March 2024 | Report

A randomised controlled trial of

MY VIEW

A therapeutic intervention for unaccompanied asylum-seeking children

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Acknowledgments

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ACRONYMS, ABBREVIATIONS & GLOSSARY

Abbreviation / acronym / term	Description
CAMHS	Child and Adolescent Mental Health Services
DfE	Department for Education
ESOL	English for Speakers of Other Languages
GAD-7	Generalised Anxiety Disorder Assessment
IPE	Implementation and process evaluation
MDES	Minimum detectable effect size
OSF	Open Science Framework
PHQ-9	Patient Health Questionnaire-9
PSSRU	Personal Social Services Research Unit
PTSD	Post-traumatic stress disorder
RCT	Randomised Controlled Trial
SWEMWBS	Short Warwick Edinburgh Mental Well-being Scale
UASC	Unaccompanied asylum-seeking children
WWCSC	What Works for Children's Social Care
YP-CORE	Young Person's Clinical Outcomes in Routine Evaluation
Heteroscedasticity	When the standard deviations of a predicted variable, monitored over different values of an independent variable or as related to prior time periods, are non-constant.

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EXECUTIVE SUMMARY

Introduction

Young refugees and unaccompanied children often experience stressors at multiple stages. In their home countries, they have often experienced multiple or prolonged traumatic events, such as war, conflict, persecution, violence, displacement, and/or separation from family. Many then face dangerous journeys and are confronted with additional stressors due to acculturation challenges and uncertainty when seeking refugee status, a safe place to live, and access to support services. In the UK, unaccompanied children can experience a 'hostile environment' for migrants including delays in the asylum process, age assessments and disputes, and detention centres.

Multiple systematic reviews have demonstrated that research studies consistently find that young refugees and unaccompanied children are at a higher risk of experiencing mental health problems, most commonly post-traumatic stress disorder (PTSD), depression, and anxiety. However, studies conducted in the UK reflect the wider literature whereby many unaccompanied children are coping with trauma but fall through the gaps of mental health provision, or the provision offered lacks the necessary sensitivity to their circumstances or fails to address mistrust and stigma.

The Refugee Council developed the My View programme in 2015. My View is a specialist therapeutic service for children and young people aged 12–17 years who are in the UK without their parents or guardians, and who are refugees or seeking asylum.

Despite the clear evidence on the need for mental health support among unaccompanied children and the issues relating to current services not meeting the needs sufficiently, there is a notable gap in empirical evidence on the effectiveness of therapeutic services and interventions for unaccompanied children. An internal evaluation of My View provided valuable insights on the feasibility of implementing My View and evidence of promise in terms of its potential for positive impact. However, the evaluation collected limited quantitative data on outcomes, and, without a control group, it was not possible to conclude whether the improvements reported would have happened anyway given time for young people to settle and/or have their asylum granted. This evaluation was designed to overcome these limitations and to add to the evidence base on My View and therapeutic interventions for unaccompanied children more generally.

Methods

The evaluation sought to assess the effectiveness, implementation, and costs of My View. To do so, the evaluation included three components. First, the impact evaluation involved a randomised controlled trial (RCT) to assess the impact of My View on participants' psychological distress (as measured by Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE)) and mental wellbeing (as measured by the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS)) compared to a waitlist control group. Second, an implementation and process evaluation (IPE)

captured the views and experiences of the staff delivering and the young people attending My View, as well as the views of wider stakeholders such as social workers, foster carers, and accommodation managers. Third, the cost analysis explored the costs associated with delivering My View, including estimated costs per child.

The evaluation collected data from June 2021 to July 2023. The evaluation was originally planned to end in summer 2022 but it was extended twice to increase the number of participants. In total, the evaluation included randomising 510 young people, analysing endline outcome data for 289 young people, and conducting 66 interviews with young people, staff, and stakeholders.

Findings

1. Most young people had not accessed support elsewhere – due to lack of options and/or waiting lists – which demonstrated the need and demand.
2. My View significantly reduced psychological distress, as measured by the YP-CORE, among young people. The estimated impact of My View was equal to a decrease of 7 points (-7.07, p-value < 0.000) on the YP-CORE in the intervention group compared to the control group (Glass's Delta effect of -0.88). Furthermore, at baseline, the average score in the intervention group was 21.67, which was well over the proposed clinical cut-off for this group of 14.1 (scores can range from 0–40). As such, these findings suggested My View shifted young people much closer to non-clinical scores.
3. The evaluation also found that young people who received My View had significantly better wellbeing, as measured by the SWEMWBS, compared to young people who had not received My View. The estimated impact of My View was equal to an increase of 3 points (3.08, p-value = 0.000) on the SWEMWBS in the intervention group compared to the control group (Glass's Delta effect of 0.65). The SWEMWBS runs opposite to the YP-CORE in measuring mental wellbeing, meaning a higher score is associated with better mental wellbeing.
4. The impact findings were supported by evidence in interviews. Young people and stakeholders described how My View helped improve their mood, hopes for the future, sleep and eating habits, and ability to manage their emotions, among others.
5. Surprisingly, even a small number of sessions (one to three) appeared to make a positive difference, though the optimal number of sessions appeared to be between seven and nine sessions. However, it was not possible to test the maintenance of the effects due to the waitlist control group design.
6. Most young people attended therapy remotely or through a mix of remote and face-to-face sessions. This suggests that remote delivery is not only feasible but effective in improving outcomes for young people.
7. The addition of a case worker helped support young people with practical issues alongside therapy. It also helped improve therapists' capacity.
8. Regular supervision, check-ins, safeguarding meetings and peer supervision were key to supporting My View therapists and staff in their roles. This supports staff in their practice

while also providing them with autonomy to tailor their expertise and skills with young people.

9. Large numbers of young people disengaged or dropped out of the intervention early. In most cases, this was because they were feeling better; however, others were for less positive reasons – for example struggling to focus on therapy while simultaneously dealing with their asylum claim and housing and education needs. Another issue appeared when referrals were made on behalf of the young person without their knowledge.

Discussion

Overall, the evaluation provided an important contribution to the evidence base that calls for more specialist therapeutic provision for unaccompanied children. It is important to recognise that very few RCTs have been conducted with this group, and this evaluation therefore highlighted a number of practical, ethical, and methodological considerations.

Overall, some of the key recommendations from this evaluation included:

- **The Refugee Council should continue to deliver My View.** This evaluation provides confidence that it results in improved outcomes for children and young people, relative to receiving care-as-usual and a small number of non-therapeutic check-ins.
- **A stable funding stream for the provision of specialist mental health support for unaccompanied children and young people is needed.** The Refugee Council and evaluation experienced periods of instability as a result of uncertainty around funding, but this issue persisted before the evaluation and will continue to be a concern for those delivering these services.
- **Organisations delivering these services should pay careful attention to stable leadership and staffing**, and this should be a consideration for future evaluation as well. Staff changes have trickle-down effects on the wider team and can result in miscommunication and low morale.
- **It will be beneficial to see the findings of this trial replicated.** A number of limitations mean that the findings should be considered with some caution. For example, collecting baseline data prior to randomisation would strengthen future evaluations and should be implemented where feasible. Future evaluations should also prioritise more objective options for administering outcome measures as the current evaluation relied on therapists to administer measures. This would help overcome concerns around the independence of data collection and reduce burden on delivery staff.
- To further explore implementation effectiveness, **a ‘Hybrid 2’ trial would be a valuable addition**. A hybrid trial type 2 is a type of effectiveness-implementation trial which simultaneously determines the effectiveness of an intervention and tests hypotheses regarding one or more implementation strategies. Specifically, this would enable us to explore differences in outcomes for young people based on elements of implementation such as:
    - Number of sessions

- In person vs online
- Group vs one-to-one.

1. INTRODUCTION

The Refugee Council developed the My View programme in 2015, which provides a specialist mental health service for refugee children and young people who arrive in the United Kingdom (UK) on their own.[1] This report details the findings of an evaluation that was conducted between 2021 and 2023 to assess the implementation, effectiveness, and costs of My View, primarily its one-to-one therapeutic support.

This chapter provides an overview of the My View programme, including its context, rationale, intervention model, and intended outcomes, and the overarching evaluation aims and research questions.

Context and rationale for My View

The formal definition of an unaccompanied asylum-seeking child (UASC) in the UK is "a person who is under 18 when the asylum application is submitted, is applying for asylum in their own right, and is separated from both parents and is not being cared for by an adult who in law or by custom has responsibility to do so" (Home Office, 2016).[2] In the ten-year period leading up to the start of My View and through the evaluation, the number of asylum applications by UASC in the UK has increased substantively (see figure 1). Most applications come from those aged 14 to 17 years old, with over 70% of applications since 2017 submitted by 16–17-year-olds. Most unaccompanied children are male (95% of applicants in 2022). On average, UASC represent around 8–9% of all asylum applications.

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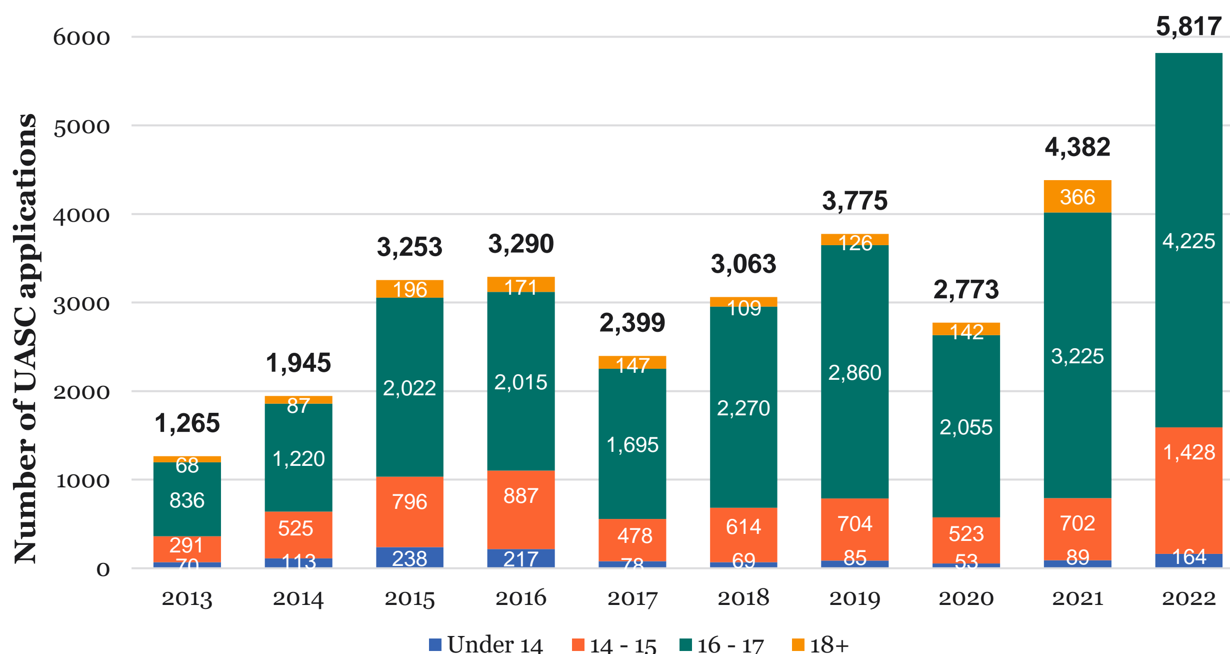
1 There are multiple terms used to describe this group of children and young people, including unaccompanied asylum-seeking children, unaccompanied refugee minors, separated children and young people, and child or young refugees. This report primarily uses unaccompanied children or simply child or young person when referring to the views of interviewees.

2 See Paragraph 352ZD of the UK Immigration Rules: https://www.gov.uk/guidance/immigration-rules/immigration-rules-part-11-asylum#:~:text=352ZD%20An%20unaccompanied%20asylum%20seeking,in%20their%20own%20right%3B%20and

Figure 1. Number of UASC applications for asylum from 2013–2022



Source: Immigration system statistics (Home Office, 2023)

Young refugees and unaccompanied children often experience stressors over multiple stages: (1) anticipation when sensing impending danger; (2) adverse events pre-journey while in their country of origin; (3) uncertainty during and after their journey to safety; and (4) resettlement and adjustment in a new country (Papadopoulos, 2001; Fazel & Stein, 2002; Lustig et al., 2004). In their home countries, they have often experienced multiple or prolonged traumatic events, such as war, conflict, persecution, violence, displacement, and/or separation from family. Many then face dangerous journeys and are confronted with additional stressors due to acculturation challenges and uncertainty when seeking refugee status, a safe place to live, and access to support services.

Traumatic experiences can contribute to emotional dysregulation, impair social functioning, and increase the risk of psychological distress. Multiple systematic reviews have demonstrated that research studies consistently find that young refugees and unaccompanied children are at a higher risk of experiencing mental health problems, most commonly post-traumatic stress disorder (PTSD), depression, and anxiety (Fazel et al., 2005; Bronstein & Montgomery, 2011; Kien et al., 2019; Daniel-Calveras et al., 2022). Accompanying symptoms of psychological distress can include irritability, restlessness, sleep problems, somatic symptoms, and conduct disorders. The prevalence rates vary significantly across studies and depend on factors such as the nature of displacement, exposure to trauma and violence, and the quality of support received. However, there is evidence that characteristics such as being female, older, and unaccompanied are associated with poorer outcomes (Fazel et al., 2012; Bamford et al., 2021; Bronstein & Montgomery, 2011). Additionally, Bamford et al.'s (2021) rapid review found that depression and anxiety were associated with discrimination, limited language attainment, and daily hassles. In the UK, unaccompanied children

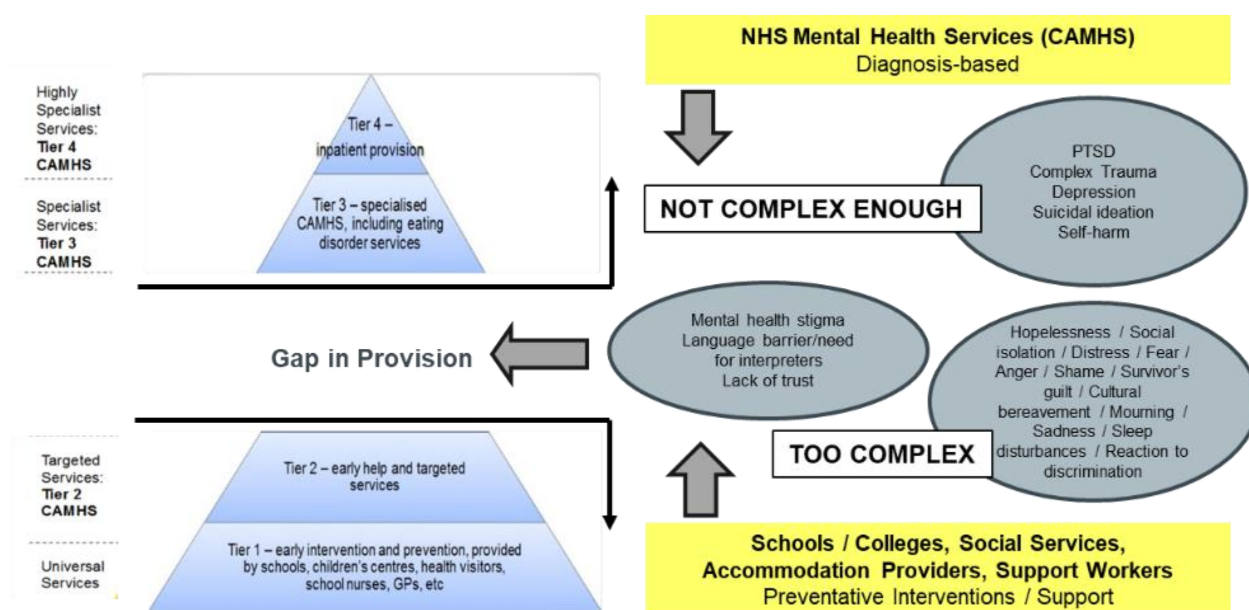
can experience a ‘hostile environment’ for migrants including delays in the asylum process, age assessments and disputes, and detention centres (Griffiths & Yeo, 2021).

The literature also highlights the importance of social support as a protective factor (e.g. Fazel et al. 2012; Daniel-Calveras et al., 2022) and calls for mental health provision to adapt to better facilitate unaccompanied children in accessing support (e.g. Hodes & Vostanis, 2019; Fazel, 2015). Despite high prevalence of mental health problems among unaccompanied children, rates of contact with mental health services are lower than expected for this group, and the key factors behind this are not well evidenced (Colucci et al., 2015). Ellis et al. (2011) categorised key barriers to accessing mental health support as: (1) distrust of authority and/or systems; (2) stigma of mental health services; (3) linguistic and cultural barriers; and (4) primacy and prioritisation of resettlement stressors. Each of these barriers is complex and multifaceted. For example, Majumder (2019) explored stigma and found three key themes, including negative perceptions of mental illness (e.g. idea of ‘madness’), feared social consequences such as abandonment and rejection, and overall denial of having a mental health problem even when accessing mental health support. Zijlstra et al. (2019) also found that poor therapist understanding of their situation contributed to dissatisfaction and disengagement with the support. Further issues relate to accessibility, working with interpreters, and continuity of care between different services, such as coordination and communication for subsequent referrals (Colucci et al., 2015). Social support around the young person can be key to accessing mental health provision – for example, Ellis et al. (2010) found that family, religious leaders, friends, and schools were often gateways to help. Davies Hayon and Oates (2019) recommended that mental health services should be available in the spaces commonly used by unaccompanied children, such as schools and community centres.

Studies conducted in the UK reflect the wider literature whereby many unaccompanied children are coping with trauma but fall through the gaps of mental health provision, or the provision offered lacks the necessary sensitivity to their circumstances or fails to address mistrust and stigma (Davies Hayon & Oates, 2019). In some cases, they do not meet diagnosis requirements for Child and Adolescent Mental Health Services (CAMHS), but their needs are too complex for support provided through schools/colleges, children’s social care services, accommodation providers, and so on (see figure 2). UASC are entitled to the same local authority provision as any other looked after child (DfE, 2017), and social workers and GPs can play an important role in making referrals to mental health services.

Despite the clear evidence on the need for mental health support among unaccompanied children and the issues relating to current services not meeting their needs sufficiently, there is a notable gap in empirical evidence on the effectiveness of therapeutic services and interventions for unaccompanied children. Services are therefore delivered in the absence of a robust evidence base on what works for improving the mental health outcomes of this group. This can also cause challenges in securing funding for services. It was in this context that My View was developed and delivered, and the evaluation was designed and conducted.

Figure 2. Summary of the gap in provision for UASC



Source: Refugee Council presentation (8 April 2021)

Overview of My View

The My View programme[3] was developed by the Refugee Council. It was initially established as a one-year pilot project in May 2015 with funding from the Department for Education (DfE), which took place in London (Croydon). The programme was then expanded in 2016 through funding from the People's Postcode Lottery Dream Fund to other areas in the UK with My View offices, including Birmingham, Leeds, and Luton. It was further expanded in 2020 to include Kent, and delivery was moved online during the COVID-19 pandemic. In 2021, ahead of the current evaluation, the Refugee Council also introduced My View Remote for children and young people outside of these regions.

Target population

My View is a specialist therapeutic service for children and young people aged 12–17 years who are in the UK without their parents or guardians, and who are refugees or seeking asylum. This includes young people at any stage of their asylum claim, whether not yet made, pending, or any outcome (e.g. asylum granted or rejected, given temporary UASC leave, or given another form of legal status). As UASC, eligible young people are in the care of local authorities. Young people must

[3] See: https://www.refugeecouncil.org.uk/our-work/mental-health-support-for-refugees-and-asylum-seekers/mental-health-services-for-unaccompanied-children/

be under 18 at the time of referral, though referrals for those currently being age-assessed are also considered.

Referral process

The My View team receive professional referrals through: (1) established internal pathways such as the Refugee Council Children's Advice Project or from the Youth Development Team; (2) established external pathways such as children's social care services, the British Red Cross, or Kent Refugee Action Network; (3) raising awareness of the service following Refugee Council training delivered to professionals and/or stakeholder outreach. Equally, young people can self-refer, for example, after attending a psychoeducational workshop delivered by the Refugee Council and hearing about My View.

Referrals are made using a standard referral form available on the Refugee Council's website.[4] The referrer is asked to provide information such as the young person's name, age (and details of any age disputes), gender, languages spoken (and whether an interpreter is required), living arrangements, date of arrival in the UK and asylum status, and contact details, as well as their region and any preference for one-to-one or group sessions. The referrer is also asked to provide their contact information and contact details for the young person's social worker, foster carer, key worker, and/or GP. Finally, referrers need to provide brief reasons for the referral.

Referrals are assessed by project administrators to check eligibility. If eligible, details from the referral form are entered into the My View database. If not eligible, the My View team informs the referrer and signposts elsewhere.

Delivery mode

Prior to the COVID-19 pandemic, My View was typically delivered face-to-face from one of the Refugee Council service hubs in Birmingham, Kent, Leeds, or London. Sessions took place at their offices, outreach locations such as further education colleges and Reception Centres in Kent, or through forums provided by other service providers (e.g. British Red Cross youth groups). During the pandemic, My View moved to remote delivery with sessions held online through video calls or over the telephone. As a result, the Refugee Council introduced a remote version of My View that was open to young people outside the four regions, and many sessions continue to be delivered remotely across all regions.

Intervention activities

Figure 3 summarises the flow of intervention activities.

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4 See a version of the referral form here: https://www.refugeecouncil.org.uk/wp-content/uploads/2019/03/My-View-Referral-Form-November-2023.docx This has been updated since the end of the trial but includes similar content.

All eligible referrals are risk-assessed through a two-stage process. First, the My View administrative team reviews the reasons for referral provided in the referral forms and flags individuals as high risk where there are concerns, for example, relating to self-harm. Second, therapists meet with every young person during an initial assessment, which are expedited for those flagged as high risk, to explore their bio-psycho-social needs as well as any practical issues that may be exacerbating their difficulties (e.g. asylum claims). If the initial assessment confirms that the young person is in need of urgent need for therapeutic support, the My View team will offer up to three crisis intervention sessions so that young people do not have to wait. The crisis sessions include stabilisation through grounding, explanation of symptoms, and drawing on internal strengths. After these sessions, young people sometimes go on to receive additional therapeutic support, which can be one-to-one or in groups as described below. Equally, some young people initially flagged as high risk based on the referral form may not require the crisis intervention and will follow the process below.

Where referrals are not considered high risk, young people are put on the waitlist for their region until a therapist has capacity to take a new client, at which point they have the initial assessment meeting. In most cases, young people will then be offered one-to-one therapeutic counselling sessions. This is a programme of 12 sessions that last one hour each. These are typically set up to take place on a weekly basis; however, it is recognised that young people may miss appointments due to conflicting schedules (e.g. Home Office appointments, college timetable changes, social worker visits), religious practices (e.g. Ramadan), sleep disturbances, and other factors. As such, it often takes longer than 12 weeks to complete 12 sessions. Equally, the therapist and young person may collaboratively agree to end the intervention before 12 sessions are completed. In exceptional cases, this may be extended beyond 12 weeks.

The structure and content of the 12 sessions is outlined in appendix B. The first three sessions focus on building the therapeutic relationship, introducing breathing techniques and grounding exercises, and using creative exercises to draw out secondary narratives beyond victimhood. Sessions 4–6 include psychoeducation, exploring support networks, story-making and talking about everyday experiences, emotional responses, and coping mechanisms. Sessions 7–9 focus on the therapist bearing witness as the young person connects with memories of identity and culture, narrative therapy exercises focused on strength and coping ability, and linking changes in therapy to everyday life. Finally, sessions 10–12 involve reflecting on goals, processing the end of therapy, and celebrating the therapeutic relationship. Decisions for onward referrals are also discussed, including referrals to mainstream or longer-term specialist services.

Alternatively, young people can be offered group therapy sessions, which include between 6 and 12 young people per group.[5] The sessions are offered weekly and while attendance was known to vary (i.e. both regular and sporadic attendance among young people), groups provide an opportunity for young people to build peer-support networks. Each session is structured as follows: (1) ‘check-in’ – gauging energy and mood levels; (2) ‘warm-up’ activity to foster participation and engagement; (3)

5 This has since been revised to include three to eight young people per group.

'main activity' following similar content as the one-to-one sessions, either as a series of group exercises or one extended group activity; (4) 'debrief' to reflect or comment on activity; and (5) 'check-out' to close and reflect on any takeaway learning (see appendix B for more detail).

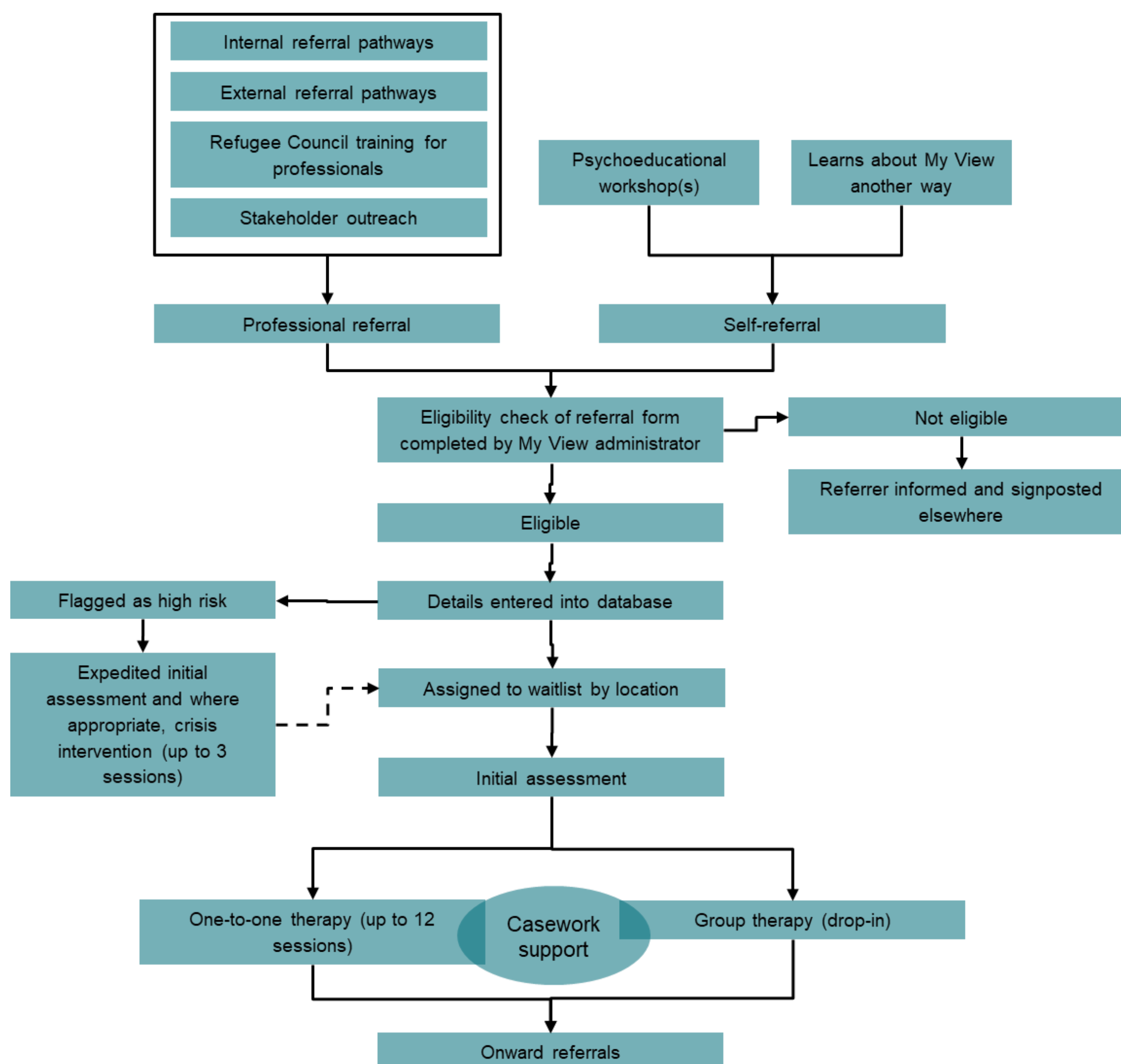
For both one-to-one or group sessions, therapists employ creative and play techniques and other activities that do not solely rely on spoken language to ensure the service is accessible to non-English speaking clients. For example, this includes drama therapy, art therapy, and music therapy.

Alongside all types of direct work outlined above, therapists undertake case work. This is in recognition that practical challenges with issues such as foster placements, housing, and asylum claims can exacerbate mental health issues. Case work includes communication with the young person's social worker, and where necessary, writing letters in support of their solicitor's legal position, responding to age disputes, and referring into other services, such as mainstream mental health assessments or education. Therapists also engage in informal clinical consultations with the young person's foster carer and/or social worker, where needed.

Finally, the My View programme also includes one-off group psychoeducational workshops involving interactive activities to raise awareness of and normalise mental health and symptoms (such as flashbacks and disturbed sleep), offer coping strategies, and signpost to further help. They are offered to organisations such as schools, colleges, reception centres, and youth groups. Young people attending any of the activities above might also attend a psychoeducational workshop, or they may have attended one prior to one-to-one or group therapy.

Ultimately, the focus of the evaluation was primarily the one-to-one therapy sessions (plus casework). While the group therapy sessions were in scope of the evaluation, this proved challenging in the context of the evaluation (discussed in chapters 3 and 4). In the light of detailed discussions during the set-up phase, it was agreed that the group psychoeducational workshops were out of scope of the evaluation as these were distinct one-off sessions run separately, including a different referral process compared to the other My View components.

Figure 3. Summary of My View components



Source: Developed using Refugee Council documentation

Delivery staff and interpreters

A team of therapists deliver My View, all of whom are Health & Care Professions Council (HCPC) or British Association for Counselling and Psychotherapy (BACP) registered. They come from various disciplines and backgrounds, for example, bringing expertise in dramatherapy, play therapy, counselling, integrative therapy, and/or art psychotherapy. Before working with My View clients, all therapists must attend five training sessions for My View, totalling approximately 14 hours. The training includes an overview the Refugee Council's trauma-informed Therapeutic Care Model, safeguarding, recordings of therapy sessions, monitoring and assessment procedures, and administrative processes (see appendix A for a detailed training schedule). Each therapist also receives external one-to-one clinical supervision for a minimum of one hour per month.

The overarching model that all My View therapists use is the trauma-informed Refugee Council Therapeutic Care Model. It takes a holistic, biopsychosocial approach to considering client needs. This recognises that practical challenges with issues such as foster placements, housing, and asylum claims can exacerbate mental health issues, which aligns with Maslow's (1943) hierarchy of needs. The Refugee Council team developed the model based on three core principles:

- **Therapeutic Relationship** – to create a safe and trusting environment to give young people a sense of safety, understanding, continuity, and transparency.
- **Bearing Witness** – to give young people a voice and a place where someone will listen, understand, bear witness to, and validate their experiences.
- **Psychoeducation** – to normalise mental health symptoms as an understandable response to abnormal events.

The model embraces the application of different therapeutic disciplines and emphasises the importance of being culturally sensitive and responsive to each individual's needs.

For the current project, the Refugee Council initially recruited eight therapists – one to provide virtual therapy, one each in Leeds and Birmingham, two in Kent, and three in London. The My View team also included a manager and administrative staff. There were multiple changes to the team during delivery, which is discussed in chapter 3.

In many cases, an interpreter is required during sessions. All interpreters used for My View sessions are therapeutically trained. Whenever possible, the same interpreter is used throughout the 12 sessions. Guided by its Good Practice Guidelines for Interpreters and Therapists Working Together, the Refugee Council sees interpreting as an integral part of services provided to clients with little or no English language. It is now widely accepted in the refugee therapy sector that whenever there is an interpreter present, there is a three-way relationship – the interpreter has a relationship with both the therapist and the client. The interpreter also has the potential to enhance the therapeutic work and relationship. For example, the familiarity of the interpreter's language and presence can be valuable when the therapist is from another culture. Interpreters are offered a bimonthly supervision group who regularly work within therapeutic services.

Intended outcomes

My View is a short-term intervention that aims to stabilise the psychological and emotional wellbeing of unaccompanied children. During the set-up phase of the evaluation, a logic model for the My View programme was developed (see figure 4), which summarises its theory of change, i.e. how the intervention is intended to achieve a set of outcomes. The My View team and evaluation team developed the logic model collaboratively through several workshops and iterations. It was expected that, if delivered as intended, young people who received My View would have:

- Improved psychological and emotional wellbeing
- Improved emotional self-regulation and ability to cope
- Improved social connection and reduced social isolation
- Improved confidence / self-image

- Improved aspirations / view of future
- Improved physical wellbeing
- Improved safety / reduced risk of harm
- Increased willingness / openness to seek support / engage with other services.

Through these outcomes, My View could contribute to the prevention of pathologies (i.e. clinical diagnoses), improved home and school stability, successful onward referrals to more intensive therapeutic intervention (dependent on waitlists) or education, and improved social integration. This could have cost savings for local authorities associated with placement and/or school changes as well as mental health and social care services.

Figure 4: My View logic model

Inputs

Staff expertise
- 8 child psychotherapists
- Therapeutic interpreters
- Administrative support
- Staff training: 5 sessions, 14 hrs, on the therapeutic model, safeguarding, admin/monitoring

Delivery sites
- **4 locations**: London, Kent, Birmingham, Leeds
- BRC offices & outreach settings (e.g. colleges)
- My View Remote (online or telephone support)

Target population
- Unaccompanied asylum seeking children (UASC) aged up to 18

Established referral pathways
- Internal e.g. BRC Children's Advice Project, Youth Development Team
- External e.g. Red Cross, Kent Refugee Action Network
- Stakeholder outreach to support professional referrals
- Self-referral

Financial resources
- WWCSC funding
- In-kind resources covered by BRC

Activities

Monthly one-to-one **external clinical supervision for therapists** (1hr) and **bi-monthly group supervision for interpreters**

One-off psychoeducational workshops for host organisations e.g. schools, colleges, youth groups involving interactive activities to normalise mental health, offer coping strategies and signpost further help (also acts as referral route)

Review online referral form / **eligibility check** and assign to waitlist

Pre-assessment session on needs (and first outcome measurement)

Casework
- **Crisis intervention:** 1-3 sessions on stabilisation through grounding, explanation of symptoms, drawing on internal strengths
- **One-to-one therapy**: up to 12 sessions, usually 1hr each, over 3-5 months, focusing on bearing witness and connecting to past memories, coping techniques, psychoeducation, support networks and more.
- **Peer support network:** drop-in group sessions with 6+ participants, focusing on bearing witness and validation of experience, stress reduction, connection and interpersonal relationships, positive peer influences, cultural readjustment, and more.

Monthly keep-in-touch email and phone call to referrer (or young person if self-referral) for those on waitlist

Outputs

280 young people supported through: crisis intervention (33); one-to-one therapy (190); and/or group sessions (57)

Key mechanisms

Actively listening of clients' narratives of distressing events/ use of creativity/imagination/games supports:
- Processing and containment of difficult emotions → reduced 'acting out' of emotions and increased ability for emotional self-regulation
- Feeling understood and moving beyond traumatic narratives as 'destructive' → more empowered

Consistency, predictability, confidentiality of therapeutic relationship (and peer support in group sessions) supports:
- Trust and sense of safety → increased ability to trust others → improved interaction with others
- Positive representation of host culture → increased potential for integration

Offering a vocabulary for experiences, based on feelings and needs supports:
- Ability to express own needs and ask for / negotiate support

Tools for coping include:
- Sleep hygiene tips → improved sleep → improved focus and concentration
- Relaxation techniques (breathing, mindfulness, grounding) → improved ability to regulate emotions

The intervention may have unintended consequences. For example, a lack of cultural validity and/or therapy options together with unmet client expectations can result in negative therapeutic processes. Young people may also have a dip in wellbeing as they process trauma and difficult emotions. This is mitigated by the careful selection of therapists and therapies, and the development of coping skills.

Short-term outcomes

- Improved evidence-base for therapeutic interventions with UASC
- Improved psychological and emotional wellbeing
- Improved emotional self-regulation / ability to cope
- Improved physical wellbeing
- Improved confidence and self-image / vision for future / aspirations
- Improved safety / reduced risk of harm
- Improved willingness to engage with other services / seek help
- Onward referrals (made by BRC or Social Services)
- Reduced social isolation and improved social connection

Longer-term outcomes

- Sustained improved physical and mental wellbeing
- Prevention of pathologies e.g. clinical diagnoses
- Improved home and school stability
- Cost savings for local authorities
- Successful onwards referral pathway e.g. increased access to more intensive / specialist interventions; education
- Improved social inclusion / integration

Rationale/context: Unaccompanied Asylum Seeking Children (UASC) arriving in the UK often have complex psychological needs not only due to the trauma they are likely to have experienced, but also in relation to resettling in a foreign environment. Many UASC are said to fall through the gaps of existing CAMHS provision, or the provision provided lacks the necessary sensitivity to their circumstances. The British Refugee Council (BRC) has developed a programme to provide specialist therapeutic support to UASC, 'My View'.

Source: Developed by the evaluation team

Previous evaluation

The one-year pilot project in London was internally evaluated by the Refugee Council in 2015–16 (Malfait, 2016). The evaluation involved 31 qualitative interviews with the project team, managers and other Refugee Council staff, external stakeholders from referral organisations, and young people supported by My View. It also reviewed qualitative feedback from another eight young people, therefore it analysed data from 19 young people in total. The evaluation then analysed key themes on the difference My View made for young people, the strengths and challenges of project delivery, and views on future needs. Key findings included:

- Stakeholders highlighted the need for this type of specialist and therapeutic support and anticipated that the need would continue to grow. The project received more referrals than expected (207 instead of 130), which were received internally and from 38 different external organisations.
- The Refugee Council successfully piloted the My View programme and delivered one-to-one and group therapeutic support to 189 young people. Most of the referrals were for group support.
- Young people felt listened to and believed, as well as supported and helped in acknowledging, expressing, and understanding painful, angry, sad, and frightening feelings. Overall, the findings suggested My View was perceived positively among young people.
- Project delivery time and capacity was limited and as client referrals, individual caseloads, and group sessions increased, the team experienced challenges in prioritising tasks. Furthermore, a waiting list was established during the pilot, which also had to be closed to new referrals during periods of high demand.
- Evaluation in this context had multiple challenges due to the nature of the programme and circumstances of young people. For example, outcomes appeared to strongly depend on immigration status. At the time of the evaluation, the team used the Outcomes Tool to measure change over time in eight areas, such as sleep, general mood, relationships, immigration, and basic needs. Overall, only 41 young people completed the tool and the evaluation noted that adjustments to the tool were necessary.

The pilot evaluation provided valuable insights on the feasibility of implementing My View and how it was perceived by young people, staff, and stakeholders. Overall, the findings reiterated the need for My View and provided evidence of promise in terms of its potential for positive impact on the mental health and wellbeing of young people. However, the evaluation collected limited quantitative data on outcomes, and it was unclear whether the Outcome Tool was an appropriate outcome measure. Furthermore, without a control group, it was not possible to conclude whether the improvements reported would have happened anyway given time for young people to settle and/or have their asylum granted.

This evaluation was designed to overcome these limitations and to add to the evidence base on My View and therapeutic interventions for unaccompanied children more generally. It represented the

first independent external evaluation of My View and included a more robust counterfactual design than the pilot evaluation.

Overall design and evaluation aims

The evaluation sought to assess the effectiveness, implementation, and costs of My View. To do so, the evaluation included three components. First, the impact evaluation involved a randomised controlled trial (RCT) to assess the impact of My View on participants' psychological distress (primary outcome) and mental wellbeing (secondary outcome) compared to a waitlist control group. Second, an implementation and process evaluation (IPE) captured the views and experiences of the staff delivering and the young people attending My View, as well as the views of wider stakeholders such as social workers, foster carers, and accommodation managers. Third, the cost analysis explored the costs associated with delivering My View, including estimated costs per child.

The evaluation collected data from June 2021 to July 2023. The evaluation was originally planned to end in summer 2022 but it was extended twice to increase the number of participants. In one instance, randomisation was paused in March–April 2022 while a decision on the first extension was confirmed. This is detailed further in chapter 3.

Research questions

Impact evaluation questions

1. *Primary*: What is the effectiveness of the My View intervention for UASC in terms of their psychological distress (as measured by Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE) measure), compared to a waitlist comparison group?
2. *Secondary*: What is the effectiveness of the My View intervention for UASC in terms of their mental wellbeing (as measured by the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS)), compared to a waitlist comparison group?

Implementation and process evaluation questions

1. *Mechanisms of change*: What are the perceived mechanisms of change for My View to intended outcomes for young people? What are the perceived changes in outcomes?
2. *Adoption*: What is the programme reach? How many took up the service? What kinds of activities did they do? What referrals were made and how many of those went on to receive the intervention?
3. *Acceptability*: How acceptable do participants and staff find My View (e.g. content, complexity, comfort,[6] number of sessions, online nature)? Is it viewed as an improvement

6 Comfort refers to the level of ease of discomfort experienced by a service user. It forms part of the Proctor et al. (2011) definition of acceptability.

on services as usual by young people, delivery partners, and social workers? What adaptations have been made to make the programme more acceptable and culturally acceptable to participants?

4. *Appropriateness*: Is My View seen as a good fit with professional/service norms (e.g. counselling co-location, therapy, psychoeducational services) and with needs of UASC (e.g. addressing mechanisms for change)?
5. *Feasibility*: What are viewpoints on the feasibility of implementing My View? What barriers and enablers were encountered, and how were these addressed?
6. *Implementation strategies*: What implementation strategies were used to recruit UASC, establish the service, and train/support My View therapeutic staff?

Cost analysis question

1. How much does it cost to introduce and run the My View programme?

Ethics and data protection

The evaluation's approach to research ethics was reviewed by Ipsos UK's Ethics Group in June 2021, which ensured the evaluation design and data collection approaches were ethical. The evaluation complied with the GSR ethical principles and other ethical codes, such as the SRA ethical guidelines, the ESRC Research Ethics Framework, and the MRS code of conduct.

A data sharing agreement and data protection impact assessment were set up between What Works for Children's Social Care (WWCSC, now Foundations), Ipsos UK, CEI, and the Refugee Council. The evaluation sought to limit the sharing of personal data using unique IDs for the impact evaluation. Personal data of staff, stakeholders, and young people, namely contact details, were shared for the purpose of inviting participants to take part in interviews. All personal data was transferred and stored securely.

Structure of this report

The remainder of the report is structured as follows:

- Chapter 2 sets out the methods employed for the evaluation, with sub-sections for the impact evaluation, IPE, and cost analysis.
- Chapter 3 details the findings of the evaluation. It first provides an overview of key contextual factors during the evaluation time frame and then reports the key findings from the RCT, including both primary and secondary outcomes, the IPE, and finally the cost analysis.
- Chapter 4 summarises the key limitations of the evaluation, both in terms of those anticipated from the outset as well as those revealed during the evaluation.
- Chapter 5 discusses how the findings relate to the wider evidence base and concludes with a set of recommendations for policy, practice, and evaluation.

2. METHODS

This chapter sets out the evaluation methodology that was adopted to answer the research questions presented in chapter 1. The methods for the RCT, IPE, and cost analysis are discussed in turn.

The study protocol outlining the research methods was finalised by June 2021 prior to randomisation and was published on the OSF[7] and What Works for Children's Social Care websites.[8]

Impact evaluation

The impact evaluation aimed to test whether unaccompanied children who have received My View have less psychological distress and better mental wellbeing than children who have not yet received My View.

Trial design

The trial was a non-blinded parallel two-armed RCT with unaccompanied children individually randomised to an intervention group or waitlist control group. Randomisation occurred on a rolling basis to account for ongoing referrals. The design is summarised in table 1 and further detailed in the sections below.

Table 1. RCT design overview

Details	Summary
Trial type and number of arms	Non-blinded parallel two-armed randomised control trial with UASC individually randomised to an intervention group or waitlist control group (on rolling basis)
Unit of randomisation	Young person
Stratification variables	Overall, six strata were used, comprising one high-risk stratum and five moderate-risk strata defined by the Refugee Council locations, which included

7 See: https://osf.io/sytvc/

8 See: https://whatworks-csc.org.uk/research-project/my-view-a-randomised-controlled-trial/

(if applicable)		four with physical geographical boundaries and a fifth with virtual boundaries. Allocation rates were 50:50 for those in moderate-risk strata and 60:40 in high-risk strata.[9]
Primary outcome	**Variable**	Continuous variable – scores ranging from 0 to 40
	Measure (instrument, scale)	Mean intervention group YP-CORE score compared to mean control group YP-CORE score collected at endline (*c.*12 weeks later) by therapists
Secondary outcome(s)	**Variable(s)**	Continuous variable – scores ranging from 7 to 35
	Measure(s) (instrument, scale)	Mean intervention group SWEMWBS score compared to mean control group SWEMWBS score collected at endline (*c.*12 weeks later) by therapists

Participants

Referrals were eligible for inclusion in the trial if they were:

- Young people who were legally defined as UASC, i.e. arrived in the UK alone without parents or guardians and were in the care of local authorities. Young people were eligible regardless of their asylum status, including those who had applied for asylum or had asylum granted.
- Aged 17 years or under at the time of referral. The Refugee Council also considered young people who were being age-assessed, thus some participants may have been over 18 years old.

Referrals were excluded from the trial if they did not meet these criteria or if they had been previously referred and randomised during the trial, i.e. they were re-referred. When the trial was briefly paused while plans to extend the trial were confirmed (discussed in chapter 3), referrals during this time were excluded from the trial as they were not randomised. Despite exclusion from the trial, they were still eligible to receive My View support.

As part of the referral process, the My View team flagged young people considered high risk based on the reasons set out in the referral forms. These young people were eligible to take part in the trial; however, there were several modifications to the trial processes to enable access to support if needed (discussed further in the Randomisation section below). Furthermore, in instances where

9 This represents a change from the protocol, which originally set out a 66:34 allocation rate.

young people were at risk of serious harm (e.g. suicide, self-harm), the My View team had a safeguarding duty and therefore bypassed the trial to offer immediate crisis intervention.

The evaluation included four sites with Refugee Council hubs – Birmingham, Kent, Leeds, and London – as well as a fifth 'site' for My View Remote. Data collection activities took place across all sites. Each site is diverse with a different context and service delivery landscape, which was considered as part of the analysis. My View sessions with young people were often delivered online or by telephone across all sites, meaning the delivery mode across sites was not expected to vary significantly.

Intervention

As detailed in chapter 1, My View is a programme of therapeutic support for unaccompanied children and young people, including one-to-one and group therapy. Ultimately, for reasons described in the findings, all young people received one-to-one therapy but a minority also attended group sessions.[10] One-to-one therapy includes an initial assessment and up to 12 therapy sessions, typically delivered on a weekly basis. However, completion of all 12 sessions can take longer than 12 weeks due to rescheduled sessions. Equally, therapists and young people can collaboratively agree to end therapy earlier than 12 weeks. As such, the length of the intervention was expected to vary and for the purposes of the evaluation, the intervention period was defined as an average of 12 weeks.

The control group was assigned to a waitlist for My View. To mirror the length of the intervention, the design stipulated that control group participants should wait 12 weeks between baseline and endline, after which they could start My View. During the waiting period, control group participants received several (usually monthly) non-therapeutic check-ins from My View staff at the Refugee Council plus care-as-usual, which was expected to include support from their social worker, foster carer, or other key workers. Monthly check-ins are normal practice for all referrals waiting to access My View (including prior to the trial) to help manage waitlists and identify any risks associated with the wait time for young people. Care-as-usual support was expected to vary by location, the source of referral, and availability of support (e.g. due to waiting times). Given the dearth of mental health support available for unaccompanied children, it was deemed unlikely that the control group would be exposed to other therapeutic interventions during this period. This also informed the rationale for a waitlist design (see the Randomisation section).

Outcome measures

There is a lack of evidence regarding the reliability and validity of outcome measures for this population. For example, Verhagen et al. (2022) concluded that "more research is needed in order

[10] This differs from the original expectations at the time of writing the protocol whereby the trial was designed to enable both one-to-one and group sessions. Ultimately, there were practical challenges in implementing group sessions as part of an RCT.

to establish cross-cultural validity of mental health assessment tools and to provide optimal cut-off scores for this population." During the set-up phase, the evaluation team worked closely with the Refugee Council to scope, review, and propose potential outcome measures. Despite this careful selection process, it was anticipated that challenges around interpretation, language, and cultural understanding of the statements could persist for some young people. As such, the evaluation captured insights on the use of the selected measures.

Primary outcome

Prior to the evaluation, the Refugee Council had started to routinely collect the Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE) measure (Twigg et al., 2009; Twigg et al., 2016) as part of one-to-one therapy. The YP-CORE is a measure of psychological distress designed for use with 11–17-year-olds. Following a review of the measure, it was selected for the primary outcome for several reasons. First, psychological distress is an indicator for risk of poor mental health outcomes, which aligned well with the core aim of the My View programme. Second, the My View team had experience using the scale, which demonstrated its feasibility, and they felt it provided an accurate reflection of acute distress. Third, the measure is brief and free to use, including multiple translations already available.

The YP-CORE has good levels of internal reliability, acceptability, and validity and it is widely used in mental health and school counselling services (Twigg et al., 2016). However, it has not been well validated with this particular population, and the evaluation therefore sought to capture feedback on its use in this context. While other mental health assessments have been used with unaccompanied children, these tend to focus on a specific disorder such as PTSD, depression, or anxiety.[11] The YP-CORE was selected to capture a broader domain for young people experiencing forms of psychological distress that may not fit within established diagnostic categories, and for practical reasons given it was already being used by the My View team.

The measure includes ten items covering anxiety, depression, trauma, physical problems, functioning, and risk to self. Example items include '*I've felt edgy or nervous*' and '*It's been hard to go to sleep or stay asleep*' (see appendix D for the full measure). For each item, the respondent selected one response to indicate how they had been feeling over the past week: Not at all, Only occasionally, Sometimes, Often, or Most or all of the time. Each response option has a value between 0 and 4 (some are reverse scored), meaning each item had a score between 0 and 4. The clinical score was calculated by multiplying the total mean score (total of all item scores divided by number of items completed) by 10. However, because the YP-CORE has ten items, this calculation was identical to simply adding the raw score of all ten items, providing all ten items were completed. Measures with one missing item were included and the clinical score was calculated by multiplying the total mean score (total score divided by 9) by 10. Re-scaling the clinical score is not recommended if more than one item is missing, therefore measures missing two or more items were marked as 'missing'. The clinical score is out of 40, and higher scores indicate higher levels of psychological distress. It is recommended that different indices should be used for clinically

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11 See for example: Child Revised Impact of Events Scale (CRIES-8) and Child and Adolescent Trauma Screen (CATS).

significant cut-off points due to differences in reliability and distribution of scores across gender and age bands (see Twigg et al., 2016). As most participants were male with an average age of 16.5 years old, the recommend cut-off point was 14.1 such that scores above this were clinically significant.

Therapists with the support of interpreters collected consent from young people to take part in the evaluation, including sharing their outcome data, during the initial assessment. Where consent was provided, they administered the YP-CORE to capture baseline for both intervention and control groups. Endline data was collected near or at the end of the intervention (intervention group) or after waiting approximately 12 weeks during a second assessment session ahead of receiving My View (control group). Mid-point data collection (after six sessions) was also originally requested; however, this was not consistently collected and therefore omitted from the analysis.

The evaluation team also developed a visual aid for the scale for therapists to use in exceptional circumstances when young people needed additional guidance on how to differentiate options such as 'sometimes' and 'often'.

Secondary outcome

The evaluation team scoped options for the secondary outcome using outcomes identified in the theory of change. This yielded a wide range of measures such as: the Emotion Regulation Questionnaire for Children and Adolescents (ERQ-CA), Strengths and Difficulties Questionnaire (SDQ), Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS), Children's Hope Scale (CHS), Child and Youth Resilience Measure (CYRM), General Self-Efficacy Scale (GSE), Rosenberg Self-Esteem Scale (RSES), Friendship Scale, UCLA Loneliness Scale, among others. Working closely with the Refugee Council, many of these were deemed inappropriate for participants due to concerns relating to language, interpretation, and length. Ultimately, the SWEMWBS was selected for the secondary outcome measure.

The SWEMWBS (Tennant et al., 2007) is a measure of mental wellbeing. Both the full length and short version of WEMWBS are suitable for those aged 13 years and above (Taggart et al., 2015; McKay & Andretta, 2017; Ringdal et al., 2018). The SWEMWBS is free to use following completion of a registration form.[12] It has also been translated into a number of languages, and some of these have been validated both psychometrically and qualitatively.[13]

The SWEMWBS uses seven of the WEMWBS's 14 statements about thoughts and feelings, which are positively worded. Example items include *'I've been thinking clearly'* and '*I've been feeling close to others*' (see appendix D for the full measure). Similar to the YP-CORE, each statement asks how the young person has been feeling over the last two weeks (instead of one) and has five similar response options: None of the time (1), Rarely (2), Some of the time (3), Often (4), or All of the time (5). To score the SWEMWBS, each statement has a score between 1 and 5 and all seven scores are summed. Scores range from 7 to 35, and higher scores indicate more positive mental wellbeing

12 See: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/non-commercial-licence-registration/
13 See: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/translations/

(i.e. a score of 27.5 indicates high wellbeing). In line with guidance, the total raw scores were transformed into metric scores using the SWEMWBS conversion table. The SWEMWBS has been benchmarked on the PHQ-9 and GAD-7 with which it is highly correlated (Shah et al., 2021). It suggests that a score of >18–20 is indicative of possible mild depression and a score of 18 or less is indicative of probable clinical depression. The SWEMWBS was collected at the same timepoints as the YP-CORE.

As above, therapists could use a visual aid in exceptional circumstances when young people needed additional guidance on how to differentiate options (e.g. 'rarely' and 'some of the time').

Randomisation

In the commissioning and planning of the current evaluation, an RCT was deemed feasible and appropriate given that the pilot evaluation did not include a counterfactual, meaning it was not possible to confidently attribute changes to My View. Furthermore, the pilot evaluation did not consistently measure outcomes. At the same time, there was evidence that the programme could be beneficial based on the pilot evaluation and the longevity of the service, as well as the knowledge that limited support of this kind exists elsewhere despite evidence of need. This formed the rationale for a waitlist design such that there was (1) sufficient uncertainty about whether My View would improve the outcomes of interest as well as (2) sufficient ethical concerns about withholding the service altogether. This informed several features of the randomisation process, described below.

Participants were allocated to their trial arm status after referral and eligibility checks but before baseline data collection. It was not feasible to collect baseline data prior to randomisation because therapists needed to know the allocation ahead of the initial assessments (when baseline data is collected) to plan their caseloads and inform young people when they could expect to start therapy. Collecting baseline data prior to randomisation would have required another meeting that would further lengthen the process and potential wait time for all young people.

The Refugee Council receives referrals on an ongoing basis with the exception of when waitlists are closed due to high demand. As such, the Refugee Council shared a log of new referrals using unique IDs (no personal data) each week, and the randomisation was conducted by the evaluation team on a weekly basis. The log with allocations was shared back with the Refugee Council so that therapists could arrange initial assessments to collect baseline data and inform participants about any waiting time.

A random stratified allocation procedure was used with six strata, comprised of one stratum for participants flagged as high risk during eligibility and five strata for non-high risk (typically moderate risk) participants across the My View sites. Random numbers were generated separately for each stratum that were used to assign participants to intervention or control as they entered the study, using the random number function within the R statistical programming software package. Different random number seeds were used for each stratum and blocks of random numbers of size 6 (3 in the intervention arm and 3 in the control arm) were generated to reduce the risk of

randomly generated long run sequences of allocation to either group. This procedure was used to mitigate potentially upsetting the balance between numbers in the intervention and control groups.

For the five 'moderate-risk' strata, the random number allocation generated the allocation lists with a 50:50 probability of assignment to intervention and control. For the high-risk stratum, a probabilistic allocation rate of 0.6 was assigned to intervention group, with a corresponding probability of 0.4 to the control group. This higher probability of assignment to intervention group for high-risk cases was requested by the Refugee Council so that fewer high-risk cases were delayed from receiving My View than moderate-risk cases. The decision not to exclude these participants was based on feedback that some high-risk cases identified at referral can be reviewed as lower risk following the initial assessment.

In addition, the Refugee Council had the right to override allocation to the control group for cases deemed to necessitate immediate intervention. The decision to override was determined by the therapist with a view to safeguard young people presenting with more severe and time-sensitive mental health problems. This could be used for both those identified as high-risk at the point of referral as well as following the initial assessment among those not initially flagged as high-risk. The override feature was designed only to be used in these exceptional cases to limit the potential impact on the analysis (e.g. the risk of false negatives). Young people remained allocated to their strata, and analysis treated them as intention-to-treat on the basis of their original allocation. The implications of the override are further discussed below under the sensitivity analysis. Analysts were not blind to group allocation.

Sample size

The sample size was informed by the number of therapists, how many young people they could support at a time, the intervention length, evaluation time frames, and anticipated attrition. The minimum detectable effect size (MDES) was calculated based on the expected achieved sample sizes, a stratified random allocation design at the individual level, and the availability of a baseline measure, which assumed a pre/post correlation of 0.71, (i.e. $R^2 = 0.5$). The PowerUp tool (Dong & Maynard, 2013) was used to calculate the sample size, using the BIRA2_1f spreadsheet with 6 strata and an average block size of 47 to be allocated evenly to intervention and control groups.[14] At protocol stage, the evaluation team estimated a sample size of 280 participants and an MDES of 0.24.

Quantitative data analysis

As per their usual practice, the My View team recorded details for each young person on an internal database. The My View administrative team then created bespoke extracts from this database for the purposes of the evaluation. This detailed individual-level information about each young person, including the My View site, unique ID numbers, demographic information (age, gender, country of

14 We used 47 cases per block as an approximation to the 280 total required (i.e. 47 x 6 = 282).

origin), dates of arrival in the UK and referral to My View, YP-CORE and SWEMWBS scores (baseline, endline, and where available, midpoint), start and end dates for therapy, and the number of sessions attended. In the final year of the evaluation, this extract was securely shared with the evaluation team on a monthly basis to monitor progress. The evaluation team received the final dataset, which sought to account for all young people randomised, in July 2023.

The data cleaning and data analysis was carried out in Stata (StataCorp, 2021). Descriptive and inferential statistics were calculated for the participants recruited to the trial and allocated to the intervention and control groups to check for any imbalances by available characteristics. Checks were also carried out for any differential attrition of those young people who remained in the study and provided data for analysis, between intervention and control groups. No evidence for any systematic difference was found between the intervention and control group characteristics from either of these checks; thus, limiting the degree of sensitivity checks required on the impact analysis.

Following WWCSC statistical guidance for RCTs, impact estimation employed an intention-to-treat (ITT) approach. This means analysis was based on the original allocation, disregarding any changes as a result of drop-out or override decisions. For the primary research question, analysts used ordinary least squares (OLS) linear regression to estimate the average effect of the intervention on the YP-CORE scores using a White robust error procedure to account for heteroscedasticity. The coefficient of the indicator variable (intervention vs control) was reported as an estimate of the size and direction of the intervention effect and its significance was tested with a 2-tailed 5% Type I error threshold. The 'basic' model included only 'structural' variables used in the design, i.e. the outcome measure, pre-intervention baseline measure of the YP-CORE, the stratification identifiers for the site, and the risk category of the individual. The results of this model were used to calculate Glass's Delta effect size. This approach was taken to allow us to estimate the primary impact without confounding arising from any other 'control' covariates in the regression model.

Further regression models explored the impact of explanatory variables (gender, age, etc.) on the estimated impact effect size. This was also intended to help ameliorate any covariate imbalance between characteristics of the intervention and control groups. We compared the impact and effect size estimates of the 'exploratory' model to the 'primary' model to assess the extent to which the further controls have increased or decreased the impact effect. A further model explored the effect of dosage, i.e. number of sessions attended, on the outcome scores.

OLS regression models were again used to analyse the secondary outcome using SWEMWBS scores. This followed the same model specification used for the primary outcome.

For missing data in endline scores, we created a binary indicator distinguishing missing from not missing to check for a significant difference in missingness between intervention and control groups using a logistic model including the covariates used in the basic model.

Technical tables are provided in appendix C.

Implementation and process evaluation

The implementation and process evaluation (IPE) aimed both to answer distinct qualitative IPE questions about the delivery of the programme and to provide understanding around implementation outcomes that aid interpretation of the findings from the RCT. The IPE research questions were developed to build upon the pilot evaluation and drew on key implementation science frameworks, including questions about the appropriateness and fit of the programme, acceptability, and cultural barriers to engagement. These IPE questions were addressed through in-depth interviews with therapists, stakeholders, and young people. The IPE aimed to provide insight into the experience of referring to, delivering, and receiving My View. Key areas explored in this strand include the perceived outcomes, implementation outputs that may be a precursor to positive intervention effects, and mechanisms of change. We also sought to provide further understanding of the programme, its implementation during this evaluation, and contextual knowledge for any future evaluations or scale up activity.

Implementation and process evaluation questions

1. *Mechanisms of change*: What are the perceived mechanisms of change for My View to intended outcomes for young people? What are the perceived changes in outcomes?
2. *Adoption*: What is the programme reach? How many took up the service? What kinds of activities did they do? What referrals were made and how many of those went on to receive the intervention?
3. *Acceptability*: How acceptable do participants and staff find My View (e.g. content, complexity, comfort, number of sessions, online nature)? Is it viewed as an improvement on services as usual by young people, delivery partners, and social workers? What adaptations have been made to make the programme more acceptable and culturally acceptable to participants?
4. *Appropriateness*: Is My View seen as a good fit with professional/service norms (e.g. counselling co-location, therapy, psychoeducational services) and with needs of UASC (e.g. addressing mechanisms for change)?
5. *Feasibility*: What are viewpoints on the feasibility of implementing My View? What barriers and enablers were encountered, and how were these addressed?
6. *Implementation strategies*: What implementation strategies were used to recruit UASC, establish the service, and train/support My View therapeutic staff?

Theory of change and logic model development

An important component of both the RCT and IPE was specifying the theory of change and developing a diagrammatic logic model for My View, as presented in chapter 1. WWCSC, who funded the delivery and evaluation of My View during this period, facilitated an initial theory of change development workshop at the launch of the My View evaluation on 8 April 2021. This was followed up with several workshops and revisions led by the evaluation team, before being finalised in the protocol of the evaluation. The theory of change development focused on identifying the key

target activities, implementation outcomes, mechanisms of change, outcomes, and assumptions. It was used to understand the intervention, context, and assumptions and to develop the evaluation plans and questions. The analysis responds to these research questions to explain how the intervention was implemented in practice, understand mechanisms of change, and examine outcomes.

Sampling

There were three groups of participants selected for interviews for the IPE: young people, My View staff, and stakeholders. Table 2 details the number of participants invited and those included in the final sample. Further information on this process can be found in the Recruitment section.

- **Young people**: As we anticipated low interest in interviews among young people, therapists were asked to inform all young people about this element. Therapists then used their professional judgement and asked young people for their consent to pass on their contact details to the evaluation team. Therapists asked young people towards the end of their therapy, including if the young person chose to disengage early. All young people who agreed to have their contact information shared with the evaluation team were invited.
- **My View staff**: All therapeutic staff, including regional and national managers, were invited to interview at each of the two timepoints to ensure coverage of implementation and delivery determinants at different stages across the project. Key administrative staff were also invited to interview.
- **Stakeholders**: Stakeholders were identified by the My View team as key referrers and leaders in the sector as well as through desk research and existing networks, to ensure a spread of perspectives. Stakeholders included individuals with direct contact with My View (referrers such as foster carers and social workers) and individuals working in the sector (representatives of other services, academics, and other allied professionals). A range of stakeholders was approached in order to understand the wider context of provision for UASC in the UK and how My View fits and interacts with other services. The initial list of invitees included a balanced number across all the My View sites, and the list was expanded to ensure an equal spread as the interviews were conducted.

Table 2. Interview recruitment

	Invited		Interviewed	
Young people	81		29	
Stakeholders	39		18	
Staff	T1: 8	T2: 11	T1: 8	T2: 11*
Total	**139**		**66**	

Note: T1 = timepoint 1 which took place at the end of 2021; T2 = timepoint 2 which took place in early 2023.
*Three of the interviewees at T2 had also been interviewed at T1.

Recruitment

Young people

Young people were first told about the evaluation interviews by their therapist in the initial assessment session or within their first few sessions. The evaluation team held briefing sessions in which therapists were given information on the interviews and a script to use, to support them to provide young people with enough information to decide whether to agree to being contacted by the evaluation team. Towards the end of their 12 sessions, or in their final session if ending engagement early, therapists asked young people for permission to share their contact details with the evaluation team to be contacted for an interview.[15] This information was then securely sent to the evaluation team on a monthly basis during the fieldwork period. All young people who agreed to pass on their contact details were invited for an interview to ensure that any sampling decisions did not confer feelings of rejection. The number of young people whose details were shared with the evaluation team and the number of interviews conducted per My View site were monitored. This monitoring identified inconsistencies in how many young people were being approached across the sites, which was addressed by the evaluation team through joining another therapeutic staff meeting to talk through the process of recruitment again and encourage therapists in sites with low numbers to provide young people with the required information.

Most young people were contacted using standardised text messages both in English and their first language, using translated materials. Potential interviewees were then followed up three times at most if they did not respond. Where consent was provided, the evaluation team received contact details used by the My View team, which included supporting adults in some cases. Where supporting adult's details were used (foster carer, social worker, key worker, etc.), they were asked to provide support in reaching the young person and providing the information, but not to encourage young people to participate, to ensure informed consent was freely given. To diversify the options for young people who wanted to participate in interviews, some young people were invited to an in-person interview in London by staff at the Refugee Council office, resulting in two in-person interviews.

Young people were only told about the £20 voucher provided as appreciation of their participation after they agreed to be invited to interview. This process was agreed with the My View national manager based on concerns from My View staff to ensure that the voucher did not act as an

15 Therapists were instructed to ask all young people where they considered it appropriate but were not asked to record instances where a young person did not give consent to be contacted for an interview, meaning we do not know the total number of young people asked.

incentive and affect their decision to participate. Once a young person responded, they were sent the information sheet and consent form and given the opportunity to ask questions about the interview. Interviews were set up at a time of their choosing. If a young person did not return the consent form prior to the interview, the consent process was conducted verbally and recorded at the start of the interview.

Details on the characteristics of young people who took part in interviews are provided in appendix E.

Stakeholders

Stakeholders were invited to interview via email using a standard template with an accompanying information sheet and consent form. Stakeholders were followed up three times if they did not respond. Once a stakeholder responded, participants were given the opportunity to ask questions and an appropriate time was scheduled. Participants were asked to return the consent form digitally, but if they did not return it prior to the interview, the consent process was conducted verbally and recorded at the start of the interview. A breakdown of the completed interviews by region is as follows:

- Kent: 4
- London: 5
- Remote: 1
- Birmingham: 5
- Leeds: 3.

Staff

Staff were informed of the interviews at several points, including the biannual briefing sessions. At each of the two timepoints, national managers then asked their team for approval to share their contact details with the evaluation team and all staff consented. Staff were then sent the information sheet and consent form via email and followed up if necessary. Interviews were scheduled at a time that suited participants. Participants were asked to return the consent form digitally, but if they did not return it prior to the interview, the consent process was conducted verbally and recorded at the start of the interview. In phase three of the evaluation, therapists provided sessions to young people across multiple regions to increase capacity and decrease waiting times. As such, these numbers below reflect therapists' 'home' office, rather than the location of the young people they supported:

- Kent: 2
- London: 3
- Leeds: 2
- Birmingham: 2
- Remote: 4
- National: 3.

Qualitative data collection

All interviews took place by telephone or video call (Zoom or Teams) according to the preference of the interviewee, apart from interviews with two young people who were interviewed in person at the London Refugee Council offices. Interviews took place at a time of participants' choosing and lasted between 20–45 minutes (young people) or 45–60 minutes (staff and stakeholders). Further information about how interviews were set up with participants can be found in the Recruitment section.

Semi-structured interview guides were developed for each participant group and reviewed and revised as necessary when interviews took place across extended periods. The guides were grounded in implementation science theory and designed to cover the research questions as well as arising topics of interest throughout the evaluation. Interview guides included suggested wording, probes and prompts but were used flexibly by researchers, to be responsive to each individual participant.

Administrative data collection

Administrative data collection was based on the Refugee Council's existing data collection systems to create bespoke extracts for the evaluation. This included relevant information for the IPE including information about the young people that attended My View, the length of their engagement, and reasons for therapy coming to an end. This was contained in the monthly extracts that also included the outcome data. The final dataset was cleaned and analysed, both descriptively and as part of the RCT analyses.

Qualitative data analysis

All interviews were transcribed using a professional transcription service. Qualitative analysis was performed using the framework analysis method (Spencer et al., 2014), which involves identifying analytical themes and summarising data both across sources within the relevant theme and sub-theme. The coding framework was developed both deductively, reflecting elements of the research questions and logic model, and inductively, including unexpected topics emerging in the data. This was an iterative process with multiple researchers working independently and then collaboratively to ensure the quality of coding structures and to facilitate analysis between and across categories of interviewees and locations.

Qualitative data from each participant group was analysed separately then triangulated and integrated to identify areas of difference and reinforcement. The evaluation team then discussed these findings in the context of the RCT to substantiate and explain findings where necessary.

Cost evaluation

The Refugee Council provided information on the costs of running My View after all data collection was completed. The evaluation requested costs for set-up (one off) and recurring costs broken down by:

- Staff time for delivering therapy as well as case work (proportion of FTE multiplied by salary plus other staff costs such as national insurance contributions)
- Any costs associated with recruiting and training therapists
- Any costs related to case work (e.g. staff time, travel costs, use of platforms (Zoom, phone calls), postage and stationary)
- Any costs related to group therapy (e.g. equipment)
- Any other overheads including facilities (cost of office and venue hire associated with face-to-face provision) and equipment costs (based on individual needs (own resources of cards, art materials, sleep packs, stress balls, work sheets for example the tree of life or team of leaf, body outlines, etc.).

Using the cost information provided by the Refugee Council, the evaluation team estimated a per pilot-site cost (given the differences in volumes) and costs per child. The per-child costs were compared with published costs for similar services, such as counselling for children with mental or emotional difficulties.[16] However, it is important to note that a full economic evaluation was out of scope of the evaluation.

Evaluation timetable

Following a set-up phase, the evaluation commenced in June 2021 when randomisation started. It was originally planned to finish in June 2022, but a decision was made in early 2022 to extend the evaluation. This was intended to increase the sample size when it became clear that more time was needed to reach the target sample of 280 participants. A further extension was granted to ensure that all young people in the waitlist control group would receive therapy and to again support achieving the sample size. This decision was driven by the goals of all parties to complete an evaluation with a sufficient sample size to detect impact and to ensure that the data collected to date could be best utilised. The last round of randomisation took place in January 2023 and final data collection was completed in July 2023. Table 3 provides an overview of the key dates for data collection.

Table 3. Data collection timetable

Dates	Activity	Strand

[16] See: https://www.pssru.ac.uk/pub/uc/uc2020/1-services.pdf

June 2021 – May 2023	Baseline data collection	Impact
Aug 2021 – July 2023	Follow-up data collection	Impact
Oct – Nov 2021	Staff timepoint 1 interviews	IPE
Mar 2022 – April 2023	Young person interviews	IPE
Aug 2022 – April 2023	Stakeholder interviews	IPE
Jan – Feb 2023	Staff timepoint 2 interviews	IPE

3. FINDINGS

This chapter details the key findings from the evaluation. It begins with a short section that provides additional information about the context of the evaluation, which should be considered when reviewing the findings. It then turns to the key findings from the RCT, including both primary and secondary outcomes, the IPE, and finally the cost analysis.

Delivery overview

The evaluation of My View lasted more than two years, during which there were several events – both internally at the Refugee Council and in the wider national and international context – that impacted delivery. This section provides a brief overview of these events and their implications on delivery and the evaluation.

Overall, the delivery can be divided into three phases.

Phase 1, June–December 2021

Phase 1 marked the evaluation initiation period. To prepare for the launch of the trial in June 2021, the programme paused conducting initial assessments and starting therapy to onboard new staff in May. All eligible referrals from this preparation period were included in the first round of randomisation. Following the launch, the delivery was running smoothly, with a steady flow of referrals higher than expected, apart from some 'teething problems'. During this period, staff were adjusting to the changes required for the evaluation and found some aspects challenging, particularly administering both the YP-CORE and SWEMWBS. The crisis in Afghanistan prompted the Refugee Council to set up additional support for Afghan refugees. The anticipated 'peak' in cases ready to start My View – including new referrals and those in the control group who had waited the required period – created capacity challenges, which resulted in both intervention and control groups waiting longer before starting therapy than originally expected. The likely need for an extension to the project was identified and communicated to WWCSC in November and the high workload led to the National My View Manager leaving his role.

Phase 2, January–June 2022

Phase 2 was marked by the My View team adjusting to the capacity requirements of both new referrals and control participants coming off the waitlist, as well as notable transition between staff. The challenges included: i) two changes in National Manager; ii) high demands on the service capacity (specifically one-to-one rather than group which required more staff time); and iii) unclear/delayed decision making around funding extensions. During this period, referrals were closed so that no young people were offered therapy that could not be provided, and several therapists left their roles, reducing the team's capacity to deliver to young people in both the intervention and control groups.

Phase 3, July 2022–July 2023

Phase 3 could be classified as a 'settling in' period. A new national manager and administrative team started in the second half of 2022 and brought in several changes to how referrals, delivery, and data were managed. These changes, along with the secured funding to continue the project, facilitated an extended period of stable delivery.

More information on the challenges, facilitators, and mitigations are described in more detail in the IPE findings section.

Delivery and evaluation

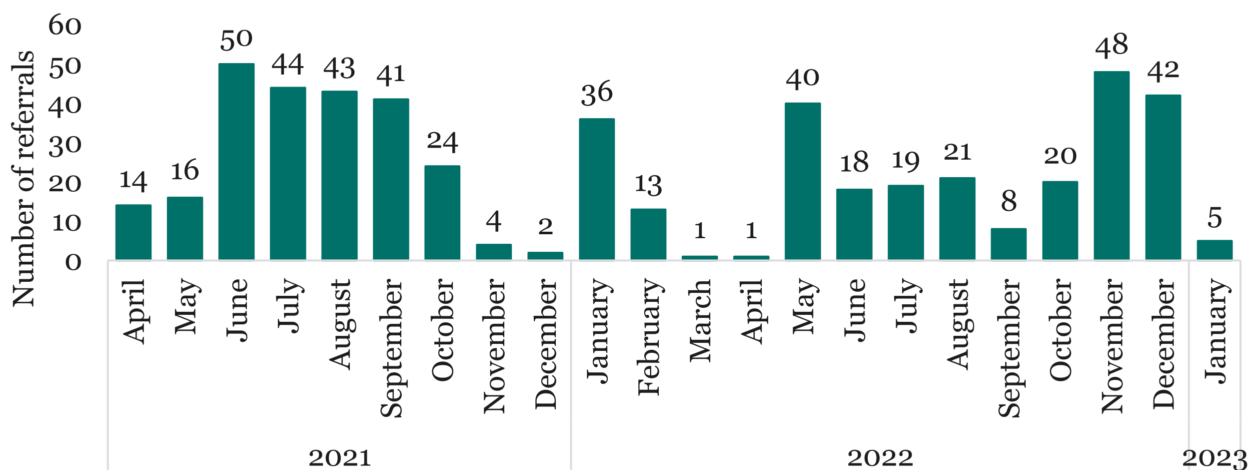
The British Refugee Council paused its commencement of beginning with new My View clients for two months prior to the start of trial delivery, in order to build up a referral list and focus on training new staff. Delivery for the trial started in June 2021 and continued until the end of July 2023 apart from a one-week pause. The one-week pause occurred from 26 October to 2 November 2021, as recommended by the WWCSC safeguarding lead, due to communication from the Refugee Council of a safeguarding concern about a staff member not involved in My View. This pause in delivery delayed all sessions by one week but is unlikely to have had significant effects on the evaluation overall.

There were periods during which new clients were not being randomised or starting therapy, due to uncertainty in the longevity of delivery funding, while the Refugee Council awaited decisions around funding extensions. This was to avoid offering therapy to young people when there was a risk that the funding would not cover the full delivery period.

Referral lists

Referrals in specific regions were closed for periods when therapists were at capacity, to prevent young people being encouraged to access or being offered therapy when the Refugee Council was unable to provide it for the foreseeable future. For example, this is clearly shown in November and December 2021 when many in the control group had waited three months and were due to start therapy, and in March and April 2022 when decisions were being made regarding an extension. Closing the waiting lists may have had consequences for the number of young people reached by the programme and may have been a barrier to accessing the service.

Figure 5. Number of referrals per month



Internal changes

Key staff changes at the Refugee Council may have made implementing the programme and the evaluation more difficult. Two leadership team members involved in setting up the project left towards the end of 2021. The new national manager started in January 2022 and stayed in post for three months, before leaving and being replaced by the current national manager in May 2022. There was no handover between managers in either case, which placed additional pressure on the rest of the team while they took on interim responsibilities as well as training the new managers. A key team member responsible for the administration of the project also left in June 2022. There was also a high turnover of therapists across the two-year period, with notable numbers leaving or switching roles within the Refugee Council in early 2022. Reasons for this varied but included uncertainty around funding extensions for My View. Though the one-to-one therapy received by young people was largely unaffected, staffing changes had implications for the team and the evaluation (described in more detail in the IPE findings section). Notably, periods of recruitment resulted in: i) reduced capacity for teams to see young people and reduced wait times; ii) less systematic administrative reporting; and iii) reduced consistency in the implementation of evaluation requirements such as inviting young people to interview, thus necessitating additional training on the evaluation.

National and international events

In August 2021, the Taliban took control of the Afghanistan government, displacing hundreds of thousands of people. This ongoing change in power had, and continues to have, significant impacts on the lives of Afghan refugees and asylum seekers living in the UK – as a reminder of previous traumatic events, through fear for family and loved ones, and by threatening the idea of 'home'. The number of Afghan young people being referred to My View significantly increased during this period (figure 5 also demonstrates a comparatively high number of referrals during this time). The Refugee Council set up a support group for young people affected by the crisis.

Border crossing incidents and policies announced by the UK government have also contributed to the level of need of young people throughout the project. For example, the government policy announcement in April 2022 that UK asylum seekers would be sent to Rwanda led to high levels of anxiety among people waiting to have their asylum claims assessed by the Home Office (Hanley, 2023).

Impact evaluation findings

Participant flow

Across the five My View sites, 567 referrals were assessed for eligibility by the Refugee Council. Of these, 57 were excluded from the trial. These were primarily young people who were referred when the evaluation was paused (n=41) and those re-referred to the service who were previously randomised (n=13) – though both groups were still eligible for support from My View outside the trial. This left 510 young people who were allocated randomly to the two trial arms: 258 were allocated to the intervention group and 252 to the control group. After accounting for loss to follow-up and missing data in the baseline or endline measures (plus excluding incomplete measures where appropriate), a total of 289 cases were available for the analysis of the primary outcome (YP-CORE) with 138 intervention group cases and 151 control group cases. The rate of attrition was higher than originally expected, which resulted in requests to extend the project. Slightly fewer cases were available for the analysis of the secondary outcome (SWEMWBS) with 122 intervention cases and 140 control cases (262 cases total).

Figure 6 depicts the CONSORT flow chart setting out the randomisation and assessment process, and the number of children and young people assessed, randomised, allocated, lost to follow-up, excluded, and included in the final ITT analysis.

Figure 6. CONSORT flow chart

Enrollment

Assessed for eligibility (n=567)

Excluded (n=57)
- Not meeting inclusion criteria (n=3)
- Referred when RCT paused (n=41)
- Re-referred (n=13), 1 re-referred twice

Randomised (n=510)

Allocation

Allocated to My View (n=258)
- Received My View (n=217)
- Did not receive My View i.e. dropped out after randomisation (n=41)

Baseline data available
- YP-CORE (n=206) (excl. 4 incomplete)
- SWEMWBS (n=188) (excl. 12 incomplete)

Allocated to waitlist control (n252)
- Remained in waitlist control (n=202)
- Received My View (override) (n=18)
- Dropped out after randomisation (n=32)

Baseline data available
- YP-CORE (n=209) (0 incomplete)
- SWEMWBS (n=194) (excl. 10 incomplete)

Follow-up

Lost to follow up YP-CORE (n=76)
- Baseline & endline data not collected (n=7)
- Endline data not collected (n=69)

Lost to follow up SWEMWBS (n=83)
- Baseline & endline data not collected (n=14)
- Endline data not collected (n=69)

Lost to follow up YP-CORE (n=60)
- Baseline & endline data not collected (n=3)
- Endline data not collected (n=57)

Lost to follow up SWEMWBS (n=57)
- Baseline & endline data not collected (n=5)
- Endline data not collected (n=52)

Analysis

Analysed YP-CORE (n=138)
- Excluded (missing/incomplete final) (n=1)
- Excluded (missing/incomplete baseline) (n=2)

Analysed SWEMWBS (n=122)
- Excluded (missing/incomplete final) (n=4)
- Excluded (missing/incomplete baseline) (n=8)

Analysed YP-CORE (n=151)
- Excluded (missing/incomplete final) (n=1)
- Excluded (missing/incomplete baseline) (n=8)

Analysed SWEMWBS (n=140)
- Excluded (missing/incomplete final) (n=7)
- Excluded (missing/incomplete baseline) (n=16)

Participant characteristics

Table 4 breaks down the results of the random allocation by the five My View sites, as well as the number of cases used for the primary outcome analysis. The number of young people randomised

in each site was similar across Birmingham (94), Kent (94), and Leeds (95), and slightly larger numbers were randomised in London (115) and for My View Remote (112).

Table 4. Number of participants by My View site (randomised and analysed)

Site	Intervention		Control		Total	
	Randomised	Analysed*	Randomised	Analysed	Randomised	Analysed
Birmingham	46	23	48	28	94	51
Kent	52	29	42	22	94	51
Leeds	47	23	48	28	95	51
London	57	27	58	32	115	59
Remote	56	36	56	41	112	77
Total	258	138	252	151	510	289

* based on numbers available for analysis of endline YP-CORE.

Overall, the number of young people allocated to the intervention group was slightly higher than the control group (258 compared to 252). This was because high-risk referrals were randomised at 60:40 allocation to intervention and control group respectively. A total of 60 referrals were flagged as high-risk from across all sites: Kent (16), London (15), Leeds (12), Remote (9), and Birmingham (8). Only in Kent was the discrepancy between the percentage in intervention and control group appreciably different (at three percentage points) (see table 5). This was because Kent had the highest number of high-risk individuals allocated to the intervention group (11 out of 16).

Table 5. Proportion of allocated participants by My View site

Site	Intervention	Control
Birmingham	18%	19%
Kent	20%	17%
Leeds	18%	19%
London	22%	23%
Remote	22%	22%
Total	100%	100%

As set out in the protocol, the Refugee Council had the option to override randomisation if young people were allocated to the control group but assessed as requiring urgent support (see figure 3). In total, we were aware of 18 cases where this was used. For the ITT analysis, these young people were analysed as part of the control group trial arm even though they had received the intervention.

Balance checks

Only a limited amount of administrative data was available for young people. Balance checks compared intervention and control groups using the following key characteristics:[17]

- Baseline YP-CORE score (0 to 40)
- Baseline SWEMWBS score (7 to 35)
- Age
- Sex (female or male)
- Number of days in the UK before referral.

Young people referred were from a total of 27 countries, so balance checks of country of origin were not conducted due to small sample sizes and large variation. Among 506 referrals, the most common countries of origin were: Afghanistan (168), Iran (82), Sudan (65), Eritrea (51), Iraq (31), Syria (22), and Vietnam (19).

On average, children and young people in the study were around 16.5 years old (see table 6), ranging from 13 to 23. The number of young people aged 18 was higher than expected given young people should have been under 18 at the time of referral. This may represent participants who had

17 We note that imbalances in baseline characteristics do not necessarily imply errors in the allocation procedure; such differences may arise by chance. However, evidence of any imbalances gives further weight to the importance of sensitivity tests of the impact analysis controlling for any such imbalances in the regression model.

since turned 18, who are eligible to continue receiving support.[18] Three outliers were present at ages 12, 19, and 23. In total, only 35 young people (6.9%) were female and 472 (93.1%) were male.

For continuous variables (baseline YP-CORE & SWEMWBS scores, age, number of days in the UK before referral), balance was tested using two sample t-tests with unequal variances. Balance in proportions (sex) was tested using a z-test. All the balance checks, except age, did not detect any statistically significant differences between intervention and control groups. The difference in the mean age of the control group (16.64) and intervention group (16.45) approached the traditional 5% significance level (p-value = 0.0535). Consequently, it was concluded that there was no evidence supporting imbalance between the intervention and control groups according to the available characteristics (see table 6 below and table C1 in appendix C).

Table 6. Baseline characteristics by intervention group and balance checks

	Intervention group mean	Control group mean	Two-sided test (p-value)
Baseline YP-CORE	21.12 (n=206)	20.31 (n=209)	0.272
Baseline SWEMWBS	20.67 (n=188)	21.03 (n=194)	0.420
Age	16.45 (n=253)	16.64 (n=250)	0.053
Female	0.06 (n=256)	0.07 (n=251)	0.813
Days in UK before referral	229.46 (n=251)	238.41 (n=258)	0.681

Of the 289 cases available for analysis of the endline YP-CORE, young people using My View Remote were more likely to be retained for analysis than were young people associated with physical location sites, with their representation rising from just over one-fifth (22%) of the sample to just over one-quarter (27%) of the sample (see tables 4 and 7, and tables C2 and C3 in appendix C). Kent had the greatest decline in control group members (decreasing from 17% to 14%), while the intervention group remained stable at around one-fifth of the samples.

18 Since the end of the evaluation, the My View team broadened the eligibility criteria to include young people up to 21 years old. This was to respond to the gap in service provision that young people experience when they turn 18, as well as to the increasing number of age disputes that occur.

Table 7. Proportion of participants available for analysis by My View site

Site	Intervention	Control
Birmingham	16%	18%
Kent	21%	14%
Leeds	17%	18%
London	20%	22%
Remote	26%	27%
Total	100%	100%

Note: based on numbers available for analysis of endline YP-CORE.

Along with the site location, the intervention group (intervention vs control) also had a statistically significant difference where the intervention group was missing a greater number of final scores. However, the interaction between intervention and project locations did not yield any statistically significant results suggesting no evidence exists to link the two characteristics (see tables C4 and C5 in appendix C).

Using the available characteristics, no statistically significant differences were found between the characteristics of young people in the intervention and control groups used for analysis (table 8). Additionally, there were no substantial differences between the characteristics of the allocated groups (table 6) compared to the sample available for analysis, though the baseline YP-CORE scores were slightly higher for the analytic sample.

Table 8. Characteristics of sample for analysis by intervention group

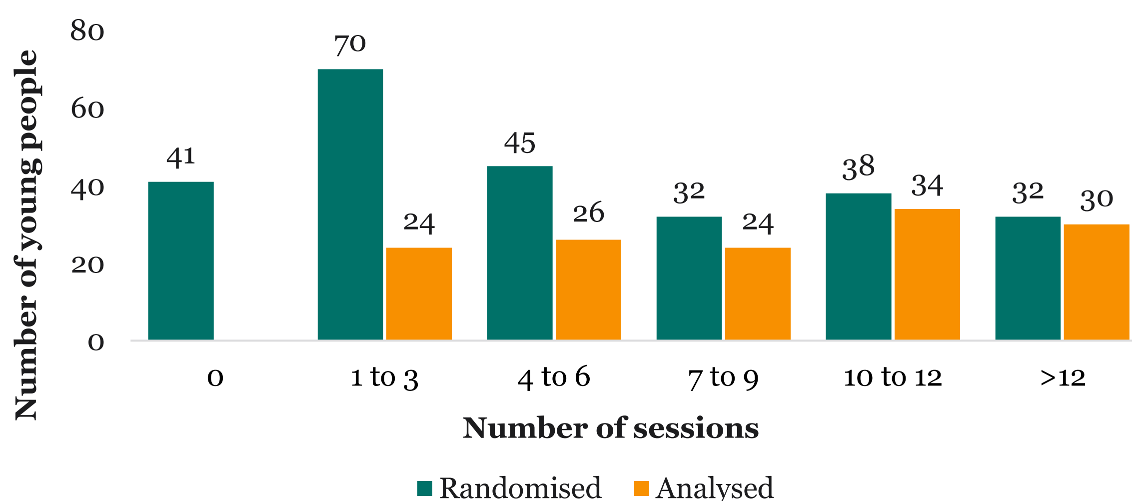
	Intervention group mean	Control group mean	Two-sided test (p-value)
Baseline YP-CORE	21.67 (n=138)	21.30 (n=151)	0.663
Baseline SWEMWBS	20.59 (n=123)	20.61 (n=143)	0.971
Age	16.48 (n=138)	16.68 (n=149)	0.091
Female	0.07 (n=137)	0.08 (n=150)	0.823
Days in UK before referral	211.08 (n=135)	218.40 (n=148)	0.651

Note: based on numbers available for analysis of endline YP-CORE.

Out of 258 young people allocated to the intervention group, 41 attended 0 (zero) counselling sessions,[19] 70 attended between 1 and 3 sessions, 45 attended between 4 and 6 sessions, 32 attended between 7 and 9 sessions, 38 attended between 10 and 12 sessions, and 32 attended more than 12 sessions (see figure 7). The median number of sessions attended was 4 and the mean was 5.76 sessions where the maximum number of sessions attended was 19. Given that My View was designed to be delivered over 12 sessions, the data clearly shows that most children and young people attended fewer sessions.

However, when looking at the analytic sample, the mean increases to 9 sessions. This shows significant loss to follow-up among young people who only attended 1 to 3 sessions (66%) as well as 4 to 6 sessions (42%). The reasons for disengaging early are discussed in the IPE findings section.

Figure 7. Distribution of number of sessions attended by treated children and young people



Primary outcome analysis

A linear regression approach was used to assess the impact of My View on the endline YP-CORE scores. The basic model included the following control variables to help improve the precision of the variance of the impact estimator:

- An intervention status indicator
- Baseline YP-CORE score
- Stratum indicators: My View sites and high risk vs standard risk.

[19] We have classified these individuals as having dropped out following randomisation (see CONSORT diagram, figure 6) as they neither completed baseline/endline nor attended any My View sessions.

An OLS was estimated in the first instance (table 9). After accounting for missing YP-CORE data, the sample size available for the OLS regression was 289 observations, with 138 in the intervention group (120 exclusions) and 151 in the control group (101 exclusions).

The estimated impact of My View was equal to a decrease of the endline YP-CORE score in the intervention group of -7.07 (p-value < 0.000) compared to the control group, which corresponds to a Glass's Delta effect of -0.88. A lower score, as indicated by the negative effect size, implies reduced psychological distress levels among young people. Furthermore, noting that the average baseline score was 21.67 and the clinical cut-off was set at 14.1, these findings suggested that My View shifted young people much closer to non-clinical scores (scores can range from 0–40). The outcome effect is statistically significant at the p<0.001 which is substantially higher than the threshold set out in the trial protocol (p<0.05).

Table 9. Ordinary Least Square regression results – Basic model – YP-CORE (Primary outcome: Endline YP-CORE score)

	Coefficient	Robust standard	95% confidence interval	Glass's Delta	Robust standard error
Intervention	-7.065706 ***	0.821	-8.683, -5.448	-0.8828	0.102
Baseline YP-CORE score	0.4517146 ***	0.060	0.333, 0.570		
Strata:					
Standard risk (base)					
High risk	1.760825	1.455	-1.104, 4.626		
Strata:					
Birmingham (base)					
Kent	1.065977	1.498	-1.883, 4.015		
Leeds	1.50632	1.330	-1.112, 4.125		
London	0.9033502	1.171	-1.403, 3.209		
Remote	1.6172	1.181	-0.708, 3.942		
Constant	8.913638 ***	1.639	5.686, 12.140		

Number of observations	289				

*** indicates significance at 1% level (p-value < 0.01)

Secondary outcome analysis

Analysis of the SWEMWBS used the same OLS method as described above for the primary outcome (see table 10). The basic regression model included similar control variables which are as follows:

- An intervention status indicator
- Baseline SWEMWBS score
- Stratum indicators: My View sites and high risk vs standard risk.

After excluding missing baseline and/or endline SWEMWBS scores, the sample size available for the OLS regression decreased to 262 observations, with 122 in the intervention group (136 exclusions) and 140 in the control group (112 exclusions).

The estimated impact of My View was equal to an increase of the endline SWEMWBS average score in the intervention group of 3.08 (p-value = 0.000) above the control group mean, which corresponds to a Glass's Delta effect of 0.65. The SWEMWBS runs opposite to the YP-CORE in measuring mental wellbeing, i.e. a higher score is associated with better mental wellbeing (scores can range from 7–35). The outcome effect is statistically significant at the $p<0.01$ which is again substantially larger than the threshold set out in the trial protocol ($p<0.05$).

Table 10. Ordinary Least Square regression results – Basic model – SWEMWBS (Secondary outcome: Endline SWEMWBS score)

	Coefficient	Robust standard	95% confidence interval	Glass's Delta	Robust standard error
Intervention	3.082257 ***	0.454	2.187, 3.976	0.654	0.096
Baseline YP-CORE score	0.4941225***	0.059	0.377, 0.610		
Strata:					
Standard risk (base)					
High risk	-2.544678 ***	0.517	-3.564, -1.524		

Strata:					
Birmingham (base)					
Kent	-0.7525831	0.768	-2.266, 0.761		
Leeds	0.773863	0.813	-0.827, 2.375		
London	-0.1658916	0.664	-1.474, 1.143		
Remote	0.555426	0.595	-0.617, 1.727		
Constant	11.05795 ***	1.404	8.291, 13.824		
Number of observations	262				

*** indicates significance at 1% level (p-value < 0.01)

Dosage analysis

The results of the dosage analysis (see table C6 in appendix C) found an unexpected pattern such that, compared to the overall impact estimate for the YP-CORE (-7.03), the effect was:

- -7.95 among participants that received 1–3 sessions
- -6.32 for those with 4–6 sessions
- -9.58 for those with 7–9 sessions
- -7.79 for those with 10–12 sessions.

The outcome data alone cannot explain this pattern of increased and decreased effects depending on the number of sessions received. This is discussed further in chapter 5.

Sensitivity analysis

Complier average causal effects

The Complier Average Causal Effect (CACE) was computed using Instrumental Variable 2SLS (2-Stage Least Square) approach as follows:

```
ivregress 2sls outcome (treatment = assignment) covariates
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Where the outcome was the final YP-CORE scores, treatment is variable indicating actual treatment status, assignment is variable indicating treatment assignment at the time of randomisation, and covariates are additional variables being controlled for, such as project location, risk strata, etc.

As there is only one-sided non-compliance (i.e. those who do not comply with treatment assignment are in the treatment group, after excluding one non-complier in the control group), the CACE can be considered a good indication of the Average Treatment Effect on the Treated (ATT), i.e. the effect for those who participated in the treatment. In total, 18 young people were moved from the control group to the treatment group by therapists, while one young person moved in the opposite direction.

Since the CACE refers to the population of compliers, it is not surprising that the estimated CACE was larger than the ITT effects estimated in the main analysis. This only further warrants the positive impact of the therapeutic intervention. Endline YP-CORE score was higher by 0.535 points in the complier group (-7.60) as compared to the ITT analysis group (-7.07) and it is statistically significant at 99% level.

Table 11. 2SLS regression results – YP-CORE

	Coefficient	Robust standard error	95% confidence interval	P-value
Intervention	-7.60107 ***	0.920	-9.404, -5.798	0.000
Baseline YP-CORE score	0.4725011***	0.061	0.352, 0.592	0.000
Strata:				
Standard risk (base)				
High risk	1.767332	1.382	-0.942, 4.477	0.201
Strata:				
Birmingham (base)				
Kent	0.5940497	1.464	-2.276, 3.464	0.685
Leeds	1.64101	1.438	-1.178, 4.460	0.254
London	0.6507853	1.403	-2.100, 3.401	0.643
Remote	1.392845	1.306	-1.168, 3.953	0.286
Constant	9.182263 ***	1.646	5.955, 12.401	0.000
Number of observations	289			

*** indicates significance at 1% level (p-value < 0.01)

Missing values

Since there are ten missing values in the baseline YP-CORE scores where the final YP-CORE values exist, we conducted a mean imputed sensitivity analysis to analyse the effect of these missing values. The missing baseline YP-CORE scores of these ten individuals was replaced with the mean baseline YP-CORE score. These values were added to the above-mentioned primary outcome regression model along with binary indicator for these ten individuals with missing value.

The effect of the intervention in the primary outcome regression model was -7.07 (see table 9) and the effect of intervention in the sensitivity regression model was -7.03 (see table C7 and C8 in appendix C), both are significant at 1% level. This difference in the magnitude of effect in both models suggests that both models are almost identical, therefore the missingness of the baseline YP-CORE data does not impact the interpretation of our results from the primary outcome analysis.

Additional covariates

Further regression models explored the impact of explanatory variables (gender, age, etc.) on the estimated impact effect size. This was also intended to help ameliorate any covariate imbalance between characteristics of the intervention and control groups; however, on exploration of the data, no evidence of imbalance was found. We compared the impact and effect size estimates of the 'exploratory' model to the 'primary' model to assess the extent to which the further controls have increased or decreased the impact effect. A further model explored the effect of dosage, i.e. number of sessions attended, on the outcome scores (see above).

Implementation and process evaluation findings

IPE research question 1 – Mechanisms of change

- What are the perceived changes in outcomes?
- What are the perceived mechanisms of change for My View to intended outcomes for young people?

A primary finding of the IPE was that My View is perceived to have a positive impact on young people and those that support them. Interviewees described these positive changes as well as the limitations of the service within two key themes. The first theme was that the effects of My View reach into all aspects of young people's lives and vary significantly across individuals, depending on their presenting needs, existing coping mechanisms, and type of support provided by their therapist. The second theme was that while My View could be very effective, it is not a quick fix – it takes time to have an impact and young people need to be open to the process for that to happen.

Theme 1: Perceived improvements

The first key theme identified was that My View has wide-ranging effects which vary across recipient. Perceived improvements and positive effects were reported in numerous areas of young people's lives by staff, stakeholders, and young people themselves. These benefits can be broadly categorised into:

- **Psychological and emotional wellbeing:** reduced stress, improved anger management, and improved mood, emotions, and feelings.
- **Sleep, diet, relaxation, and lifestyle changes:** improved amount and quality of lifestyle changes such as sleep, diet, and exercise.
- **Social connections:** building networks, making friends, socialising, reduced loneliness.

These impacts reach into all areas of young people's lives and include areas intentionally targeted by the My View therapeutic model as well as secondary or associated outcomes. It is important to note that many of the benefits listed are linked and not reported in isolation. Notably, there are broad differences between young people's responses to the intervention, according to contextual factors such as personal history and culture, openness to therapy, baseline wellbeing, and social care support.

The elements of My View that young people found helpful and the aspects of their lives which benefited varied significantly between individuals, but there was overwhelmingly positive feedback about its contribution to their lives.

> "It's like a recipe book; you can't create a masterpiece off every recipe but it's a good book because the majority do come out pretty good and that shows me that something works in there." – Therapist

Psychological and emotional wellbeing

Changes to mental wellbeing perceived to result from My View included a more positive and hopeful outlook on their life, improved ability to cope with stress, anger, and emotions, and reduced shame about experiencing problems. Mental wellbeing is one of the key short-term and long-term outcomes specified in the theory of change, and this positive change was also evidenced by positive impact on both the YP-CORE and SWEMWBS measures in the trial. Young people reported the sessions as life-changing in some cases.

> "I was hopeless, I didn't know what is the meaning of life, it was so hard for me, but she gave me hope. With that hope, I can live in hope to see the future." – Young person

> "I came out of those sessions, like, when I finished, I was a completely different person with a completely different view to life, and me being different. So before, I was like hopeless and I didn't want to live, but after that, I was more like comfortable and everything was much, much better for me." – Young person

Similarly, therapists and stakeholders saw positive shifts in young people's mentalities, with them appearing more relaxed, brighter, and more settled.

> "There's a big impact in their attitude, their outlook on their lives, they're a lot more optimistic, they feel empowered after having had 12 sessions at My View." – Therapist

Social workers and foster carers reported that these changes in mental health can have tangible outcomes such as reduced or an end to safeguarding concerns, self-harm, and suicidal thoughts.

Sleep, diet, relaxation, and lifestyle changes

The interviews supported the theory of change in terms of the importance of the tools for coping, including sleep hygiene. In line with the literature, difficulties and improvements in sleep was a very common topic raised across interviews. Improved sleep duration and quality can support cognitive and mental health benefits both in the short term and the long term. Improved sleep and reduced nightmares were reported widely by young people and the adults around them. For instance, one young person explained:

> "This is really helping me and there is a lot of change in my sleep."

The therapists also helped young people to reduce unhealthy habits and develop healthier routines, such as a regular bedtime, mealtimes, and exercise, which led them to feel better physically. One young person reported that they had stopped smoking marijuana, drinking alcohol, and taking hard drugs since his therapy started. Another young person noted improvements in the sleeping and eating routines:

> "At the beginning, I was not sleeping, and I was not eating properly and all of that. And she helped me through all of these problems, like, how to sleep, what I had to do, to go to bed, and not to stress, and how to eat." – Young person

Young people enjoyed being given new tools to try and review at their next session, although at times it took a few weeks before they tried them. Many young people reported still using and benefiting from the advice they had been given at the time of their interview, suggesting some longevity of these effects.

Social connections

My View was reported to have a big impact on young people's social lives and integration into society by helping to '*break the loneliness*'. After My View, young people were making more social connections and spending more time out of the house. Young people sought more connections within their community during and after therapy, with one young man replacing obsessive hours spent on social media tracking the news from his homeland with socialising.

This is seen as a positive in most cases although accommodation support workers also see the value in young people spending time at home where there is stability and support available. The need for support in this area also varied by culture.

Wider and longer-term benefits

The psychosocial approach enabled the therapists to have an impact beyond short-term mental wellbeing, such as supporting young people into education or resolving housing issues. This is expected to ultimately lead to sustained psychological benefits over the longer term. The added caseworker focused on this aspect of the work, and participants highlighted the benefits of letters of support to the Home Office and practical support to change their home environment.

Mechanisms of change

Interview participants reflected on the key features of My View that are likely to have led to these positive changes in young people's wellbeing, which have been summarised here with reference to the anticipated mechanisms of change outlined in the theory of change. These mechanisms were hypothesised to contribute to improved confidence, physical wellbeing, and safety and lead to an increased willingness to engage with other services.

Actively listening to clients' narratives and using creative therapeutic techniques:

- Feeling heard and understood via trusting their therapist and being listened to rather than being talked at enabled young people to process their emotions in a safe space without judgement.
- A strengths-based approach, which included focusing on the positives in the present and being encouraged to see beyond current difficulties and make aims for the future.

> "I learned how to think about the future, about the present, and to plan for the future and to think better." – Young person

Consistency, predictability, and confidentiality of the therapeutic relationship:

- Having the consistency of weekly interactions in a private space with an adult who is not a social worker and feeling that someone is genuinely trying to help increased young people's trust in supportive adults and helped them to feel safe.
- Strong therapeutic relationships based on confidentiality, trust, patience, and openness helped young people to process their experiences.
- Forming a strong relationship with the therapist supported the young people to make other positive social connections. This was both formal connections such as gaining access to education, social clubs, and group sports, and informal connections such as making friends at school.

Offering a vocabulary for expressing feelings and describing experiences:

- Talking about emotions, experiences and responses and having them normalised and contextualised – through groups with other young people or in one-to-one sessions – supported young people to feel that they were 'normal', express themselves and to know when to ask for support.

> "I think the biggest gift that that therapeutic intervention gave him was the fact that it was somebody from his community there to reassure him, you know, and to give him a little bit of hope that things were going to get better." – Stakeholder, Foster carer

Providing tools to improve sleep and emotional regulation:

- Being given tips such as breathing exercises to manage strong emotions such as anger helped improve young people's ability to self-regulate their emotions.
- Learning to use practical tips for managing sleep, morning routines, and physical wellbeing improved young people's physical wellbeing. Reduced concerns about sleep deprivation and nightmares also gave young people more time and energy to focus on other areas of their lives such as education.
- As well as sleep hygiene and emotion regulation, therapists gave advice on eating and exercise.

> "The therapist told me a lot of techniques and skills, how to cope with problems that I was having at that time. And now I'm okay, you know, I'm equipped with lots of techniques, the skills, how to deal with it." – Young person

> "The things that she taught me were useful and I used the techniques she taught me. They were helpful." – Young person

Theme 2: Evolving experience and 'dosage'

The second key theme to emerge, was that it takes time for young people to become receptive to therapy and feel its effects. On average, young people in the intervention group attended 5.76 sessions (increasing to 9 sessions for the analytical sample). As such, many disengaged or came to a mutually agreed ending before all 12 sessions.

Young people reported finding the sessions hard and frustrating at the beginning, as they were not used to opening up or talking about their feelings. One young person explained that he did not understand the process at first, but after a few sessions he understood it and it became more helpful.

> "I think, for the first session I think, because at the time I didn't understand much about the way how they work, the work how they help me and I wasn't sure if the way I applied is helpful for me or not, if it's effective for me or not. So for those few first sessions, it wasn't really helpful for me but after that when I fully understood and I follow it, it's helpful." – Young person

With time and the development of the therapeutic relationship, they began to see how it could be helpful and felt it starting to be effective. They found that the repeated weekly sessions contributed to feeling better, and even missed them between sessions.

> "It's really perfect. Helpful. It doesn't help in one go, but when you do it again and again it's good." – Young person

Likewise, stakeholders reflected on the need for several sessions to make a difference. This was predominantly down to the time it takes for a trusting relationship with the therapist to develop.

> "It's not like turning a lightbulb on and off. Just because the sessions have ended, you suddenly see this new person. That's not how it works. But I think over time, sleep became easier, self-harming stopped." – Stakeholder, Foster carer

They also noted that My View support took place in parallel with other aspects of young people's lives settling down, starting school, and the development of relationships and support networks, so it is difficult to isolate the impact of My View qualitatively. A therapist provided the example of a young person who had started My View very reluctant about therapy, who culturally saw it as taboo, and was uncomfortable about sharing any experiences from his childhood.

> "It took us about 5 to 6 sessions until he felt very safe and comfortable with me, to the point where I didn't need to ask any prompt questions, he would just share things that was on his mind, things about his past. He felt comfortable to openly discuss things that were bothering him at the time." – Therapist

Conversely, the work done in My View sessions was thought to lead to positive shifts in young people, even in cases where the young person only attends a few sessions.

> "Clients can within 3 or 4 weeks say, 'That's okay, and it's made a difference.'" – Therapist

Furthermore, it was perceived that even a handful of sessions was thought to make young people more likely to access therapeutic or other types of support and to share information and concerns with social workers or foster carers in the future.

These findings corroborate those of the dosage analysis such that a positive impact was visible even after only 1–3 sessions and 7–9 sessions appeared most impactful. As such, there may be a minimum duration or number of sessions that is necessary to benefit young people, but even a small number of sessions might be useful depending on a young person's culture, individual needs, and openness to talking therapy approaches.

Limitations to the effectiveness of My View

There were some limitations to the ability of My View to positively support on young people's wellbeing. Those with more significant or diagnosable mental health issues expressed a need for psychiatric support or medication, which is beyond the scope of the My View model.

> "Counselling, as good as it is, is not going to cure all ills. Certainly, for the trauma these people experience, it's not going to." – Stakeholder, Foster carer

The stress of waiting for a decision by the Home Office on asylum status and ongoing difficulties in their home country was also considered a limiting factor.

> "I'm in a better situation, but this change won't fully show its impact until I get my Home Office papers and until I get enough information about the safety of my parents." – Young person

Unintended consequences of My View

Not all the effects of the programme were reported as positive. A minority of young people found that their ability to sleep was adversely affected by talking about their traumatic experiences, and, in some cases, this led them to end the sessions early.

These effects reemphasise the value of the inherent flexibility in the My View model and the importance of taking an individualised approach to the therapy, by assessing what kind of support is going to be most helpful for each young person, and weighting casework support more strongly than talking therapy where appropriate.

IPE research question 2 – Adoption

- What is the programme reach?
- How many took up the service?
- What kinds of activities did they do?
- What referrals were made and how many of those went on to receive the intervention?

Referrals and recruitment processes

Referrals were typically made by social workers, support workers, foster carers, and supported accommodation providers. Less-commonly mentioned referrers included a teacher, a Refugee Council staff member, an English for Speakers of Other Languages (ESOL) teacher, a doctor, a solicitor, and a police officer. Data on referrals was captured through the interviews.

Stakeholders described their experience of the referral template and the overall referral process as straightforward. One stakeholder appreciated receiving an automated response from My View with information on waiting times and reported receiving timely responses and clear answers to emails from the My View team.

A finding relating to the effectiveness of referral processes was that while social workers were well placed to make referrals in terms of their understanding of young people, they were not always making referrals. The hypothesised reasons for this among stakeholders included not being aware of My View or not having time. There are also concerns that other relevant stakeholders may not be aware of the referral process and their ability to refer. This includes:

- **Foster carers:** Although interviewed foster carers were not all aware of My View or aware that they could refer, they reported knowing young people's needs and having more time than social workers to make referrals. Foster carers themselves benefited from being in contact with therapists, for example providing reassurance about the benefit of sessions and getting advice and resources that helped them understand the young person's behaviour.
- **Teachers:** Some stakeholders felt that teachers would be well placed to make referrals as they are in regular contact with young people in education who would likely be eligible.

- **Supported accommodation providers:** Again, these stakeholders often know young people's needs and have more time to make referrals. However, interviewees were not always aware of the service.

Several stakeholders referred to the need for improved collaboration between agencies to coordinate referrals and share safeguarding concerns. However, there are confidentiality implications with this approach, further highlighting the importance of all relevant stakeholders being able and empowered to make referrals.

Explaining My View to young people

Staff and stakeholders agreed that a trusted relationship between the young person and the referrer helped young people to overcome initial concerns about My View. Stakeholders described being careful in how they described My View to young people, to avoid deterring them.

Due to the prevalence of stigma relating to mental health (discussed further below), many stakeholders described how they attempted to normalise having mental health issues and challenging binary perceptions of mental health as being 'sane or crazy', sometimes drawing on their own experiences of mental health issues and accessing therapy. Some were careful to avoid terms such as mental health, for example using the term 'difficult times' instead.

Stakeholders also highlighted the importance of talking about feelings and offloading with a view that young people would feel better and lighten their load.

> "We know that it's been a tough journey and it's been hard to get here, and to leave your family and to leave your country. It's just a way of exploring how you're feeling." – Stakeholder, Representative of a refugee support service

> "Not saying that it will cure you, but it will make you understand things differently, and see things in a different light. Then they do understand, most of the time." – Stakeholder, Representative of a youth support service, including support for UASC

One stakeholder described how after they explained My View, they gave young people time to think and make their own decision. Where young people were reluctant because they do not fully understand the service, stakeholders suggested that they have an initial appointment with a therapist before making a decision.

Barriers to engagement and retention

Cultural norms

Most stakeholders and staff reported that a key barrier to engagement and retention was stigma towards accessing mental health services. They reported that many young people came from cultures where there is stigma towards mental illness, meaning they did not want to admit to experiencing mental health issues. This could be because of fear of being judged, marginalised, or even excluded from their community. It could also be linked to their own self-perceptions,

preferring to see themselves as strong rather than vulnerable or even ‘insane’. Several stakeholders mentioned that this tended to be more prevalent among young people from South Asia.

> “One young person who came through who did really [have] ... quite a lot of trauma, slept with the light on, wouldn’t turn the light off, etc. And I remember when I spoke to him and I said, ‘Look, I’m not saying that you have got mental health issues, but I think you might need some help with being able to turn the light off and this, that and the other.’ And he basically turned round and said, ‘If anybody from my culture found out that I was mentally ill, nobody would ever speak to me, and I’d never get a job, and I’d never get this.’” – Stakeholder, Supported accommodation provider

Linked to this, another barrier was a lack of awareness and understanding of talking therapy among young people from countries where these services are less common. Stakeholders found that some young people preferred to see a doctor, which was more familiar to them. However, this was not universal. For example, one stakeholder noted that a young person was more receptive to therapeutic support than medical intervention such as antidepressants, which he worried would label him as sick.

> “To be honest, it was very new to me that a doctor can help with just talking, so it’s quite new to me but I got used to it.” – Young person

One proposed solution from a staff member to address these barriers was co-producing programmes with communities to ensure they are clear on what wellbeing and healing means to people from different cultures, enabling them to work more holistically.

Timing

An additional barrier that prevented young people from engaging and impacted dropouts was a reluctance to revisit and discuss past trauma, particularly given that many young people have to do this as part of their asylum claim. This links to the importance of timing which was highlighted by many staff and stakeholders. They reported that young people generally need to feel safe and have their basic needs met before being ready to address mental health needs. Getting the timing right was not straightforward. For example, some stakeholders described how they periodically discussed My View with young people in case they felt ready, but equally it was thought that social workers and other referrers have submitted referrals as a ‘box-ticking exercise’ when young people have not been ready.

> “She [the therapist] did ask me about my history and lots of occasions ... When sometimes I remember those occasions, I can’t sleep [that] night because I had a terrible life in my backstory, so I don’t want anyone asking me about my history and also, about my background. It’s affected me so much. That’s why I stopped going to sessions with [therapist].” – Young person

One of the main timing-related barriers was when young people were focused on receiving an outcome on their asylum claim and therefore did not have capacity to address wider issues.

Stakeholders described how young people were sometimes more receptive to My View once they received a decision on their asylum claim.

> "I have lots of people come here and they ask me about my future, 'Where would you like to be in the future?' and 'What kind of job you want in the future?' I didn't tell them because I know I haven't got my residence yet, so why [do] they ask me about it? … I haven't got my paper yet. I've got many struggles, so I'm always thinking, overthinking about it." – Young person

> "The young people that I find that we tend to lose are the ones who can't tolerate even just that fear of, 'What is this going to bring up for me?' They're the ones that we tend to lose. Or the other ones that we might tend to lose, are, 'My biggest concern is my immigration status and if you can't help me with that, then let's not talk.' Again, it's about that readiness, and stability, and feeling of safety, in order to be able to engage in something like this, and benefit from it." – Therapist

Lack of understanding of My View

Several stakeholders and staff described how young people started sessions without a clear understanding of My View. This was corroborated in interviews with young people, where many mentioned they started the sessions without knowing what to expect. In cases where young people perceived that the sessions were not changing their situation, they were more likely to drop out. This highlights the importance of stakeholders that make referrals taking the time to explain and answer questions and recommending that young people have an initial conversation with a therapist to better understand what they can (and should not) expect from My View. Therapists also need to carefully judge that young people are clear on the My View approach after the initial appointment.

Stakeholders also described how young people can be exposed to mixed messages about whether My View could affect their asylum claim. For example, there is a misconception – sometimes spread by traffickers and other individuals – that it would have a negative impact, while others are told that taking part in My View would result in a letter supporting their asylum claim.

Life changes

Stakeholders described how under the National Transfer Scheme, unaccompanied children often need to move despite settling somewhere and accessing My View support. This can result in them moving away from the Refugee Council site and cause instability.

Stakeholders also described how some young people felt they had had enough sessions before 12 sessions. For example, this could be because they felt that they had got what they needed after a few sessions or that they preferred spending their free time with friends instead.

Programme and evaluation design

The My View model is not appropriate for young people with very high levels of risk who require longer-term specialist mental health interventions, for example through a CAMHS diagnosis. However, some stakeholders raised concerns about whether these young people were able to access other services. While the Refugee Council aims to signpost to other services, one stakeholder reported that they were not provided with recommendations after a young person was deemed ineligible. In an interview with a young person, they described how they agreed with the therapist to stop the sessions and seek out a psychiatrist via the GP, but they were still trying to get an appointment at the time of the interview.

Due to the capacity challenges and the evaluation design (discussed further below), many young people were placed on a waiting list before they could access services, or referral lists were sometimes closed. Stakeholders described how having to wait to access My View created mistrust among some young people, for example thinking that it meant their need was being questioned. Multiple stakeholders described how forward planning can be difficult for young people as their futures are often uncertain, which made young people uneasy about waiting. Furthermore, while on the waiting list, young people's situations could also change, which in some cases meant they were no longer interested in accessing My View.

Enablers to engagement and retention

Flexibility

Staff, stakeholders, and young people described the importance of My View's flexible approach to working around young people's schedules and other factors affecting their availability (such as sleeping medication resulting in oversleeping or not feeling comfortable talking for whatever reason). This included understanding these barriers, rearranging sessions, including at short notice, and not removing young people from the programme for missing a small number of sessions. One stakeholder felt that to meet some more vulnerable young people's needs, an even greater degree of flexibility was needed to be more responsive in the moment and over time.

> "For some of the harder to reach young people, it may be that on one particular day, they're actually open and willing and able to access the service but it's for that day, for that week. And actually by the time you've done a referral and waited through the referral process that window of opportunity has gone; so something that's perhaps less formal and easier to access may be able to reach some of those young people." – Stakeholder, Social worker

Therapist background

Several young people, staff, and stakeholders described how having a shared language and background supported a connection and shared understanding between therapists and young people. However, many young people whose therapists were from different backgrounds felt that this was not an issue.

> “We speak the same language, and I felt comfortable with her.” – Young person

> “I’m not concerned about whether the person is from my country or not, as long as I get the help I need.” – Young person

As such, My View’s approach to having a range of therapists in terms of gender, nationality, cultural background, and languages was acceptable among young people, with additional benefits where they shared backgrounds.

More importantly, interviewees agreed that therapists taking the time to establish the relationship and ensure young people felt at ease was most important for effective sessions and reduced the risk of dropouts.

External–referrer relationships and supportive adults

Good relationships with referrers were thought to facilitate the recruitment and engagement of young people with the therapeutic process. Strong relationships were partly built on the reputation of the Refugee Council and partly built on individual relationships with therapists. Sharing updates with referrers at every stage of the process with a young person smooths these interactions and helps referrers know what is being asked of them. This reputation led to more frequent referrals.

> “[Referrers] value the work that we provide at My View, and they do see how effective and how much of an impact it has on the young people’s lives.” – Therapist

Stakeholders and staff described how foster carers or supported accommodation providers were a key enabler to retention. For example, they supported young people with managing appointments, reminding them of appointments, taking them to appointments, and ensuring they had the required technology and a safe, private, and comfortable place to join sessions. They were also a key point of contact for therapists when they could not reach young people. Social workers and support workers were also sometimes involved in reminding young people of appointments.

> “It would be picking them up from wherever they were, if they were at school or college or doing something, making sure they were out of bed, making sure they were ready, making sure that they had water and they were warm when they were doing it. … When you’re talking through trauma and things, you can become quite cold. Certainly, they would, so we used to warm up the blanket and stick it over their lap and it would make them feel nice and warm and cosy which helped them, you know, to engage.” – Stakeholder, Foster carer

The converse experience of young people who did not receive this type of support was not explicitly discussed in interviews, but it is implied that it would be more difficult to engage and benefit from the therapy.

In some regions, overstretched local authorities were difficult to communicate with, took a long time to deal with concerns, or did not understand the My View service offer, which resulted in

inappropriate referrals. Additionally, unresponsive or unhelpful social workers made it more difficult to have regular sessions with a young person.

> "So it depends from region to region and some regions have been really difficult; it has been difficult to manage the communication, that relationship with stakeholders, more than the others." – Therapist

IPE research question 3 – Acceptability

- How acceptable do participants and staff find My View (e.g. content, complexity, comfort, number of sessions, online nature)?
- Is it viewed as an improvement on services as usual by young people, delivery partners, and social workers?
- What adaptations have been made to make the programme more acceptable and culturally acceptable to participants?

Practicalities

Young people came to their My View sessions with an array of individual needs and expectations. The flexibility of the session format, therapeutic approach, and therapists themselves helped ensure that the programme was acceptable to young people, despite the significant variation between them.

Group vs one-to-one

My View was designed to be able to offer young people either one-to-one or group therapy and some groups were run prior to the evaluation starting. Prior to the evaluation, the attendance at group sessions was sustained on a more informal basis than other referrals, where young people could drop in, bring friends, and attend over extended periods of time. However, there were many challenges in setting up groups for the purposes of the RCT (e.g. creating groups with only those randomised to the intervention group). This meant all participants received one-to-one therapy, though some joined groups in addition to their therapy. These challenges are detailed below.

- **Set up:** It proved challenging to achieve sufficient numbers of young people interested in group therapy, who were also allocated to the intervention group, needed to set up a new group at any one time.
- **Appropriateness:** Some young people did not feel comfortable sharing details of their traumatic experiences in a group, for example if they had been sexually abused.
- **Language:** Groups with more than one language other than English were not feasible to run due to the overlapping interpretation. Groups in which all participants other than the therapist spoke the same language were also challenging to manage.
- **Restricted recruitment routes:** Before the evaluation, groups were sustained by young people bringing their friends along or joining while waiting for one-to-one therapy. However, these were not feasible routes because i) bringing friends would bypass

randomisation and ii) attending groups while waiting for therapy would expose the control group to the intervention prematurely.

- **Less desirable:** Young people sometimes explicitly preferred one-to-one therapy or did not consider group sessions worth waiting for.

For example, one young person expressed their hesitancy to be involved in a group:

> "It's only me and them listening, you know, it's not five, six people sitting around listening to me. So, that's why it's easier for me to talk when I have talking therapist and things like that." – Young person

However, some young people had positive experiences with group therapy because hearing about other people's stories and responses helped to normalise their experiences. They were also able to share tips and learn from other people with similar backgrounds.

> "By participating in that group, I used to take some really useful things, or some helpful ideas." – Young person

Online vs in person

Both online and in-person delivery were seen to have benefits and disadvantages for access to the service and the extent to which young people could benefit from it. It was also dependent on each individual young person's needs, requiring flexibility from the therapist to find the approach that worked in each case. Many staff stated a preference for face-to-face delivery but recognised that this needed to be determined on a case-by-case basis given that online services can be more accessible.

The benefits of face-to-face delivery as articulated by therapists, stakeholders, and participants are as follows:

- Young people can read their therapist's body language better.
- The service felt more personal which enabled young people to develop trust and be more honest with their therapist.
- Staff can make better use of their tools and training (e.g. play therapy, use games, and crafting activities).
- It is easier to navigate natural silences.
- Staff know the local area and services and are better able to make recommendations.
- Young people get 'out of the house'.

A professional in a separate Refugee Council service explained their expectation:

> "To be honest, I reckon that the majority of people that do remote would probably prefer face-to-face." – Refugee Council staff member

However, there were some limitations to face-to-face delivery, and there was a preference for online delivery among young people interviewed. Travel to Refugee Council offices could take young people a long time, add a financial burden, add the risk of getting lost, and contribute to

young peoples' worries about the sessions. Furthermore, the unfamiliar therapist's office was described as 'an unknown, cold, alien place' where a young person might struggle to open up.

Conversely, positive views of online therapy included that being in their own safe space put young people's minds at ease while discussing difficult topics. The benefits of online therapy included giving young people confidence and the freedom to open up, a sense of control, and the choice of phone, voice, or video call.

> "I personally think that although attending therapy in person physically has, you know, its own essence of therapy and its own value basically, online I feel like it adds that extra bit of safety for the client. They know that they're sitting or in a space where they feel safe and they're talking about their experience that puts them in a very unsafe mental space." – Therapist

> "It is better for me online because I was confident. If it was face-to-face maybe it would be difficult for me." – Young person

The accessibility of online therapy was a major reason for young people's preference for it – young people liked that they could join from anywhere and could take the call even if they had forgotten about the appointment. Young people appreciated the ability to move between phone and video sessions as it suited them, although therapists preferred video for relationship-building and widening their options for using activities. Online sessions were more flexible around young people's often busy timetables of college and appointments with the Home Office, doctors, social workers, and solicitors. Online delivery also removes the geographical limitations of the service – young people could receive therapy even if they lived somewhere without a Refugee Council office.

> "I prefer it because most of the time I'm in college, so I don't have time, so I don't want to be present at some specific location at a specific time." – Young person

Negative views of online therapy included that it limits the scope for building a trusting and honest relationship, particularly with the most disenfranchised young people.

In most cases, access to a device, reliable internet, and a private space was not seen as a barrier to online therapy by young people, though this finding may be skewed by the sample who consented to an online interview. Staff and stakeholders reported that some young people were 'panicked' by Zoom or were unfamiliar with using technology. Foster carers often supported this access and speculated that it would be more difficult for a young person in independent accommodation who did not have that support.

There was consensus that group delivery does not work as well online – young people and therapists found it challenging to establish a cohesive group dynamic due to the complexity of managing different languages and interpreters.

Number and timing of sessions

In general, young people interviewed felt that the number of sessions was about right for them. This varied across young people, which suggests that therapists were well attuned to young

people's needs and levels of engagement. A small number expressed an interest in having more sessions.

They appreciated scheduling in the sessions and flexibility to change these if needed. As mentioned above, young people fit the sessions in around their other commitments, and this would often mean that sessions needed to take place outside of school hours. This imposes some limitations on therapists when scheduling sessions across their caseload.

Language and culture

Despite all young people engaging with My View either in their second language or via an interpreter, this was considered largely acceptable and not a major barrier to benefiting from the programme. However, there were also some recommendations for improving the experience, such as using only therapeutically trained interpreters. The young people who received therapy in their own language had very positive experiences.

Young people reported being 'used to' working with interpreters and did not perceive it as positive or negative. They also noted they can very quickly tell if an interpreter is good or bad. Good interpreters were described by therapists and young people as giving full and accurate translations, having the same manner as the therapist, and supporting the young people by providing appropriate cultural links or further explanation if necessary. Stakeholders and staff reported that some interpreters diminish the professional training of the therapist by providing inappropriate further information or adding complexity in an attempt to be helpful or to insert their own perspective. This is a frequently cited issue for clinicians working with interpreters (Gartley & Due, 2017; Raval, 1996).

Having a third person in the room during therapy could be 'kind of complicated' and make young people more guarded to sharing sensitive information.

> "You lose a lot of immediacy, don't you, with an interpreted conversation. When you're pouring out emotion, you need to just keep going really. To be stopped and that interpreter to then have to start again, I think you'd lose your [flow]." – Stakeholder, ESOL teacher in school with refugees and asylum seekers

Speaking English in sessions was welcomed by some, as they felt confident expressing themselves in it and/or did not trust interpreters to interpret fully. Meanwhile, having to use English because interpreters in their language were not available sometimes meant that young people missed what the therapist was saying, or they could not fully express themselves.

Therapist qualities

Therapists' perceived qualities and characteristics supported young people to find the programme acceptable, even when they had previously been resistant. Therapists were valued for being polite, patient, and having good manners. Young people also described their therapists as kind, helpful, loyal, passionate, genuine, and familiar with the specific problems that unaccompanied asylum-seeking children face. One young person particularly appreciated that their therapist did not show stress or discomfort in response to their stories.

> "And I got so many things that helped me which I was not aware of, that I could be helped that way." – Young person

IPE research question 4 – Appropriateness

- Is My View seen as a good fit with professional/service norms (e.g. counselling co-location, therapy, psychoeducational services) and with needs of UASC (e.g. addressing mechanisms for change)?

Over the two-year evaluation period, 567 referrals were received across the five My View sites and the My View team regularly had to close referral lists. This clearly demonstrates that the service is of interest and in demand by stakeholders making referrals, due to a gap in the wider context of services available. While the evaluation saw many young people drop-out prior to and during the intervention, the majority of young people proceeded with My View, indicating the need among young people.

Need for specific support for unaccompanied children

Staff and stakeholders reported that there is a high level of need among unaccompanied children for tailored mental health support that is responsive to their unique needs and situations. Interviewees described how My View's service met these needs through:

- **My View is a unique and specialist service for these young people:** Several staff members described My View as holistic, flexible, and interpretive as My View therapists understood the trauma experienced by unaccompanied children in their home countries and on the journey to the UK, and the ongoing challenges they face in the UK. They reflected that this understanding is lacking in most mainstream services, which are not tailored. One stakeholder reported that professionals can feel unskilled when working with unaccompanied children, and internal biases and racism can affect intervention. Some mainstream providers were reportedly asking referrers to use My View as they did not have experience with unaccompanied children.
- **By having lower thresholds and a more preventative approach, My View is available to young people who do not meet thresholds for mainstream services:** Staff and stakeholders reported that My View fills a gap in services as young people often do not meet standard psychological support thresholds from NHS/community mental health services (e.g. diagnosis through CAMHS), despite the unique and nuanced challenges and trauma they face which can present in different ways. For example, staff were aware of referrals being made to My View when young people were referred to CAMHS but did not meet the thresholds or were on long waiting lists. One stakeholder described this as demonstrating the need for more preventative support such as My View:

> "My View bridges that gap … we can offer specialist therapeutic support to young people who are not considerably high risk, but are still struggling with mental health difficulties." – Therapist

- **My View is responsive to cultural barriers:** My View therapists understand the cultural barriers – including stigma – that make some unaccompanied children cautious or sceptical about accessing therapeutic services. My View therapists are experienced in supporting clients to better understand mental health, be receptive to support, and understand the links between mental and physical pain. Where therapists are from the same background as clients, this can offer an additional benefit of trust and shared understanding.
- **My View generally offers clients an interpreter if needed**, a service not typically provided in mainstream provision. The importance and value of an interpreter is discussed in more detail below, and the lack of an interpreter was seen by staff and stakeholders as a barrier for young people:

> "There is a gap in the system in relation to offering that in the language and with a cultural nuance and understanding as well, for refugees and asylum seekers." – Stakeholder, Representative of a refugee support service

- **Clients have greater trust in My View than other services:** Stakeholders reported that young people view My View as impartial, unlike social workers and other state-appointed individuals/organisations that they often mistrust or fear. This was also because of the reputation of the Refugee Council and the skills and experience of its staff, including their cultural responsiveness.

While stakeholders and staff agreed about the gap in services both nationally and locally and the need for UASC-specific support, several acknowledged that many young people also had non-therapeutic needs that required other support services. Non-therapeutic needs included support with access to services and navigating UK systems such as health and education, opportunities to build life skills, and activities to tackle boredom, build social links, and establish a sense of community (especially in rural areas). Additionally, these young people require support to build stability due to their undetermined status in the UK, the National Transfer Scheme, UK government policies relating to asylum, adapting to a new country and culture, and experiences of trauma, in addition to the normal difficulties relating to being a developing young person. Staff and stakeholders found that it can be easier to engage young people in practical activities that are less explicitly linked to mental health due to the cultural stigma around mental health that many young people hold.

> "Quite often it's just the need for safety, community and to feel heard and feel cared for." – Stakeholder, Social worker

Existing UASC-specific support

None of the stakeholders interviewed identified any other specific services delivering therapeutic support for unaccompanied children, though more general, practical support services were available. Other issues highlighted were long waiting lists among mainstream services and service reduction or closure due to the COVID-19 pandemic, which particularly affected the level of need at the start of the project in 2021.

Some unaccompanied children will receive emotional support from support workers; however, this support is unlikely to meet the specialised therapeutic needs that some require. In terms of wider networks, some more established communities can offer support, with one stakeholder describing how their local Eritrean community has elders who can support unaccompanied young people. However, others who do not have communities nearby (such as those in rural areas), do not have such a strong religious culture, or are first-generation migrants who are less able to draw on these resources. The same stakeholder also noted that advice from community members can sometimes be out-of-date or lack understanding of young people's needs.

IPE research questions 5 and 6 – Feasibility and Implementation strategies

- What are viewpoints on the feasibility of implementing My View?
- What barriers and enablers were encountered, and how were these addressed?
- What implementation strategies were used to recruit UASC, establish the service, and train/support My View therapeutic staff?

Staff recruitment and skills

The passion and skills of therapists was seen as a major driver of the success of My View. Therapists were recruited for several qualities, including their professional training, experience with unaccompanied children, and passion and/or personal experience driving them to help unaccompanied children. At the first timepoint of interviews (T1), there were concerns that the low pay was affecting who was attracted to the work. However, in 2022, all therapists and new therapist appointments were put into Grade 6 (they had previously been on Grade 5), to attract a higher calibre of candidate and overcome previous unsuccessful recruitment attempts. In the latter stages of the project, candidates for therapeutic roles were also informed that the work would be challenging, with the intention of both preparing staff for the reality of the work and helping to select the best people for the job. Combined, these skills, traits, and experiences are thought to have created a dedicated team of experts in providing therapy to individuals who have experienced significant trauma, which aided implementation of the programme.

Staff training and support

Training

Staff reported receiving significant amounts of training and this contributed to their ability to work successfully with young people and also to staying in the role.

Training in the My View model, safeguarding, data systems, Refugee Council policy and procedures, and the evaluation procedures were all mandated trainings (see chapter 1 and appendix A). Other continuing professional development was not only provided but encouraged, and therapists reported that this played a role in the quality of care they were able to provide to young people. Induction training was considered to be thorough and sufficient to deliver the programme. There was a more positive attitude to the training provision overall in the T2

interviews than at T1, with one therapist describing the national manager as the 'queen' of sharing and facilitating useful training to add expertise to the team.

> "The focus was on making me familiar with how I can work smoothly to make this experience smooth for myself and obviously for my clients and the people I was working with." – Therapist

Some therapists felt that more specific training for the My View approach, such as working with interpreters, delivering short-term therapy, and dealing with trauma, as well as more in-house sharing of expertise, would enhance their ability to provide quality care to young people even further.

Support

Therapists held very positive attitudes towards the support provided for delivering the programme, from national and regional managers, administrative staff, and their peers across both timepoints. Regular supervision, check-ins, safeguarding meetings, and peer supervision contributed to therapeutic staff feeling respected and supported, while also being trusted with the autonomy to work in the way that works best for them. Managers were also 'just a phone call away' to support with any issues that arose.

> "It's a really supportive, caring, nice place to work. And that means people are motivated to work hard and they do their best." – Therapist

> "I think it's one of the things that I really appreciate the most out of this role, is the support that we have and the learning opportunities there rather than a lot of the time as a therapist you're working in a silo." – Therapist

Peer-to-peer support was set up towards the end of Phase 1 and was widely praised:

> "This is a great space for myself and my colleagues to share any concerns that we're going through with any clients, but it's also a great space to share information, resources, and skills with each other." – Therapist

At timepoint 1 (T1) interviews, most therapists reported needing time to adjust to changes in their processes from before the evaluation started. This was not covered as an issue at T2, possibly because new staff joined once the evaluation was under way and did not have to adjust their working processes. However, new staff needed a lot of support throughout the onboarding process.

Also at T1, managers reported not having enough management time on the project, and additional hours were approved by the end of 2021 which supported the growth of the team. Support from the administrative team was deemed crucial to delivering the therapy and evaluation activities efficiently. The administrative team initially received a lot of questions from therapists and set up weekly meetings with each one to ensure their reporting was up-to-date and to check training needs. They would then compile frequently asked questions to share with the whole delivery team. However, this weekly support stopped in early 2022 due to the administrative team's limited capacity, which may have contributed to an increase in missing and inaccurate data reporting.

These positive reflections of support may disguise some of the challenges reported by staff due to the timing of the interviews. Many therapists left their positions in the first half of 2022, as discussed in more detail in the next section, while the interviews took place in late 2021 and early 2023.

Staff morale and top-down communication

Morale among therapists dipped during the first half of 2022 (Phase 2). This was in the context of two changes to the My View national manager, high levels of demand from the combination of new referrals and those coming off the waitlist control group, and uncertainty about funding prospects for the first extension. Therapists and staff interviewed reported that there was a lack of clarity and mixed messaging from both senior leadership at the Refugee Council and the funder regarding the extension. For example, the rationale for the extension was driven by the need to achieve a sufficient sample size for the evaluation, which proved not feasible within the original time frames. In interviews, therapists reflected that when this was communicated to them by senior leadership, it suggested they were not meeting targets in line with the funder's expectations. This made them feel underappreciated and as though the decision makers did not understand the programme or the amount of work that it required.

> "There was a sense of, you know, you've all failed horribly, whereas we knew that we were working our guts out doing everything we possibly could, and that wasn't being recognised, and that was very difficult." – Therapist

Therapists reported that the length of time for the funder to confirm the extension also contributed to feelings of uncertainty as this took multiple months. Therapists described how their contracts aligned with the original end date for the project and were not given reassurances about the extension, and therefore some had started looking for future opportunities to ensure their job security. It was reported that some staff proceeded to move to other positions within the Refugee Council or left the organisation. To illustrate this, only three of the eight staff interviewed at T1 were still in post at T2, and there was further turnover within this period. This "mass exodus" (Therapist) placed additional pressure on retained therapists. While they did not feel that the quality of therapy they provided was hampered, it appeared to have an impact on team morale and therapist wellbeing.

> "No matter how much we are committed to our jobs and everything, we need a bit of security as well." – Therapist

However, the T2 interviews suggested a large positive shift in morale and an optimistic outlook in Phase 3. This shift in morale was viewed as being in response to the support and emphasis on self-care provided by management, as detailed in the previous section, as well as being moved up a paygrade. Therapists felt they had an integral role to the Refugee Council's services, that their work was valued by the organisation, and that they were working in a connected, communicative, and supportive team. Additionally, a caseworker was brought into the team to support with young people's needs that were outside the therapeutic process, enabling therapists to work more effectively in their sessions with young people.

> "And just, kind of, self-care of the therapists ... like every time I meet with, especially managers, that's just so emphasised and it really helps me to feel supported." – Therapist

Mitigations

To help overcome the challenges to implementation and staff morale described above, national and regional managers put several mitigations in place to improve recruitment, increase capacity, speed up the waiting times (for the intervention group), and reduce therapist stress, particularly in the latter half of 2022. During Phase 3, the national manager spent a lot of time looking at the barriers to meeting their targets and implemented the following changes:

- Removed regional limitations to pick up young people from waitlist wherever was needed the most
- All managers took on clients themselves to stay in touch with therapists' challenges
- Extended paid hours of part-time therapists, brought in sessional workers
- Increased the number of clients per day from three to five – in line with British Association for Counselling and Psychotherapy (BACP) guidelines
- Introduced policy so that if a young person missed three consecutive sessions without explanation, therapy would be ended
- Focused on building a trusting relationship with the funder
- Introduced a case worker.

Some of these measures were received well by staff (e.g. introduction of a case worker), while others were more controversial. The increase in expectations of number of clients scheduled per day was not popular with therapists, particularly those who had been involved for some time with My View. However, the national manager also clarified that due to frequent no-shows (or DNAs 'did not attend') and the times young people were available (e.g. after college), they were unlikely to have a full client load each day and may not see more than three young people per day. These changes were perceived to improve the number of young people seen and workflow.

Experiences taking part in the evaluation

To fully understand the implementation context, it is also important to examine the impact of this evaluation on delivery and the impact it had on young people and staff. Many staff reported that the evaluation meant they had to shift their focus from putting young people at the centre of therapy to having to balance this with the evaluation procedures of baseline and endline data collection. Nevertheless, some acknowledged the importance of the evaluation and the data it produces, as did some of the young people. Overall, attitudes towards the evaluation and understanding of the processes improved over time.

Impact evaluation: intervention and control approach

The RCT approach was criticised by many of the staff members interviewed in both waves. They questioned the ethics of the waitlist control group given all the young people seeking support had

urgent needs. They found it difficult to systematically determine which young people in the control group had the most urgent needs to request an allocation override so they could receive My View sooner. One staff member also questioned whether the allocation override function was being used as intended and whether this should have been employed more frequently to support the most vulnerable young people. They explained that one young person had disclosed self-harm during the outcome measures but a request to override the allocation was not made. This reflects discussions between the evaluation team and the new national manager in Phase 3 that highlighted a misunderstanding among therapists on when and how often to request overriding the allocation. Some therapists felt the tension of keeping the integrity of the evaluation design vs responding to control group participants in the same way as they would intervention group participants during the initial assessment, which was predominantly focused on outcome measurement.

> "I'm juggling in my mind at what point I say, you know, 'I've got to stop this, I've just [got] to be with this child, and I've just got to say he needs to be outside the evaluation.' And I'm thinking, 'But we haven't got enough, and we need our control group.' And I'm really bargaining it, you know; in my mind I'm thinking if in the next few minutes, he isn't crying anymore, if I'm able to ask him some questions and he answers looking straight at me, I will just go ahead, and if he doesn't, and if he can't look at me, I'm going to have to just stop. Those are not the considerations, they should never have been a consideration, the moment he started to show distress, I should have said, 'Don't worry about these questions, don't worry, let's just talk, we'll talk today and then I'll be here every week for you.' I should have been able to say that to him, but I couldn't. That is something that has I think really got into the soul of all the therapists, it's really difficult." – Therapist

In the initial assessments, therapists had to explain the purpose of the sessions, complete two questionnaires, explain confidentiality processes and complete the data sharing agreement, and allow time for interpreters to translate. This was described as not feasible in the time frame as well as not being engaging for the young people. In some cases, staff reported that young people had dropped out after the initial assessment because they felt that the session was not engaging. It also put pressure on therapists' time outside the sessions.

More broadly, involvement in the evaluation meant the My View team felt the support offered was less flexible. Examples of this included:

- Being less able to use group therapy to transition young people into one-to-one support
- No longer being able to offer a taster session to encourage young people who were unsure if they wanted to take part
- No longer being able to offer a shorter set of sessions which may have been more convenient and appealing – though in practice most participants received less than 12 sessions, including a high proportion receiving only 1–3 sessions.

Consequently, therapists felt less able to meet all young people's individual needs in a timely manner and it was thought to have affected take up among some young people.

Length of waiting lists

Another key concern relating to the RCT and capacity issues was the length of the waiting list at some points during implementation. When designing the RCT, it was expected that the intervention group would start therapy relatively soon after referral, randomisation, and initial assessment, while the control group waited the designated period. In reality, the intervention group also often had to wait between referral and initial assessment and between initial assessment and the start of therapy due to capacity and workflow challenges. My View had historically operated using waitlists when therapists were at capacity, but the waitlist RCT design introduced additional complexity. After the first three months, therapists needed capacity to deliver My View to both new referrals for the intervention group and those ready to come off the waitlist control group. While adjusting to this change, wait times lengthened (discussed more in chapter 4). More broadly, there was staff turnover and periods of heightened demand (e.g. due to the crisis in Afghanistan) throughout the evaluation that contributed to wait times for both intervention and control groups.

Most referrers and young people felt that the wait time was manageable. However, some referrers and young people reportedly had to wait for up to six months and at points the referral lists were closed due to capacity. This was especially an issue towards the end of Phase 1 and through Phase 2. Even when young people reached the top of the waiting list, other factors could lead to further delays, such as young people's availability and responsiveness to calls. Stakeholders reported that long waiting times resulted in young people no longer being interested, feeling like they had been forgotten and feeling that their needs were being minimised. Young people and stakeholders described how the waiting time led to general confusion about the programme, what it involved and when they would start. In some cases, these barriers led to disengagement.

> "So before, I was waiting when you have a problem, and the problem gets more difficult for you to cope with it, like, there's no one to help you. It's like getting bigger, bigger, bigger, bigger. For yourself, for myself, it was like that." – Young person

Questionnaires

Most of the young people interviewed could not remember completing questionnaires as part of the programme. This could be due to the length of time between finishing the sessions and participating in the interview, losing track of the many questionnaires they complete for different services, not finding them remarkable, or not having been asked to complete a questionnaire. For some other young people, they remembered completing the baseline and endline questionnaires, and reported that they were not an issue and that they understood the need for them.

> "[The questions were] very good because there were all types of questions regarding general wellbeing and how things have been improving." – Young person

> "Boring. Because I know all the questions already because I spoke to too many psychologists and talking therapists. So, I knew the questions and I knew what the answers were." – Young person

The evaluation design was designed to have minimal interruption on the intervention due to data collection. British Refugee Council management decided on which secondary measure to add after extensive options and discussions with the evaluation team, data collection was minimised through two short measures, and data collection was undertaken by therapists as is their common practice and to not introduce another adult. However, staff raised concerns about the impact of the questionnaires on engagement, young people's wellbeing, and their ability to offer support in the initial assessment. The key barriers reported by staff are detailed below.

- Although the Refugee Council already used the YP-CORE, the addition of the SWEMWBS lengthened the time spent on data collection during the initial assessment. Data on the length of time spent on measures was not collected but some therapists reported that this doubled the amount of time. This meant less time for therapists to initiate the therapeutic relationship. However, from the perspective of the evaluation, it was also important to avoid moving into therapy during this session for control group participants.
- Some young people did not understand the purpose of the questionnaires and confused this with part of the therapeutic support. This meant they sometimes started talking about the issues they were facing and staff had to ask them to wait until therapy started. In some cases, young people became distressed when going through the questions, and staff found it difficult to offer support when they faced a time pressure to get through the required content and also to avoid building a therapeutic relationship especially for the control group.
- The SWEMWBS (although translated in many languages and used across cultures) could feel unnatural, for example, asking young people whether they felt optimistic about the future reportedly did not translate well and could be inappropriate if young people had disclosed self-harm or were facing ongoing trauma (for example, linked to the safety of their family or their asylum claim). For some young people, the question on self-harm was offensive, and for others, it opened a conversation that therapists did not have adequate time to offer support during the initial assessment.

> "They're saying, 'Hang on a minute. I'm telling you about my family who are in the middle of a war, and you are asking me about these questions?' So that has been really difficult." – Therapist

- Staff also raised questions on the robustness of the answers gathered. The items and response options were reportedly confusing to young people, particularly where they needed translating and phrases did not translate well.
- Before the evaluation, some staff would have shifted questionnaires to a later session with more vulnerable young people as it affected engagement and the therapeutic relationship.
- Where young people disengaged early from the programme, it was very challenging and often impossible to engage them to complete the endline questionnaires.

Many of these challenges are common with data collection with a vulnerable group. Concerns were primarily raised in Time 1 interviews by staff, and they were not raised in interviews by stakeholders or young people.

Cost analysis

Data on costs of delivery were obtained from the Refugee Council after the end of delivery. The annual costs for delivery are detailed in table 12 below. These costs account for delivery to young people in both the intervention group and the control group once they had waited for the required amount of time. In addition, around 50 referrals represented re-referrals or were made when randomisation was paused, for whom the Refugee Council would also have delivered during this time.

According to administrative data, a total of 436 (of the 510 randomised) received at least one therapy session. However, additional time and associated costs would be incurred prior to the start of the intervention. For example, as part of the referral and eligibility checks, contacting referrers, logging case details, and setting up and conducting the initial assessments. As such, using all 567 referrals, a rough average cost per child was £1,737. Costs would be significantly less for those who disengaged early and more for those engaging for the full 12 sessions or more.[20] In total 3,185 sessions were delivered over three years costing a total of £985,039. Therefore, the average cost per session is around £309 (this includes any set-up fees even for those that do not attend any sessions so the additional cost of a session will be lower).

Table 12. My View delivery costs

	2020/21	2021/22	2022/23	Total
Total Staff Costs	155,548	368,866	156,594	681,008
Total Direct Costs	12,292	19,044	11,181	42,517
Total Infrastructure Costs	41,550	54,903	39,908	136,361
Total Indirect Costs	29,315	61,994	33,844	125,153
Total Expenditure	238,705	504,807	241,527	985,039

In addition, the cost of delivery and the number of young people/sessions served vary depending on location (see table 13). The London site had the highest expenditure at £356,020 while the costs

20 The My View team estimate that the average cost per child is £2,300 for their latest model of support.

from the Kent site totalled £159,124, the least of the physical sites. A total of £84,689 was spent on remote referrals accounting for less than 9% of spend, meanwhile delivering 777 sessions, over 24% of total sessions. Therefore, the cost per session of remote sessions was £109, which was notably lower than the next physical site, Kent, at £289 per session. Birmingham had the highest per session cost at £463.9 similar to London (£441.7 per session), which perhaps reflects the cost of delivery in large cities like Birmingham and London. However, it is important to note that regardless of site, many sessions were delivered remotely. There was also no statistically significant difference in the impact of sessions provided at different locations. As such, the difference in costs likely reflects costs associated with physical Refugee Council sites, such as larger overheads.

Table 13. My View delivery costs by centre and year

Total expenditure by project location	2020/21	2021/22	2022/23	Total
Birmingham	65,900	86,646	60,850	213,396
Kent		133,561	25,563	159,124
Leeds	62,325	73,211	36,274	171,810
London	110,480	151,255	94,285	356,020
Remote		60,134	24,555	84,689
Total Expenditure	238,705	504,807	241,527	985,039

To assess the cost-effectiveness of My View, we can look to the estimated costs of similar therapy sessions (see table 14). For example, the Personal Social Services Research Unit (PSSRU) calculate an average cost per counselling intervention for children to be £1,165 (assuming average cost per working hour £49, average cost per client-related hour £97).

Similarly, the Greater Manchester Combined Authority (GMCA) cost database, estimates an average cost per hour for counselling, psychotherapy and other 'talking therapies' delivered by trained practitioners at £60 (or £69 in 2021 prices). The cost is derived from salary costs (including on-costs such as national insurance and pension contributions), plus an element to account for a proportion of overheads (management, admin, travel, telephone, supplies, and services and utilities) and capital costs.

A cost–benefit analysis of psychological therapy by the Centre for Economic Performance suggests the cost of therapy to be £750 in total. The cost includes a delivery of ten meetings, an effective per session cost of £75. Another randomised trial done in Amsterdam to measure the cost-effectiveness of internet-based treatment for depression suggests the total cost of delivering cognitive behavioural therapy and problem-solving therapy sessions was €958 & €888 respectively. The

cognitive behavioural therapy was 8 sessions long and the problem-solving therapy was 5 sessions long, therefore, the average cost per session was €119.75 & €177.6 respectively.

While the overall unit cost for My View is higher than the examples shown above, it is important to note that the therapeutic intervention of My View is targeted at young people who have particularly complex needs requiring specialist services which are likely to come at a higher cost. For example, this includes the regular use of therapeutically trained interpreters during sessions. Similarly, therapists conducted casework to support young people, and later on a designated caseworker was recruited to provide wider support for young people alongside therapy.

Table 14. Estimated costs per therapy session

Intervention	Cost per session	Cost in 2021 prices (£)[21]	Year
Cost-effectiveness of internet-based treatment for depression[22]			
Cognitive behavioural therapy	€120	£106	2007
Problem-solving therapy	€178	£158	2007
GMCA cost database	£60	£69	2013/14
Cost–benefit analysis of psychological therapy – Centre for Economic Performance[23]	£75	£99	2007
PSSRU costs of health and social care[24]	£97	£98	2019/20

Although this study does not include a monetary estimate of the benefits of My View, we can look to existing estimates to get a sense of the value for money that similar programmes have had.

21 Converted using BOE Daily Spot Exchange Rates and BOE GDP Deflators.
22 See: https://www.jmir.org/2010/5/e53/
23 See: https://eprints.lse.ac.uk/19673/
24 See: https://www.pssru.ac.uk/pub/uc/uc2020/1-services.pdf

Place2Be commissioned Pro Bono Economics to assess the value for money of its one-to-one counselling service in primary schools. Every £1 invested in the service in 2016/17 results in benefits of £6.20 in terms of improved long-term outcomes. The estimated benefit of counselling is £25.9 million for all the children who received counselling in 2016/17 compared to a cost of £4.2 million for the service. The potential benefit per child from counselling is just over £5,700 per child, including a saving of over £2,000 per child for government.

4. LIMITATIONS

This chapter sets out the limitations of this evaluation, which should be taken into account when interpreting the findings. It details a number of practical challenges encountered given the nature of the intervention and the young people involved, which provide valuable lessons for future research and evaluation with unaccompanied children and young people.

Impact evaluation

The impact evaluation was designed with both practical and ethical considerations in mind, and several limitations resulted from these. First, randomisation took place before baseline data collection. This was to maintain some of the existing processes in place, such as collecting the YP-CORE during the initial assessment meetings. There were concerns about therapists meeting with young people to conduct the initial assessments and gather baseline data but not be able to say when the young person could expect to start therapy, i.e. soon or in 12 weeks' time. This would create uncertainty for both young people and therapists, who would have less notice to plan their workload in coming months. However, by conducting randomisation before baseline, this could have introduced bias because therapists were aware of which young people were allocated to the intervention and control groups. Equally, young people in the control group were aware that they would eventually receive therapy, which may have influenced their experience relative to a traditional RCT design.

The above was also related to the decision to have therapists administer the baseline and endline outcome measurements. This was considered the most appropriate approach for several reasons. First, this was consistent with previous procedures for the My View team. Second, it ensured that young people were in the presence of a therapist at the time of completion, given that some young people might find the questions difficult or distressing. Third, it was necessary to have an interpreter available, even where translated questionnaires were available, so a more systematic approach to data collection was necessary. However, this introduced challenges for therapists as discussed in chapter 3, and it also became clear that staff were taking a more hands-on role in collecting data than originally anticipated. It had been hoped that young people would be able to complete the questionnaires independently – with the support of an interpreter – but interviews and meetings with staff revealed that they were often helping to explain what the questions and scales meant and helping them to answer them.[25] It was therefore unknown to what extent the administration of the measures varied across young people and therapists. Given challenges with

25 Measures were selected collaboratively with the Refugee Council to ensure they were best suited for the young people they work with. This led to the decision to continue using the YP-CORE and introduce the SWEMWBS given it was a short scale, had available translations, and relevant statements.

comprehension and therapists' involvement, this raised some concerns about the data quality and whether the data was an accurate representation of young people's responses.

Due to the discussions around the questionnaires, some young people started to explain their answers to the therapists, which in some cases led them to feeling distressed. Interviews with staff and therapists highlighted their commitment to the evaluation and data collection, though it also highlighted instances where they felt the need to continue data collection even when young people were distressed. This meant therapists had to carefully judge any safeguarding concerns and check that young people were still happy to continue with the questionnaires. While the young person could always choose to stop if they wanted, therapists were conscious of the evaluation needs, which affected how they would normally respond. Ultimately, this placed burden on the therapists and prematurely introduced elements of the therapeutic intervention – which was common practice prior to the trial. Linked to this, while the design accounted for high-risk young people and included an option to override randomisation, it was clear that decisions to override randomisation were not consistent across cases.

Another key issue for the evaluation included changes to the wait times for both the intervention and control groups. Over time, in order to accommodate the young people rotating from the control group into intervention group after waiting, the participant journey shifted for new referrals allocated to the intervention group. The intended design is one where young people allocated to intervention and control groups have initial assessments and complete baseline outcome measurements around a similar time after their referral and then the intervention group receives therapy in parallel to the control group waiting the same amount of time. In practice, young people allocated to the intervention group were sometimes waiting longer for their initial assessment and then waited for several weeks because therapists did not have capacity to take new cases immediately. Equally, some young people in the control group were waiting longer than 12 weeks before endline data collection and starting My View. This improved over time as the Refugee Council worked through capacity and workflow difficulties. However, the timing of data collection and length of time between baseline and endline timepoints varied more than expected in both groups. These inconsistencies should be interpreted such that they temper the positive impact findings and emphasise the importance of further research and evaluation of My View.

Likely linked to the wait times among other factors was the large number of young people lost to follow-up, resulting in a large volume of missing endline data. The original calculations for attrition were overly optimistic, and the evaluation was extended on two occasions to increase referrals and the sample size. While the analysis examined differences between those who were and were not lost to follow-up across both intervention and control groups, it is possible that there were unobservable differences that affected the outcome measures. For example, it is unclear whether the large number of young people who only attended one to three sessions but did not complete an endline measure may have skewed the results.

Finally, the waitlist control group design limited any follow-up measures that would have enabled analysis of the maintenance of the effect. As discussed, this design was selected in light of the ethical concerns of withholding support from this group so young people received My View following the waiting period.

Implementation and process evaluation

There were a number of limitations to the IPE, particularly in relation to interviews with young people. Young people were reached for the qualitative interviews via therapists, which may have introduced selection bias in terms of who was being approached for interviews. There was also less of an opportunity to reach those who had dropped out or disengaged, although a small number of interviews with this group were also achieved.

Despite providing initial consent to be contacted and multiple invites, young people and stakeholders were very challenging to reach for interviews, with fairly low response rates, so this may have introduced self-selection bias. While the interview samples covered a range of characteristics, some factors may have made individuals more or less likely to take part. For example, young people interviewed were predominately in foster placements where they may have had more support around them to engage. Where contact details were available for the young person and their accommodation manager, social worker, foster carer, or key worker, they were typically contacted in parallel to support engagement.

In some cases, young people had completed therapy months ago, particularly at the beginning due to delays putting necessary data sharing, translated materials, and interpreter structures in place. This meant that some of the contact details were for accommodation, foster carers, or social workers that young people no longer had a link to by the point of recruitment. Furthermore, young people often change their telephone number. Some young people initially responded and then stopped, and others provided times when they were available but were then busy when called or had to finish the interview early due to other commitments. A combination of these factors meant it was often a time-consuming and lengthy process to arrange interviews. Ultimately, fewer young people were interviewed than target numbers (29 compared to 40). However, early analysis suggested saturation had been reached in terms of the themes emerging, and the sample included a range of young people in terms of location, number of sessions, country of origin, and so on.

A key issue when conducting interviews with young people was ensuring they understood the evaluation and the purpose of the interviews. These issues arose from multiple intersecting factors:

- **Initial engagement:** Young people did not consistently read the information sheet in full, and in some cases, it appeared that some may not have been able to due to different dialects. Not all young people recruited through gatekeepers had a clear understanding of the purpose of the interviews.
- **Introduction to the interviews:** Young people did not always ask questions in the introduction section of the interview and would sometimes query mid-interview the purpose. This confusion arose due to several reasons, including clarity of translations and regional dialects, concentration, and the clarity of the introduction.
- **During interviews:** Discussion of My View and the young person's present situation sometimes led participants to ask the evaluators questions about available support – either through My View or from wider services. This indicated that the purpose and scope of the research was not clear. In two instances, young people said something that raised

safeguarding concerns, for which interviewers followed the safeguarding policy for the project. In these cases, the evaluation team provided details of local organisations that could offer support.

The use of interpreters was necessary for undertaking interviews, but this introduced some room for miscommunication and misunderstanding. Young people often spoke languages with very few interpreters and those available are of varying quality. There were instances where interviews were delayed due to issues sourcing an interpreter, cut short due to mismatched dialects, or stilted due to difficulties translating the material. It also brought practical challenges for booking interviews, though it was typically possible to offer young people their first preference. Overall, there was a risk that using an interpreter limited our depth of understanding regarding young people's views and experiences.

Finally, the methods were limited in the extent to which they could explore what exactly happened during My View sessions. Observations were deemed inappropriate as these could interfere with the therapeutic relationship and overwhelm young people by having three adults in the room (therapist, interpreter, and observer). My View followed a structure but was also intended to be flexible and responsive to young people's needs. As such, the IPE was not able to fully unpick how this varied across young people, therapists, and locations.

5. DISCUSSION

This evaluation focused on a topic with complex ethical issues, which necessitated an adaptive, reflexive, and purposeful response by the evaluation team and close working between the Refugee Council, evaluation team, and funder.

This final chapter discusses the findings of the evaluation and their contribution to the wider evidence base, as detailed in chapter 1. The report then concludes with a set of recommendations for policy, practice, and evaluation.

Contribution to the evidence base

As discussed in chapter 1, there is no question that unaccompanied children and young people experience poor mental health outcomes. For example, they are known to experience more difficulties sleeping than other young people due to needing to be alert for their safety on journeys to the UK and traumatic experiences during key developmental years. Sleep deprivation has a myriad of secondary effects on wellbeing including increased likelihood of mental health issues and more difficulty managing emotions. While this is only one example, there are many more difficulties faced by these young people detailed in the literature and highlighted in the qualitative interviews conducted as part of this evaluation. The young people in this evaluation were experiencing poverty, transitioning to adulthood, moving accommodation, managing a traumatic background, separation from family, acculturation and language challenges, discrimination, and managing their insecure immigration status as well as other challenges.

Despite being more likely to experience poor mental health, the literature also highlights that unaccompanied children are often less likely to access mental health support. Previous research and evidence have uncovered a myriad of reasons for this including cultural stigma, lack of awareness and understanding of this type of support, and language/accessibility barriers. Equally, there is widespread recognition that there is a gap in available, mainstream services when it comes to meeting the needs of these young people. This was echoed in the interviews with staff and stakeholders.

Ultimately, the evidence from this trial showed very promising results with positive improvements for young people's psychological, emotional, and mental wellbeing demonstrated through the RCT and IPE. The estimated impact of My View was equal to a decrease of -7.07 on the YP-CORE (scores range from 0–40, Glass's Delta effect of -0.88), indicating reduced psychological distress, and an increase of 3.08 on the SWEMWBS (scores range from 7–35, Glass's Delta effect of 0.65), indicating improved emotional wellbeing. Most young people had not accessed support elsewhere – due to lack of options and/or waiting lists – which demonstrated the need and demand. While the positive results need to be considered in the context of a series of limitations discussed in chapter 4, the findings support the continued delivery of My View and highlight the importance of specialist therapeutic support for unaccompanied children.

Surprisingly, even a small number of sessions appeared to make a positive difference, though it was not possible to test the maintenance of the effects due to the waitlist control group design. The pattern of findings relating to the number of sessions attended remained difficult to unpick and should be a focus for future research. We can hypothesise that this may be related to a young person's journey through therapy and the content covered in each of the stages of therapy (see appendix B). For example, a higher impact early on could have reflected immediate benefits due to young people having someone there for them and practical tips that can be applied quickly, such as breathing techniques. A lower (but still very positive) impact for those who attended 4–6 sessions might have represented a more complex period of the therapeutic journey as young people reflected on their coping mechanisms and support networks and started to confront their traumatic past experiences. The highest impact appeared for those who received 7–9 sessions, at which point therapists were supporting young people to work through their emotions and translating therapeutic concepts into their everyday life. Finally, the impact for those that received 10–12 sessions shifted back towards the overall impact estimate.

In addition, the implementation touched on some of the major current debates for therapeutic services, including online vs in-person therapy, dosage (i.e. number of sessions), group vs one-to-one therapy, and timing of therapy in one's life in order to process trauma. The evaluation added to the research by offering a diversity of perspectives on all the issues, with the main finding emphasising the importance of client-centred services and flexibility. There is currently insufficient evidence on the effectiveness of online/telehealth vs in-person therapy (Greenwood et al., 2022; Novella et al., 2022). Where evidence can be inferred from other populations and services, group therapy has been found to be equally as effective as one-to-one (but not more so) (Schwartze et al., 2019).

It is important to recognise that very few RCTs have been conducted with this group, and this evaluation therefore highlights a number of practical, ethical, and methodological considerations. For example, embedding the use of interpreters and translation is critical but introduces challenges that should be considered upfront. Equally, the use of outcome measures, even where translated materials are available, requires more time and often additional explanation.

Overall, the evaluation provides an important contribution to the evidence base that calls for more specialist therapeutic provision for unaccompanied children. This evaluation found that the My View therapeutic intervention improved their mental health and wellbeing, along with a range of other positive outcomes, compared to those who have not yet received the therapy.

Implications and recommendations

Based on the findings, limitations, and context of this evaluation, this section concludes the report with a set of reflections, implications, and recommendations for policy, practice, and future research and evaluation.

For policy and practice

The following recommendations are for policymakers, funders, and delivery organisations.

- **The Refugee Council should continue to deliver My View.** This evaluation provides confidence that it results in improved outcomes for children and young people, relative to receiving care-as-usual and a small number of non-therapeutic check-ins.
- **A stable funding stream for the provision of specialist mental health support for unaccompanied children and young people is needed.** The Refugee Council and evaluation experienced periods of instability as a result of uncertainty around funding, but this issue persisted before the evaluation and will continue to be a concern for those delivering these services.
- **The Refugee Council should continue providing My View therapists and staff with regular supervision, check-ins, safeguarding meetings, and peer supervision to support them in their roles.** This supports staff in their practice while also providing them with autonomy to tailor their expertise and skills with young people.
- **Organisations delivering these services should pay careful attention to stable leadership and staffing** – this should be a consideration for future evaluation as well. Staff changes have trickle-down effects on the wider team and can result in miscommunication and low morale.
- **Refugee Council and other similar services should consider more specific training** – such as working with interpreters, delivering short-term therapy, and dealing with trauma, as well as more in-house sharing of expertise.
- **Similar interventions should consider the addition of a case worker.** Although this role was introduced later in the evaluation, the findings highlighted the importance of supporting young people with practical issues alongside therapy. It also helped improve therapists' capacity.
- **Other services should consider both face-to-face and virtual options for delivery to offer flexibility for young people.** Based on the available evidence, most young people attended therapy remotely or through a mix of remote and face-to-face sessions. This suggests that remote delivery is not only feasible but effective in improving outcomes for young people.
- **The Refugee Council and other similar services should consider maintaining and expanding their remote service offer** to ensure that young people can access therapeutic support that is appropriate to their needs, regardless of where they live in the UK.
- To mitigate against early disengagement – including between referral and initial assessment – **referring organisations should ensure young people are interested, rather than making referrals without their knowledge**. Large numbers of young people disengaged or dropped out of the intervention early. In most cases, this was because they were feeling better; however, others were for less positive reasons. For example, this included young people finding it challenging to focus on therapy while simultaneously dealing with their asylum claim and housing and education needs.

- **Stakeholders that make referrals should take the time to explain and answer questions about My View** – therapists should also cover this again during the initial assessment and as needed to help young people have a better idea of what to expect. Linked to the above, the findings highlighted the importance of young people understanding what My View can and cannot do for them.
- The evaluation found improvements in outcomes despite the number of sessions attended, including those who only attended one to three sessions. Two key takeaways from this analysis for future delivery include: **(1) even a small number of sessions can have benefits; and (2) the optimal number of sessions appeared to be between seven and nine sessions.**

For future research and evaluation

The following recommendations are for researchers conducting further research and evaluation on mental health interventions for unaccompanied children.

- First and foremost, **it will be vital to see the findings of this trial replicated**. A number of limitations described in chapter 4 mean that the findings should be considered with some caution.
- **Collecting baseline data prior to randomisation would strengthen future evaluations** and should be implemented where feasible.
- **Future evaluations should prioritise more objective options for administering outcome measures.** This would help overcome concerns around the independence of data collection and reduce burden on delivery staff. For example, this might involve evaluators collecting data directly or working with a third party.
- Where possible, **future researchers should carefully pilot measures, conduct extensive data collection training**, and continue to emphasise the protocols on implementation and ethics (e.g. when to stop data collection). Overall, the use of the YP-CORE and SWEMWBS appeared appropriate, though there were challenges associated with completing both measures, including the sensitive topics and timing. These are issues that will likely remain relevant for other measures.
- More broadly, **evaluations of similar interventions should consider piloting an RCT on a smaller scale to test processes and assumptions**. For example, attrition was underestimated, and it proved difficult to include group therapy as part of the trial as originally planned.
- To further explore implementation effectiveness, **a 'Hybrid 2' trial would be a valuable addition**. A hybrid trial type 2 is a type of effectiveness-implementation trial which simultaneously determines the effectiveness of an intervention and tests hypotheses regarding one or more implementation strategies. Specifically, this would enable us to explore differences in outcomes for young people based on elements of implementation such as:
    - Number of sessions
    - In person vs online

    - Group vs one-to-one.
- The management of the evaluation included meetings that were more regular than originally planned in order to build and maintain strong working relationships. **Time for these relationships – including activities to improve understanding of the evaluation approach, scope, and requirements – should be built into timelines** for future evaluation.

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APPENDICES

Appendix A: My View staff training schedule

Topic	Audience	Detail of session
WWCSC: New Procedures – 3h	Compulsory for everyone (staff and volunteers)	1. Introductions 2. External evaluation 3. Flowchart of activities and RCT 4. Evaluation and feedback 5. Targets 6. Focus on changes: referral procedure / times / waiting lists 7. Focus on changes: YP CORE 8. Focus on changes: contact with Evaluator and Funder
Therapeutic Care model – 3h	Compulsory for everyone (staff and volunteers)	1. The Refugee Experience & Implications for Separated Children 2. Adolescence, Migration, Trauma: The intersection 3. Refugee Council Therapeutic model (Therapeutic relationship, Bearing witness, Psychoeducation) 4. Toolkit of interventions 5. Preventing burnout and self-care
In-Form Induction / refresher – 2h	Compulsory for new starters and open to everyone (staff and volunteers)	1. Recording of 1:1 (IA, other, final, DNA) 2. Recording of group session (first and other, DNA) 3. Recording workshop / outing 4. Recording group feedback / YP CORE 5. Recording communication with clients/stakeholders 6. Recording referral to external service 7. Change in client's details (agencies)
Safeguarding Training – 3h	Compulsory for everyone (staff and volunteers)	1. Risk and classification of risk 2. Self-harm: assessment & management 3. Emergency management

		4. Risk from others / risk to others 5. Procedures: respond – record, refer 6. Exploration of examples & case studies
Admin & Life at the Refugee Council Induction – 3h	Compulsory for new starters and open to everyone (staff and volunteers)	1. Key processes (Team drive, Team folder, Team calendar) 2. Annual leave, toil and how to request 3. Expenses claim 4. Interpreter timesheets and Big Word 5. Client Data Spreadsheets & Weekly waiting lists 6. Other procedures & changes

Appendix B: My View therapy structure and content

Sessions	Complete	Content 1:1	Content Group
1–3	• Confidentiality mandate • Risk Assessment • Assess and prioritise needs together, including referrals • YP CORE • Identify goals	• Trust: Therapeutic Relationship – explain role of therapist and organisation • Embodiment: Breathing techniques and grounding exercises • Identity/role: Creative exercises (i.e. 5 things about me, personal flag, etc.) – beginning to draw out secondary narratives beyond victimhood	• Trust: Therapeutic Relationship – explain role of therapist and organisation • Embodiment: Breathing techniques and grounding exercises • Identity/role: Creative exercises (i.e. 5 things about me, personal flag, etc.) – beginning to draw out secondary narratives beyond victimhood
4–6	• 6 SESSION REVIEW – YP CORE, revisit goals	• Psycho-Education: normalising, normal response to abnormal events • Psycho-Education: Extra offer of specific tools needed • Bearing witness: Projection – explore support networks, story-making to assess coping mechanisms • Creative exercises and/or talking about everyday experiences: exploration of alternatives (emotional responses, ways of communication, roles/identities, etc.)	• Psycho-Education: normalising, normal response to abnormal events • Psycho-Education: Extra offer of specific tools needed • Bearing witness*: Projection – explore support networks, story-making to assess coping mechanisms • Creative exercises and/or talking about everyday experiences: exploration of alternatives (emotional responses, ways of communication, roles/identities, etc.) • *: by therapist
7–9	*Flag up ending in session 9 *explore and plan ending	• Bearing witness: projection – space to connect with past	• Bearing witness*: projection – space to connect with past

		memories of identity and culture • Bearing witness: narrative therapy exercises – reinforce secondary narratives of strength and coping ability – Tree of Life, Narratives in a Suitcase, etc. • Beginning to link creative explorations and/or change within the therapy space to everyday life; noticing changes, even small	memories of identity and culture • Bearing witness*: narrative therapy exercises – reinforce secondary narratives of strength and coping ability – Tree of Life, Narratives in a Suitcase, etc. • Beginning to link creative explorations and/or change within the therapy space to everyday life; noticing changes, even small • *: by therapist and other group members
10–12	Session 10 – review goals, consider onward referrals Session 11 – YP CORE Session 12 – what will you take away + what will you do this time next week	• Opportunity to reflect back and solidify any gains from therapy • Opportunity to express and process emotions related to the upcoming (and past) endings • Trust: Celebrate the therapeutic relationship and use it as a model for a new narrative about others and the world to possibly be established (if not here, then in 7–9 above) • Embodiment: Use of rituals to mark and contain the experience of the ending • Therapeutic relationship: invitation to internalise this and make it part of inner resources	• Opportunity to reflect back and solidify any gains from therapy • Opportunity to express and process emotions related to the upcoming (and past) endings • Trust: Celebrate the relationships in the space and use it as a model for a new narrative about others and the world to possibly be established (if not here, then in 7–9 above) • Embodiment: Use of rituals to mark and contain the experience of the ending • Therapeutic relationship: invitation to internalise this and make it part of inner resources

Appendix C: Technical tables

Table C1. Balance test of baseline characteristics of intervention and control group

Characteristics	Control mean	Intervention mean	Difference	P-value	Number of observations
Female	0.071	0.066	0.005	0.814	507
Age	16.644	16.454	0.189 *	0.0535	503
Baseline YP-CORE	20.308	21.117	-0.808	0.272	415
Baseline SWEMWBS	21.027	20.666	0.360	0.420	382
Number of Day in UK before referral	238.419	229.462	8.957	0.681	499

* Indicates significance at 10% level (p-value < 0.1)

Table C2. Logit regression on missingness of final scores – Basic model (YP-CORE) (Primary outcome: Endline YP-CORE score)

	Coefficient	Robust standard error	95% confidence interval	P-value
Intervention	0.2933415	0.184	-0.069, 0.655	0.113

Female	-0.4215856	0.380	-1.168, 0.324	0.268
Age	-0.0422971	0.091	-0.222, 0.137	0.645
Strata:				
Birmingham (base)				
Kent	-0.0432367	0.303	-0.638, 0.552	0.887
Leeds	-0.1224768	0.297	-0.705, 0.460	0.681
London	0.1611647	0.287	-0.401, 0.724	0.575
Remote	-0.5983908 **	0.297	-1.182, -0.014	0.045
Constant	0.3343207	1.536	-2.676, 3.344	0.828
Number of observations	500			

** indicates significance at 5% level (p-value < 0.05)

Table C3. Logit regression on missingness of final scores – Basic model (SWEMWBS) (Secondary outcome: Endline SWEMWB score)

	Coefficient	Robust standard error	95% confidence interval	P-value
Intervention	0.3893268 **	0.184	0.028, 0.750	0.035
Female	-0.4155214	0.381	-1.162, 0.331	0.276
Age	-0.104004	0.092	-0.286, 0.078	0.263
Strata:				
Birmingham (base)				
Kent	0.1541539	0.303	-0.440, 0.748	0.611
Leeds	0.1018804	0.297	-0.480, 0.684	0.732
London	0.1101529	0.288	-0.456, 0.676	0.703
Remote	-0.643161 **	0.299	-1.231, -0.055	0.032
Constant	1.35264	1.558	-1.701, 4.406	0.386
Number of observations	500			

** indicates significance at 5% level (p-value < 0.05)

Table C4. Logit regression on missingness of final scores – Interaction model (YP-CORE) (Primary outcome: Endline YP-CORE score)

	Coefficient	Robust standard error	95% confidence interval	P-value
Intervention	0.1898185	0.425	-0.643, 1.023	0.655
Female	-0.4409195	0.388	-1.201, 0.319	0.256
Age	-0.0422408	0.092	-0.223, 0.139	0.648
Strata:				
Birmingham (base)				
Kent	0.0321501	0.435	-0.821, 0.885	0.941
Leeds	-0.3564934	0.422	-1.185, 0.472	0.399
London	0.208972	0.397	-0.569, 0.987	0.599
Remote	-0.750355 *	0.426	-1.587, 0.086	0.079
Strata:				
1#Birmingham (base)				

1# Kent	-0.1145151	0.601	-1.293, 1.064	0.849
1# Leeds	0.4606146	0.597	-0.710, 1.631	0.441
1# London	-0.0909448	0.573	-1.214, 1.032	0.874
1# Remote	0.2972256	0.599	-0.878, 1.472	0.620
Constant	0.3838398	1.567	-2.688, 3.456	0.807
Number of observations	500			

* indicates significance at 10% level (p-value < 0.1)

Table C5. Logit regression on missingness of final scores – Interaction model (SWEMWBS) (Secondary outcome: Endline SWEMWBS score)

	Coefficient	Robust standard error	95% confidence interval	P-value
Intervention	0.0911376	0.425	-0.488, 1.199	0.830
Female	-0.3979841	0.385	-1.153, 0.357	0.302
Age	-0.1019153	0.093	-0.285, 0.081	0.277
Strata:				
Birmingham (base)				
Kent	-0.0647167	0.436	-0.919, 0.790	0.882
Leeds	-0.1579866	0.411	-0.965, 0.649	0.701
London	0.0390095	0.395	-0.736, 0.814	0.921
Remote	-0.8375681 **	0.428	-1.676, 0.001	0.050
Strata:				
1#Birmingham (base)				

1# Kent	0.4313283	0.601	-0.746, 1.609	0.473
1# Leeds	0.5310744	0.593	-0.632, 1.694	0.371
1# London	0.1555209	0.573	-0.968, 1.279	0.786
1# Remote	0.3937417	0.601	-0.784, 1.572	0.513
Constant	1.460252	1.585	-1.648, 4.568	0.357
Number of observations	500			

** indicates significance at 5% level (p-value < 0.05)

Table C6. Dosage analysis (YP-CORE) (Primary outcome: Endline YP-CORE score)

	Coefficient	Robust standard error	95% confidence interval	P-value
Intervention	-0.4215856	0.380	-1.168, 0.324	0.268
Strata: Session number	-0.0422971	0.091	-0.222, 0.137	0.645
0 (base)				
1–3				
4–6	-0.0432367	0.303	-0.638, 0.552	0.887
7–9	-0.1224768	0.297	-0.705, 0.460	0.681
10–12	0.1611647	0.287	-0.401, 0.724	0.575
Baseline YP-CORE score	-0.5983908 **	0.297	-1.182, -0.014	0.045
Constant	0.3343207	1.536	-2.676, 3.344	0.828
Number of observations	500			

*** indicates significance at 1% level (p-value < 0.01), ** indicates significance at 5% level (p-value < 0.05), * indicates significance at 10% level (p-value < 0.1)

Table C7. Sensitivity Ordinary Least Square regression results – basic model (Primary outcome: Endline YP-CORE score)

	Coefficient	Robust standard error	95% confidence interval	P-value
Intervention	-7.034673 ***	0.814	-8.636, -5.432	0.000
Baseline YP-CORE score	0.4441717 ***	0.064	0.325, 0.563	0.000
Strata:				
Medium risk (base)				
High risk	1.718959	1.453	-1.141, 4.579	0.238
Strata:				
Birmingham (base)				
Kent	1.51644	1.482	-1.401, 4.434	0.307
Leeds	1.10072	1.316	-1.490, 3.692	0.404
London	1.07189	1.174	-1.239, 3.383	0.362
Remote	1.505873	1.181	-0.820, 3.831	0.204

Constant	9.052799 ***	1.642	5.819, 12.286	0.000
Number of observations	293			

*** indicates significance at 1% level (p-value < 0.01)

Table C8. Sensitivity Ordinary Least Square regression results – with interaction (Primary outcome: Endline YP-CORE score)

	Coefficient	Robust standard error	95% confidence interval	P-value
Intervention	-7.034673 ***	0.814	-8.636, -5.432	0.000
Strata:				
Medium risk (base)				
High risk	1.718959	1.453	-1.141, 4.579	0.238
Strata:				
Birmingham (base)				
Kent	1.51644	1.482	-1.401, 4.434	0.307
Leeds	1.10072	1.316	-1.490, 3.692	0.404
London	1.07189	1.174	-1.239, 3.383	0.362
Remote	1.505873	1.181	-0.820, 3.831	0.204
Sen baseline indicator				

#Baseline YP-CORE:				
0	0.4441717 ***	0.060	0.325, 0.536	0.000
1	0.4223564 ***	0.133	0.158, 0.686	0.002
Constant	9.052799 ***	1.642	5.819, 12.286	0.000
Number of observations	293			

*** indicates significance at 1% level (p-value < 0.01)

Appendix D: Outcome measures

YP-CORE

	OVER THE LAST WEEK...	Not at all	Only occasoinally	Sometimes	Often	Most or all of the time
1	**I've felt edgy or nervous**	0	1	2	3	4
2	**I haven't felt like talking to anyone**	0	1	2	3	4
3	**I've felt able to cope when things go wrong**	4	3	2	1	0
4	**I've thought of hurting myself**	0	1	2	3	4
5	**There's been someone I felt able to ask for help**	4	3	2	1	0
6	**My thoughts and feelings distressed me**	0	1	2	3	4
7	**My problems have felt too much for me**	0	1	2	3	4
8	**It's been hard to go to sleep or stay asleep**	0	1	2	3	4
9	**I've felt unhappy**	0	1	2	3	4
10	**I've done all the things I wanted to**	4	3	2	1	0

SWEMWBS

Below are some statements about feelings and thoughts.
Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Appendix E: Young person interview sample

	Characteristic	Number of interviews*
Total		N=27
My View site	Birmingham	2
	Kent	5
	Leeds	8
	London	7
	Remote	5
Gender	Female	4
	Male	23
Age	16	7
	17	13
	18	6
Country of origin	Afghanistan	6
	Eritrea	4
	Ethiopia	5
	Iran	5
	Iraq	2
	Vietnam	2
	Others	3
Counselling sessions attended	1–3	4
	4–6	3
	7–9	3
	10–12	9

	>12	7

*Missing admin data on two interviewees.