**Unaccompanied Asylum Seeking Children**

**Emotional Health and Wellbeing Early Interventions**

**An Action Research Project**

Therapeutic formulations towards enhance emotional health and wellbeing on arrival to the UK.

This therapeutic formulation is for early emotional health and wellbeing interventions with Unaccompanied Asylum Seeking Children (UASC) in Kent.

As with all action research this representation will evolve and the ideas and interventions discussed are under review, critique and modification.

In the use of this methodology, Sussex Partnership NHS Trust is taking as a given that every human is naturally resilient. Yet there is risk for a decreased ability to sustain patterns of wholeness and healing behaviours in adverse situations or moments of crisis. There is therefore a need to inoculate against natural resilience being compromised and to understand from the perspective of a UASC, who is living the experience, what it is that would protect and support their resilience to what has already taken place and to the asylum process they are undertaking.

In the literature there are recognised protectors to resilience which are:

* Knowledge and effective strategies
* Own strengths and resources
* Health promotion activities.

With this in mind, the following interventions have been formulated with knowledge gained through conversations with social workers, reception centre staff and UASC’s, in which a thematic understanding of the issues of concern and compromise were identified.

The thematic understanding, as well as the current literature has shown that a UASC may experience one or more of the following:

* Poor sleep (a lack of sleep or disturbed sleep)[[1]](#endnote-1)
* Vivid flashbacks
* Intrusive thoughts & images
* Nightmares or sleep terrors
* Lack of concentration
* Hyper vigilance
* Poor emotional regulation
* Poor understanding of nutrition
* Deliberate self-harm
* Irritable and aggressive behaviour
* Issues with cultural acclimatisation
* Intense distress at symbolic or real reminders of trauma
* Physical manifestations: trembling, sweating, pain and nausea
* Self-destructive behaviours or recklessness

Many of these symptoms are contextual to the journey they have made to reach the UK and a natural by-product of the experiences had and the passage made. Therefore it is understood that the context and detail of the experience had will have communality of themes. Yet there will be variants in the story and the character of the individual may also affect the behavioural response. To enable the right support systems to be given according to identified need of a child, the UASC project has developed a set of competencies from which any professional can deliver EH&WB interventions and has the right training and support to ensure quality in the work being undertaken[[2]](#endnote-2).

If the symptoms which may be natural in the context of the experience had and the journey made, are not managed and supported with protectors to the UASC natural resilience, it is possible the above issues and symptoms can manifest into chronic mental health disorders such as:

* Severe Anxiety
* Phobia
* Depression
* Dissociative disorder
* Suicidal feelings
* Personality issues later in life
* Post-Traumatic Stress Disorder
* Severe deliberate self-harm
* Alcoholism
* Drug use

To avoid chronic mental health issues from developing, we need to know and test which interventions are going to make a difference at the early stages of arrival in the UK.

We therefore have taken time to listen and witness the dilemmas of staff in reception centres, to UASC who are in reception centres and to social workers who are the parental custodians. The early intervention framework has come from the stories being told and lived by UASC in the first few months of arrival.

As already stated, this framework is designed to be a form of inoculation in which the intervention acts as a protector to their natural resilience. It is multi-factorial in that as mental health clinicians we recognise that the formulations we make have to be supported by the staff living along-side these young people and by the young people themselves. Therefore in addition to the development of this framework, we are also consulting, training and supporting staff in the daily interactions they have with each individual child. The teaching and training taking place links to the competency framework which has been agreed as the clinical quality standard by a large group of stakeholders who have formed an EH&WB Network for UASC in Kent[[3]](#endnote-3).

The proposed interventions are designed to be multiple protectors to a young person’s resilience and wellbeing. They are interlinked and act in conjunction with each other. Yet like with all protocols there needs to be awareness that each child is an individual and that their particular story will have some similarities and yet will not all be the same.

The following formulations will be used within the reception centres and UASC in supported housing, as part of an action research process from which all concerned and affected by such symptoms can assist the understanding and development of quality, evidence based interventions.

**The method**

Action research is a step by step methodology, in which the researcher(s) plan, act, observe and reflect. It is humanistic as it looks to work with and collaborates with those involved and affected to explore the emergent meaning and understanding under observation. In observing the effect of our actions at each stage of the cycle from which change emerges, we were looking to build a scaffolding of knowledge which allowed us to continuously incorporate findings into subsequent stages of the investigation.

As already stated the project team, staff at reception centres, social workers and UASC are all within the observations and actions taking place. Therefore all those involved, affected and connected are an active part of the research team and relational in nature. Bjorn (1996)[[4]](#endnote-4) and Shotter (1998)[[5]](#endnote-5) refer to participatory action research as multi-dimensional, dialogical and a fluid form of self-development.

What we are finding is that the action research steps are a mirror to the process being undertaken in interventions being developed. These interventions are responsive to the needs identified with UASC in reception centres and link to Shotters ideas that everything is related to everything else.

Alex Ntung who has experience of being a UASC described what he called the ‘steps’ to success (see appendix 1) and has been involved in supporting and advising on the interventions being observed. Therefore the framework is interlinked step’s from which protectors are collaboratively made and UASC are supported with new understanding being a practical relational responsiveness.

The current framework has the following steps:

* Sleep education and packs as well as circadian rhythm re-set formulations.
* Nutritional intervention and re-feeding strategies
* Sports therapy to aid bilateral movement for desensitisation and reprocessing to take place as a natural enhancement to the body’s healing abilities.
* A dialogical process using the multiple faces of hope – a therapeutic support system to identify aspirations and hopes as drivers beyond the asylum process.

These interventions will be the interlinked steps being made in developing the protectors to resilience framework that support emotional health and wellbeing to be maintained.

**Sleep disturbance for UASC newly arriving in the UK and those in supported living:**

In the Initial Health Assessment (IHA) which is undertaken by every UASC there was a high incidence as part of the Post-Traumatic Stress Disorder (PTSD) screening of young people reporting sleep disturbance.

In the reception centre’s a key theme in the conversations witnessed with staff and UASC was in respect of their sleeping habits. Most of the young people slept during the day and were unable to sleep at night. This created an issue as the routine of the centre were not able to be established and the opportunities for English and skills training were being lost.

The teachers in the centre also reported that the young people were often sleepy in the sessions and that some failed to attend classes because they were asleep in the mornings when lessons took place.

In therapeutic conversations with UASC, they described travelling during the night and sleeping in the day. This happened for several months at a time. Others described becoming fishermen and working through the night to catch fish and then needing to sleep during the day.

Reception staff also reported that many of the young people slept in packs in one room with the light on, which is something they had learnt to do to protect each other. There were also repeated requests from staff that the young people stop putting towels over the main light, as this could be a health hazard and the young people reported that they could not sleep with the light off and yet the brightness of the main light hampered their ability to sleep.

The steps taken in the participatory action research were:

* To witness and be in the dilemmas being described.
* To formulate an immediate orientation of past and current circumstances in relationship to sleep.
* To explore each situated participation in relationship to other situated participations, as per the dialogical descriptions made above.
* To develop a sleep hygiene presentation as a practical relational responsiveness.
* To continue to witness and be in the dilemmas being described
* To develop sleep packs as a practical relational responsiveness
* To continue to witness and be in the dilemmas being described
* To develop a circadian rhythm body clock reset formulation
* To continue to witness and be in the dilemmas being described
* To understanding the effects of Ramadan on circadian rhythm reset formulations.
* To consider who needs to be involved in the spiritual conversation about religious observation.
* A spirituality paper has been written and circulated to the UASC EH&WB Network and the possibility of a spirituality group considered.

The sleep hygiene presentation

This presentation was formulated and the aims given were to:

* Gain better sleep
* Achieve more
* Look good
* Feel good
* Have more energy

For the full presentation see the good sleep presentation:

Some of the young people reported that they had learnt not to smoke before going to bed, others reported that they didn’t realise that blue light from their phones might hamper sleep and other reported that they had been drinking high energy drinks and hadn’t realised this might affect their ability to sleep.

Sleep packs

Due to the continued reports of lack of sleep and the different narratives that have emerged in which the lack of sleep becomes coupled with night terrors and being disturbed by others in shared rooms we devised sleep packs, which the young people put together and gave each other.

The good sleep packs contain:

* A plug in night light
* Night masks
* Ear plugs
* Lavender bags
* Worry dolls[[6]](#endnote-6)

The plug in light enables the young person to have ways in which they can manage the hyper-vigilance they have developed whilst on the journey to the UK. The night masks and ear plugs support them being able to block out noise and light to aid their ability to sleep. Lavender is a known smell that enhances calm and the worry dolls are there to support them letting go of concerns about their friends and families while they sleep.

These items are in response to the themes described by the young people and those who look after them.

An initial trial has been made with the packs and all the UASC in a reception centre said they had aided their sleep and were a useful resource. They showed their pleasure at the difference the packs had made by standing up, cheering and clapping their hands when asked.

Coupled to this, staffs are requesting additional packs for when people arrive, as they have found that they make a huge difference in the young people’s ability to sleep on arrival at the reception centres. Also staff reported that when the young people leave the reception centre, they always take their sleep pack with them and they don’t know of an incident where one has been left behind.

Despite this, there were still some young people whose circadian rhythm started in the early hours of the day from which sleep took place and they would naturally wake in the early afternoon.

A circadian rhythm reset formulation

Due to the nature of the journey these young people have made travelling across Europe, their circadian body clock rhythm has been set into a nocturnal pattern. On arrival to the UK, these young people start to experience an intense form of Jet Lag of which the symptoms are:

* Indigestion
* Constipation
* Diarrhoea
* Nausea
* Loss of appetite
* Difficulty concentrating
* Feeling disorientated
* Anxiety
* Irritability
* Memory problems
* Clumsiness
* Lethargy
* Light headedness
* Confusion
* Headaches
* Sweating
* Muscle soreness
* Generally feeling unwell[[7]](#endnote-7)

The general practitioner reported that many of the young people described some of these symptoms and staff also reported a lack of appetite.

Also the UASC team within the Children in Care, Child and Adolescent Mental Health Service reported that many of the UASC in foster care and supported living were experiencing prolonged difficulties with sleep.

Despite the previous interventions in the reception centre, there was for some young people a need to consider ways in which their circadian rhythm could be reset.

A formulation was devised from literature on sleep disorder which suggested that any change to the circadian rhythm should be gradual and incremental. There was also a given wisdom that suggested that 7 hours sleep per night was optimal. This said it was also understood that each individual has their own optimal sleep requirements.

Therefore the following formulation was devised:

* The current circadian rhythm
* The desired circadian rhythm
* 15 minute incremental change to current circadian rhythm every two days.

This formulation has been set into a calculation from which a programe can be deviced and used when a UASC is reporting a continued inability to sleep and experiencing some of the symptoms of continued lack of sleep deprivation.

See the negative body clock spreadsheet calculator which we have deviced to support a UASC to re-set the circadian rhythm.



The effects of Ramadan on circadian rhythm reset formulations.

Many of the UASC are muslim in faith and practice, therefore Ramadan is an important ritual which they are keen to adhere to.

Within the Muslim faith there are exemptions for people in which they can postpone Ramadam to another time in certain circumstances. Many of the young people still choose to undertake Ramadam despite illhealth and fatigue from the journey. It is therefore imporant that concerns can be communicated to faith leaders who can support the young person in the decisions they are making.

Audit as a way of understanding what it is we are achiving.

To enable us to understand what it is our actions have formulated, we used the BEARS sleep screening tool pre and post interventions.

This screening tool is in the BEARS sleep document.

We have audited the work from an outcomes perspective with the findings being described in our audit protocol.

Please see the sleep audit 2016 document.

**Semi-starvation on the journey to the UK:**

Reception centre staff reported that many of the young people ate very little and seemed to struggle to manage food. At the centre they had 3 main meals and snacks inbetween, including cakes made by the local community in support of the young people.

The known physical symptoms of semi-starvation are documment in the Minnasota experiment which is used as a seminal understanding for clinicians working with eating disorders in the UK. This study is of interest as a high proportion of UASC in Kent are 16+, male and were fit before leaving their country of origin and experiencing semi-starvation.

Some of the symptoms of semi-starvation were found to be:

* Gastro-intestinal discomfort
* Decreased need for sleep
* Dizziness
* Headaches
* Hyper-sensitivity to noise and light
* Reduced strength
* Oedema (an excess of fluid causing swelling)
* Hair loss
* Decreased tolerance of cold temperatures (cold hands and feet)
* Parasthesia (abnormal tingling or prickling sensations, especially in the hands and feet)
* Decrease in metabolism (decreased body temperature, heart rate and respiration)

Coupled with the above symptoms, the following were also present for those that participated in the study:

* Binge eating and purging
* Self-harm behaviours
* A loss of interest in the future
* Anxiety
* Depression
* A facination with food (a high majority went on to become chefs).

In the clinic sessions with a GP many of the UASC in the reception centre complained of the same symptoms. Often the young people would be wearing warm clothing on a hot day and would complain of gastro-intestinal discomfort. Some were symptomatic with headaches and most of all they complained of disturbed sleep which also is linked to the noctornal pattern of sleep used on the journey.

There is therefore a need to consider the effect of the semi-starvation aspect of the journey, as self-harm actions, anxiety and a loss of direction for the future are something that is being exibited in some of the behaviours of UASC in the reception centres and in those placed in the community.

To enable us to address the effects of semi-starvation we are;

* Ensuring staff working with UASC are aware of semi-starvation
* Teaching UASC about good nutrition and the effects of semi-starvation
* Recruiting a diatician to support additional formulations
* Providing therapuetic support through staff consultation and direct contact

There is a need to ensure that all professionals working with UASC are aware of the symptoms of semi-starvation and the psychological complications this brings. Primary care clinicians such as general practitioners, paediatricians and emotional health and wellbeing clinicians should be accessed as required post baseline assessments as part of the initial health assessment.

From a health perspective, the risk parameters of semi-starvation and re-feeding should be adjusted for age and gender[[8]](#endnote-8). That said a complexity in determining risk is the definition of age from an individual UASC perspective and how this is translated into UK culture. A child who states they are 16, may not neceserraly be that age. Therefore to quantify risk can be problematic. Yet these young people do not have an eating disorder with the complexities such a disorder brings, rather they have experienced starvation as a result of the immigration journey they have made. A BMI should be used to quantify the level of malnutrition they are experiencing with caution due to the above factors.

Transitions should also be carefully monitored, such a moving into supported living, where a UASC is required to self cater, as this may disable any re-feeding programe that has been commenced.

The task of services and clinicians supporting a semi-starved UASC are:

* GP to look for any underlying physical issues so that re-feeding can be commenced safely.
* Use weight and height against population varients from age and gender via calculator.



* **If a UASC is red or amber on the Junior MARSIPAN risk assessment framework, they should be monitored for re-feeding syndrome using the Great Ormond Street refeeding guidance**[[9]](#endnote-9)**.**
* If green on the Junior MARSIPAN risk assessment framwork, safely support a re-feeding program for the child which takes into account religious and cultural eating patterns.
* Manage via a MDT any manifestation of semi-starvation that emerge.
* Ensure staff are skilled to undestand the issues of semi-starvation and to refer to other members of the disciplinary team according to the competencies required.
* Support joint-working in the re-feeding transition.

Food is at times a trigger to emotional bonds with others and evidence from research work done around childhood bereavement shows this connection. We have put together some guidance on how to better understand these connections for the child in the UASC comfort food information book:

Re-feeding menu example

Each day it is important to consider giving the young person a live yogurt to support their body’s ability to process food. Also they may need some antacids to manage any indigestion or gastric reflux. They are also likely to become constipated and a laxative should be considered and prescribed as required. This menu example is suggestive and it is important that the child’s cultural context is understood from which their pallet has been schooled. Therefore it is important to look at making a menu plan with the child, to ensure that they are getting familiar foods that connect to their emotional wellbeing. Also be aware of ‘comfort food’ and what this looks like for the child.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Day | one | Two | Three | Four |
| Breakfast | Small bowl of porridge  | Small bowl of bran flakes | Small bowl of Weetabix  | Small bowl of Shredded wheat  |
| Midmorning snack | Banana and yogurt | Toast and jam | Crumpet and honey | Fruit salad  |
| Lunch | Beans on toast | Scrambled egg on toast | Tuna salad with a roll | Sushi pack  |
| Mid-afternoon snack | Crackers and cheese | Piece of fruit  | Ice cream | Tea cake and butter |
| Dinner | Small portion of curry and rice/nan  | Small portion of beef with potatoes and vegetables | Small portion of chicken with rice and vegetables.  | Small portion of tuna pasta bake with vegetables.  |
| Bedtime snack | Peanut butter on toast | Small bowl of granola  | Prunes/figs and yogurt | Small bowl of muesli |

**Sports & by-lateral movement to manage trauma symptoms.**

There is a body of literature that shows that sport and physical activity triggers chemicals in the brain that make you feel happier and more relaxed. It also supports your brain to process information, thus learning therefore is enhanced. Physical activity is a distraction from daily stresses and reduces the level of stress hormones secreted and stimulates the production of endorphins, keeping stress and depression at bay. It has been shown to improve the quality of sleep which also has an impact on mood and general outlook.

As per the symptoms described above, many of the UASC would benefit in the early days of arrival and assimilation into the UK from sports related activity to reduce the symptoms which can escalate into long term and chronic mental health concerns. Many of the symptoms are suggestive of trauma experiences, which given the right support can be naturally processed by the brain. There is also a volume of evidence that shows that bi-lateral movement helps the brain to process and desensitise from traumatic experiences. Sports such as running, cycling and swimming are bilateral in nature and NICE recommend bilateral movement which causes the memory that is looping in the emotional side of the brain to integrate with the cognitive side of the brain as the preferred treatment for PTSD.

Coupled with the above evidence some of the narrative feedback given by UASC in reception centres and in the community has been that they have been unable to do sport or any physical activity and would welcome the opportunity to do so. Many can be found in parks playing football together, as a way of socialising and also being active which enhances their emotional health and wellbeing and ability to process the trauma they have experienced.

To enhance the body’s natural ability to process, there is a need to support access to sport that is bilateral in movement as a regular activity that a young person can undertake while in a reception centre and living in the community. It is an early intervention strategy that acknowledges that trauma is likely to be present and puts protectors in place that enhance not only the body’s natural ability to process and desensitize, but enhances on multiple levels a sense of emotional wellbeing.

 What we have found in Kent:

Current data from health screening in Kent of UASC shows that 45% of UASC are exhibiting post traumatic symptoms. This finding shows that there is a need to consider the reduced repeat of story-telling about traumatic events. Also a vigilance in respect of flashback moments and a relational containment that supports desensitisation and reprocessing to take place, anxiety to be relieved and other associated symptoms to be normalised and supported. If the right interventions are not in place, there is likelihood that the traumatic symptoms could be exacerbated into a complex post-traumatic stress disorder (PTSD).

To aid the vigilance required in respect of potential PTSD symptoms, we have devised a protocol which is multi-professional in nature to work around the needs of the child, as well as to share

outcomes, goals and values. The evidence asserts that this would reduce the risk associated with cohorts who are complex and high risk.

See PTSD protocol for UASC in Kent.

What doesn’t work?

There are a variety of protocols and interview that are undertaken with each individual child by a variation of stakeholders due to the complex nature of a UASC presentation. These stakeholders often work in silo and there is evidence that different stories emerge at different times that need to be shared and understood by all stakeholders.

The child is required to tell their trauma stories to each individual stakeholder with a high likelihood of exacerbating the trauma symptoms they are likely to be experiencing. This way of working could lead to complex PTSD which will increase their anxiety, reduce their ability to integrate and to build healing interpersonal patterns of behaviour and relationships. Therefore silo pattern of working which requires the child to repeat trauma stories increases the likelihood of long term mental health concerns.

Currently a child is health screened by a paediatrician, is interviewed by the border agencies and is assessed by Social Services which causes fragmentation and reduces story to a linear understanding from which the needs of the child is evaluated and understood. Other agencies such as the police, legal and mental health services may also be called upon to interact with the child and would ask them to recount their story.

Stories are a part of life and are shared in most cultures and there is evidence that shows that it helps people make sense of their lived experiences, dilemmas and hardships. Stories are also known to be constantly changing, reconstructed and disregarded. It is also known that forming stories about experience help improve people’s physical and mental health. Yet stories are complex in nature as they act as conductors from which the following takes place:

* Communication
* Educating and informing
* Building rapport
* Establishing connections
* Preserving cultural identity
* Inspiring and encouraging
* Clarifies emotions
* Coping with experiences
* Healing and honouring.

In the moment that asylum is claimed, we have a rare opportunity in setting the scene and permission for a conversation, in which the first communication is a platform for future talk to take place. It is the first time they can formulate the story of their arrival, their experiences on the journey and the things

that activated them to migrate. How we hear the story told and are curious about those that are untold, how we understand and respond to emergent stories is likely to affect the health of the child. It will open up or close down stories and will set the scene from which each person will act their part. It is a pivotal moment that only comes once.

Early therapeutic trauma intervention:

There is a need to access sport that is bilateral in movement as a regular activity that a UASC can undertake. It is an early intervention strategy that acknowledges that trauma is likely to be present and put protectors in place that enhance not only the body’s natural ability to process and desensitize, but enhances on multiple levels a sense of emotional wellbeing.

To enable this early intervention to take place, there is an agreement to employ sessional sports coaches 2 times a week to undertake bilateral physical activity with UASC in designated hubs across Kent. This is being done in partnership with the project lead for UASC at Sussex Partnership Foundation NHS Trust, who will formulate an EMDR intervention to support the therapeutic aspect of what is being delivered. This work is seen as a multi-agency in which we are all stakeholders in what it is we are delivering. The following level service agreement was devised to support the governance from which this work has been developed.



Key characteristics of this intervention are:

* Sport coaches to deliver running sessions with UASC for 1.5 hours 2 times a week. Venue to be agreed according to hub facilities for bi-lateral sports activities.
* Short early intervention EMDR template pre running session.
* Pre and post screening via the validity of cognition and SUD’s to evaluate the intervention. :

The following template is being used by technicians supporting the sports trauma work:



Outcomes:

We are currently in the process of looking to develop the evidence base for this work and will be auditing the work being undertaken in the next few months.

There is a likelihood of the following outcomes which would need to be evidenced:

* Enhanced emotional health and wellbeing
* A protector to levels of anxiety and depression
* Enhanced ability to learn and acclimatise culturally.
* Ability to process trauma symptoms.
* Reduction in future PTSD diagnosis.

**Hope as a driver towards the future.**

Therapeutic work with unaccompanied asylum seeking children (UASC) is often seen as difficult because there is often no back story from which to understand their skills and abilities. They are disadvantaged by trauma, by cultural isolation which creates socio vertigo, by a loss of formal education and language from which they can express themselves and the relational isolation that comes from arriving in the UK alone. On arrival they struggle to articulate hopes for the future, their hopes being realised in reaching the UK. They don’t know what is possible and have often been told stories of a promised land, which doesn’t materialise in the way they imagined. So how do we talk about hope, hope being a driver towards a certain type of future, the energy behind actions that form and shape possibilities.

The future is going to happen with or without aspirations, with or without family re-unification, with or without asylum being granted. Each moment is a movement towards something, so what can we hope for as professionals and how does what we do make a difference to the future and all its potential? I want to share some of my experiences of working as a systemic psychotherapist with UASC in Kent. In my work, other professionals involved and connected to an individual child often ask me to support the child to move on from the trauma they have experiences and the associated losses along the way to enable them to start to function towards assimilation. As a nation we make judgements about ‘good’ and ‘bad’ outcomes and feel the child has failed which by association calls into question what we have done and what we have achieved together. We talk about these children being not in education, employment or training (NEET) yet seemingly motivated and aspirational. We need to consider what the blocks are and how it is we can support a little bit of dreaming to take place.

In a therapeutic environment the child can often be in a dilemma as to what to talk about, who to talk about and what the effects of talking might be. They may have beliefs about what they need to say to receive asylum and this may prohibit other stories to be told. There is therefore a dilemma when those involved in the conversation have different wishes or needs about whether or not to talk. This dilemma is in the relationship between the ‘stories lived and stories told’ (Pearce & Pearce, 1998)[[10]](#endnote-10). There is a dilemma for everyone involved, the young person, the corporate parent, staff involved in the child’s care and the therapist supporting the system. The corporate parents in the need to protect, provide, support and

manage the variant needs of the child. There are also members of staff who perceive distress, who hear as yet untold stories and develop a relational closeness with the child. Coupled with this, there are educators and other providers who are involved and connected to the child. At times there are therapeutic dilemmas as a prioritising of the child’s needs take place. How I formulate and support emergent priorities from an emotional health and wellbeing perspective needs to hold in mind the other competing dilemmas. I also need to be mindful to support the system to give a coherent account of situated abilities to form the best possible outcomes for the child. This way of working is the concept of hope as dynamic action.

When we formulate a multiplicity of hope in language and there are agreed actions within the system towards those hopes, we are likely to form a dynamic relational interaction from which things can emerge. Explicit disclosures or an acknowledgement of trauma does not tell the whole story. As professionals, we can underestimate the need not to talk, to avoid, to act and form stories which are about wellness and being in a place of safety. One of the worries is that talking about what has been can create too much reality, a reality that a UASC does not want to re-live or re-experience. So we need to consider which voice do we privilege at each point and what it is we are creating for each other in the actions we take.

Recently I met with a UASC who had been asleep for the first 72 hours of arrival to the UK, had exhibited a high level of distress which was causing reception staff concern. In my assessment of him, I looked at family stories of pride and as the narrative unfolded about the massacre of his parents and sister. A key aspect of his story was education at a boarding school and the meaning this was given by his parents in who he could be and what he should become. From an emotional health and wellbeing perspective, I wanted to link this person into continuing bonds that would support his ability to process the traumas he had experienced. My formulation linked to the virtual school agenda, which was to support and facilitate education to take place. Yet the corporate parent wanted to move the child to a county where he would be more likely to receive foster care, a key indicator of positive protectors for the child. Each had the best interest of the child in mind, yet there were competing agendas which needed to be understood and explored together. There was an impasse in what it was that was happening and conversations needed to take place to support an understanding to emerge from which actions were taken and needs met.

This example shows that there can be a dichotomy of needs: a need to be in living routines of the past, and yet a need to recognise the emergent needs in the here and now. When as a system we find ourselves in this type of impasse, we often privilege one person’s need rather than work with the dilemma in a way that enables both the past routine and the current emergent necessities talk to happen.

Therapeutic conversations about hope:

Here is an excerpt of a therapeutic conversation I had with a UASC where I facilitated the bond he has with his mother to inform and support the new living routines he was making. In doing this I am connecting the past with the present so that coherence and permission is given as he starts to engage with life here in the UK.

|  |  |
| --- | --- |
| Who spoke | What said |
| Ana | What were you running away from? |
| J | From the army, as I didn’t want to become a soldier. |
| Ana | Who else in your family agreed with you? |
| J | My Mum arranged for me to leave, my brother died and she didn’t want the same thing for me. |
| Ana | So she wanted to protect you? |
| J | Yes; she wanted me to have a good life. |
| Ana | What does a good life look like? |
| J | To learn, to have a job, to be safe. |
| Ana | So you hope to learn new things, to get a job and to be safe? |
| J | Yes |
| Ana | So today, how can you make hope real? You know in the choices you have now? |
| J | I can learn English? |
| Ana | What would your Mum say if she knew that you are learning English? |
| J | Good, good, she would be very happy |
| Ana | So hope is yours and hers every time you say something in English? |

This is a snapshot of a therapeutic conversation with J, who was anxious, distressed, and was struggling to connect with life here in the UK. It illustrates that it is possible to be alongside a UASC, to join the past familial bonds they do have that gives permission for them to focus on living, and the links to the hopes had in the journey they have made. It enabled J to explore hope and what it might look like in his daily activities. As a result of this therapeutic conversation, J went on to attend English classes, to apply to go to college and to consider trying to become a doctor in the future. He became motivated to speak English, because in speaking he was able to connect with his mother.

Creating hopeful conversations when all seems lost;

Yet when a UASC has had their asylum claim denied, how can we ensure that what we talk about is useful and productive? I have found that conversations about the loss of asylum become focused on the loss of hope. It is not unusual to hear a young person cry that it is the

end of all the hopes they had. This can lead to a sense of despair, a loss of meaning, and a not knowing how to go on. This has been described as being ‘frozen in time’ (Penn,

1999)[[11]](#endnote-11) and we need to consider the implications of this loss of hope to the present and future. What is it to be a ‘hopeless’ person? What narrative does this shape and form for future relationships and the return journey about to be made? How can we respond therapeutically in a way that acknowledges the fear and yet retains hope?

Again, here is an excerpt of a therapeutic conversation that facilitated the ability to retain hope in the face of deportation.

|  |  |
| --- | --- |
| **Who spoke** | **What was said** |
| Ana | It sounds like there is a high possibility that you will go back. |
| H | Yes |
| Ana | I see the fear and yet I wonder what of being here you want to take with you? |
| H | I don’t understand |
| Ana | Have you made friends, have you learnt anything?  |
| H | Yes, I have learnt how to look after myself. |
| Ana | Do you cook? |
| H | Yes, sometimes in the house, we share doing this. |
| Ana | You have learnt how to negotiate who does what? |
| H | We live together |
| Ana | Do you feel you have learnt about this culture? |
| H | Something’s. |
| Ana | What things? |
| H | Some English, how to manage money, how to travel |
| Ana | These are amazing skills that many young people struggle to do, especially managing money. |
| H | I save my money so I can go to church |
| Ana | You save to be able to do what is important to you. |
| H | Yes I want to go to church; I have to go to London. |
| Ana | So when you go back you can take with you the ability to negotiate, to know what is important and to get it for yourself.  |
| H | Yes but I don’t want to go back. |
| Ana | Sometimes we can’t change the decisions being made; sometimes we have to find ways beyond them. Can you take what you have learnt, the hopes you have realised here with you? |
| H | Yes; but it is different there, I am scared |
| Ana | I can see that it is scary, what does fear make you do? |
| H | It makes me want to run away, to hurt myself |
| Ana | You have made some really difficult journeys, the one to get here, the one once you arrived and all the learning you had to do and I wonder if fear is reminding you of how hard the previous two journeys have been? |
| H | Yes, I want to stay, I don’t want to go back, I am scared. |
| Ana | Did you feel fear in your previous journeys? |
| H | Yes I am very afraid. |
| Ana | So fear is stopping you having hope? If you were able to negotiate with fear to allow a little hope to be present what would the hope be? |
| H | To stay here. |
| Ana | And if you couldn’t stay and had to go back, what hope could you have? |
| H | To be safe, to find my family |
| Ana | From when you left home and the learning you have done in the two journeys you have made, what of the learning will keep you safe and help you find your family? You said that you had learnt that you can travel, you can save money to access important things, and you can negotiate with others. |
| H | Yes |
| Ana | Will these skills help you in the hopes you have? |

In re-directing H’s belief about himself, I was able to help him move into what I have come to call the multiple faces of hope. What the conversation did was to change his belief of what hope has to be. Before, hope was all in the staying and there was none in the going. The conversation enabled him to refocus, to take control and to act purposefully when the threat of deportation came.

In my work with H, I found that this therapeutic conversation eventually allowed him to explore the future after deportation in a more hopeful way. That is not to say that he didn’t grieve and wasn’t scared, yet it did give him a new ability in how to manage what was taking place. If he had lost the ability to hope, this would have further fuelled the loss of meaning and the sense of despair that so often overwhelms people who have no control over decisions made about their future.

As professionals we also can lose hope and the situation being presented becomes overwhelming. So I want to end with my hopes in the writing of these ideas;

I hope that what you are reading is what you have seen, heard and therefore recognise in the conversations you have had with UASC.

 I hope that in sharing these therapeutic stories and ideas, they support the hopes you have when you prepare to meet with a UASC, and that this understanding of the dilemmas faced will guide your conversations.

1. UASC in their journey through the continent describe traveling at night and sleeping during the day to avoid detection. They therefore are nocturnal on arrival to the UK. Staff in reception centres describe young people sleeping in ‘huddles’ on the floor of a room as a way of protecting each other and disliking being separated into individual rooms as they are vigilant to any perceived threat. [↑](#endnote-ref-1)
2. See Competency Framework for UASC in Kent. [↑](#endnote-ref-2)
3. The stakeholders who have formed the UASC EH&WB Network consist of Sussex Partnership Foundation NHS Trust, The Refugee Council, Kent County Council, The Red Cross, Kent Refugee Action Network, Asphaleia, Save the Children, Mind, Focus for Change, Diocese of Canterbury, Sevenoaks Baptist Church, Samphire Project, Kent Kindness, Migrant Help UK, Home for good, Barnados, Headstart and Kent Virtual Schools. [↑](#endnote-ref-3)
4. Björn Gustavsen (1996) Development and the social sciences: an uneasy relationship. In Toulmin, S, and Gustavsen, B. (Eds.) *Beyond Theory: Changing Organizations through Participation*. Amsterdam and Philidephia: John Benjamins [↑](#endnote-ref-4)
5. Shotter, J; (1998), Participatory Action Research in a New Age of Distributed Learning and multidimensional dialogically discursively structured flexible, decentralised, heterachical, fluid forms of self-developing organizations. *Work Organization and Europe as a Development Coalition*, Brussels, Jan 28th, 1998 [↑](#endnote-ref-5)
6. Worry dolls are currently being changed to worry beads due to sourcing issues. [↑](#endnote-ref-6)
7. See http://www.nhs.uk/Conditions/Jet-lag/Pages/Symptoms.aspx [↑](#endnote-ref-7)
8. Junior MARSIPAN Guidelines (2012) **Management of really sick inpatients with anorexia nervosa. CR 162.** Royal College of Psychiatrists, London [↑](#endnote-ref-8)
9. See <http://www.gosh.nhs.uk/health-professionals/clinical-guidelines/re-feeding> [↑](#endnote-ref-9)
10. Pearce, W.B. & Pearce, K.A. (1998) Transcendent story telling: Abilities for systemic practitioners and their clients. *Human* *Systems*, Vol 9, issues 3-4. [↑](#endnote-ref-10)
11. Penn, P. (1999) Metaphors in a region of unlikeness. *Human Systems,* Vol 10, issue 1. [↑](#endnote-ref-11)