the school can be approached to see if they would like to participate or not.

What happens next?
Contact will be made with the school secretary/administrator on dd/ mm/ yyyyIf you are interested in participating you can either (1) let the school secretary/administrator know that you are happy for the researcher to contact you directly in order to answer any questions you might have and, if you wish to participate, to schedule an interview or (2), if you prefer, you can contact the researcher Rebecca Tyrer yourself (contact details can be found at the top of the first page) to address any questions or to arrange an interview. If you choose to take part in this research study you will be asked to sign a consent form to confirm this.

If you would like any further information about this study, then please contact Rebecca Tyrer, contact details can be found on the top of the first page.

Thank you for considering taking part in this research and taking time to read this information sheet.

Appendix 14C: Consent Form

CONSENT FORM

School Psychological Support Study

Developing a school-based support package for refugee and asylum-seeking children

I confirm that I have read and understood the Information Sheet and have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that participation is voluntary and that I am free to withdraw from the study at any time, without giving a reason. I am aware that I will receive a copy of my transcript and be given until .....(DD/MM).....to notify the researcher of my withdrawal, inaccurate information or any sections I wish not to be quoted directly after which it will be assumed I wish to remain in the study. ☐

I understand that the project has been reviewed by the University of Birmingham Research Ethics Committee and received ethical approval. I understand how to raise a concern or make a complaint about this study. ☐

I understand that data collected during the study will be stored on the University computer network (which is password protected). ☐

I agree to take part in this study. ☐

……	…….	.....
YOUR NAME	Signature	Date
……	…….	.....
RESEARCHER'S NAME	Signature	Date

When completed: 1 copy for participant, original copy to be retained in research file.

Appendix 15C: Semi Structured Interview Schedule

1. Describe the aim of the research and gain written consent from participant.

2. Participant and school demographics.

    - Participants name?
    - His/her role in the school?
    - Length of time in that role?
    - Size of the school?
    - Number of causal admissions?
    - Number of refugee and asylum-seeking children?
    - Number of unaccompanied children?
    - Number of languages spoken in the school?
    - Size of the EAL department?

3. Describe range of problems you see among refugee and asylum-seeking children?
    - What kind of emotional difficulties/needs do you see?
    - What about children who aren't necessarily externalizing bad behavior?
    - What other difficulties do you see?

4. Describe current work with refugee and asylum-seeking children in schools
    - Main things that are happening in the school around emotional and social competence?
    - How do you feel it is going?
    - What do you do to help these children achieve (or integrate) in school?
    - How do you help them make friends?
    - How is it decided who receives what support?
    - Do you have teaching assistants in classes?

5. Ask directly if they would use specific support for: sleep; anxiety; peer and family relationships; aggressive behaviours; behavioural change.

6. Ask what has been helpful and unhelpful in their work.
    - What kinds of things have been helpful?
    - What kinds of things have been unhelpful?

7. What they think they need to better support these children?
    - What further support would you like/ what would be helpful?
    - Do you think there are any mental health skills that staff would find useful to be able to do themselves?

- Taking a more holistic focus do you believe it would be helpful to include more parent, family or community involvement?

8. What mental health training have you received and what would you like: ideal length; location; topics?

9. Collaboration with other statutory and non-statutory agencies?
   - What outside support is the school receiving?
   - Support from your EAL?
   - Support from statutory bodies (social services)?
   - Voluntary bodies?
   - Government initiatives?

10. Any other information?
    - Anything else that would be interesting for me to know, in terms what your experience is of working with these children?

Appendix 16C: Worked example from Mohsen's Interview

Demands of sense making and meeting needs	**Page/line**	**Quote**	**Comments**
Problems that are often different to those of children growing up in "normal" environments	3/114-118	"Quiet, from my experience when refugees and asylum-seeking children I work with, when they arrive in school they would go through a period of quietness."	*New starters go through a silent period in school which changes over time.*
	5/162-173	"So yes, some children we have are very quiet, and then we had another group of children who were, you know, very into protective of themselves and of course maybe a bit behavioural issues in there and not responding to instructions and things like that. Again, maybe it was a defence mechanism, you know, because you're new, the only thing is to argue or to fight so we had those issues."	*Mohsen is defensive of the Children's behaviour and his choice of language 'bit behavioural issues' suggests that he is trying to play down the difficulties experienced.* *He appears to be understanding of why children are behaving the way they are and wants to protect and give reason for bad behaviour.*
	6/235-241	"We had one boy from Afghanistan, he was very, you know, like… but suddenly he would get very angry and he would completely lose control and it was very hard to, you know, we had to physically restrain him."	*In the wider context of the interview Mohsen is discussing the way a pupil would respond when someone would say something he didn't understand. Mohsen refers to the situation as being 'very hard', suggesting that it was difficult for him to do what he needed to do.*

Cultural, historical and religious understanding	5/194-210	"Other issues is women related issues because the countries they've come from, you know, women are treated differently but in here they are different and of course the clothes they wear back there, clothes here. So we had some sexual issues, maybe as I said again, it's a completely different country when you come here. As a boy you are fourteen / fifteen, you've never seen, you know, a woman without a veil for example, so that issues as a mentor or as a professional we had to deal with it and sit down with the child and explain that, 'look things are different in here.'"	*Understands that the environment must feel very alien for new starters.* *Wants to make them feel comfortable.* *Well informed/knowledgeable* *Able to understand that it's not just experiences pre migration that are challenging but that there is on-going stress in resettlement.*
	12/513-523	"For example a Muslim kid has been put in a Sikh family, for example, so now there is a collision in the family so we had lots of issues in the school in the end involving them, that the kids were living... There was a Hilal issue, there was this issue, there was that issue, the prayer issue so now I think what happens since then is that they are trying to put family kids with the same faith kind of."	*Goes beyond concerns in the school to those in that family.* *Social services are starting to give me attention to ensure children are placed in care suitably.*
Awareness raising	7/264-271	"… now again you have to explain this to your colleagues, 'cause your colleagues, most of my colleagues are from England, grew up in here. So to explain cultural differences as well between these two groups, most of the time you are a mediator."	*Feels like a mediator – having to go between Asylum-seeking and refugee children and the teaching staff.* *Difficult for teachers who have not experienced the kind of atrocities faced by many refugee and asylum-seeking children. Mohsen discloses earlier in the interview that he was a refugee – own experiences enhance his role.*

9/383-389	"… staff that are working with refugees and asylum-seekers here, they have to be prepared because every year the law changes about immigration about benefits about things like that."	*Staff need to be aware of immigration law.*
12/497-501	"I was trying to explain this to a teacher that look this child has been through this so you've got to comprehend, understand the needs and this and that."	*Finds it difficult/ frustrating to get across information to general teaching staff who he feels are unable to comprehend what's gone on and the effect that has had in the present.*
14/603-609	"Um we offered a training session for teachers who could come and kind of find out where these children are coming from, what these children are going through in those countries and war zones and the system that they have to go though in this country."	*Mohsen speaks as an expert needing to train others so they can respond appropriately to the target children's needs.* *Want's other staff to increase their awareness.*
18/ 766-781	"… teachers need to know need to be trained, maybe, you know, we have maybe a training day, one or two, maybe take only two hours if I have to tell you these are the, you know, if I talk to you about refugees and asylum-seekers and about their issues so it will stay with you and you will know, that you are teaching a refugee and asylum-seeking children, maybe more, I don't know maybe your be more understanding of that students situation or more understanding of raising his hands and things like that, so you will not be that critical."	*Teachers need more awareness in order to be more understanding. Training can be helpful in understanding and dealing appropriately with children.*

	21/910-916	“I think that we learned on the job. I think there was no training, you couldn't, you cannot just train someone who, if you haven't got trainers you cannot train, you know, you have to have people who has done or who has been through it”	*Doesn’t feel supported enough by the school. Difficult to find appropriate trainers because a true understanding can only come from people who have been though it themselves.* *There is a sense that he believes he knows best.*
Alienation	3/96-106	“… nobody speaks you’re language, you don’t speak their language. The way people eat is different here, the way people sit is different here and everything is different. So for that refugee and asylum-seeking child, very daunting, very, you know, difficult place or area or situation I should say. Yes they are suffering from a lot of things when they come here.”	*Having to adapt to a completely different way of operating.*
Different migration experiences	12/502-512	“Some of them maybe they just paid someone and the journey was again on the plain, come here, landed, not with parents and went into care. So that kid is always, as well, is always, you know, very wary, landed here, no one is here, no mum, no dad, they just do an interview with you the social services and they drop you outside someone’s house, 'this person will look after you'.”	*Mohsen doesn’t talk positively of the work of social services in regards to working with the target children.* *No care taken over placing children with appropriate foster families.*

Empathy and awareness of how the past affects the present	3/80-88	“Well as a refugee myself, I was an asylum-seeker now I’m a refugee; um yes I would say definitely, yes they are all suffering from um emotional. The things they have seen back in their countries and it will defiantly affect them when they come in here. And when they come in here as a child I think that another battle begins.”	*Identifies himself as a refugee and empathises with the difficulties refugee and asylum-children are going through. Constant battle as a refugee or an asylum-seeker. Resettlement countries cause distress which has to be handled as well as difficulties of the past.*
	12/482-495	“Now the children that go through loads of difficulties on the way, they take them months or years to reach England. Those even though they are twelve or thirteen or fourteen by the time they reach here they think like twenty mentally. You know, the things you go through, I mean it took me, my personally as well more than a year to come here when I was seventeen um so I can, you know, see what they are thinking because we've been though the same thing.”	*Unaccompanied children are forced to grow up fast.* *Mohsen empathises and understands the children’s experiences; he can put himself in their shoes.*

Wellbeing and education: the overwhelming sense of one and the other	**Page/line**	**Quote**	**Comments**
Distressing to hear some stories	19/807-818	"I think supervision would help. If, you know, we had supervision as mentors because yes we did hear a lot of horrible, you know, things that have happened to children and that kind of really affects you so we have regular supervisions we could go and talk and kind of talk about it um yes I think there should be a supervision opportunity for the teachers if they hear something or if they want to go and talk, you know."	*Hearing these stories can be emotionally upsetting and supervision is needed to contain staff to allow them to think about the child and contain the child's stress and anxiety.* *Need opportunity to debrief.*
Difficulties of working with children who have no understanding of the conventions of school	6/246-252	"… he's never been to school in his life, so he was only, thirteen or fourteen, never been to school, never held a pen in his hand. Um student/ teacher, teacher/ student relationship had to be explained, sitting in the class had to be explained."	*Integration has to start from scratch* *The school environment is stressful/ debilitating for newly arrived children.*
Unwillingness to take on a mental health care role	21/874-876	"… what skills a teacher? I think, from experience, a teacher will be more kind of, would like to pass it onto the mentor…"	*Doesn't believe many teachers have the skills to take on emotional and behavioural issues.*

Whole school approaches in development	Page/line	Quote	Comments
Assessment	20/ 826-832	"First of all, is to assess, to start with is to assess the child, if the child has been to school in the country, how many years the child has been to school in that country, the subject that he or she has done in that country um so then you take it from there."	*Determining the support a child is likely to require*
Interventions to modify conflict situations	5/180-191	5/180 "… I would say it was more misunderstanding and if you don't understand. Somebody say's something and if you have already emotional issues, and you have seen things back in your country as a refugee or an asylum-seeker, you will react to it. You see, the kids that come from the other country um I think, my personal view is they need training, you know, you need to train even emotionally and things like that."	*Children need training in understanding their emotions and also cultural differences.* *Help children gain awareness of how they present themselves to others and teach more appropriate ways to express feelings in a fun and participative way.*
Step-by-step approach	8/309-318	"… we keep that child for six weeks in for example the EAL department, that kid doesn't go and follow the timetable because if you don't speak English you're not going to physics, science and things like that. So survival English, you need to prepare that kid with survival English before we let them go into mainstream."	*When children first arrive they are placed in the EAL department to learn survival English.*

20/835-843	"… have a department like EAL [*English as an additional language*] department have a classroom um so that child can develop a bit of survival English first not to just straight away send to mainstream, I don' t think that child will ever come back to school. It would be a very frightening experience if you just throw someone in jungle this is how it will be."	*Very frightening to be put straight into mainstream.*

Responsibility to provide and protect	Page/line	Quote	Comments
Attentive	20/1007-1014	"Yes everything, we build a file for that child and kind of follow, see the progress, you know, family members who, social workers, everything that child was like a case to you, that was my case and you make sure that the child, you know, is looked after well basically."	*Paying close attention to the children and what's going on.* *Ensures no harm.*
Staff and student relations	4/123-140	"… and of course it all depends on the staff or the people who work with these refugee and asylum-seekers. Um how you are going to make that experience very easy and the transition actually very easy. To introduce them to everything in here, because you must remember maybe their parents are outside working or they're trying to, they get to know everything, but the children, everything they get to know about me, you, this country, everything, I mean even the food is in school. So again it's very important for a long term effect to have professional people who are really well trained to work with these children."	*Learn everything in the school so it plays an important role.* *Teachers and people working with these children play a crucial part in making their transition experience as easy as possible.* *Need well trained professionals.*
Fitting in	13/556	"… sometimes the buddy has kind of introduced him to a bigger crowd of friends so that kind of buddy has stepped back to give a chance for refugee and asylum-seeking child to make friends with the rest."	*Strategies used to help children fit in with their peers/ school.* *The buddy systems work and feels the buddies do a good job.*

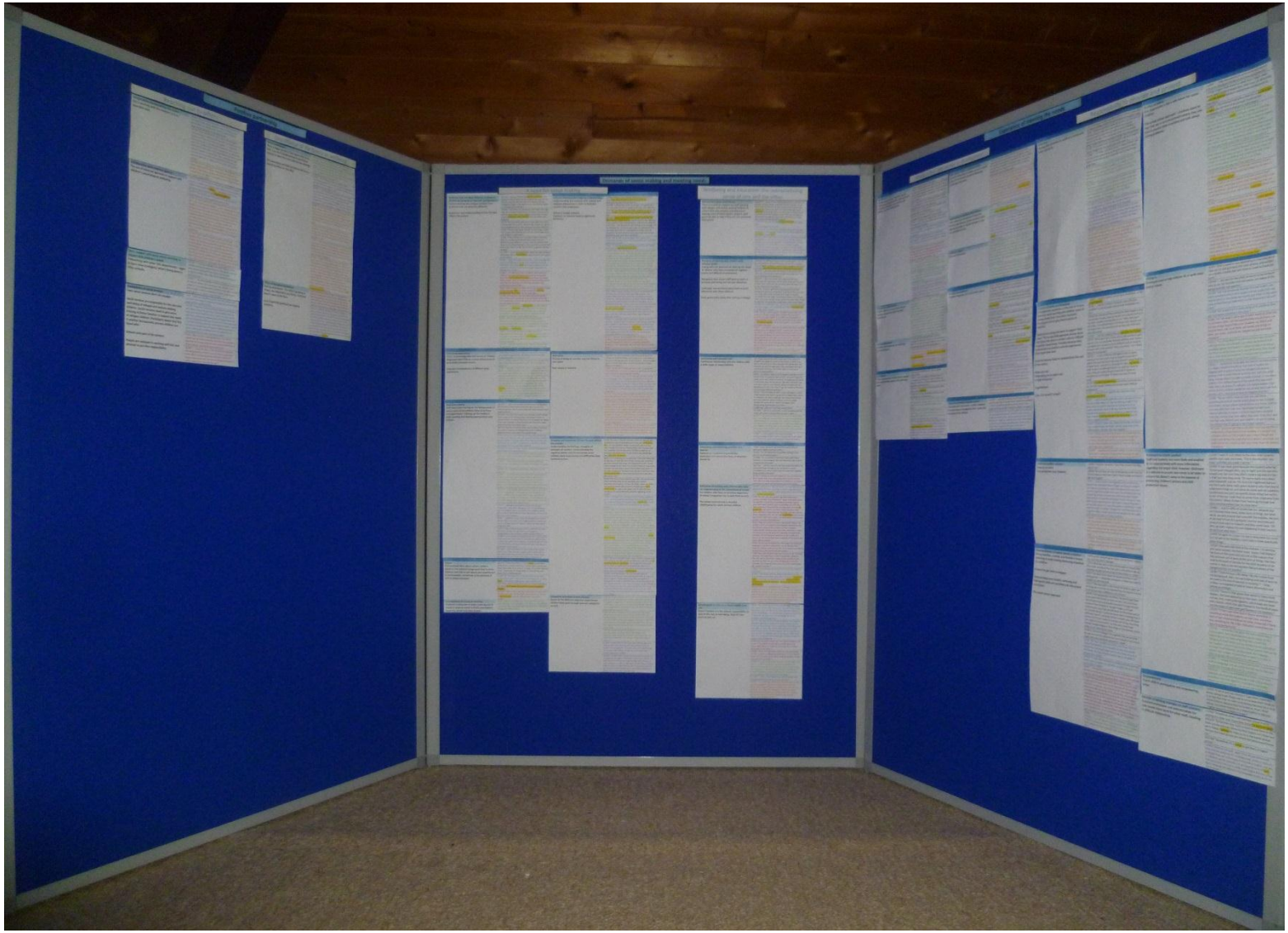
	14/581-593	“So we had to come up with um, you know, something to kind of mix the whole group so we changed lunchtimes, we put games and activities, you know. And for example and from next year, September we will have vertical tutoring, it means in a form class there could be four year sevens, four year eights, four year nines, four year tens four year elevens and four year twelve’s. So we're mixing the whole thing. It's going to be a house system.”	*Vertical tutoring will help children integrate.*
Disclosure to inform conduct	7/291-298	“… my job was to kind of file everything, come and talk to you and explain. ‘This is the history; I give you the history so that you can understand better your student. The better you understand your student the better you can teach them’. And misunderstandings and things like that.”	*Inform teachers about students so they are more equipped to handle problems as they arise.*
	15/618-636	“Every year we have arranged to go and celebrate the refugee week, you know, we took children from, you see, there was maybe some minor conflict between native children and refugee and asylum-seeking children, bit of a rift maybe but it's not knowing the difficulties. So what we did here we just took children from every year group especially native children we took them to the refugee week and they have activities there in city centre which was very helpful, they went to the tents and in those tents it was explained everything and actually some of them came back and they were like 'oh we didn’t know', so more sympathy kind of more understanding from the native children.”	*Inform children about the experiences of refugees and asylum-seekers to break the rift that exists.* *Everyone needs greater understanding. Stigma decreases as understanding increases.*

Manner of working impinges on staff relations	16/669-678	“Most of the time, again from my personal work here with the children, it's misdiagnosed, children who are so bright they say no because of the lack of English was put in a bottom set for example, so you have to kind of fight and say no look 'this kid is really really bright the only thing that is keeping him behind is the language so let’s work on the language.’”	*Children are put in the wrong ability sets because of their English ability. Wary of the damage a misdiagnosis can have* *Battle to get refugee and asylum-seeking children in the right sets.*

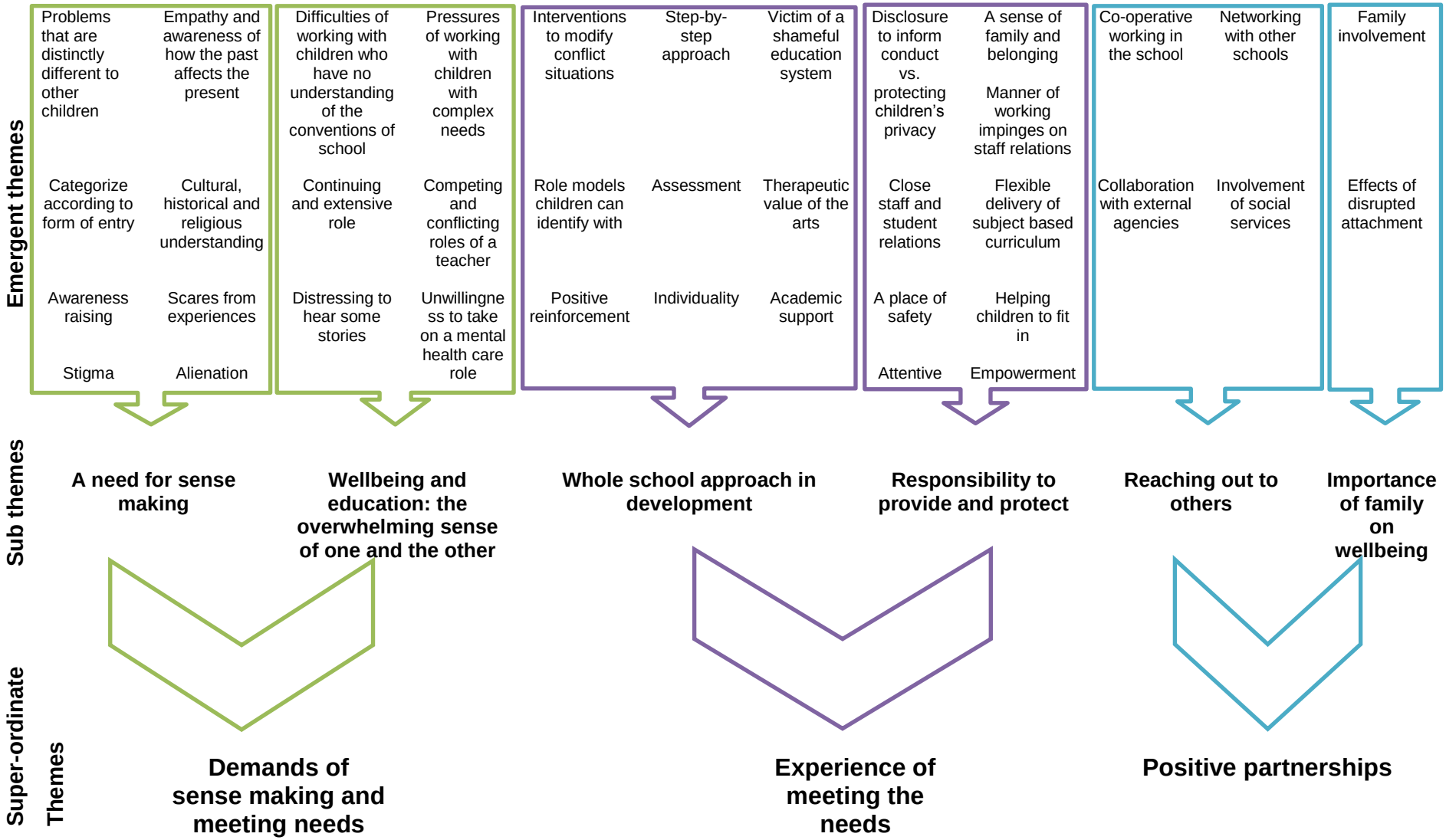
Reaching out to others	Page/line	Quote	Comments
Co-operative working within the school	19/781-795	"Um from there of course again getting bigger is that professional working with that child, working with the family, so all the information he gathers, or she gathers is sharing that kid is 'I've seen marks, I've seen this I've seen that' 'that maybe means this or means that' or the teacher feeding the information back saying that the child has some low self-esteem so maybe then again um that personal contact can kind of look around and look at what other external agencies can work with that child. So basically a mentor."	*The whole school needs to work together, a circular process. Feeding relevant information to one another. Knowledge improves conduct.*
Collaboration with external agency's	16/679-684	"We did have some students we referred to 'torture', it was in London there was an organisation that work with children who suffered torture so, you know. Here in the school we have for example anger management."	*Children referred to external agencies outside of the city.* *The use of external agencies to support refugee and asylum-seeking children's psychological wellbeing.* *Anger management run in the school.*
	16/689-691	"Counselling again it's loads of things that were there before but now it's gone because of cuts."	*Support is in short supply due to funding cuts.*
Learn, support and assist others working to support refugee and asylum-seeking children's needs	22/937-945	"… we would debate and talk and then we would try to find the solution. So I would go. I was working in this school so if my colleague had a problem in the other school with an Afghan child for example or Polish, so we would work together as a team to kind of find, because there was nobody well trained."	*Rely on each other's experiences* *Would benefit from professional support.*

Importance of family on wellbeing	Page/line	Quote	Comments
Family Involvement	9/349-354	"… the family's so important because we're concentrating always on the kids, but we're forgetting the parents. We have to educate the parent as well, as much as possible so they can help us really."	*Educating the whole family is really important, because they can help staff to work with their children.*
	9/390-399	"… it was the case that sometimes, the kid fainted here and the kid hadn't eaten because there was nothing at home so the parents couldn't, for example, they didn't know how to fill the forms and things like that, to apply for benefits that they are entitled too. So that's the thing that you have to have a very regular connection to the family."	*Recognises that the families' circumstances will have a knock on effect on the child's progress at school so it's important to help the parents in order to support the child.*
Effects of disrupted attachment	10/414-428	"… Children who are with parents, um they are more protected, you know, they haven't taken any risks with for example later on in life if I say so. Um and they go to college, children with parents they go to for example come to school, year eleven they go to college, but with unaccompanied children by the time they hit sixteen they can leave their carer and they have an option to stay on most of them but ninety nine per cent of them they chose to leave and live in a semi-independent living so in that case they become a bit de-railed."	*Unaccompanied children are more likely to "go off the rails". No parent to guide them – less likely to go on to further education.* *Don't form strong attachment with carer* *Views unaccompanied children as more at risk*

Appendix 17C: Display of Themes



Appendix 18C: Table of Emerging Themes



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