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EVALUATION OF THE SLEEP PROJECT FOR UNACCOMPANIED ASYLUM-SEEKING CHILDREN IN KENT

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Executive Summary

It has been a privilege to evaluate the Sleep Project intervention for unaccompanied asylum-seeking children (UASC). The opportunity to evaluate this project arose through discussions between the authors and Dr. Ana Draper, exploring the work of Ana, her team and colleagues across the various agencies in supporting newly-arrived migrant children in Kent. From 2015, there was a rapid increase in the number of UASC arriving into the region and services were quickly adapted to meet the specific and immediate needs of these vulnerable children and young people, the Sleep Project being just one of the innovative interventions put in place.

Unaccompanied asylum-seeking children and young people have usually experienced harrowing journeys to the United Kingdom (UK) in seeking safety and refuge. Once in the UK, adapting to life within reception centres, foster families or supported housing, brings further challenges and within this context, practitioners and the young people identified sleep as a key problematic issue for which they required extra support. Through conversations with practitioners and young people, sleep difficulties were a recurring issue. Lack of sleep and disturbed sleep was preventing the young people from engaging in planned activities such as language classes. Tiredness was having negative health and social/educational impacts. This evaluation studies the benefits and challenges of the creative support mechanisms that were developed to address the sleep issues. This report presents our findings from the evaluation study of the Sleep Project intervention. The study comprised of 18 interviews with practitioners either working directly or indirectly with UASC, in paid and voluntary capacities. From the interviews, the qualitative data was thematically analysed to develop themes under which the benefits and challenges of the intervention could be explored.

Throughout the interviews with practitioners working either directly with UASC or indirectly in managerial roles, it became apparent that there was a high level of commitment from individuals to develop their understanding of UASCs' needs and to develop appropriate social care practice and support. The interviews highlighted that practitioners were prepared to think and act creatively to improve and to tailor support for this group of children and young people.

The findings of the evaluation suggest that the Sleep Project was very well-received by young people and practitioners alike. It provided practical resources and support for good sleep, and it encouraged conversations to develop between the practitioners and the young people, and between the young people themselves, normalising the sleep issues that they were experiencing, and, according to interviewees, the young people were found to be encouraging other young people to use the good sleep packs. The intervention helped the practitioners feel more confident and equipped with skills to talk to the young people about sleep and, possibly, this led to deeper discussions about individual journeys and experiences, allowing care to become more empathetic, specific and person-centred. Significantly, interviewees reported that the project allowed them to 'look at the basics', that is, practical help such as providing night lights and educating young people about factors that hamper a good night's sleep, whilst practitioners gained a greater understanding and responsiveness as to why the young people could struggle with sleep. This greater understanding has been important for shifting the perceptions of practitioners, particularly those in educational roles, helping them to be more patient and supportive to young people struggling to get to lessons on time and to concentrate.

Key messages from the findings of this evaluation study are encapsulated in the following quotes from interviewees:

- '*I think it's thinking a bit more innovatively about the care we can provide*'
- '*A confidence to look at the basics*'
- '*Context switched concepts*'.

Proposed recommendations involve: sustaining the work so far, looking at how the project could/should have a legacy, and building on the developed knowledge and networks. At the time of the publication of this report, young people are being transferred to other receiving local authorities outside Kent – a national dispersal scheme that was agreed by the Home Office in June 2016 to ease the pressure on Kent - therefore good practice from this project should be widely disseminated to service providers and policy makers at regional and national levels.

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Definitions

A Refugee

The UN Convention defines who is a refugee, and sets out the rights of individuals who are granted asylum and the responsibilities of nations that grant asylum as follows:
'*A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it*' (United Nations Convention Relating to the Status of Refugees,1951).

Unaccompanied Asylum-seeking Children (UASC)

This term refers to children (and young people) under 18 years of age who have applied for asylum in their own right, who are outside their country of origin and separated from both parents, and are not being cared for by an adult who in law or by custom has responsibility to do so (Home Office, 2016).

Young People

This report has deliberately used the term 'young people' as much as possible to highlight that we are referring to a vulnerable group of individuals that have needs beyond their asylum status and that they are children first and foremost. Being a migrant implies challenges arising from difficult journeys, however integration and adapting to a new society whilst being a developing adult brings a complexity to these challenges.

The 'vulnerability' of the young people is often referred to within this report, in terms of mental health and social care needs, however the resilience of these young people is recognised, in their survival of traumatic life-changing events.

Practitioners

The interviews included a wide range of people working with the young people, including those in a paid capacity and volunteers. The term 'practitioners' has been used to refer to all those who were interviewed in recognition that they are all working towards improving the welfare of the young people and utilising skills of care and caring values.

1. Introduction

1.1. Background

Currently, there are unprecedented levels of displacement recorded worldwide, with 65.3 million people forced from home; among these, there are nearly 21.3 million refugees, over half of whom are under the age of 18 (UNHCR, website). Refugee children on the move, whether on their own or with other family members, in some regions account for close to 40% of all those seeking refuge. Only a small proportion of refugee children reach the UK, which is ranked 7th among European states receiving asylum seekers (UNHCR statistics, 2016).

In 2015, there was a rapid increase in unaccompanied asylum-seeking children (UASC) reaching the UK and seeking asylum, with 3,043 applications submitted in total, figures which do not include those children seeking asylum as dependents or who are irregular/undocumented. Of these 3,043, 989 UASC arrived in Kent, with the port of Dover being a key point of entry, 722 of these young people arriving June-October, and these numbers increased further in 2016-2017. The young people were mainly boys, claiming to be aged 16 and 17 years old, from countries such as Eritrea, Afghanistan, Iraq, Syria and Sudan.

Young people often become displaced due to fear of, or experience of persecution, through organised violence of war (Kohli, and Mather, 2003; Hodes et al., 2008). Other reasons for departure include: economic hardship deriving from armed conflict; dangerous families or kinship networks; and illicit and illegal activities such as sexual trafficking. In this way, children are victims of humanitarian crises. UASC have similar purpose for fleeing, that is, escaping from harm and seeking asylum in countries that are geographically or culturally far away from their country of origin (Kohli, and Mather, 2003).

UASC are considered to be highly vulnerable in terms of negative health outcomes. During the pre-flight and flight phases, many experience cumulative traumatic life events and difficult living conditions, which are likely to adversely affect their health status. Previous studies of UASC have mainly focused on the mental health burden (Marquardt et al., 2016). Research indicates a prevalence of 19-54% of refugee children suffering from post-traumatic stress disorder (PTSD) (Bronstein and Montgomery, 2011; Huemer et al., 2009; Fazel et al., 2012) and 3-30% having depression, with UASC reporting greater symptoms compared to their accompanied peers (Fazel and Stein 2002; Fazel, Wheeler and Danesh, 2005; Marquardt et al, 2015; Keating, 2016). In 2015, 42% of the new arrivals to Kent were assessed as having symptoms of post-traumatic stress disorder, so as a response, seven Clinical Commissioning Groups (CCGs) funded the one-year UASC Emotional Health and Wellbeing Project to ascertain the needs of UASC in Kent. To avoid chronic mental health issues from developing, the UASC project team sought to introduce interventions that would make a difference at the early stages of arrival in the UK. The Sleep Project was one of four areas of early intervention: Sleep; Nutrition and Refeeding; Trauma and Bilateral Movement; Hope and Aspiration.

Assessment of Needs and Interventions with UASC

In the UK, in accordance with the Children's Act 1989 and 2004, looked-after children, including unaccompanied children, are initially health assessed to identify their needs. A study by Coyle et al. (2016) analysed the results of 154 initial health assessments of UASC arriving in Kent in 2015. The key health issues identified were psychological symptoms (particularly of PTSD), dental health needs, and dermatology complaints. Although physical complaints were common, most were non-acute and could

be managed in the community. Infectious disease is an important issue in this cohort, which can be managed through simple, preventative measures such as immunisation and screening (Coyle et al, 2016).

There is an on-going debate about the appropriateness of applying Western mental health concepts such as PTSD to UASC populations. One potential way of overcoming the conceptual arguments is through the assessment of sleep problems within this population. Subjective sleep problems, such as difficulty initiating sleep and nightmares, are common in the aftermath of traumatic events. For example, a study by Montgomery and Foldspang (2001) of parents of 311 accompanied refugee children aged 3 to 15 from various countries living in Denmark, found that approximately one-fifth of the children experienced frequent nightmares, problems falling asleep and staying asleep. Moreover, Bronstein and Montgomery (2013), in a study of 22 male Afghan children aged 13 to 18, assessed sleep patterns and PTSD via self-report questionnaires. Findings indicated that UASC who were screened above the clinical cut-off for PTSD reported significantly greater sleep onset latency, increased nightmares and less total sleep time compared to the non-PTSD group. For assessment purposes, the assessment of sleep may be less culturally-laden compared to screening measures for PTSD, and could provide quick and helpful insight into the distress experienced by UASC (Bronstein and Montgomery, 2013).

Patterns and quality of sleep remain one of the least researched aspects of UASC well-being (e.g. Groark, Sclare and Raval, 2011). Sleep problems such as difficulty sleeping and sleep disturbances, such as nightmares, are often common features following traumatic events, particularly in adolescents (Wiggins and Freeman, 2014), and are also core features of PTSD (Soffer-Dudek and Shahar, 2010; Spoormaker and Montgomery, 2008; Pace-Schott, Germain, and Milad, 2015). In Sinha (2016), it was argued that traumatic events can induce sleeplessness, and such sleep problems may occur in the absence of full-blown PTSD, and may be an antecedent of subsequent PTSD development.

Most interventions with unaccompanied asylum-seeking children to improve the mental health and social-emotional functioning (e.g., cognitive behavioural therapy, creative expression and multi-tier or multimodal models) predominantly address PTSD (e.g., Sullivan and Simonson, 2016). However, these interventions may not be targeting specifically sleep problems, which, if untreated, could lead to serious physical or mental health problems. Moreover, these interventions tend to be mainly psychological, targeting the particular symptoms of trauma and not acknowledging the wider issues that UASC may be faced with. Few interventions focused on sleep matters have been carried out with young people (e.g., Tan et al., 2012, with Australian youths aged 10 to 18 years), and there appears to be a lack of sleep interventions in the UK specifically involving UASC populations.

One of the very few UK examples is the Well-Being Project in the London Borough of Hillingdon (Austen et al., 2007) that employed a holistic approach to UASCs' mental health needs and took into consideration the individual's physical care, social, educational and health needs to promote optimal well-being. Project activities consisted of youth work, training workshops with UASC, consultation with professionals who care for their well-being, training and one-to-one therapeutic work with UASC. One of the main interventions used to ameliorate young people's mental health was the Orientation Memory Box (OMB). OMB engages young people in discussion about events, terminology and issues of being in the care of the local authority. The OMB enables a form of life story work using creative and narrative therapy in private time for the young person and in the group context to reflect on experiences about coming to and being in the UK. In the Hillingdon project, the OMB was conducted in a group setting with two facilitators and interpreters for the young people. The intervention aimed to facilitate and help the young people to become more active participants in their care, providing a safe, contained and therapeutic space for the young person. It also enabled communication, social and

networking skills, consequently reducing the isolation experienced by UASC when they initially arrive in the UK.

1.2. The Context of the Evaluation

1.2.1. Policy Context and Services for UASC in Kent

In July 2016, A Parliamentary Select Committee report, *Children in Crisis: Unaccompanied Migrant Children in the EU,* acknowledged the continuous increase in the number of unaccompanied children in the European Union (European Union Committee, 2016). In particular, the 3,043 asylum applications from unaccompanied asylum-seeking children made in the UK gave an increase of 56 per cent from 2014. Due to the location of Kent, UASC numbers are considerably higher compared to other local authorities in the UK. Thus, Kent as a local authority plays a pivotal role in developing and disseminating good practice for supporting this vulnerable service user group.

Under the Children Act (1989; 2004), a local authority has the duty to provide support for children in need (Section 17) and a duty to provide accommodation to those in need (Section 20). Local authorities have a statutory duty to support UASC, ideally as 'children first, asylum seekers second' whilst recognising that this is a particularly vulnerable group with specific needs (Crawley, 2006).

The significant increase in unaccompanied asylum-seeking children (UASC) reaching Kent as a port of entry in 2015 overwhelmed statutory structures as they were trying to meet the needs of each child on their initial arrival. Having previously managed approximately 17 UASC arriving each month in the Kent region to having 20 arrive in a day, there was a mounting pressure on the capacity within the system to meet the statutory requirements of each child (from project report). As children arrived in Kent and claimed asylum in the UK, they became children in care. Kent County Council (KCC) the corporate parent, opened up reception centres for boys deemed 16 years of age, from where they then moved to community housing. Boys under 16 and all girls are placed in foster care as assumed more vulnerable.

Due to increased demand for support, KCC recruited additional frontline staff. To meet the health needs of the UASC population, it was decided to bring together a multi-disciplinary team of professionals, namely Kent CCG designated professionals for LAC from Local Authorities, CCG Commissioning, Mental Health and Public Health. When the professionals came together, they recognised the complexity of needs and of the system that interacted with this cohort of young people. A mapping of contacts in the first 2 weeks with an individual UASC showed that they had 48 separate professional contacts in which they had to re-tell their story to fulfil assessment requirements.

The multi-disciplinary team identified and agreed the following objectives, to:

1. Commission additional capacity to meet statutory requirements
2. Undertake a Health Needs Assessment of the current cohort
3. Mobilise strategically and operationally to share intelligence and coordinate response, including safeguarding
4. Improve the quality of Initial Health Assessments (IHAs) delivered to UASC
5. Improve knowledge and response of primary care and other health systems to the health needs of UASC
6. Understand better the emotional wellbeing and mental health needs of the cohort
7. Engage with the Home Office regarding National Dispersal and develop a model of health screening within 5 days
8. Share learning, tools, templates and guidance.

To develop a contextualised understanding of UASC in Kent, a review of the IHAs data was commissioned which found that 42% had symptoms of post-traumatic stress disorder (PTSD), depression and/or anxiety (as previously referred to). This correlates with other literature that suggests a higher incidence of PTSD, depression and anxiety in this population (e.g., Fazel et al., 2012). In response to this finding, the seven Kent CCGs agreed to use Children and Young People's Transformation Funding over two financial years to commission SPFT (the Kent CAMHS provider) to set up an UASC Emotional Health and Wellbeing Project

The aspirations of the UASC Emotional Health and Wellbeing Project at the onset were: to identify all UASC in reception centres and supported accommodation with compromised emotional health and well-being; to offer screening using a validated tool to assess their emotional health and well-being; to show measured improvements in emotional health and well-being; and to increase the ability and confidence of staff to provide supportive interventions[1].

This report presents findings from our evaluation of one particular area of the early intervention work: the Sleep Project.

1.2.2. The Sleep Project

The UASC Project Team used a participatory action research methodology to capture the voices of UASC and staff in reception centres and the linked social workers. Knowledge gained through conversations with individuals highlighted that UASC were experiencing: poor sleep (a lack of sleep and/or disturbed sleep); vivid flashbacks; nightmares or sleep terrors; lack of concentration; and poor understanding of nutrition (from the project report 'An Action Research Project' as indicated in Appendix 1). Many of these symptoms were contextual to the journeys made to reach the UK and it was noted by professionals that if symptoms were not managed, it was possible that symptoms could manifest into chronic mental health disorders, such as severe anxiety, depression, and a dissociative disorder (from the project report 'An Action Research Report' as indicated in Appendix 1). Alongside the sleep issues for the young people, practitioners were holding safeguarding concerns that the young people were awake at night, with little supervision.

To avoid chronic mental health issues from developing, the UASC project team lead sought to test which interventions would make a difference at the early stages of arrival in the UK. Based on findings from the action research, it was decided to focus and address four areas of early intervention:

These interventions were designed to be multiple protectors to a young person's resilience and wellbeing. They are interlinked and act in conjunction with each other (from the project document 'BACCH Report' as indicated in Appendix 1).

To enable the Early Intervention Framework to be delivered, a UASC Emotional Health and Wellbeing

[1] A website was developed to disseminate the findings from the project – www.UASChealth.org

Network was formed. Fifteen different organisations came together and agreed terms of reference that promoted openness and collaboration, enabling responsive and proactive preventative care to be delivered, developing outcome measures. The network met once a month for information sharing and collaboration in service delivery.

Sleep Problems Experienced by UASC

The key theme in the conversations with practitioners and young people in reception centres, witnessed by the project team, was in respect of sleeping habits. Most of the young people slept during the day and were unable to sleep at night. This prevented the routine of the centre being established and opportunities for English and skills training were being lost. The teachers in the centres reported that the young people were often tired in sessions, and some failed to attend classes as they were asleep in the mornings when lessons took place. In therapeutic conversations, young people described their journeys, travelling at night and sleeping in the day for prolonged periods of time. Others described becoming fishermen and working through the night to catch fish and then needing to sleep during the day. Reception centre staff reported that many of the young people slept in packs in one room with the light on; the young people talked about learning to protect each other on their journeys to the UK. There were repeated requests from staff that the young people stop putting towels over the lights, as this was a fire risk; 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. Meanwhile, the General Practitioner (GP) for the reception centres reported that almost all of the young people reported disordered sleep patterns in their consultations with him.

Bronstein and Montgomery (2013) argue that sleep problems should be considered as problems in themselves since lack of adequate and quality sleep can lead to various functional impairments in memory, concentration, attention, motor performance, behaviour and academic performance (Pilcher & Huffcutt, (1996). In order to attempt to reset the sleep circadian rhythms and improve the quality of sleep for the young people, the Sleep Project was developed and implemented with the UASC groups in the reception centres.

The Sleep Project intervention consisted of the following 3 steps:

1. The Sleep Hygiene Presentation

First, sleeping hygiene education was introduced to young people via a PowerPoint presentation (Sleep Presentation, retrieved from: http://www.uaschealth.org/resources/mental-health/sleep-eat-hope/).

This sleep presentation was formulated to help participants gain 'better sleep; achieve more; look good, feel good and have more energy' (from presentation slides). Information given during the presentation included the consequences and implications of stimulants on sleep, such as smoking before bedtime, the impact of drinking high energy drinks and the blue light from mobile phones hampering sleep. Many young people reported that they had not been aware that these stimulants affect the ability to sleep. Anecdotally, the young people had been drinking many high energy drinks and not appreciating the physical effects.

2. The Sleep Pack

The next step was the distribution of sleep packs to young people. Due to the continued reports of lack of sleep and the different narratives that emerged in which the lack of sleep was coupled with night terrors and being disturbed by others in shared rooms, the project team devised sleep packs with help from the young people. The 'good sleep' packs contained: a plug in night light; night masks, ear plugs, lavender bags and 'worry dolls'. The plug in light enabled the young person to have ways in which they could manage the hyper-vigilance they had developed whilst on the journey to the UK. The night

masks and ear plugs helped block out noise and light, aiding sleep. Lavender is a known smell that enhances calm and the 'worry dolls' supported the young people to let go of concerns about their friends and families while they slept. These items were in direct response to the themes described by the young people and those who look after them from the participatory action research.

After an initial trial with the packs, it was reported that the UASC in one reception centre said these packs had aided their sleep and were a useful resource. They had shown their appreciation of the packs by standing up, cheering and clapping their hands. Coupled to this, practitioners continue to request additional packs for when people arrive, as they have found that they make a difference in the young people's ability to sleep on arrival at the reception centres. However, there were still several 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.

Figure 1 *The Sleep Pack*

3. A Circadian Rhythm Reset Formulation

Due to the nature of the journeys across Europe, young people showed circadian body clock rhythms set into nocturnal patterns. On arrival to the UK, the young people started to experience an intense form of jet lag of which the symptoms were: difficulty concentrating, indigestion, and memory problems.

Despite the previous interventions in the reception centre, for some young people, there was 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 is optimal. 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 was set into a calculation, otherwise called a sleep prescription, from which a programme was devised and used when a UASC reported a continued inability to sleep and experienced symptoms of continued sleep deprivation.

1.3. Aims of the Evaluation

This evaluation aimed to explore experiences of the Sleep Project intervention from the practitioner's point of view, identifying the benefits and challenges of this project. The aim was to look for examples of good practice and to produce transferable knowledge, promoting mental wellbeing for UASC through a sleep intervention.

In particular, the evaluation questions were as follows:

1. What were the practitioners' views on the implementation and process of the Sleep Project for UASC?
2. What did the practitioners consider as benefits and challenges (for both staff and young people) participating in the project?
3. What were the practitioners' suggestions for ways forward for sustaining and developing the intervention further?

1.4. Evaluation Strategy

An initial review of key project documents provided by the Project Lead informed the research team of the context of the intervention (Appendix 1). Then, taking a qualitative research approach, semi-structured interviews were chosen as the main method of data collection. An interview guide (Appendix 2) was constructed and piloted before interviews were conducted with key informants, those involved in delivering support to newly-arrived UASC to Kent during the period of time that the UASC Emotional Health and Wellbeing Project was introduced and running (April 2016-March 2017).

Ethics approval for the conduct of this evaluation was granted by the Research Ethics Committee at Canterbury Christ Church University, Kent and from Kent Social Services and Sussex Partnership NHS Foundation Trust. There was governance approval by the Audit Team at Sussex Partnership Trust. Informed consent to participate in the study was obtained prior to interviews and the authors ensured coding of interviews maintained a good level of confidentiality.

1.4.1. The Sample

Due to the exploratory nature of this evaluation study, a purposive sampling strategy was adopted. With the assistance of the Project Lead, key informants were identified for interview and, in total, 18 practitioners were interviewed, two face-to-face and sixteen by telephone. Participants consisted of a range of different health and social care professionals and volunteers (see Table 1), including social workers, an assistant psychologist and a general practitioner. These interviews lasted between forty minutes to one hour. The focus of the interviews related to how the intervention was implemented, what worked well, any challenges and suggestions/recommendations for ways forward.

Table 1 *Description of participants in the study*

Role with Sleep Project	No. of Interviewees
Social Workers	5
Managers (incl. Commissioner)	3
Psychologists (incl. Project Lead)	2
Health Professionals	3
Volunteer Teachers	3
Paid Social Care Staff	2
TOTAL	**18**

1.4.2. Analysis of Data

Interview data was recorded as verbatim notes at the time of the interview. The interview data was then analysed thematically according to the qualitative model of Attride-Stirling (2001). Thematic network analysis facilitates the structuring and depiction of themes as reported directly through the interviews. Two researchers conducted data analysis separately and reliability of themes was attained by creating codes and themes separately and then cross-checking these. Discrepancies were resolved through discussion and re-examination of the data.

2. Findings

Findings are presented by the themes developed and agreed from the thematic network analysis of data on practitioners' experiences of the Sleep Project.

2.1. Working Interprofessionally

> *'… a tight project group, we worked well together, and we could get things done quickly'* (Interview 12, Health Professional)

The sleep intervention was part of an interprofessional project. Interprofessional working can improve collaboration and the quality of care of service users (Centre for the Advancement of Inter-Professional Education (UK) CAIPE, 2002). The Project Lead, as a Systemic Psychotherapist, was working with social workers, social work assistants, G.Ps, nurses, volunteers and teachers, across health and social care settings. The evaluation aimed to capture this interprofessional experience, specifically asking how the different agencies and professionals worked together for the young people and whether the Sleep Project had an impact on interprofessional working. It was suggested that collaborative working improved the quality of the service provision, developing greater communication and efficiency in decision-making.

Improved Access to Support

From the start, the UASC Clinical Network encouraged collaboration and sharing expertise on casework. There were monthly Emotional Health and Wellbeing Network meetings, with short consultations discussing anonymous case examples, which helped practitioners to understand procedures and the questions to ask, especially in liaising with GPs. These meetings were experienced as very useful as they disseminated information between professionals, raising awareness about issues and encouraging interagency working.

Interviewees noted the importance of having good access to advice, the sharing of ideas and quick referral processes between professionals. Interagency working allowed practitioners to see different perspectives and enhance their understanding of the context for young people. One interviewee noted her experience of working closely with CAMHS:

> *'It has been an immensely powerful experience…the body clock, this is a more scientific, a different approach, and the result of that has helped strengthen the relationship with partner agencies…'* (Interview 12, Health Professional).

Communication

> *'I think it's just developed better discussions and questioning around sleep'* (Interview 15, Manager).

The project encouraged greater contact between the different stakeholders and for staff to feel *'supported in a multiagency way'* (Interview 17, Manager).

> *'Us, as the mental health team in the reception centres, we are separate but became*

interlinked…hear what people are saying at different times, creating responses, and evaluating as we went along. There were lots of feedback loops with each other. We've been very focused on the young people, making a difference together, with people knowing their roles and supporting each other in that. Always feeding back into social work to maintain their parental role – it felt organic rather than hierarchical' (Interview 2, Manager).

Good communication was important to the success of the intervention:

'people engaged with each other, willing to help each other. It allowed them to know other professionals involved, improved communication and the ability to work together' (Interview 3, Health Professional).

'it's about clearer communication and being able to talk about what we can and cannot do' (Interview 13, Psychologist).

Misunderstandings and barriers between professions started to be reassessed as the project progressed. One volunteer teacher expressed relief that the social workers were starting to trust the volunteers. Initially this volunteer had felt her role had been limited through safeguarding concerns, but gradually trust was developing and the social workers began to ask the volunteers for help (Interview 12, Health Professional) and in this way, a community of support developed around the UASC.

There was a sense that the project had the right backing to be effective. The status of the Project Lead seems to have given the project credos:

'You think, brilliant, it is obviously important if someone like… [Project Lead] *takes it on, it gives it value'* (Interview 6, Volunteer Teacher).

Alongside this, the action research approach was appreciated:

'One thing I've liked about the work of… [Project Team]*, they have always asked opinions and listened to what people have to say, they take things out, put things in, and listen to the views of all staff'* (Interview 4, Manager).

2.2. Benefits for Practitioners

Increasing Confidence and Empowerment

'… professionally, people feel upskilled regarding supporting young people, they have not just got an understanding of why they are finding sleep difficult but how they can move them forward so it has been empowering to staff and had a knock on effect of adding to other stuff they are doing…I think they are getting better support because staff are better informed' (Interview 15, Manager).

Interviewees highlighted that through the intervention, they were '*upskilled*' and gained a better understanding and knowledge for supporting the young people with sleep problems. The result of such '*new learning*' led to immediate changes in professional practice and an improved quality of frontline-based provision of services and seems to have reduced the referral to specialist medical or mental health services.

'Knowledge, just knowing that there are resources we can use for young people…knowing that there is something available we can use quickly and confidently rather than having or waiting for professional input to do that' (Interview 7, Social Worker).

'It adds to our ways of being able to help young people, gives us different techniques on how to deal with it. Before, when they say they can't sleep, we try to get them to the doctor, but now it's not always to get them to the doctor and sleep tablets but to use this method to help them first' (Interview 10, Social Worker).

'…it has been awareness raising. It has been helpful. Before the Sleep Project, young people would have medical appointments…there were cases where people have been prescribed sleeping tablets, I am not aware of any prescription for sleep in the centres since the Sleep Project started, it's the first time I think of it that way now. When they are doing the discussions with the G.P. they would refer them to [the Project Lead] instead of medicine prescription' (Interview 15, Manager).

Interviewees made many references to improved support for young people through their own development of understanding and skills.

'A solution rather than pushing up to mental health or the general practitioner, they can have conversations with the young people themselves about sleep' (Interview 17, Manager).

'A confidence to look at the basics and to work together and to listen to what young people are saying, this is a really powerful thing… an overall confidence of what we can achieve if we listen to the client group. None of it is rocket science but to have the confidence to have basic ideas' (Interview 12, Health Professional).

'…it has been positive and reaffirming how these simple measures can have an impact' (Interview 13, Psychologist).

Looking at the Basics

It was a repeated theme that staff had felt empowered to 'look at the basics' and initiate discussions with the young people about their sleep.

'…there is now more discussion about why the behaviours take place. So when there are issues that arise in the centre there is more routine approach to talk about it than there would have been. This is mainly due to the training and much more awareness about how sleep can affect their wellbeing. It's a shift from the view staff had of 'we give them a few days and they will bounce back…' (Interview 15, Manager).

'*Frontline staff were not reporting information as they were not seeing it as significant – such as towels over light bulbs, not seeing this as an issue but it was such a big clue*' (Interview 12, Health Professional).

'*…to have not thought experiences impacted on sleep is ridiculous…*' (Interview 12, Health Professional).

Interviewees considered they had developed skills and confidence to investigate issues in more depth to uncover underlying factors that could be causing poor sleep. There was an increased '*confidence to look at the basics and work together and listen to'* the young people (Interview 12, Health Professional); staff were less reliant on referring care to G.Ps. Through this development, frontline staff could work with the young people to address their own sleep issues, looking for their own solutions. This appears to be parallel to an aspect of solution focused therapy. This 'focuses on interventions designed to facilitate clients' finding solutions to their problems and then incrementally putting a solution into practice' (Langdridge, 2006). Learning initially seemed to depend on the Project Lead, an expert in the field of mental health, thus giving '*it value'* from staff perspectives.

Changing Practitioner Attitudes: 'context switched concepts'

> *'Staff attitudes have changed, it has improved understanding, to be open to understand different cultural needs and attitudes, it has shown workers and staff how important it is to provide support for young people around sleep pattern'* (Interview 3, Health Professional).
>
> '*The biggest gain – we're all adults, and we all understand the need for a good night's sleep, but it is important to understand the young peoples' opinions and that they are not just being lazy, there is a bigger picture to this*' (Interview 4, Manager).

The project has impacted on the attitudes of people working with unaccompanied asylum-seeking children. Interviewees recounted initial misunderstandings towards young people's sleep problems. These ranged from perceptions of the young people as *'grumpy'*, *'not grateful'*, *'naughty'* and *'lazy'* with practitioners not believing that the young people had sleep problems but were exhibiting such problems '*because they have been told to'* by '*agents*'. There was also a lack of cultural understanding and awareness of journey experiences to the UK. The Sleep Project helped to change attitudes and helped develop a better understanding that pre-flight experiences can potentially result in sleep disturbances, which could in turn lead to them appearing *'grumpy'*; *'tired'* and/or *'lazy'*.

> *'For staff attitudes – there was a sense, a negative sense, if trying to teach a group of young boys and they are grumpy, yawning and tired, they could be questioned to be negative and not grateful for the support going in…..*' (Interview 12, Health Professional).
>
> '*The staff see them as naughty boys not going to their English lessons*' (Interview 2, Psychologist).
>
> '*…when you start dealing with young people they are told by agents what to say to try in order to get certain thing when they arrive to the country and quite easy for us to say they say they don't have that problem because they have been told so, so it helps to soften that attitude. It helps you to analyse deeper, that there could be more than what we may have originally assessed there to be'* (Interview 10, Social Worker).

Through developing awareness and confidence, the project encouraged the young people to share their stories with enquiring and concerned practitioners. One interviewee raised their concern that young people had been expected to fit in with the routine of the reception centres, when actually, the impact of imposing a daytime routine on the young people could further their sleep deprivation; raising staff awareness about young people's journeys and the potential impact of this on sleep helped address this issue. Furthermore, as young people got more sleep, it was noted that there was a better attitude from the young people towards the staff (Interview 4, Manager).

2.3. Benefits for Young People

> '*It* [the sleep intervention] *helped him manage daily life a little bit better*' (Interview 7, Social Worker).

During the intervention period, service providers at all levels, managers and practitioners, identified the following direct benefits of the sleep intervention for the young people:

- improved access to CAMHS support;
- closer liaison between stakeholders leading to better communication and problem-solving;
- a shift of professional attitudes to providing more immediate and frontline-based support with sleep issues;
- through education and support, the young people had an improved understanding of the importance of good sleep and ways to address their own sleep issues.

Improvement in Sleep

Interviewees reported that the young people's sleep improved as a result of the intervention. The importance and result of improved sleep led to positive psychological and functional outcomes such as improved adaptive daily skills with increasing positive attitude, being '*happier*' (Interview 13, Psychologist), and '*more alert'*. The young people could wake up in the morning for meetings, school and college, and be more receptive in the classroom.

> *'…things did calm down, it enabled them to be receptive. If they can sleep better, they can hear you and respond to you… obviously, the lessons are easier to focus the boys in, the fact that they can be calm and can engage more than they would have without sleep, and makes things easier'* (Interview 18, Volunteer Teacher).

> *'… a young man with big problems sleeping…You could see a big difference when he left us – more alert, ready for meetings, not just as if he had crawled out of bed, a massive improvement'* (Interview 4, Manager).

Youth Participation

The delivery method of the project, the action research approach was received very positively. Interviewees highlighted that the project was empowering, providing a sense of '*ownership the children had over the project'* (Interview 17, Manager).

> *'It is teaching them that we are beginning to understand, it is a living project, rather than us telling them how they feel'* (Interview 3, Health Professional).

> *'The outcomes are co-produced with the young people and social workers within a framework of mental health expertise'* (Interview 17, Manager).

The young people were given the space to tell the stories of their journeys and to reflect on the impact on their sleep. This gave an opportunity for the young people to experience a '*validity to their story, being heard and a response'* (Interview 2, Psychologist).

Importance of Group Work and Peer Networks

The group work approach was appreciated for wider delivery:

> *'The way it has been rolled out has given the best opportunity to give information to the many rather than the few, meeting with groups of young people'* (Interview 3, Health Professional).

Interviewees also reported that the young people shared information relating to the Sleep Project with their peers, particularly when the intervention had helped them to improve their sleep. In this way, the social network of the young people further disseminated information on good sleep practice.

> *'They valued it and they have strong networks so if it worked for one of them they would recommend to each other'* (Interview 15, Manager).

Promoting Resilience and Self Support

It could further be argued that the intervention benefitted the young people by equipping them with coping and problem-solving skills to manage and gain some control over aspects of their own lives, very important for a particularly disempowered service user group. The intervention was important in *'reducing the level of unnecessary intervention, such as through CAMHS'* (Interview 12, Health Professional) and for promoting empowerment skills for the young people in relation to their well-being.

> *'… a tool to control it themselves, and these are young people who have had little control, a tool to help themselves'* (Interview 6, Volunteer Teacher).

These benefits (i.e., skills development and empowerment) could arguably have also fostered resilience for the young people. Resilience may have occurred by strengthening their ability to successfully adapt to change, a new country, society, living arrangements, ways of life, and adapt to stressful events such as pre-flight trauma, through managing sleep disturbances in healthy and constructive ways (Catalano, Berglund, Ryan et al., 2002a). Building skills that help promote resilience in young people is a crucial method for improving mental health problems (Oliver et al., 2006). This skills development of young people is a component of youth participation and meaningful participation can itself boost a young person's sense of connectedness, belonging, self-esteem and confidence, and thereby positively impacting on mental health and well-being (Oliver et al., 2006).

> *'A lot of them I feel have gained confidence, which I was surprised about. Obviously when you sleep better you are better… but a lot were confident and talked more about things they were able to do because of it, like waking up on time, going to college'* (Interview 13, Psychologist).

The intervention clearly improved a wide range of aspects of the young peoples' lives.

Overcoming the Stigma of Mental Illness

The positive outcomes of resilience and meaningful youth participation was reported in the context of the young people gaining confidence to express their emotional/psychological state and overcoming stigma attached to accessing mental health support.

> *'They (the young people) need the opportunity to normalise the symptoms of what they've just been through'* (Interview 2, Psychologist).

'It (the project) helps create a culture where it is okay to say I am having a problem sleeping…it is reducing stigma around sleep. So I think it has been a huge success' (Interview 15, Manager).

The participation of the young people in the sleep intervention not only fostered connectedness to other group members and staff participants but also created a '*fun*' and '*informal*' space for the young people to talk about mental health issues associated with sleep, normalising a mental health condition that could otherwise have been stigmatising.

'The workshops stopped one person being stigmatised for their lateness… made it normal to talk about sleep amongst themselves…making it fun, informal and normal helps…The project encouraged them (the young people) to come forward…it normalised the issue…talking about horror stories in a more normal setting, in their own space, without awkward waiting rooms' (Interview 1, Paid Social Care Staff).

This project was unusual in that it was commissioned for a specific group of young people within local authority care; services are usually commissioned nationally however it was recognised '*the way they* (the young people) *see mental health is different, different backgrounds, they need a service accessible to them'* (Interview 3). This project allowed practitioners to develop skills to bring a service to the young people. Being unaccompanied, '*they've not got a parent reinforcing the boundaries and what's important'* (Interview 12, Health Professional) and the Sleep Project gave staff an opportunity and the confidence to educate the young people. There would have needed to be a good level of trust between the practitioners and the young people to encourage engagement.

The Sleep Packs

'…it's nice for them to be given something, something for them, they do not have to share, kind of their own…fun little things to help them, they are always positive' (Interview 16, Social Worker).

Interviewees reported that the young people appreciated the sleep packs, *'would thank you a lot'* (Interview 12, Health Professional), which they often shared and distributed to their friends. The night lights were considered the most useful item in the sleep packs, being perceived to have assisted in reassuring the young people of safety when they were, for example, woken up at night by startling noises.

'…I think they wanted the night light, for example, to check if there was a noise and go back to sleep. It's all about making their life a little bit bearable' (Interview 8, Social Worker).

'The night light is quite cool, and they like the masks as you get them on planes' (Interview 1, Paid Social Care Staff).

The other sleep items, the sleep mask, the lavender pouch and the worry doll, were also considered useful for their varying attributes. The lavender pouch was noted for reminding the young people of home and warm memories with family and often placed under their pillows at night. The worry dolls were named after family members and then placed under pillows. These items seemed to help the young people build resilience and overcome issues of worry and anxiety.

'He had named each worry doll after a family member and he put them under his pillow at night to feel he was still holding them as he slept' (Interview 2, Psychologist).

> *'He said he was talking to the worry dolls as his brothers and sisters in a positive way so thinking about the family left behind, so it helped him deal with it, stay in touch with them. I thought it was quite good, he found a way to deal with it'* (Interview 7, Social Worker).

For the sleep packs, the inclusion of worry dolls requires further consideration, as discussed below.

2.4. Cultural Considerations

Through the interviews, the need for greater understanding of cultural difference was raised. The use of worry dolls was concerning for two interviewees and reportedly some young people. Also, there were general assumptions around mental health of unaccompanied asylum-seeking children, highlighting a need to normalise mental health. Furthermore, it was suggested that staff require further training to have a better understanding of migrants' journeys to the UK.

Worry Dolls

It was noted that the initial group of young people chose the sleep pack items and anecdotally within the interviews, examples were given of these being beneficial for putting worries to one side at night. However, two interviewees raised concerns that there can be cultural connotations linking to voodoo dolls.

> *'The young people were wary about using the worry doll as some didn't like it, I am not sure if they felt it represented something else…The dolls are quite small, being from a cultural background they might think they represent voodoo, but not sure and that is my view being from a cultural background. Coming from my background where a doll has the connotation of voodoo, it's a bit wary and a lot are coming over and people are thinking they are being radicalised so it's weird for them to have'* (Interview 13, Psychologist).

In response to concerns raised, the cross-cultural team that funded the sleep packs replaced these dolls with stress balls.

The Mythology of Unaccompanied Asylum-seeking Children and PTSD

Considering the delivery of the intervention, mental health can be:

> *'the taboo issue, some young people respond 'I'm not crazy', I hear it a lot, a general barrier to accessing mental health support, but making it fun, informal and normal helps'* (Interview 1, Paid Social Care Staff).

This project broached the issues of health and wellbeing informally and through group sessions aimed at being fun:

> *'There is the myth that anything to do with UASC and sleep is PTSD so reducing the mythology around this cohort. Worry is an issue, they need to process the trauma, or there could be PTSD. They need the opportunity to normalise the symptoms of what they've just been through'* (Interview 2, Psychologist).

The sessions allowed the young people to talk through sleep issues, at a place that was convenient and familiar to them rather than in a medical room, and amongst peers. It was an opportunity to normalise experiences at an early intervention stage.

Understanding Journeys to the UK

The interviews raised issues of the level of cultural awareness of staff:

> *'Staff don't seem to have that cultural awareness of peoples' journeys. The young people were expected to get up and get on, and start the regime of daytime activities in the reception centre. There needs to be more cultural understanding'* (Interview 9, Manager).

So, the message is it takes time for sleep to adjust considering the journeys experienced. This lack of understanding shifted towards possible stigma for one interviewee:

> *'There is something about stigma here, of being thought lazy, unengaging and an economic migrant, particularly because these are boys between 16 and 17 and not the babies on the boats in the Mediterranean'* (Interview 17, Manager).

2.5. Challenges for Practitioners and Young People

Misunderstandings and Safeguarding Concerns

At the start of the project, there appeared to be a lack of understanding amongst practitioners as to what the young people were experiencing in relation to their health, psychological and emotional state. Some practitioners ascribed their '*lethargic*' state and '*depressed*' mood to symptoms of '*trauma and depression'*. The Project Lead of the sleep intervention, in her capacity as a systemic psychotherapist, was receiving referrals of young people and as she explored and enquired further into their '*lethargic*' and '*depressed*' state, it was discovered that these conditions were predominantly due to a lack of good sleep.

> *'We were hearing these people were quite lethargic and depressed and unable to concentrate in the day. KCC (Kent County Council) was pouring in resources in the day, such as nurses talking about sexual health, advisors giving asylum information etc., people thought it was depression and trauma…We realised the boys were nocturnal, there was a need to reverse body clocks, and we were getting anecdotal stories of the boys covering up light bulbs with towels, not wanting to sleep in the dark'* (Interview 12, Health Professional).

The Sleep Project provided staff with the knowledge that contextualised the young people's actions of, for example, sleeping together in one room, being nocturnal and covering the lights with towels. These actions could be described as signs and consequences of pre-flight, flight, and post-flight experiences (Bronstein and Montgomery, 2011).

> *'They were on their own from 10pm at night so we didn't know what was going on and the staff would go in in the mornings, finding them asleep altogether. Initially this gave safeguarding concerns…and there was mistrust, questioning if they were doing odd things at night, why did they sleep together, with lights covered up, sleeping on top of each other…*

then this unravelled to this is how they sleep and safety in numbers was not understood before…' (Interview 12, Health Professional).

Through the Sleep Project, practitioners gained a comprehensive understanding as to why the young people were not used to being awake at 9.30am when practitioners asked them to have an early start for meetings and English classes. It was felt that staff had previously been contributing to the young people's sleep deprivation in urging them to be ready for this time.

Also, there was a noted expectation that the young people would quickly start fitting in with the timetable of the reception centres now that they were in a place of safety:

'…they were sleeping in packs, and they needed to fit into the sleeping and daytime regime of the reception centres' (Interview 9, Manager).

'...I don't think there was an understanding that sleep was the problem…The young people were distressed, because people/staff start expecting them to think 'you are safe now, you are in a comfortable place now so you should be able to sleep okay'…It's a shift from the view staff had of 'we give them a few days and they will bounce back, back to business as usual' but now there is more understanding that such issues may linger and ways to support them…' (Interview 15, Manager).

The Sleep Project involved increasing the understanding of teaching staff:

*'…school was not understanding their nocturnal sleeping pattern' (*Interview 5, Health Professional).

'The reception centre staff were holding a high level of risk, [Project Lead] was almost in a managerial role as a problem solver…so, there was a love for the project, the expertise and safety brought to a difficult situation' (Interview 17, Manager).

Trusting Relationships

'*…because of apprehension….it can sort of take time to build trust with them (the young people)*' (Interview 10, Social Worker).

The initial staff misunderstandings about the night time sleeping arrangements could have created further barriers to developing trusting relationships between practitioners and young people.

As the project developed, it seems that the depth of the trust within relationships of practitioners and the young people developed, assisted by informed caring conversations:

'…at first it was a struggle getting people to realise specific concerns with the young people, who had previously been thought of as healthy young boys … AD's work face-to-face in the reception centres, showed we didn't know because we hadn't asked' (Interview 12, Health Professional).

Through this project, the young people were asked about the impact of their experiences on their sleep.

Lack of Supervision

Unaccompanied asylum-seeking children are often placed within accommodation without 24 hour supervision and support. The young people referred to in this evaluation were placed in accommodation where there was just a security guard at night.

> *'…the structure of the centre is not residential as such, the social workers leave at 10 and security takes over from there'* (Interview 15, Manager).

This arrangement can make applying the sleep tools problematic if those around the young person are also struggling with sleep.

> *'…when they are in the reception centre where there is no space, there is logistic problems of being in a room with someone that is noisy…At the reception centres the staff finish at 10pm so the young people would come alive at those times'* (Interview 10, Social Worker).

Commitment of Young People to the Project

Whilst the interviewees were very positive about the impact of the Sleep Project on improving sleep, it was noted that the young people needed to be committed to improving their own sleep for it to be successful. For a few young people, the intervention did not show an improvement in sleep:

> *'Some would try and follow it, some would not bother trying and say that doesn't work, 'well I tried it one night, it didn't work, I didn't go to sleep.' You have to get them to understand that their clock needs adjusting over a period of time and can't be expected to adjust itself after a night as it would take time to reset as it took time to be out of sync - you have to encourage them'* (Interview 10, Social Worker).

Language and Communication

Language and communication were additional practical challenges faced in the implementation of the Sleep Project. Challenges included issues of trust and the practicalities of arranging interpreters.

> *'For staff the limitation is language and trusting the interpreters, so that was our biggest limitations'* (Interview 13, Psychologist).

> *'The only barrier is communication, as most of them do not speak English we have interpreters otherwise'* (Interview 14, Social Worker).

Vostanis (2007) recommends a collaborative approach with interpreters; consideration should be given to issues, such as booking an interpreter from the appropriate ethnicity, dialect, gender, and where appropriate, using the same interpreter at each appointment to enable consistency. These considerations can improve relationships and communication.

2.6. Sustainability of the Sleep Project

'…will the legacy carry on? Not sure' (Interview 5, Health Professional).

Five interviewees raised concern over the legacy of the project, questioning whether the positive outcomes would continue to support the health and wellbeing of UASC, hoping the network meetings continue:

> *'…It would be a shame if it stops, it's like we would be going backwards if it does'* (Interview 16, Social Worker).

One interviewee emphasised the need for a strategy to keep the project alive and information disseminating:

> '*it's about looking and planning for post project and turning outcomes into a business as usual tool, that it becomes normal to offer this support, to include it in training….it could be something that is built in a bit more formally*' (Interview 3, Health Professional).

One interviewee made the point that, although there should be a legacy from this project,

> *'… we need to remember that culturally they (the young people) might need something different'* (Interview 13, Psychologist).

So, needs change with time and culture.

> *'We usually commission across services nationally – the way they (the young people) see mental health is different, different backgrounds, they need a service accessible to them'* (Interview 3, Social Worker).

This was a time-bounded project, a unique opportunity to address the specific needs of UASC directly with the young people. Funding was limited; there was an initial difficulty producing the sleep packs and finding the transport costs for the young people to travel to the appointments and sleep education sessions. The sleep packs were funded eventually through a charity.

Interviewees agreed that the project was beneficial for the young people, that it was not expensive support and ultimately saved money and resources through providing young people with early intervention strategies and self-help skills that they can call upon at any point in their lives. However,

> *'… unfortunately it comes to the money'* (Interview 10, Social Worker).
>
> *'… we get a good project, even though it's good, or gets reviewed, it doesn't continue due to funding'* (Interview 8, Social Worker).

There was a clear sense of achievement of the project but also that it would have been beneficial to continue.

> *'How to take forward after March – the main challenge is the need for training to continue and for understanding to keep evolving and to keep reminding people of it. It's tricky with a one year project – the sustainability of a one year transformation'* (Interview 2, Psychologist).

In planning for post project and for sharing findings of the health needs assessment both locally and nationally, there have been conference presentations by the Project Lead. Three months after these interviews (March 2017), the Project Lead reported that the project came to an end and this work has been absorbed into the mainstream work of CAMHS Children in Care Team. The Sleep Project intervention was viewed as part of an early intervention strategy rather than the specific tiered work of CAMHS.

Sleep Packs are still being issued at the time of writing this report, being given by the Refugee Council to children and young people on their arrival, however the follow up work that encourages them to consider the supportive nature of the items in the packs and the conversations this triggers may be lacking.

Training

> *'I think it's thinking a bit more innovatively about the care we can provide'* (Interview 13).

Five interviewees discussed the need for training to continue and to share knowledge across the professions:

> *'A specific training programme to help us do the basics well'* (Interview 2, Psychologist).
>
> *'training means staff are better prepared for a young person to go to them and to be ready to respond…makes professional lives so much easier'* (Interview 1, Paid Social Care Staff).

This would require revisiting as the unaccompanied asylum-seeking child population in Kent fluctuates and staff turnover fluctuates accordingly.

Dispersal of UASC

> *'I would hate to see someone saying the demand is not there now as it can be dealt with by the county they are in….The number of people coming in the county reducing doesn't mean the programme goes because there isn't demand there for it anymore'* (Interview 10, Social Worker).

There is a need to continue sharing good practice within and outside Kent, to keep sleep on the agenda and as a topic that practitioners question when supporting young people:

> *'The challenge is getting the message to the new local authority areas where the children are being dispersed'* (Interview 17, Manager).

Interviewees highlighted the importance of young people being given the opportunity to discuss their sleep.

2.7. Transferability of the Sleep Intervention

Regarding the transferability of the intervention, it was highlighted through the interviews that '*because sleep is important…. it would be amazing if it can be used in other arenas as well'* (Interview 12, Health Professional). Firstly, the intervention could be expanded to reach UASC in other settings such as foster care:

> *'… we need to take the message to where the child is placed…we need to deliver the knowledge, to get the information to grow'* (Interview 17, Manager).
>
> *'There is lots that can be done for these boys, but it's in small pockets'* (Interview 18, Volunteer Teacher).

Initially it has been easier to access and give direct support to UASC within the reception centres. With dispersal, the knowledge and skills and self-help strategies need to follow the young people to where they are placed.

Looking broadly, there are many service user groups within care settings experiencing poor sleep patterns. One participant noted:

> *'I would like to see it rolled-out for UK-born children, particularly for groups that have experienced domestic violence and trauma which usually occurs at night'* (Interview 12, Health Professional).

3. Conclusions

'…it has been positive and reaffirming' (interview 13, Psychologist)

'…a fantastic team and worthwhile' (Interview 6, Volunteer Teacher)

Initially, this project was introduced as part of the wider UASC Emotional Health and Wellbeing Project to ascertain the needs of the young people and to reduce the number of referrals to mental health services. Findings from the evaluation study suggest that the Sleep Project was a successful intervention, perceived positively by all the practitioners interviewed. They felt that it had resulted in significant change, improving the sleep for the young people, and ultimately their general health and wellbeing. One practitioner who delivered the workshops reported that their sleep had also improved. The success of this intervention is also indicated through the project team's evaluation with the young people, who reportedly stood up clapping and thanking the project team.

The Sleep Project developed through initially finding out about the needs of the young people directly from the young people themselves and through listening to the practitioners' difficulties and concerns from working with the young people. Part of the success of the project seems to be due to the co-production approach taken, highlighting the importance of involving the young people and practitioners.

Delivery of the project was through individual support and group work. The individual support would have allowed the young people to have time set aside to discuss their issues and the group work allowed the normalisation of talking about sleep and mental health and peer support. It possibly added to the young people feeling valued and listened to.

The status of the Project Lead as a systemic psychotherapist was significant for some practitioners in that this signified the importance given to the project. The Project Lead also gave a sense of safety to practitioners who felt they had been holding a high degree of risk; they could now have direct support with their decision-making. From having safeguarding concerns, practitioners moved to a place of greater understanding of the context of the young peoples' sleep difficulties. Practitioners also noted that as the project progressed, it became easier to work with the young people and behaviour became less challenging; the project may have primarily focused on healthy living however more trusting relationships may have developed through the attention, greater understanding and care available. As the key driver to this project was the Project Lead, there are challenges for the sustainability of this intervention, as to who will drive this in the future.

According to the interviewees, the Sleep Project was informative and empowering for both practitioners and the young people. The practitioners developed confidence in their own abilities to deliver direct support to the young people, whilst the young people were learning self-help tools that they can also draw upon in the future. Based on the evidence provided, this reduced the number of referrals to CAMHS. Long term, the intervention could support the young people to be more resilient and self-sufficient.

'Context switched concepts' is an important outcome from the intervention. Seemingly, several practitioners' noted changing perceptions from considering the young people in a stereotypical way, stigmatising the young people as lazy and ungrateful for the available support, to having a greater understanding of the impact of journeys of migration on health and wellbeing. It was noted that it was, and would be, beneficial for teachers to have training to develop this understanding of the

context and implications of forced migration so as to be more empathetic in the classroom.

The Sleep Project challenged the assumption that the young people were more than likely suffering from post-traumatic stress disorder that required medical intervention. It encouraged practitioners to see disrupted sleep patterns and lack of sleep as giving rise to a set of symptoms that can initially be confused with PTSD and it may be best to start by considering sleep.

The sleep packs were perceived as beneficial for good sleep. They were a medium to introduce innovative work, not perfect, there was noted discomfort with the worry dolls, yet a means to initiate a conversation.

The field of migration is fast-changing and complex. The opportunity to work interprofessionally improved decision-making and communication, through the network meetings and the professional relationships that grew from this project. Practitioners appreciated having direct support from mental health professionals.

Overall, it was noted that the young people gained more sleep after the intervention, attended more educational opportunities and promoted the sleep packs to other young people, thus reinforcing the value of and engagement with the intervention. It seems that the sleep intervention improved a wide range of aspects of the young peoples' lives, helping them to engage more fully into activities.

4. Recommendations

The evaluation study could be enhanced if the voices of the young people were captured by independent researchers in order to understand better their perceptions and experiences of support as UASC in Kent. This was deemed difficult due to the complexities of conducting time-limited research with a vulnerable group. Also, the Sleep Project ran in conjunction with three other projects (Nutrition and Refeeding, Trauma and Bilateral Movement, Hope and Aspiration). Aspects of these other projects could also have aided improved sleep and well-being of young people and could have contributed to changes in practices. Therefore, a significant suggestion is that future intervention projects can benefit from embedding independent evaluation from the start of the project, which will involve all relevant stakeholders.

Nonetheless, findings from the evaluation study lead to the following recommendations:

- Support for continuity of current practice in relation to the Sleep Project and follow up of the young people to where they are dispersed.
- Good practice issues, highlighted in the evaluation, are considered for UASC in other settings, such as in foster care.
- Ongoing training for practitioners working with UASC, e.g. teachers, looking at the importance of sleep, the tools from the Sleep Project and cultural competency.
- Training of General Practitioners in relation to sleep issues in UASC, thus reducing the first response of medical interventions. This can also help GPs when assessing young people, as they can then elaborate further and deeper in relation to sleep issues.
- Findings from this report to inform standard practice; making it 'business as usual' so to

embed it as normal/ formal practice for staff working with UASC. For example, this could take place within assessment of young people.

- A holistic care approach, as seen in the evaluation findings, appears to be cost effective and beneficial.

- Working in partnership with young people and practitioners improves the outcomes of such an intervention and an action research approach is beneficial for empowering both practitioners and young people. The project was successful as it developed through regular discussions with people at the frontline asking what they needed for support. The Project Lead's psychological model gave a structure to the work.

- Interprofessional working usually promotes better communication and efficiency for decision-making in practice.

- Good accessibility to advice from the mental health services is beneficial, rather than long referral processes. Linked to this is the practitioners noted the young people had been able to get support within a less medicalised setting.

- This was a time-bounded project and there seems to be a reluctance to set aside future funding for one specific group of young people, with a preference to fund projects that can be beneficial to all children in care. Arguably, all children in care can benefit from the findings of this project – practical ways to support good sleep, ways to start those conversations with the young people, and ways to give the frontline practitioners the tools to support – however, it is also argued that unaccompanied asylum-seeking children do have very specific needs having experienced the trauma of migration and loss and now requiring skills and support to integrate into a new culture and country whilst processing their loss.

- There will be other groups of service users to whom the findings and a sleep intervention may be beneficial, such as for service users in other residential settings or children who have experienced domestic abuse. This requires further exploration.

Key Messages

- ***'I think it's thinking a bit more innovatively about the care we can provide'***
- ***'A confidence to look at the basics'***
- ***'Context switched concepts'***

The Legacy

The legacy to the Sleep Project is to embed the findings for good practice into expected standards for working with unaccompanied asylum-seeking children, through training and including sleep as part of the initial assessments with the young people, opening up the conversations whilst equipping practitioners to manage such conversations and sleep tools themselves at the frontline. Furthermore, the success of the Sleep Project should be celebrated and information disseminated widely. This is the start of embedding even better quality care.

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APPENDIX 1: Intervention Resources and Documents

At the onset of the evaluation, resources and intervention documents were sent to the research team from the Project Lead. These formed the foundations and noted the direction of the Sleep Project:

The BEARS Sleep Screening Tool (Mindell, J & Owens, J (2003) *A Clinical Guide to Pediatric Sleep Diagnosis and Management of Sleep Problems,* Lippincott, Williams and Wilkins) is a simple tool used for screening for major sleep disorders in children aged 2-18yrs. It consists of five domains (bedtime problems; excessive daytime sleepiness; awakenings during the night; regularity and duration of sleep; snoring), each with age appropriate trigger questions for clinical interviews.

UASC Clinical Network: Vision and Strategy (Draper, A., Feb 2016)
This sets out the purpose and vision of the network: to manage an operational model 'Kent county wide', managing emotional health and wellbeing of UASC. The aim was to keep UASC at the centre of the network and to take a holistic approach to health and wellbeing. Self-management by UASC was important from the start, as was collaborative working. The importance of early identification of need is noted, with the development of a screening tool. This report discusses the efficient use of clinical resources, the dangers of over-diagnosing PTSD (Post Traumatic Stress Disorder), with early intervention being the way forward. It notes the impact of bereavement on young people in general and looks long-term to costs of healthcare. Attached to this report is the job specification for the Project Lead role.

A UASC Story (compiled by Ana Draper and Young People, April 2016)
This is two pages covering themes of similarity but difference between the young people, highlighting the difference of their journeys but also the similarities. This story refers to fear, safety, refuge and breaking the myths and stereotypes of being UASC (such as wanting to learn to earn and contribute to the economy). Two significant quotes are:
'My loss is never gone, it is in my breath, in my eyes, in my steps' – linking to the young people needing to learn interventions for self-support that they can fall back on throughout their lives as the loss does not disappear.
'Today I am held and I hold you by sharing my steps to success' – raising ideas of shared support, need for respect and care, with a sense of obligation and gratefulness.

Draper, A. (2016) BACCH Report within BACCH News – Special Edition, The Quarterly Newsletter of the British Association for Community Child Health, Oct 2016, p18-19.
Dr. Draper has an article in this newsletter, looking at the need for a resilience model and early intervention to enable resilience. The ethos should be 'caring vigilance'. PTSD is the expectation, 'the catch all compartmentalising diagnosis' whereas young people are exhausted on arrival and often malnourished. The UASC experience leads to hypervigilance as the young people have had to 'focus on immediate survival' (p19). Draper argues that the young people display sleep issues but these are not necessarily a symptom of PTSD. She calls for a wait, watch and see approach, rather than referring for trauma work and over-diagnosing as suffering from PTSD. The four areas of early intervention are: sleep; nutrition and refeeding; trauma and bilateral movement; hope and aspiration. By providing support with sleep, this is 'equipping the child with a stable place from which to work'.

Draper, A. (Date Unknown) UASC: An Action Research Project

This discusses the participatory action research approach to the Sleep Project: it was important to understand from the UASC perspective what they needed, to take time to listen and witness the dilemmas of the staff and young people, and then to plan, act, observe and reflect. The project aimed to be humanistic and collaborative, exploring emergent meaning, 'to formulate an immediate orientation to the past and current circumstances in relation to sleep'. Draper states the need 'to inoculate against natural resilience being compromised' and highlights the protectors to resilience: knowledge and effective strategies; own strengths and resources; support through health promotion activities. On arrival, the young people were demonstrating an 'intense form of jet lag' – there is a list of symptoms. The aims of the sleep presentations to the young people were to help the young people: gain better sleep, achieve more, look good, feel good, and have more energy. The key messages that the young people noted as having learnt through the presentations were to avoid stimulants, technology, emotionally upsetting conversations and big meals just prior to bedtime, eat healthy, let go of worries, think happy memories (smells, colours and thoughts), avoid day-napping and the importance of daytime light.

Script/Podcast

This script, written by Dr. Ana Draper with the young people, is now a podcast. It explores: journeys to safety and protection; tiredness and the impact on memory, concentration and learning; feelings due to tiredness, such as feeling irritable, clumsy and at times, aggressive; hopes and dreams; anxiety of what has been and what will be; and worry dolls as a way of holding others as well as being held. The script opens up discussions, encouraging young people to talk about good memories, such as picnics and days with friends in mountains picking fresh food.

UASC Update: Corporate Parenting Panel (23 September 2016)

This provides the backdrop to the situation in Kent prior and since dispersal from a local authority perspective. In 2015, there were 95 UASC referrals in Kent – an unprecedented increase in number. Numbers have become more manageable with government and other local authority support, so Kent social work teams are moving beyond compliance (*i.e. the legal minimum of care required*) to quality work of supporting this highly vulnerable group of Children in Care (*The Sleep Project is not specifically mentioned in this report).*

Draper, A., Clinical Audit Report (12th October 2016)

This report covers the 3 month period, 1st July – 30th Sept 16. During this 3 months, 83% of UASC reported disordered sleep. Of those who received sleep intervention, 92% reported improvement, with a reduction in symptoms on the BEARS tool. By the end of this period, the majority still reported not feeling they get enough sleep. This report does not note how many screenings took place or the number that participated in the sleep intervention.

APPENDIX 2: Interview Questions

Interview Guide

1. **Background Information –**

    - Educational and professional background/qualifications
    - Work experience/length of service

2. **Experience with the Sleep Project –**

    Prompt questions (will not ask about individual stories but only experiences of young people as a group according to interviewee):

    - Tell me about the sleep intervention; how and when did it take place; for how long; how many staff took part in it; how did the different agencies and professionals work together for the young people?
    - Young people's needs – as a group - before the intervention?
    - What were the young people's reactions – as a group - to the Sleep Project?
    - How were the young people involved in the intervention?

3. **Impact –**

    - Has the Sleep Project had any impact on interprofessional working in your opinion? Implications on staff attitudes?

4. **Benefits –**

    - What have the young people gained from the Sleep Project?
    - What have you and the staff team gained (if anything?) from the Sleep Project intervention? What are the benefits of the Sleep Project for young people?

5. **Barriers/Challenges –**

    - What were the barriers/challenges for implementing the Sleep Project?

6. **Additional Support –**

    - What other support would you like to see take place? For staff? For young people?
    - What would you like to see as the next step for supporting UASC?