New Perspectives on UASC Health and Interventions: Beyond Post Traumatic Stress Disorder

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Context

It may be a cliché that meaning is dependent on context, but often we seem to forget this simple yet profound insight.

I remember, when I was a child, a Tsachela woman came to my mother very distressed because her 14-year-old daughter had started to menstruate. In the Tsachelas' understanding, menstruation did not occur until a girl was sexually active – their daughters got married very young, so that was the sequence of things in their own lived experience. For me, this story illustrates perfectly the way perceptions become 'facts' – and when that happens, people rarely explore or investigate any other possibility than what they believe to be the truth.

As professionals, we need always to be asking 'How did things get to be this way?' We need to ensure that our professional curiosity is not lost in the already known and familiar, the things that, as experts, we simply take as read.

I want, therefore, to talk about the key contexts from which I write and make sense of the new understanding that has come from the Unaccompanied Asylum-Seeking Children (UASC) health project in Kent.

Europe as a Gateway

To date, one in every four asylum-seekers in Europe since the start of 2015 has been a child. A total of 110,000 children sought asylum in Europe between January and July 2015 – an average of more than 18,000 every month, UNICEF 2015[i]. When we consider emotional health and wellbeing, the needs and best interests of each of these children should always come first. This is something that invokes our deepest principles of humanity and responsibility. Children are victims of humanitarian crises; they are not the cause of them.

UNICEF (2015) states:

> *The refugee and migrant crisis in Europe – whether off its coasts, on its shores, or along its roadsides – is a crisis for children*[ii].

The displacement of minors is part of a Europe-wide crisis that provokes extreme political and emotional reactions, as illustrated both by the recent reversal of Germany's 'open door' policy and by the language used by the British press. There is widespread confusion, in both people's attitudes to the problem and their understanding of what can be done. This is compounded by a conflation of the notion of 'immigration' – currently perhaps the most inflammatory topic in British politics – with the terrible reality of what it means to be a refugee and asylum-seeker.

A recent literature review (for a bid for EU funding to look at the health needs of UASC) found that there was no established governance framework or clinical underpinning from which the health needs of this vulnerable group of children were being met.

We cannot disregard the political volatility this crisis has created, and yet as humanitarians we have a moral obligation to look urgently past the rhetoric to the reality of what is happening right now. The health needs of these children require a Europe-wide response, including both operational strategies and further research.

I say this despite Britain's recent decision to leave the EU, because what we have observed in Kent is just a part of the journey these children make across Europe. As I said in a recent speech at the House of Lords: ‘We are better together.’ That was not a political statement but a practical observation about the way to get better outcomes for Britain by supporting these children to become active participants in and contributors to our society.

What has happened in Kent is, in miniature, what is happening all over Europe, and so the lessons we have learnt here, and the understanding we have gained, need to be shared, not lost. This is my purpose in writing this chapter: to draw attention to what in the past we have failed to see. I want to pass on the gift of the stories that have challenged my assumptions, the stories Alex, Ibrahim, Abdul, Aland, Mohammed[iii] and many more have told me about their journeys.

The Kent Experience

Kent is a large county in the south-east of England. Large parts of it lie within London’s commuter belt, and its strong transport links to both the metropolis and the nearby continent make Kent ideally placed for those seeking asylum in Britain.

In 2015, there was a rapid increase in the number of UASC reaching Britain and seeking asylum, as shown by the following data from the Refugee Council[iv]:

Year	**2011**	**2012**	**2013**	**2014**	**2015**
Asylum applications by unaccompanied children	1,248	1,125	1,265	1,945	3,253
Change from previous year	–18%	–10%	+12%	+54%	+67%

Of the 3,253 children inbound, 948 arrived in Kent – of whom no fewer than 722 arrived between June and October 2015. When an unaccompanied child arrives in Kent, an initial safeguarding-and-wellbeing assessment has to be conducted by a social worker, supported by an interpreter. Any such child who is assessed as under 18, whether seeking asylum or not, becomes a child in care, with the local authority taking the role of corporate parent. In 2015, the number of children Kent was looking after in this way increased by more than one-third.

The care is shared with other organisations as well, such as the National Health Service (NHS), the education system and the police. There is also a need for solicitors to support the asylum journey and for non-governmental organisations to provide additional resources – for example, the Red Cross helps to trace families.

As the demand for accommodation and placements in Kent for UASC grew, capacity became saturated. As a result, new protocols emerged that meant that children were placed in the local community according to age and gender. Boys who were deemed to be 16 years old were put in one of the county’s two reception centres, to allow girls and younger boys to be placed in foster care.

The difficulties Kent was experiencing were recognised nationally. For example, Alison O’Sullivan, president of the Association of Directors of Children’s Services, stated:

> *The situation in Kent is now critical. There has been a gradual increase in numbers of unaccompanied asylum-seeking children in the past few months and a spike in July has created an acute and immediate capacity issue for the Council. These children, some as young as 12, are extremely vulnerable and in need of our help and support. Our sole focus needs to be on the best interests of the children and*

> *ensuring that they are properly supported and cared for.*[v]

Not only did the local authority's capacity became saturated but other agencies, too, began to struggle to meet the children's needs in a timely way – for example, the NHS, which is required to do an Initial Health Assessment (IHA) of all children entering care.

The Kent UASC Health Project

The key health project objective emerged from the work done by community-based pediatricians who were concerned by the data that was being shared in the IHA process. A review of this data found that 42% of the children showed symptoms of post-traumatic stress disorder (PTSD), depression and/or anxiety. This agreed with other literature that suggests a higher incidence of PTSD, depression and anxiety than in the general population. In response to this finding, the project commissioned an emotional-health-and-wellbeing participatory action inquiry, which took place over the 12 months from March 2016 to March 2017.

Recent feedback for a bid for EU funding from Canterbury Christ Church University acknowledged that UASC are highly vulnerable and that Europe's health-care systems are not meeting their needs.

The literature cited in the bid showed that there was nothing in place to enable health systems to respond appropriately to the needs of UASC. It was necessary, therefore, to consider what preconditions had to be developed to ensure that the emotional health and wellbeing of this cohort could be understood, so that formulations and interventions could be developed.

The project developed guiding principles which encompassed the human rights of the child, an action research methodology that took account of multi-agency working and the different voices caring for a child and agreed a governance matrix which comprised of supervision, identification and evaluation. Please see UASChealth.org, for further information, in the emotional health and wellbeing section of the site.

Early Intervention Framework

For the first three months, the project was embedded in Kent's two reception centres. This gave the project team an opportunity to hear the different stories and concerns of the UASC themselves, the staff and the social workers. Several themes emerged from the conversations we had that we used as a starting point for our interventions. We reviewed the effects of each intervention and developed new formulations based on the feedback we received.

The following themes emerged:

- Disordered sleep patterns
- Semi starvation and refeeding symptoms
- Trauma symptoms
- Loss of hope

As the project was based in reception centers, at the newly arrived stage of a UASC immigration journey, there was an opportunity to consider what early intervention would be significant and make a difference to their ongoing emotional health and wellbeing. The project looked at a resilience model of care in which interventions became a form of inoculation from which the child's resilience was protected.

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

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

To enable protectors to resilience to be in place an early intervention framework was devised, trialed and significant shifts were seen in reported symptoms.

Disordered sleep patterns are associated as a symptom of Post-Traumatic Stress Disorder. Yet what this work was showing is that it was contextual to the journey through Europe where traffickers moved them by night, they kept hidden by the cover of the night to ensure safety and that once in Calais, they looked for lorries at night. It was not surprising therefore that they had a nocturnal body clock which required support to change.

The sleep work evolved into a 3-pronged protocol. This encompassed social education through a sleep hygiene presentation, the development of a sleep pack[vi] that was given to each child on arrival to support the physical dysregulation such as hypervigilance to be managed. The 3rd. intervention was a body clock reversal prescription that enabled a slow and incremental change to a nocturnal sleep pattern.

When this work was audited, there was a 92% reduction in symptoms; young people were requesting sleep packs as were staff, and staff reported that no young person ever left a sleep pack when leaving the reception center(s). Social workers told stories of how the young people were using the sleep packs, such as the worry dolls, as a way of holding their families while they slept.

Therefore, some of the aspirations of the project were met in that young people with disordered sleep patterns were identified; had a measured improvement in their symptoms and staff became confident to support and deliver aspects of the sleep work[vii]. Paul Gringras a professor of children's sleep medicine based at the sleep disorder centre at Guy's and St Thomas NHS Trust said of the sleep work:

In brief-what great work! We are really impressed by the initiative and systems you have set in place. The demand will grow and it's important for others to learn from your experiences. Personal communications 2016.

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

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

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

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

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

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

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

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

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

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

From a health perspective, the risk parameters of semi-starvation and re-feeding should be adjusted for age and gender[1]. That said, a complexity in determining risk is the definition of age from an individual UASC perspective and how this is translated into UK culture. A child who states they are 16, may not necessarily be that age. Therefore to quantify risk can be problematic. Yet these young people do not have an eating disorder with the complexities such a disorder brings; rather they have experienced starvation as a result of the immigration journey they have made. A BMI should be used to quantify the level of malnutrition they are experiencing with caution due to the above factors.

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

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

- GP to look for any underlying physical issues so that re-feeding can be commenced safely.
- Use weight and height against population varients from age and gender via a height and weight calculatorIf a UASC is red or amber on the Junior MARSIPAN risk assessment framework, they should be monitored for re-feeding syndrome using the Great Ormond Street refeeding guidance[1].

- If green on the Junior MARSIPAN risk assessment framwork, safely support a re-feeding program for the child which takes into account religious and cultural eating patterns.
- Manage via a multi-disciplinary team any manifestation of semi-starvation that emerge.
- Ensure staff are skilled to understanding the issues of semi-starvation and to refer to other members of the multidisciplinary team according to the competencies required.
- Support joint-working in the re-feeding transition.

In the day to day it is important to consider giving the young person a live yogurt to support their body's ability to process food. Also, they may need some antacids to manage any indigestion or gastric reflux. They are also likely to become constipated and a laxative should be considered and prescribed as required. It is also important that the child's cultural context is understood from which their taste pallet has been schooled. Therefore, when making a menu plan with the child, to ensure that they are getting familiar foods that connect to their emotional wellbeing. Coupled with this, food is at times a trigger to emotional bonds with others and evidence from research work done around childhood bereavement shows this connection. The project has put together some guidance on how to better understand these connections for the child in an information booklet for staff called UASC Comfort Food[ix].

As identified in the literature and the presentation of UASC in reception centers, trauma was an issue of concern. It is known that these young people experience trauma in their country of origin which caused them to flee, trauma on the journey across Europe and the trauma of assimilation and the immigration process once they arrive in the UK.

I also was often told by the young people that they felt better when doing sport, such as playing football. I also heard stories of UASC congregating in local parks to run or play football together. Having received training in Eye Movement Desensitization and Reprocessing Therapy, I became curious about the bilateral movement they were simulating and how this might be enabling them to process the trauma they have experienced.

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

Many of the symptoms reported by UASC in the early days of arriving in the UK are suggestive of trauma experiences, which given the right support can be naturally processed by the brain. There is also evidence that shows that bi-lateral movement helps the brain to process and desensitise from traumatic experiences. Sports such as running is bilateral in nature and NICE recommend bilateral movement as it causes the memory that is looping in the emotional side of the brain to integrate with the cognitive side of the brain as a treatment for PTSD. To enhance the body's natural ability to process, there is a need to support access to sport that is bilateral in movement, such as running or swimming, as a regular activity that a young person can undertake while in a reception centre and living in the community. It is an early intervention strategy that acknowledges that trauma is likely to be present and puts protectors in place that enhance not only the body's natural ability to process and desensitize, but enhances on multiple levels a sense of emotional wellbeing. Current data from health screening in Kent of UASC shows that 45% of UASC are exhibiting post traumatic symptoms. This finding shows that there is a need to consider the reduced repeat of story-telling about traumatic events. Also, an awareness about flashback moments and a relational containment that supports desensitisation and reprocessing to take place, anxiety to be relieved and other associated symptoms to be normalised and supported. Social Workers in Kent would ask me when they needed to be concerned and refer a young person for treatment. So support their understanding I devised a watch, wait and see protocol[xi] which is multi-professional in nature and creates the opportunity to reduce the risk associated with this cohort developing PTSD.

In Kent we found that there was a need to access sport that was bilateral in movement as a regular activity that a UASC can undertake. As an early intervention strategy, it acknowledged that trauma is likely to be present and put protectors in place that enhanced not only the body's natural ability to process and desensitize, but also enhanced on multiple levels a sense of emotional wellbeing.

We were able to employ sessional sports coaches 2 times a week to undertake bilateral physical activity with UASC in designated hubs across Kent. Added to the bi-lateral movement, a formulation of an early intervention trauma protocol was used to support the therapeutic aspect of what was delivered.

Key characteristics of the intervention were:

- Sport coaches to deliver bilateral movement with UASC for 1 hour 2 times a week.
- Short early intervention trauma protocol linked to the bilateral movement.
- Pre and post screening outcome measurers to evaluate the intervention.

Outcomes:

What was developed was a 'fast feet forward' program which used bi-lateral movement through running to work on traumatic 'hot spots' which a UASC reported as highly disturbing. The 49 UASC who took part achieved a significant increase in their positive cognitions and an organic shift in the self-reported disturbance levels. Again, this work linked to the project's aspirations in that trauma symptoms were identified, 'hots spots' became better understood and there was a measured improvement in their symptoms. This work has been written up so that it can replicated by other services and is about to be used by educational agencies and local authorities supporting UASC.

Here is the story of one UASC who participated in the fast feet forward trauma group:

AK is a 17yr old Sudanese Unaccompanied Asylum-Seeking Child who had been imprisoned and experienced torture before fleeing to the UK. He left his mother and younger sibling and was terrified that they would be harmed. He reported flashbacks and the inability to sleep in his bedroom as the colour and shape of it reminded him of his prison cell in the Sudan. This transcript is part of a therapeutic conversation with AK two months after the fast feet forward trauma program. Since the programme he has turned 18, lost his SW, was told he needed to move from his accommodation and found out that his mother, who is still in Sudan, was ill and needed surgery. He was also awaiting a court hearing and his transport grant had not materialised, making it difficult for him to attend college.

Person	**What was said:**
Ana	I can see that lots of difficult things have been happening.
AK	Yes, it’s been difficult.
Ana	I wonder what has helped you to cope, you look different, like you are managing somehow?
AK	I did what you taught me.
Ana	What I taught you?
AK	Yes, you know, running
Ana	You ran?
AK	Yes when I was sad or scared, I ran.
Ana	And what did that do?
AK	It made it better, it changed things, and it helped me to cope.

Beyond these protocols and early interventions, there are a variety of protocols and interviews that are undertaken with each individual child by a variety of stakeholder’s due to the complex nature of a UASC presentation. These stakeholders often work alone and there is evidence that different stories emerge at various times that need to be shared and understood by all stakeholders.

The child is required to tell their trauma stories to each individual stakeholder with a high likelihood of exacerbating the trauma symptoms they are likely to be experiencing. This way of working could lead to complex PTSD which will increase their anxiety, reduce their ability to integrate and to build healing interpersonal patterns of behavior and relationships.

Therefore, a silo pattern of working which requires the child to repeat trauma stories increases the likelihood of long term mental health concerns.

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

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

In the moment that asylum is claimed, we have a rare opportunity in setting the scene and permission for a conversation, in which the first communication is a platform for future talk to take place. It is the first time they can formulate the story of their arrival, their experiences on the journey and the things that activated them to migrate. How we hear the story told and are curious about those that are untold, how we understand and respond to emergent stories is likely to affect the health of the child. It will open up or close down stories and will set the scene from which each person will act their part. It is a pivotal moment that only comes once. It is therefore essential that all professionals working with UASC hold these ideas in mind and are curious in the stories being told as a way that supports the child.

Stories as hope; a driver towards the future.

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

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

In a therapeutic environment, the child can often be in a dilemma as to what to talk about, who to talk about and what the effects of talking might be. They may have beliefs about what they need to say to receive asylum and this may prohibit other stories to be told. There is therefore a dilemma when those involved in the conversation have different wishes or needs about whether to talk. This dilemma is in the relationship between the 'stories lived and stories told' (Pearce & Pearce, 1998)[1]. There is a dilemma for everyone involved, the young person, the corporate parent, staff involved in the child's care and the therapist supporting the system. The corporate parents has the need to protect, provide, support and manage the variant needs of the child. There are also members of staff who perceive distress, who hear yet untold stories and develop a relational closeness with the child. Coupled with this, there are educators and other providers who are involved and connected to the child. At times, there are therapeutic dilemmas as a prioritising of the child's needs take place. How I formulate and support emergent priorities from an emotional health and wellbeing perspective needs to hold in mind the other competing dilemmas. I also need to be mindful to support the system to give a coherent account of situated abilities to form the best possible outcomes for the child. This way of working is the concept of hope as dynamic action.

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

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

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

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

Who spoke	What said
Ana	What were you running away from?
J	From the army, as I didn’t want to become a soldier.
Ana	Who else in your family agreed with you?
J	My Mum arranged for me to leave, my brother died and she didn’t want the same thing for me.
Ana	So she wanted to protect you?

J	Yes; she wanted me to have a good life.
Ana	What does a good life look like?
J	To learn, to have a job, to be safe.
Ana	So you hope to learn new things, to get a job and to be safe?
J	Yes
Ana	So today, how can you make hope real? You know in the choices you have now?
J	I can learn English?

Ana	What would your Mum say if she knew that you are learning English?
J	Good, good, she would be very happy
Ana	So hope is yours and hers every time you say something in English?

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

Yet when a UASC has had their asylum claim denied, how can we ensure that what we talk about what is useful and productive? I have found that conversations about the loss of asylum become focused on the loss of hope. It is not unusual to hear a young person cry that it is the end of all the hopes they had. This can lead to a sense of despair, a loss of meaning, and a not knowing how to go on. This has been described as being 'frozen in time' (Penn,1999)[1] and we need to consider the implications of this loss of hope to the present and future. What is it to be a 'hopeless' person? What narrative does this shape and form for future relationships and the return journey about to be made? How can we respond therapeutically in a way that acknowledges the fear and yet retainAgain, here is an excerpt of a therapeutic conversation that facilitated the ability to retain hope in the face of deportation.

Who said	What was said
Ana	It sounds like there is a high possibility that you will go back.
H	Yes
Ana	I can see the fear and yet I wonder what of being here you want to take with you?

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

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

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

H and I and had these conversations as a way to protect his resilience in which we explored his knowledge of himself, the effective strategies he had used so far, his strengths and abilities as resources for the future. This allowed him to explore the idea of hope in the threat of deportation, without minimizing the reality of such a threat.

As professionals, we also can lose hope and the situation being presented becomes overwhelming.

I want to end with my hopes in the writing of these ideas;

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

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

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[i] These figures are reported by UNICEF in the following report https://www.unicef.org/publicpartnerships/files/Refugee_and_migrant_children_in_Europe_-_Sept_2015.pdf

[ii] See https://www.unicef.org/publicpartnerships/files/Refugee_and_migrant_children_in_Europe_-_Sept_2015.pdf

[iii] I name names of different children I have worked with, they are generic names such as Kevin, Joshua or Peter and therefore are not denoted to one individual child, rather all the children who I have met and worked

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with as a whole. In giving them a name, I give them a shape and a voice which is to humanise them and to honour their individuality.

[iv] See for more information; https://www.refugeecouncil.org.uk/stats

[v] See http://adcs.org.uk/safeguarding/article/comment-on-the-increase-of-uasc-in-kent (11/10/2016).

[vi] For further information of what was in the sleep packs please see UASChealth.org

[vii] This audit and sleep protocols can be found at UASChealth.org website which has compiled resources for clinicians in other parts of the UK working with UASC.

[viii] See the following website for additional information about this experiment. http://www.refinery29.uk/minnesota-starvation-experiment?utm_r29_redirect=us

[ix] To access this resource see the UASChealth.org website.

[x] For further description of the protocol and literature supporting it please see http://www.uaschealth.org/

[xi] Access to the watch, wait and see protocol is at http://www.uaschealth.org/

[xii] I would define socio vertigo as the experience of rules and etiquette being upside down and back to from the cultural heritage a person has come from. It expands the linguistic turns which are used to express a sense of dislocation in time and place, such as being 'homesick'. See http://metalogos-systemic-therapy-journal.gr/en for an article I wrote about dislocation and location which expands on this theme further.