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School-based Support for Syrian Refugee Pupils in Northern Ireland

Vulnerable Persons Relocation Scheme
Research and Evaluation Scoping Project

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Chapter 1: Introduction

"We are facing the biggest refugee and displacement crisis of our time. Above all, this is not just a crisis of numbers; it is also a crisis of solidarity"

Ban Ki-moon[1]

Background

10 years of conflict in Syria has resulted in 6.6 million Syrian people seeking refuge in other countries and another 6.7 million internally displaced persons[2]. A relatively small number of these have arrived in the UK over the past 5 years through the Vulnerable Persons Relocation Scheme (VPRS). Northern Ireland (NI) has welcomed approximately 1,900 Syrian refugees, including almost 700 school-aged children and young people[3]. Many of these have experienced war, violence, bombings and persecution pre-migration. During and post-migration, they may also have faced other adversities including poverty, discrimination, and limited access to education, housing and health services (Sirin and Rogers-Sirin, 2015; UNHCR, 2013).

In NI the VPRS has been led by a consortium of public agencies, local government and voluntary sector organisations. A 'Welcome Centre' reception model (described in Robertson, 2020) supports the initial resettlement of Syrian refugees. The Education Authority (EA), through The Intercultural Education Service (IES), provides advice and support to help meet the learning needs of Syrian pupils in NI.

Alongside language proficiency, 'trauma' has been the most common challenge reported by teachers, support staff and principals to IES personnel. During 2020-21 a new pilot referral service for schools, the Schools Trauma Advisory and Referral Service (STARS), has been formed. STARS supports Syrian VPRS children and young people, their families and school staff, with the overall aim of reducing the impact of trauma as a barrier to learning and managing the demands of a school day. The EA/IES funded the current research to provide an evidence base to inform the service design and delivery of STARS.

[1] https://www.un.org/press/en/2016/sgsm17670.doc.htm
[2] https://www.unhcr.org/uk/syria-emergency.html- updated 15/3/21
[3] The programme has since been renamed the Northern Ireland Refugee Resettlement Scheme (NIRRS). However, we have referred to 'VPRS' throughout this report as that was the term used in our tender/contract and the more familiar term within schools.

Educational experiences of refugee and asylum-seeking[4] pupils

There is limited research into the needs of refugee children in educational settings within NI. In a previous study, commissioned by The Education Authority (NI), we investigated the mental health and wellbeing needs of all 'newcomer' (immigrant) pupils in schools in NI (Jones et al. 2018; McMullen et al., 2020). The newcomer pupils in our study presented with average levels of emotional well-being and had developed resilience and coping skills. They enjoyed school and valued education. However, they also reported previous experiences of stress, loneliness and isolation. School staff and youth worker participants outlined a range of adversities faced by newcomer pupils in school including: language acquisition; difficulties establishing friendships; parentification; instability and loss of a sense of belonging; community hostility and racism; unrealistic expectations and pressures to succeed academically; and limited support for some at home. These challenges are reflective of those found in previous studies in NI (Murphy and Vieten, 2017), Republic of Ireland (Skokauskas and Clarke, 2009) and elsewhere (e.g. Kim et al. 2018; Shakya, Khanlou, and Gonsalves 2010).

School staff in our study consistently highlighted additional challenges that were specific to refugee and asylum-seeking pupils, including pre-existing stress and trauma. They emphasised a lack of information and support for schools in relation to working with traumatised refugee pupils. This information informed the development of the current study.

Robertson (2020), for Barnardo's, investigated the overall integration experiences of Syrian refugee children and their families. As in our previous study (Jones et al., 2018; McMullen et al., 2020), the Syrian pupils in the Robertson's focus groups spoke positively about their teachers and their support was highly valued. However, school approaches varied considerably in terms of how they supported refugee children, in particular with regard to addressing their language needs. The report highlighted how parents' involvement in their children's education is limited by language barriers, suggesting schools do not consistently avail of the resources available to support home-school communication. There were also examples of good practice in schools in NI including: employment of an Arabic speaking teaching assistant; EAL resources; trauma training for staff members; a befriending scheme for parents; English language classes; and sharing of information and good practice with other schools. Robertson (2020) also highlighted how the appointment of a VPRS Support Officer within the EA had resulted in substantial improvements in accessing school placements for Syrian pupils in a timely manner.

[4] Within this report we mostly refer to 'refugee' children and young people as our research involved Syrian pupils with refugee status via the VPRS. 'Asylum-seeking' children and young people including unaccompanied minors (i.e. those that have not been granted refugee status) face additional challenges. However, they have exactly the same entitlement to full-time education as other UK pupils and economic migrants. See- https://www.gateshead.gov.uk/media/3285/Education-refugee-Asylum-seekers/pdf/Education-refugee-Asylum-seekers.pdf

There is a dearth of research into teacher views and experiences of supporting refugee pupils in school. Where these have been considered, school staff have reported a range of challenges including: a lack knowledge and competence resulting in staff feeling overwhelmed and unqualified; social and cultural barriers; a lack of resources (e.g. additional staff, funding and time); and a lack of training and language barriers (Morgan, 2018; Pastoor, 2016; Szente, Hoot & Taylor, 2006).

Trauma in refugee children and young people

Refugees and asylum seeking children and young people have a more elevated risk for psychological difficulties than other 'newcomers' (Kim et al. 2018). They are less likely to be prepared for migration and more likely to have limited or interrupted education prior to arriving in the host country (Taylor and Sidhu 2012). Some studies have found very high levels of trauma among Syrian children (e.g. Save the Children, 2017; Sirin and Rogers-Sirin, 2015). Refugees may be subjected to multiple traumatic events and severe losses, as well as ongoing stressors within the host country. Seeking asylum in itself can place young refugees and their families under strain due to lack of money, accommodation changes and ongoing fear of detention or deportation (Ehntholt and Yule 2006).

Previous research with war-affected children and young people has found a strong correlation between the number of traumatic event types experienced and the likelihood of developing psychological distress (McMullen et al., 2012). Other research has concurred that a cumulative exposure to traumatic events is associated with a range of psychological difficulties (Derluyn and Broekaert, 2007). More severe types of trauma, such as the violent death of a family member, witnessing someone being killed, or a perception of a direct threat, lead to higher levels of distress (McMullen et al., 2012; Reed et al., 2012).

Trauma experiences increase *the risk* of psychological distress and potential social, emotional, behavioural and learning difficulties. However, Reed et al. (2012) emphasise that risks cannot be simply added up, but the inter-related pathways that lead to the outcomes need to be assessed. They propose Bronfenbrenner's (1979) ecological systems model as a conceptual framework to shape humanitarian responses to children in crisis. This model emphasises the importance of the interacting roles of family, community, and society in refugee life.

Post-migration factors, related to family, peer, community, school and service provision, can either mitigate or exacerbate mental health difficulties (Fazel, 2018; Robertson, 2020). A systematic review into the mental health of refugee children resettled in high-income countries found that exposure to violence has been shown to be a key risk factor, whereas stable settlement and social support in the host country have a positive effect on the child's psychological functioning (Reed et al., 2012). Awareness of the particular needs of refugee children is vital, as is a phased model of intervention and holistic support (Ehntholt and Yule 2006; Kim et al. 2018).

It is important to emphasise that not all refugee pupils will present with traumatic distress as a result of their experiences. Many display resilience, resourcefulness and high functioning despite the adversities they have encountered (Ehntholt and Yule 2006; McMullen et al., 2013). For example, a 12-year follow-up study of war-affected Cambodian adolescents in the USA found that participants demonstrated resilience, regardless of diagnostic status, and most were in education or employment. The authors concluded that post-traumatic stress disorder (PTSD) need not be associated with major functional impairment (Sack, Him, & Dickason, 1999).

The British Psychology Society 'Guidelines for Psychologists Working with Refugees and Asylum Seekers in the UK'[5] emphasise that we should not pathologise the suffering of refugee families. For many refugee children and young people, their presentation can be understood in terms of being a normal response to abnormal circumstances. It is important to take a holistic perspective, recognising the diversity, strength and resilience of refugee communities (BPS, 2018; Rutter, 2006).

Treating refugees as a homogeneous group can result in the masking of individual experiences that are critical to both the identification of needs and the development of appropriate interventions (Rutter, 2006). Awareness of intersectionality is important, whereby refugees are offered specialist support if needed in terms of race, gender or sexuality (BPS, 2018). However, for all refugee children, regardless of the traumatic experiences, prompt access to schooling has been noted to support integration into their new community and improve their quality of life (BPS, 2018).

Language for resilience

Schools in Northern Ireland are increasingly multilingual but the language of instruction in the majority of educational settings in the region is English. In all other United Kingdom jurisdictions additional languages must be taught in primary schools, but in Northern Ireland there is no such requirement. The Syrian refugees in this study are immersed in a learning environment dominated by English. Experiencing linguistic diversity in the form of entering a new educational environment without communication skills in the language of instruction can be stressful for children and young people (Jones, 2020).

A report by Capstick and Delaney (2016) provided cross-disciplinary perspectives on the role of language in enhancing the resilience of Syrian refugees and host communities. They demonstrate how language learning can build resilience through, for example, giving a voice to young people and adults, building social cohesion and providing individuals with the skills they need to access information, education and other services. Capstick and Delaney also

[5] https://www.bps.org.uk/news-and-policy/guidelines-psychologists-working-refugees-and-asylum-seekers-uk

assert that quality language learning can promote safer and more inclusive classrooms, as well as developing life skills and helping to meet psychosocial needs of refugee pupils.

Madziva and Thondhlana (2017) modified Tikly's (2011) context-led framework to conceptualise quality education as resulting from the interactions between the wider education context, the school and the home/community environments, taking into consideration the issue of linguistic capability. They situate linguistic capability at the core of the interactions of enabling environments in the integration of Syrian children in schools. Other elements include the schools' ability to: promote inclusivity; address specific needs; meet psychosocial needs (especially on arrival); provide adequate training for teachers; develop peer relationships; promote multi-agency support; and facilitate reciprocal home-school interaction.

School-based support for refugee pupils

There is a growing body of evidence that suggests that schools may be the most appropriate place to address the psychosocial needs of refugee pupils, build resilience and enhance individual capacities for learning (Fazel, 2015; Nagel 2009). For children who have experienced trauma before migration, stability can begin to be reintroduced by attending school regularly and thereby having some structure to their daily life (McMullen, 2020; Rutter, 2006; Yule 2002).

Refugee children and young people who participated in a study in Ireland described education as the most important factor in enabling ongoing access to social support and enhancing resilience. They described school-related opportunities to develop social networks (including supportive adults); create a sense of belonging, access information, and have recreational outlets (Smyth, Shannon & Dolan, 2015).

There is a substantive body of research demonstrating the positive impact of school-based interventions on social, emotional and educational outcomes, regardless of students' race, or socioeconomic background (Taylor et al. 2017). School-based interventions have also demonstrated effectiveness in reducing psychological distress and promoting wellbeing among war-affected children and young people (McMullen et al. 2013; O'Callaghan et al., 2013).

Rutter (2006) asserts that most refugee pupils do well at school, and do not need therapeutic intervention. However, for those that do, schools can help to reduce stigma and reach out to individuals who may face barriers in accessing mental health support beyond the school due to linguistic difficulties and a lack of understanding of services (Fazel 2015). Fazel (2015) suggests that embedding mental health workers within the school environment could provide a therapeutic, non-stigmatising, social space in which to conduct consultation and intervention.

This Study: Rationale, Aims and Overview

This research took place within Northern Ireland (NI), which has recently witnessed a rapid demographic change over the past decade, with the number of ethnic minority pupils in NI schools almost trebling. This has presented a range of challenges and opportunities for schools, not least in supporting Syrian, and other, refugee pupils. While toolkits have been produced on supporting newcomer pupils, there has been limited official guidance, policy or research into how schools in NI can best to support refugee pupils.

To our knowledge there has been no previous research in NI that specifically considers the educational experiences, impact of trauma and the support requirements of schools. Internationally, there is limited research considering teacher views and experiences of supporting the social and emotional wellbeing of refugees. In addition, further information is needed in relation to evidence-based, school-based interventions that address the impact of the trauma in refugee pupils worldwide.

The overall aims of the study were:

1. To better understand the educational experiences of Syrian refugee pupils and explicate the support requirements of teachers and schools.
2. To investigate barriers to accessing the educational environment which may have resulted from the sequelae of previous trauma.
3. To provide both an evidence base to support the service design and delivery of the Schools Trauma Advisory and Referral Service (STARS).

We addressed these aims in 3 distinct strands, that are outlined in the following chapters:

- **Chapter 2:** A literature scoping review of school-based trauma and psychosocial interventions/practices for refugee pupils worldwide.
- **Chapter 3:** Researching the views and experiences of Syrian parents/carers, children and young people.
- **Chapter 4:** Researching the views and experiences of school staff.

COVID-19 Contingency

We had originally intended to complete interviews and focus groups with Syrian parents and pupils within the school setting. However, the funding for this research only extended from December 2020 - March 2021, which coincided with a second wave of COVID-19 and consequent lockdown and school closures. It was not deemed ethically or practically feasible to complete qualitative data-gathering with these families online. Therefore, the research team agreed that the most effective way of consulting with VPRS families was to change methods to an online survey. Focus groups with school staff were possible as they were in school supporting keyworker children.

Ethics

Ethical approval was obtained from the Research and Ethics Committee of Stranmillis University College. Information letters and consent forms were sent to all potential participants. These outlined the voluntary nature of the research and assured anonymity, confidentiality and the right to withdraw at any time. Information letters, consent forms and questionnaires for Syrian parents/carers and pupils were translated into Arabic and Kurdish (see details on consent procedures in Chapter 3). The researchers discussed and followed the safeguarding policies and procedures already in place within Stranmillis University College and the schools themselves.

Chapter 2: A Scoping Review of School-Based Trauma and Psychosocial Interventions for Refugee Pupils

A scoping review of international evidence relating to school-based interventions, practices and approaches that address trauma and other psychosocial difficulties among refugee pupils was conducted in order to inform the wider research project and the new STARS service.

Method

We conducted a comprehensive search of three academic databases in December 2020 (EBSCO Education Source, ProQuest Education Journals and APA Psychinfo). The search strategy was drafted and revised by the research team and carried out by one team member.

To be included in the review, papers needed to a) have been published between January 2011 and January 2021 in a peer-reviewed journal; b) describe a study based on an experimental or pseudo-experimental research design; c) describe one or several school-based interventions (excluding non-statutory settings); d) describe an intervention related to the effects of trauma; e) describe research conducted no later than January 2005; and f) describe a study sample consisting of or including refugee children.

January 2011 was identified as the earliest relevant date of publication due to its proximity to the beginnings of the Arab Spring and the subsequent migration crisis in the Mediterranean, caused as multiple Arabic countries underwent political change and conflict that both led to outward migration of refugees from those countries (primarily Syria but also Libya, Yemen, and elsewhere) and a greater volume of refugees from Asia and sub-Saharan Africa entering Europe via these weak and war-torn states. January 2005 was set as the earliest date for data collection to ensure that studies were timely in their analyses. Research designs that included pre- and post-intervention data and analysis of outcomes were included to ensure that some measure of effectiveness could be demonstrated. Due the range of educational systems and settings that exist around the world, school-based interventions were understood in their broadest sense, including non-statutory educational settings for children and young people. The scoping review focused on interventions related to the effects of trauma within a population of refugee children, because it was intended to inform a trauma service for refugee children.

The following search string was used, though adapted for each individual database search engine;

“(‘child*’ or ‘adolescen*’) AND ('refugee*' or 'asylum seek*') AND ('school*' or 'education' or 'learning') AND (‘intervention’ or ‘treatment’ or ‘therap*’ or ‘trial’ or 'practice' or

'approach' or 'ethos' or ‘curriculum’) AND (‘trauma*’ or ‘mental health’ or 'resilience' or 'psychosocial' or 'psychological' or ‘well-being’)”

Two reviewers independently screened titles and abstracts and removed studies that didn’t match the inclusion and exclusion criteria detailed above. Disagreements were resolved by discussion and consensus, drawing on senior team members’ input to resolve conflicts. Full texts were then retrieved and screened by the same two reviewers. Studies that were found not to meet the inclusion criteria following full-text review were excluded as well. The searches yielded 144 (EBSCO), 208 (PROQUEST) and 139 (APAPsychinfo) results respectively. 30 duplicates were removed automatically by Covidence. Title and abstract screening resulted in the removal of 437 studies, which didn’t fully meet the inclusion criteria.

We were able to retrieve 22 of the resulting 24 articles. In addition to the two studies that were unavailable, nine studies were removed following full-text screening because the intervention was not implemented in a school setting (3), the study design was neither experimental nor pseudo-experimental (5), or because the intervention studied didn’t target the effects of trauma (1). A further two studies were systematic reviews (Sullivan & Simonson, 2016; Tyrer & Fazel, 2014). We used these to inform this review, but did not extract data from them. This resulted in a final sample of 11 studies reporting on 14 interventions. The selection process is summarised in figure 1 below, and an overview of the 11 studies is given in table 1 overleaf.

Figure 1: PRISMA Chart

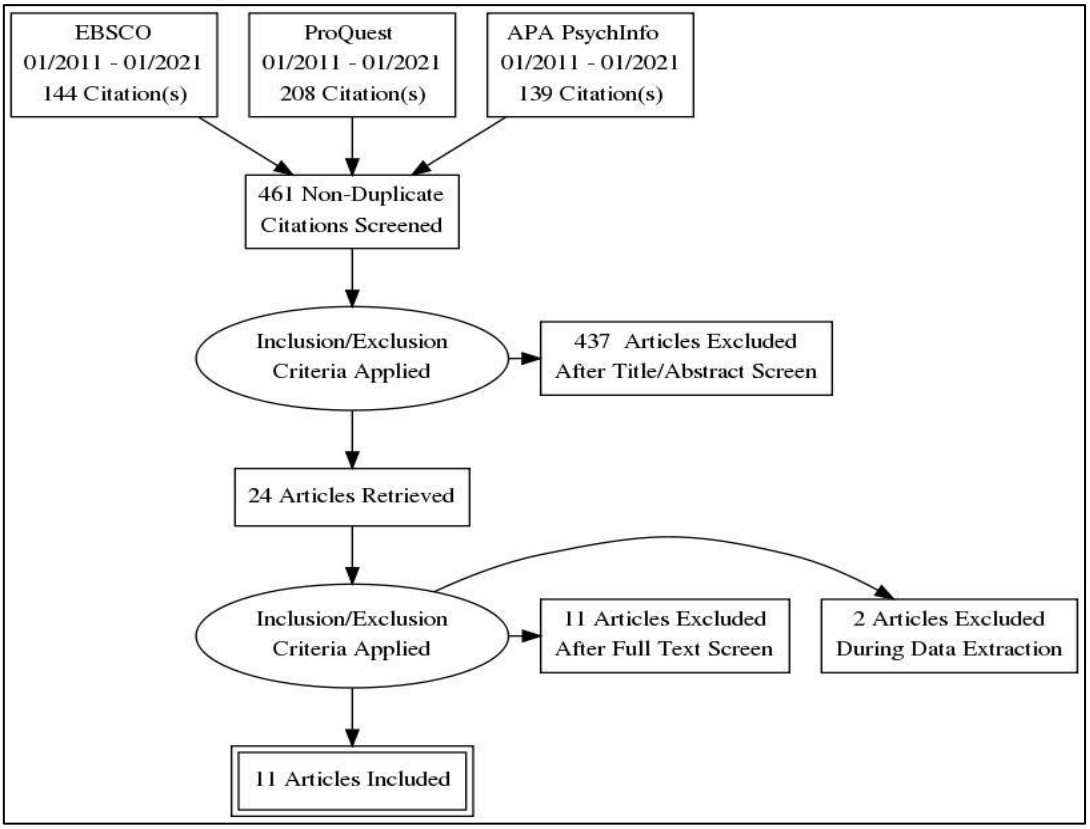


Table 1: Overview of studies included in scoping review

Authors	*n*	Age	Participants	Location	School Type	Intervention	Study Design	Outcomes
Acosta Price et al. (2012)	32	14-16	Central American origin with symptoms of trauma	Los Angeles, USA	High School	Cognitive Behavioural Intervention for Trauma in Schools (CBITS)	"Practice-based evidence" from pilot projects	Majority (77%) reduced trauma symptoms, improvements in school attendance and achievement reported
Acosta Price et al. (2012)	200+	Not specified	Newly arriving immigrant and refugee students	Chicago, USA	Elementary & High School	Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)	"Practice-based evidence" from pilot projects	Decrease in disciplinary referrals, improved access to mental health services
Acosta Price et al. (2012)	14	Not specified	Somali/Latinx parents affected by trauma	Minneapolis, USA	Not specified	Parenting Through Change (PTC)	"Practice-based evidence" from pilot projects	Positive emotional and behavioural changes. Limited programme acceptability among Somali group
Acosta Price et al. (2012)	80	Not specified	Somali youth in ELL at target school	Boston, USA	Middle School	Trauma Systems Therapy (TST)	"Practice-based evidence" from pilot projects	Improvements in emotional regulation and environmental stress, excellent project uptake
Allison and Ferreira (2017)	23	10-14	Spanish-speaking Latinx pupils with symptoms of trauma	New Orleans, USA	Middle School	CBITS	Pre- and post-test design (no control)	Significant reduction in symptoms of trauma and depression post-intervention, irrespective of gender.
Cardeli et al. (2020)	34	11-15	Bhutanese refugee pupils	New England, USA	Middle School	TST	Pre- and post-test design (no control)	Reduction in symptoms of trauma, particular avoidance symptoms.
Ellis et al. (2013)	30	11-15	Somali youth in ELL at target school	New England, USA	Middle School	TST within a multi-tiered prevention and intervention program	Pre- and post-test design (no control)	Stabilization of resource hardships were associated with significant improvements in symptoms of depression & PTSD
Gormez et al. (2017)	32	10-15	Accompanied Syrian Refugee pupils	Istanbul, Turkey	Temporary Education Centre	Group CBT	Pre- and post-test design (no control)	A significant proportion of the participants no longer met the

								diagnostic threshold for anxiety and PTSD after the intervention
Kalantari et al. (2012)	88	12-18	Afghan war-bereaved refugee pupils	Qom, Iran	School for Afghani refugees	"Writing for Recovery" group intervention	Randomized Control Trial	Statistically significant reduction in traumatic grief symptoms in experimental group
Mancini et al. (2020)	34	6-11	Immigrant and refugee pupils of diverse origins experiencing trauma symptoms in ELL class	Midwestern USA	Elementary School	Somatic Soothing and Emotional Regulation Skill Development (SSERSD), n=4 received Eye Movement Desensitization and Reprocessing (EMDR)	Pre- and post-test design (no control)	Statistically significant improvements in anxiety, depression, psychological functioning, and trauma symptomology, no significant differences for EMDR group
Mhaidat and ALharbi (2016)	20	Not specified	Female Syrian refugee pupils	Zarqa, Jordan	10 public schools	CBT	Randomised Control Trial	Statistically significant reduction of depression and sense of insecurity scores in experimental group compared with control
Quinlan et al. (2016)	42	M=15	Newly arrived refugee children of diverse origins (Middle East, East Asia, Africa)	Brisbane, Australia	Intensive English language school and settlement service	Home of Expressive Arts in Learning (HEAL) Programme	Pseudo-experimental including a control group	Moderate effect sizes for the reduction of behavioural difficulties, emotional symptoms, hyper-activity and peer problems
Schottelkorb et al. (2012)	31	6-13	Refugee children of diverse origins, primarily African	Northwestern USA	Middle School	Child-Centered Play Therapy (CCPT) and TF-CBT (Control)	Randomised Control Trial	CCPT appeared as effective as TF-CBT in reducing symptoms of PTSD, and parent sessions were not essential to their success
Sirin et al. (2018)	147	9-14	Syrian refugee children not in education	Sanliurfa, Turkey	Not specified	Online, game-based learning intervention	Randomised Control Trial	Experimental group registered improved cognitive functioning, language, coding skills and life satisfaction

Study Designs

All study designs included a pre-test and post-test comparison, with the exception of the studies reported in Acosta Price et al. (2012) which drew on "practice-based evidence", which at times was not clearly defined. Some included control groups, while the others did not.

Some interventions specified one or several specific ethnicities, such as Somali/Somali Bantu (Acosta Price et al., 2012; Ellis et al., 2013), or a specific regional origin or home language, such as Latinx students who spoke Spanish at home (Allison & Ferreira, 2017). One study allowed all Bhutanese enrolled in the intervention school to take part, regardless of diagnostic status (Cardeli et al., 2020). Age, class, or length of stay were also criteria in several studies (Allison & Ferreira, 2017; Quinlan et al., 2016).

However, most studies applied inclusion criteria based on trauma symptomology. One study simply required the presence of trauma symptoms (Mancini et al., 2020), but several others defined a minimum score on one or more mental health measures (Gormez et al., 2017; Allison & Ferreira, 2017; Schottelkorb et al., 2012) or applied pre-intervention measures to a larger study sample and targeted the intervention at those most in need (Kalantari et al., 2012; Mhaidat & ALharbi, 2016). Some studies relied on teacher referral to identify students most likely to benefit from the intervention (Ellis et al., 2013; Quinlan et al., 2016; Schottelkorb et al., 2012).

Those presenting with severe psychiatric disturbances (Allison & Ferreira, Mancini et al., 2020) or engaged in treatment outside the study context (Schottelkorb et al., 2012) were excluded from some of the interventions.

Measures

A wide range of measures were used to assess symptoms and intervention impact. Both interviews and self-administered instruments were used, and teachers, pupils, and parents were included in the assessments. Trauma measures included the Child Version of the UCLA PTSD Reaction Index (UCLA PTSD-RI) for DSM-IV, used five times; the War Trauma Screening Scale (WTSS), used twice; and the Child Posttraumatic Symptom Scale (CPSS), used once. Symptoms of depression were measured using the Depression Self-Rating Scale for Children (DSRS-C), the Center for Epidemiological Studies Depression Scale for Children (CES-DC) and a modified version of the Hopkins Symptom Checklist. Anxiety measures included the Spence Children's Anxiety Scale (SCAS) and the Screen for Child Anxiety Related Disorders (SCARED), each used once. Measures for sense of school belonging, acculturation, resource hardships, traumatic grief, sense of insecurity, hopelessness, and psychological functioning were also used by individual studies. The Strengths and Difficulties Questionnaire was used twice to assess behaviour and

symptomatology. Some studies used modified versions of measures that had been adapted for a specific cultural group, such as the Somali version of the Adolescent Post-War Adversities Scale (Ellis, et al., 2013) or an adapted version of the Language, Identity, and Behavior scale (LIB) for Bhutanese refugees (Cardeli, et. al., 2020).

Interventionists

Within the sample studies, interventions often used interdisciplinary teams that included both clinical and non-clinical staff. The intervention discussed by Cardeli et al. (2020) was delivered by a clinician and a cultural broker, but the authors discuss the possibility of using school personnel instead in order to reduce costs. Although several of the interventions did indeed involve specialist mental health professionals, this suggests that there is a degree of flexibility with regards to interventionists' background.

Non-clinical professionals such as licensed social workers (Acosta Price, et al., 2012; Allison & Ferreira, 2017; Mancini, 2020), 'a pair of instructors supplied with a lesson plan' (Sirin et al., 2018), and Arabic-speakers teachers (where Arabic-speaking psychologists were unavailable) (Gormez et al.,2017) delivered some of the interventions. This intervention is particularly interesting due to its use of teachers, who underwent an intensive 2-day training programme prior to the intervention and were supported through supervision following each session. However, the training and in particular the ongoing supervision may prove cost-prohibitive for many schools outside a study context. On the other hand, the study authors point out that teachers gain lasting skills which can be used outside of the scope of the research project, thus offering a comparatively sustainable solution.

Regardless of their specific professional backgrounds, most interventions required highly qualified staff, who had often undergone postgraduate training or were certified in a range of therapeutic techniques and received regular supervision during the programme. For example, Quinlan et al. (2016) report on an intervention delivered by registered arts psychotherapists and music therapists with extensive experience in their fields, while the team studied by Mancini (2020) included a licensed masters-level counsellor and three licensed masters-level social workers. Team members were also certified in EMDR, therapeutic yoga, and TF-CBT. Acosta Price et al. (2012) report on a parent intervention where the interventionists – all mental health practitioners – received approximately 90 hours of training in the intervention, as well as ongoing coaching and consultations from intervention experts. The intervention described by Schottelkorb et al. (2012) was delivered by trained second- or third-year master's-level counselling students, who had been educated about working with refugees, interpreters, and refugee trauma, had completed training in their respective treatment manual (CCPT or TF-CBT), and were supervised by doctoral-level licenced professionals.

A salient feature of several of the studies included in this review is a strong emphasis on cultural and linguistic competence. One of the four interventions covered in Acosta Price et al. (2012) employed bilingual mental health professionals with similar ethnic backgrounds to their target demographic: for example, a group for Somali pupils was co-led by one Somali and one other African mental health practitioner, and a group for Latinx pupils was led by two Spanish-speaking mental health professionals. A second project discussed in Acosta Price et al. (2012) went to great lengths to improve the cultural sensitivity of its service: as no Somali mental health practitioners were available in Massachusetts, two Somali individuals were offered scholarships in partnership with Boston University School of Social Work. Both subsequently became active members of the study team and acted as mental health providers in project schools and cultural brokers in the wider community. Similarly, unable to recruit any Arabic-speaking psychologists, Gormez et al. (2017) trained teachers to deliver their intervention for Syrian refugees in Turkey. Allison and Ferreira (2017) used a school social worker of Mexican-American descent who was fluent in Spanish. The intervention described by Cardeli et al. (2020) also employed a cultural broker. Mhaidat and Alharbi's (2016) intervention for female Syrian refugee adolescents in Jordan was carried out in Arabic, a language which the interventionists shared with their participants, although this aspect is not explicitly discussed in the study. The Afghan refugee students who took part in Kalantari et al.'s (2012) study in the city of Qom, Iran, were native Farsi (Dari) speakers and the intervention was carried out in the same language.

As Acosta Price et al. (2012) point out, culture influences mental health treatment in many ways and culturally competent mental health professionals are key to programme success. They found that involving community informants allowed service providers to select, adapt and implement an evidence-based intervention that would be acceptable and relevant to the target community. They conclude that using treatment strategies that are "consistent with community priorities, cultural norms, and values" can make mental health services more accessible and culturally responsive for diverse communities (p. 109).

Types of Intervention

A typology for classifying the types of interventions covered by the studies included in this review was developed based on classifications used in Sullivan and Simonson (2016) and Tyrer and Fazel (2014):

Verbal Processing: interventions that centre on the verbalisation of past experiences by the intervention subject, often using a form of CBT.

Creative Arts: interventions that use a range of practices of creative expression (movement, writing, play) as therapy.

Multi-tiered/Multi-modal: interventions that combine different approaches across populations, either based on need (e.g. severity of symptoms) or status (e.g. pupil, parent, teacher).

The main findings of each study are summarised according to this typology below.

Verbal Processing interventions

Cardeli et al. (2020) carried out a single-group pilot pre/post evaluation on an intervention for Bhutanese refugee students who are at risk for mental health problems due to traumatic exposure and stressors related to resettlement. Targeting refugee students' sense of school belonging and mental health, skills-based, hour-long, gender-segregated groups using a 12-week curriculum were implemented at a public middle school in New England as part of a Trauma Systems Therapy for Refugees (TST-R) programme.

Groups were co-led by a mental health clinician and a Bhutanese cultural broker, who also facilitated meetings with families to describe the intervention, invite children, and obtain parental consent. Group activities included "learning through games, role-plays, and experiential exercises in addition to cross-cultural discussions about similarities and differences between American and Bhutanese culture, as modelled by the clinician and cultural broker" (p. 736).

34 Bhutanese refugee students in sixth, seventh and eighth grade (11-15 years old) participated in the programme. Pre- and post-intervention measures were taken on mental health symptoms, school belonging, and acculturation. Four students, whose group participation revealed a need for more intensive intervention, were also referred for individual clinical services.

High levels of mental health symptoms were found at baseline, with ca. 49% of participants meeting partial or full criteria for PTSD. Sense of school belonging was significantly inversely associated with depressive and PTSD symptoms at baseline. No statistically significant improvements were found for either sense of school belonging or depressive and post-traumatic stress symptoms, apart from avoidance symptoms. However, the effect size for avoidance symptoms was only small to medium (Cohen’s d = 0.36). Descriptive findings on the small group of more severely affected students suggest much greater improvements in depressive and PTSD symptoms, as well as sense of school belonging.

Reporting on a prospective experimental single-group study with pre-test/post-test design, **Gormez et al. (2017)** discuss a school-based, teacher-delivered group CBT intervention for trauma-affected primary and secondary-grade Syrian refugee students attending a temporary education centre in Istanbul, Turkey.

32 randomly selected boys and girls, aged between 10 and 15 years, took part in the 8-week protocol-based programme. Each session lasted about 70-90 minutes and groups consisted of 8-10 students and two teachers. Sessions consisted of a wide range of techniques and exercises, including psychoeducation, warm-up group activities, relaxation techniques, and interventions to address strong emotions and maladaptive thinking styles. The programme also included: creating alternative explanations for depressive, anxious, and stress-related experiences; interventions addressing trauma and grief-related experiences; group- and pair-based games that foster problem-solving strategies and strategies for relapse management.

The intervention resulted in a statistically significant reduction in total scores of PTSD and anxiety measures, and in the intrusive and arousal symptoms of PTSD. A significant proportion of participants no longer met the diagnostic threshold for anxiety and PTSD post-intervention. Conduct, hyperactivity, prosocial behaviour and peer problems showed no significant change.

Mhaidat and ALharbi (2016) used a randomised case-control study design to assess a cognitive-behavioural intervention aimed at reducing symptoms of depression and sense of insecurity among female Syrian refugee adolescents at a government school in Jordan. Twenty girls were selected from a study sample of 220 based on their Depression and Sense of Insecurity Scale scores. Of these, half were randomly assigned to the treatment group and half to the control group. The treatment group received twelve twice-weekly 45-minute sessions of an intervention which focused on reducing cognitive distortions. Participants were also given homework to complete between sessions. Baseline measures indicated medium-level scores for depression and sense of insecurity, which were significantly reduced following the intervention.

The CBT-based interventions studied by Gormez et al. (2017) and Mhaidat & ALharbi (2016) appear to have been comparatively more successful in reducing symptoms of trauma, including anxiety, PTSD, depression and sense of insecurity, than the TST-R-informed skills-based group intervention discussed by Cardeli et al. (2020), which had no significant impact on either sense of school belonging or depressive and post-traumatic stress symptoms other than a small to medium effect on avoidance symptoms. More promising outcomes for a small group of children with high baseline depression and PTSD scores suggest potential for this group, but a larger study is needed to confirm this assessment.

Creative Arts

Quinlan et al. (2016) discuss evidence from a controlled trial on the only creative arts intervention included in this review. The non-standardised intervention combines a wide range of arts and music therapy activities used within the creative therapies programme Home of

Expressive Arts and Learning (HEAL). It also incorporates the Tree of Life and BRiTA Futures programmes, both of which target self-identity and cultural identity.

42 newly-arrived Middle-Eastern, East Asian, and African students attending graduation classes in an intensive English language State High School in Brisbane, Australia, took part in the intervention (mean age 15 years 5 months, SD = 1 year 5 months). Students were assigned to the intervention and control group based on referral by teachers and community case workers.

As part of the 10-week intervention, students received a minimum of one individual hourly session per week, as well as a group music therapy (40%) or arts therapy (60%) intervention. Group interventions were segregated by culture and gender. A quarter of the sample also accessed an additional weekly 45-minute session of individual therapy.

There was "significant variability" (p.76) with respect to the specifics of the intervention, including different therapists, variations in length and type of interventions, whether children took part in a group or individual capacity, and whether they received music or art therapy intervention. The programme was not manualised.

Mental health and behavioural measures were taken pre- and post-intervention. Changes in behavioural difficulties were observed in the expected direction, but stopped short of statistical significance. There was a significant reduction in emotional symptoms. Effect sizes for behavioural difficulties, emotional symptoms, hyperactivity and peer problems were moderate. Qualitative pupil feedback was very positive.

Mancini (2020) conducted a pilot study with a single-group pre- and post-test design on a somatic soothing intervention for refugee and immigrant children suffering from dissociative and dysregulatory symptoms as a result of experiencing war, interpersonal violence and neglect, as well as stressors associated with migration, displacement, and resettlement. Based in a mid-western elementary school district in the US, the intervention consists of exercises and activities on 1) relaxation and movement strategies, 2) creating space and boundaries, 3) body and somatic resources, 4) grounding resources, 5) releasing activities, and 6) somatic resource movements.

A convenience sample of 34, mostly Latinx children aged between 6 and 11 years participated in the intervention and received on average twelve 35–40-minute sessions twice a week during the regular school day. Four participants also received 9-12 sessions of Eye Movement Desensitization and Reprocessing Therapy. At baseline, participants scored highly on measures for PTSD, depression, and anxiety. Following the intervention, participants reported statistically significant improvements in anxiety, depression, psychological functioning, and trauma symptomology. Effect sizes were medium to large (0.46-1.08). Qualitative teacher reports also

indicated improved confidence, communication, academic functioning and social interaction for most participants.

Kalantari et al. (2013) conducted a randomised controlled trial on a "Writing for Recovery" group intervention to address traumatic grief symptoms in war bereaved Afghani refugees attending a school for Afghani refugee students in the Iranian city of Qom.

88 students were screened using the Traumatic Grief Inventory for Children (TGIC) and a study sample of 64 boys and girls, aged between 12 and 18 years, was chosen based on highest scores and randomly assigned to intervention (n=32) and control (n=32) groups. 29 subjects in the experimental group completed the intervention.

The intervention consisted of six 15-minute, gender-segregated group sessions delivered over three consecutive days and progressed from unstructured writing on feelings and thoughts about traumatic events or loss to more structured writing on advising someone in a similar situation, culminating in a retrospective reflection on insights from a 10-years-on vantage point. At the end of each session, writings were placed in a box, followed by a short break and the start of the next session.

The intervention resulted in a significant decrease in TGIC scores post intervention for the experimental group, compared to a slight increase in the control group. These outcomes are particularly notable given the short duration of the intervention (90 mins over three days), the relatively large group size, and the extremely deprived setting, which make the intervention potentially feasible in many contexts. Long-term effects could not be assessed due to the participants' unstable situation.

Sirin et al. (2018) report on a randomised controlled trial on an innovative, game-based digital learning intervention for refugee children who are not in education. Aimed at improving language proficiency, educationally relevant cognitive skills of executive functions, and sense of hope, as well as teaching coding skills, the intervention consisted of four playful digital learning environments and games. Minecraft was used to encourage children to "imagine a better future" by building their "dream room, dream house and dream community". The site was a local school computer lab, where children were taken for the purpose of the intervention.

A sample of n=147 Syrian refugee boys and girls in the Turkish city of Sanliurfa, who were not in education at the time of the study, were recruited with the help of a local aid agency and randomly assigned to an intervention (n=75) and a wait-list control group (n=72). Children in the intervention group engaged in the intervention for 2h/weekday over 4 weeks, 40h in total.

Compared to control group, pre-/post-intervention measures indicated significant improvements in executive functioning and Turkish language scores, a significant decrease in hopelessness, as well as an understanding of basic concepts of coding. The authors also report high student satisfaction rates but note that it is unclear whether the benefits of participation in a structured environment or the Minecraft component more specifically was responsible for the observed improvement in mental health symptoms.

As with the multi-modal and multi-tiered interventions, the studies and interventions included in this category are difficult to compare due to the wide range of approaches and therapeutic methods used. Again, all interventions seemed to have some kind of positive impact on symptoms of trauma and related areas of functioning. Perhaps surprisingly, Schottelkorb et al.'s (2012) study comparing a new CCPT intervention with an evidence-based TF-CBT intervention found no significant whole-sample impact for either of them. Unlike the other CBT-based interventions discussed in this review, the specific circumstances in Schottelkorb's study – perhaps the missing parent involvement – seem to have precluded a significant effect on any but the most severely affected children in the sample.

Multi-modal and multi-tiered interventions

Multi-modal interventions

Drawing on "practice-based evidence", **Acosta Price et al. (2012)** report on four separate multi-tiered/multi-modal projects in the US. The first was an intervention at a high school in a Los Angeles school district with large numbers of English Language Learners, children from deprived backgrounds, and recent Central American immigrants affected by civil war, gang violence and poverty. About half of the district's middle school population had experienced violent victimisation in the previous year and close to one-third was experiencing clinical levels of PTSD.

A school-based, trauma-informed intervention for 9th and 10th grader students was developed and implemented at a high school in the district to address trauma in these pupils. Provided by a licensed social worker and social work interns, the intervention combined intensive home- and school-based services. Although parent, teacher, and community education also formed part of the project, the primary intervention, Cognitive-Behavioural Intervention for Trauma in Schools (CBITS), targeted pupils only. The authors only report on the CBITS component of the programme.

The intervention consisted of ten sessions and aimed to "decrease the negative effects of violence exposure by teaching cognitive behavioural skills in a small group format" (Acosta Price, et al., 2012, p. 102). 32 ninth grade pupils participated in the intervention. Of these, 77% responded favourably, 6% saw no change, and 18% had continued need for treatment, although

no details are given on measures used to assess outcomes and whether any changes were statistically significant. The authors furthermore report that grade point averages and attendance rates showed a “notable improvement” compared to previous semesters, although previous rates and grade point averages are not reported.

The second multi-modal intervention discussed in **Acosta Price et al. (2012),** based at three public schools in Minneapolis, was designed to better engage with and serve Somali and Latinx youth and families affected by trauma and various stressors relating to acculturation, discrimination, and family problems. The programme addressed mental health barriers by 1) placing bilingual, bicultural mental health professionals in schools, 2) building trust and seeking feedback through community leaders, 3) using narrative approaches to help students and families process traumatic events, and 4) using group activities that teach life skills. The intervention discussed in most detail, Parenting through Change (PTC), falls in the fourth of these categories and aimed to address difficult parent-child relationships resulting from trauma experienced by parents and children.

PTC consists of a 14-week, 90-minute parenting group intervention which encompasses behavioural training and strategies to manage emotions. Strategies are practiced through role play. Separate groups for Somali and Latinx parents were facilitated by African/Somali, and Spanish-speaking mental health professionals respectively, who also offered weekly phone calls to provide support between sessions.

14 parents completed the group sessions and reported "substantial improvements in their ability to regulate their emotions, parenting practices, and interactions with their children" (p. 104). No details are given on the character of the school-based services for youth, although the authors report that schools noted “positive changes” in the 141 students involved in school-based services, including improvements in behaviour, attendance, and academic performance. 80% of parents and 87% of teachers also reported reduced emotional and behavioural symptoms in youth who had received school-based services.

Allison and Ferreira (2017) report on a study using a pre-test and post-test design to assess the use of a CBITS, a brief standardised skill-based group intervention which "promotes the development, improvement and use of problem-solving skills, relaxation and coping skills, techniques for reframing distorted and negative cognitions of self and others; and addresses the child's trauma narrative in order to reduce trauma, depression and anxiety symptoms" (p. 183).

The multi-modal intervention consisted of ten weekly group sessions of an hour in length, and four individual sessions during which participants shared their trauma narratives and practiced coping and relaxation skills while retelling their narrative until feelings of anxiety and stress were

reduced. They also identified a part of their narrative that they felt most comfortable sharing with other group members. Furthermore, two psycho-education groups (or alternatively phone calls) for parents and one information session for teachers also formed part of the programme.

The student population of the programme school, located in New Orleans, consisted mostly of recently immigrated Spanish-speaking Latinx children and youth from low-income families. Eligible students were between 10 and 14 years old, in 6th, 7th, or 8th grade, spoke Spanish at home, and had a minimum score of 14 on the Child Posttraumatic Symptom Scale as well as at least one significant traumatic experience. 23 children and youth participated in the study.

Pre- and post-intervention measures of trauma and depression symptoms were taken to assess the impact of the intervention. The authors report a statistically significant reduction in symptoms of trauma and depression for both boys and girls, reporting large effect sizes. The impact was particularly strong for older participants (12-14), due to higher levels of exposure to trauma at baseline.

Schottelkorb et al. (2012) conducted a randomised controlled trial comparing the effectiveness of child-centred play therapy (CCPT) and trauma-focused cognitive-behavioural therapy (TF-CBT) in reducing symptoms of trauma among refugee children. CCPT is a manualised treatment which helps children communicate their feelings, thoughts and desires through play. Toys used in CCPT are reflective of the child's cultural background.

This was originally a multi-modal intervention with a significant parent component. However, due to scheduling problems, actual parent involvement turned out to be minimal. 38 children were recruited, by teacher referral, from three elementary schools with higher than the district average numbers of ELL students and high percentages of children from economically deprived backgrounds. Children with either a full or partial PTSD designation on the UCLA PTSD Index for DSM-IV or a clinical score on the Parent Report of Posttraumatic Symptoms were eligible to take part in the study. Seven children, who did not meet these levels of PTSD symptomology or received counselling outside of the study setting, were excluded. The resulting study sample of n=31 boys and girls, aged between 6 and 13 years, and from 15 African, Asian, European, and Middle Eastern countries, was randomly divided into two intervention groups, receiving CCPT and TF-CBT respectively.

Children in the CCPT group received individual, twice-weekly 30 min. sessions over 12 weeks (mean=17 sessions). The protocol also included six 15-minute, script-based parent consultations. However, fewer parent sessions actually took place. Children in the TF-CBT group received twice-weekly 30-min sessions (mean=17 sessions). Planned weekly parent and joint parent-and-child sessions did not take place and therapists only met parents twice on average.

Although statistical significance for the whole sample could not be achieved, effects were both significant and large for children who met criteria for Full PTSD on UCLA PTSD Index for DSM-IV or who scored in clinical range on the PROPS regardless of treatment received. Both interventions were thus effective in reducing trauma symptoms for the most severely affected children. A remarkable finding is the fact that both interventions were effective despite the lack of substantial parent involvement.

Multi-tiered interventions

A multi-tiered intervention, piloted at two Chicago schools, is also described in **Acosta Price et al. (2012**). The programme schools, an elementary school and a high school in a neighbourhood with a large percentage of recent immigrants, sought to develop "ways to integrate and provide support to newly arriving students" (p. 105). Due to the difficulties associated with determining the cause of learning, behavioural, or mental health problems in newly arrived refugee children, a universal component was implemented to ease integration, thereby improving the school environment and reducing conflicts. Consultation and professional development for teachers and administrative staff were offered to sensitise and educate staff on challenges faced by newly arrived populations and effective and inclusive ways to work with them. Selective preventive services were offered to all newly arrived refugees in English as a Second Language pull-out classrooms. At the high school, pupils participated in preventive psychoeducational, experiential arts, and acculturation groups. Indicated mental health services were also offered in programme schools for individual treatment, using a range of treatments including TF-CBT.

The authors report that behavioural problems, measured by the number of disciplinary referrals for refugee and immigrant students, were reduced substantially, and that school administrators felt that this was due to the universal and selective services offered. The authors also found that the number of pupils receiving individual mental health treatment from the project schools doubled with the implementation of the programme, suggesting that it improved access to mental health services for the target population.

Two studies discuss a trauma intervention for Somali and Somali Bantu refugee students in the USA, project SHIFA (Acosta Price et al., 2012; Ellis et al. 2013). The four-tiered programme consisted of prevention and community resilience building for the community at large (Tier 1), school-based early intervention skills-based groups for at-risk students (Tier 2), and direct, school based (Tier 3) and home-based (Tier 4) intervention using a Trauma Systems Therapy (TST) model, for those with significant psychological distress. The treatment model, Trauma Systems Therapy (TST), helps a child gain control over their emotions by reducing stressors from the social environment and helping the child contain their emotional dysregulation.

Acosta Price et al. (2012) report on the skills-based pupil groups (Tier 2), which were complemented by parent meetings addressing the effects of violence exposure on youth and teacher training on refugee mental health and trauma. All Somali youth in ELL classrooms in the programme school were eligible and invited to take part in weekly peer skills groups, which focused on decreasing peer aggression and discrimination, as well as acculturative stress. 80 pupils participated in some aspect of the programme.

The authors report improvements in participants' experience of environmental stressors and in their emotional dysregulation. A sample that completed outcome measures reported significantly decreased trauma symptoms, but no details are given on the size of the sample or the specifics of the outcome measures. A 100% success rate in obtaining parental consent, and at engaging youth in treatment were also notable findings considering the previously low uptake of mental health services in the local Somali community.

A more rigorous study of the same intervention is presented by **Ellis et al. (2013),** who used a randomised pre- and post-test design and collected data at baseline, 6 months and 12 months after baseline. All Somali and Somali Bantu students in the programme school's ELL classroom (n=30) were eligible and took part in the programme and in the study. Participants were between 11 and 15 years old and in 6th to 8th grade. All students participated in Tier 2 (skills-based groups), 50% received Tier 3 services (individual school-based TST), and 13% in Tier 4 (home-based TST). Tiers 3 and 4 were offered following teacher, parent or group leader referral. Measures were taken at time of enrolment, 6-month follow-up, and 12-month follow-up.

Students across all tiers demonstrated statistically significant improvements in mental health and reduced resource hardships. The study also found that resource hardships were significantly associated with PTSD symptoms over time and that a stabilisation of resource hardships coincided with significant improvements in depressive and PTSD symptoms for the worst-affected group, who had received home-based TST treatment. The authors note that continued resource hardships reduced the effectiveness of the Tier 3 and 4 TST interventions in addressing PTSD symptoms, suggesting that these may not have been sufficiently intense and/or focused on social-environmental problems. In particular, they suggest that the school-based TST intervention for Tier 3 may have failed to address significant stressors at home. A positive outcome was a high level of treatment engagement, as all students referred for Tiers 3 and 4 agreed to and engaged in treatment.

Discussion / Implications for practice

A number of implications for practice emerge from the studies discussed in this review. They highlight the diverse range of potentially beneficial school-based interventions to support

refugee children and adolescents' recovery from traumatic experiences, ranging from CBT-based interventions, to others informed by a TST model, to a wide array of alternative approaches that harness the beneficial effects of music, art, and play.

The characteristics of the multi-modal and multi-tier interventions included in this review vary substantially between studies, and sometimes even within a single study – as was the case for the creative arts intervention described by Quinlan et al. (2016). Likewise, the rigour of the studies and the amount of information offered on the interventions discussed varies widely between studies included. This makes direct comparison or meta-analysis impossible. Overall, it appears that most multi-modal interventions seemed to have some positive impacts on at least some of the targeted domains, although it is often unclear which particular aspect or combination of aspects led to such positive outcomes.

The importance of school-based mental health services for improving access to treatment for children and adolescents from marginalised backgrounds, including refugees, is documented in Chapter 1. Barriers such as stigma, access to transportation, or lack of insurance are avoided and services are integrated into a system where the target group is already engaged (Acosta Price et al., 2012; Allison & Ferreira, 2017). Several studies in this review found that school-based services successfully improved access to mental health services for previously underserved groups of children and adolescents (Acosta Price et al., 2012; Ellis et al., 2013; Allison & Ferreira, 2017). Expanding low-threshold mental health services in schools can thus be an effective way of engaging refugee children, adolescents, and their families in mental health services. However, Ellis et al. (2013) raise an important caveat against relying exclusively on school-based services: where resource hardships at home are a significant factor, school-based services may be inadequate. Acosta Price et al. (2012) also report that parents in one of the projects covered weren't always comfortable meeting clinicians in school, but were more open to home-based services. Flexibility on the location where services can be accessed is thus key.

The importance of cultural considerations was stressed in several of the studies included in this review. Explanatory models of mental illness and associated treatment models are culturally bound, and Western ideas on mental health may not always be acceptable to non-Western communities. To improve uptake and effectiveness of mental health services for refugee children and families, several studies stress the need to include target communities in the process of selecting, adapting, and implementing interventions, and to adapt trauma services to meet the unique needs of the target community, taking into account their priorities, norms and values.

Language appears as a significant barrier to accessing mental health services among refugee and immigrant communities. Conducting the intervention in the target community's native language is therefore important, as using interpreters can be a significant barrier to intervention success.

Where possible, interventions engaged mental health professionals from the target community, but where this was not feasible, training bilingual teachers or other members of the target community emerged as an alternative. Including cultural brokers – typically a trusted member of the target community – as part of the intervention team has also been shown to be a successful strategy for community engagement and to ensure cultural sensitivity and relevance of the treatment programme. Community organisations are invaluable sources of cultural expertise and trusted agents, and involving them in programme development is essential.

Some of the studies in this review present interventions that are exceptionally cost- and resource-efficient and can be successfully implemented even in very deprived contexts and with minimally trained staff. Schottelkorb et al.'s (2012) findings suggest that some programmes could be successfully implemented in a condensed version and that components previously considered essential, such as parent involvement in a TF-CBT intervention, could in fact be omitted. However, for many of the interventions discussed, the need for highly trained staff remains a potential barrier for implementation in schools, where budgetary constraints are often significant.

Chapter 3: Syrian Parent and Pupil surveys

Method

An online survey for parents/carers[6] and a separate survey for pupils were designed and piloted with representative members of the Syrian community in Northern Ireland, before being professionally translated into Syrian Arabic and Kurdish. The translated versions were also checked by our Syrian advisor. The survey, along with an information letter was sent to VPRS families via Barnardo's and Extern WhatsApp broadcast, and contact schools. Contact details of the STARS team were provided in case of any questions or distress resulting from completing the survey. Advice on what to do if parents had concern about their children's wellbeing was also provided. The surveys were open for two weeks.

Prior informed consent was assured by the first, mandatory question of each survey. For pupils, parental consent was sought by asking respondents to supply a unique code that would match their parent's response. All parents completing the survey were asked first if they wanted to give their consent for their child to participate and then to create a six-digit code using a random number generator linked to the survey. Pupils were then asked to supply this six-digit code at the start of their survey. In theory, this meant that pupil responses could be linked to parent responses for analysis, whilst maintaining anonymity. This was not always successful, as in some cases the 'unique' code was not unique (e.g. 123456), or it was clear that an adult had completed the survey on behalf of their child. Both for this reason, and because of the low number of responses (n=25), the findings from the pupil survey should be understood not to be representative of the wider VPRS pupil population.

A summary of numbers of respondents is contained in table 2 below.

	Parent Survey		Pupil Survey
	Responses	Children Represented	
Arabic	66	97	20
English	1	3	5
Kurdish	0	0	0
Total	67	100	25

Table 2: Summary of Survey Responses

The findings below summarise and quantify the responses gathered by the survey, and draw some comparisons within the data. The surveys contained a number of open text questions which

[6] The survey and accompanying information were written for parents or carers. All respondents were parents of Syrian children and young people so we refer only to 'parents' from this point.

required further professional translation prior to qualitative analysis. Open thematic coding was undertaken by one member of the research team and validated by another, to produce frequencies of key themes mentioned by respondents in their answers.

Parent Survey: Findings and Discussion

Demographic Data

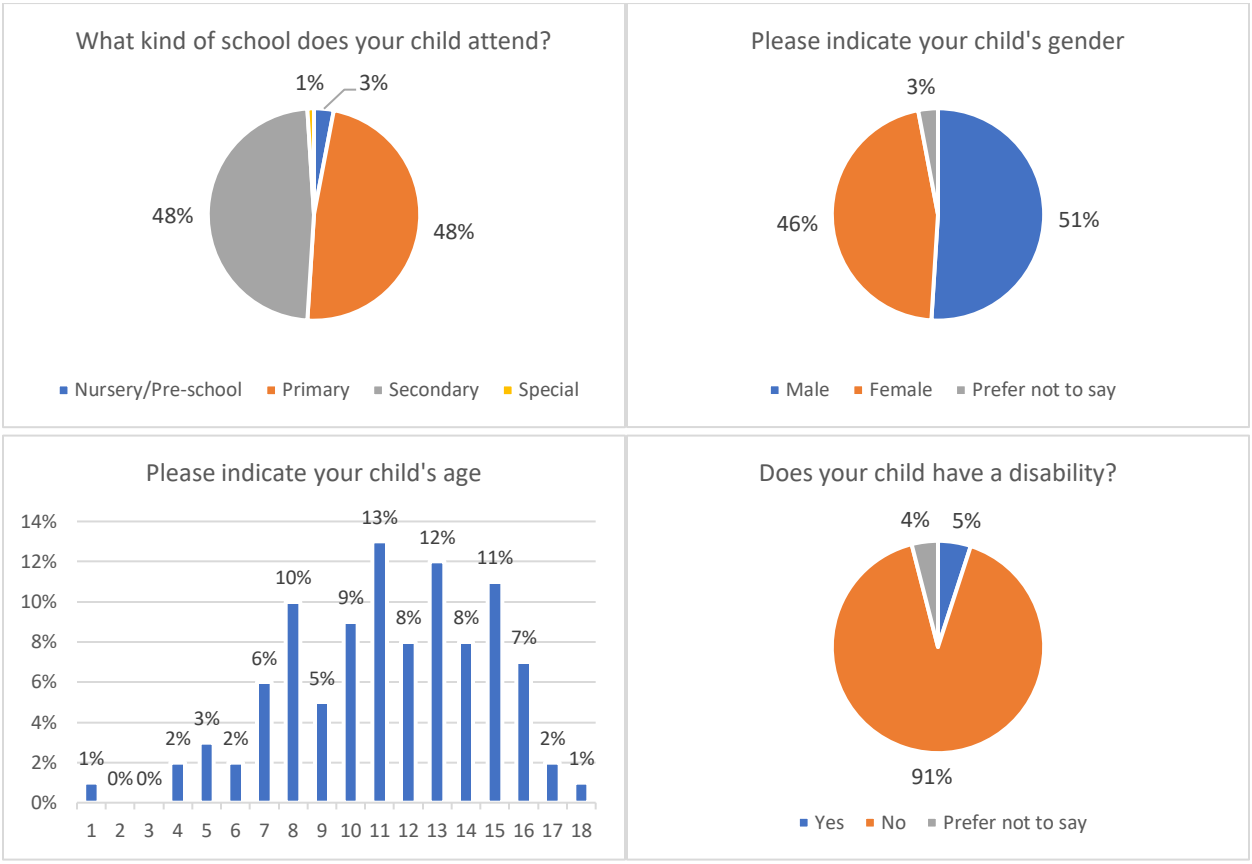


Figure 2: Child School Type, Gender, Age and Disability

The four charts contained within figure 2 give an overview of the demographic data of respondents' children. Given that parents provided data for a total of 100 pupils, the data given above as percentages is equal to the total count of pupils. Gender and school type are split quite evenly, and a fairly normal distribution is observed for age. Rates of reported disability, simply defined, are not dissimilar to the general population.

Views on their children's school experiences

The survey asked respondents a series of questions relating to their individual children's wellbeing at school. Data from a series of Likert scales, summarised below, indicate that parents generally gave positive accounts of their children's wellbeing. Areas of least positive responses were self-confidence and comfort, whilst reported feelings of welcome were particularly high.

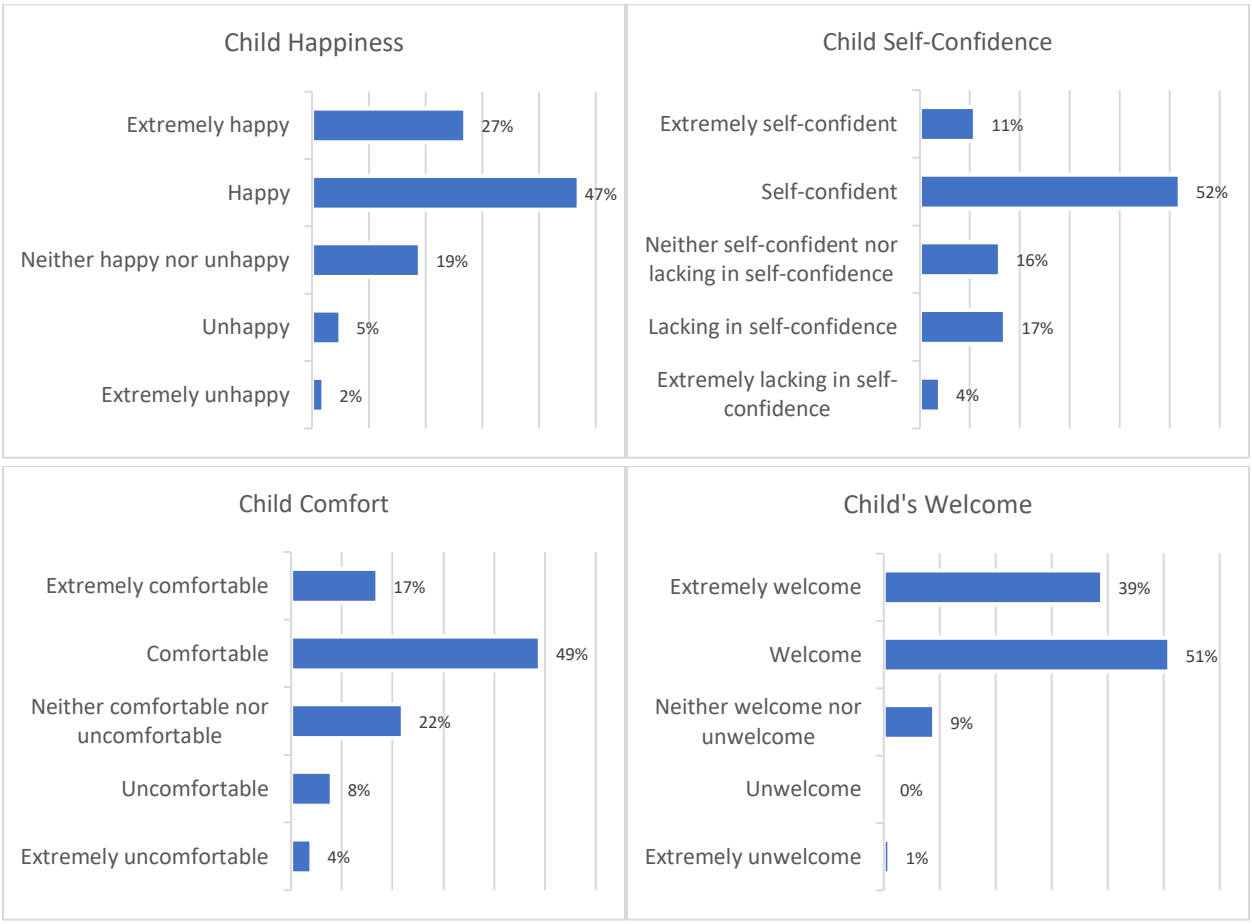


Figure 3: Child Happiness, Self-confidence, Comfort and Welcome

Further open comments offered by respondents following these Likert scale questions. A number of these expressed gratitude for the support from schools and teachers:

> "She is very happy in school and wants to go to school every day and also the teaching staff is very helpful, thanks to them" [parent of girl, 8]

Challenges expressed focused primarily on language difficulties, and the barrier these posed to learning, friendships and play. For example:

> "He feels lonely at times because of the difference in language and culture, especially during breaks, which constitutes a burden on him in forming friendships outside the classroom, and thus drives him not wanting to go to them despite my contact with his teacher in this regard" [parent of boy, 7]

Parents were also asked to report what common barrier or difficulties their individual children faced at school. The results are summarised in the chart below, and clearly indicate that language / communication and related difficulties with learning and relationships were most common.

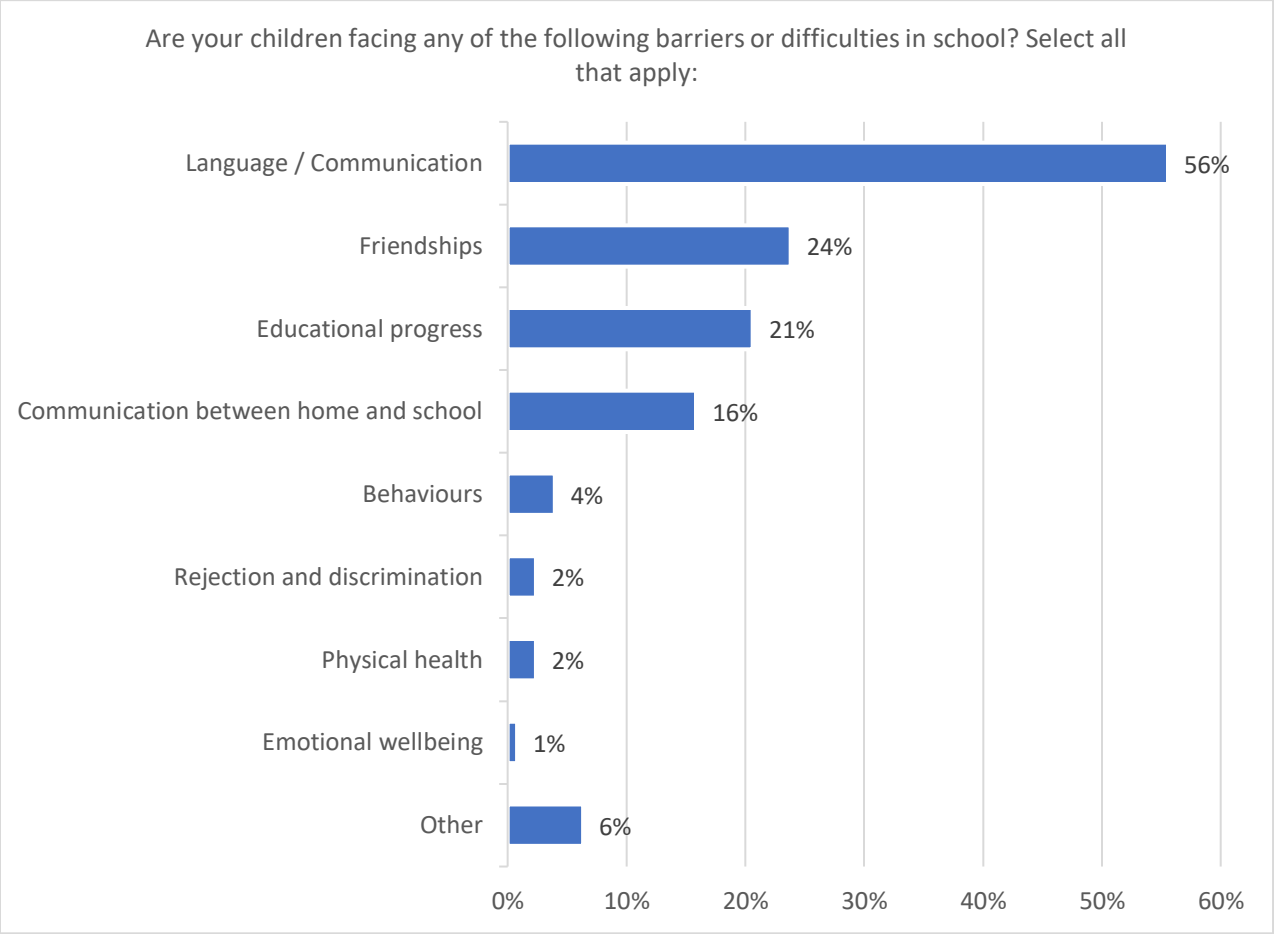


Figure 4: Barriers faced by children in school

Experiences of Trauma

We asked parents about potential traumatic events their children may have experienced before and since arriving in Northern Ireland. Based on the lead researcher's previous research and a review of the literature, the research team agreed on a definition of trauma as follows:

> "*Trauma refers to a scary, dangerous, violent, or life-threatening event that overwhelms an individual's ability to cope and impacts their sense of safety and security*".

This was checked with our Syrian advisor who confirmed that it would be understood but cautioned that parents/carers may be reluctant to disclose this information. The responses are shown below.

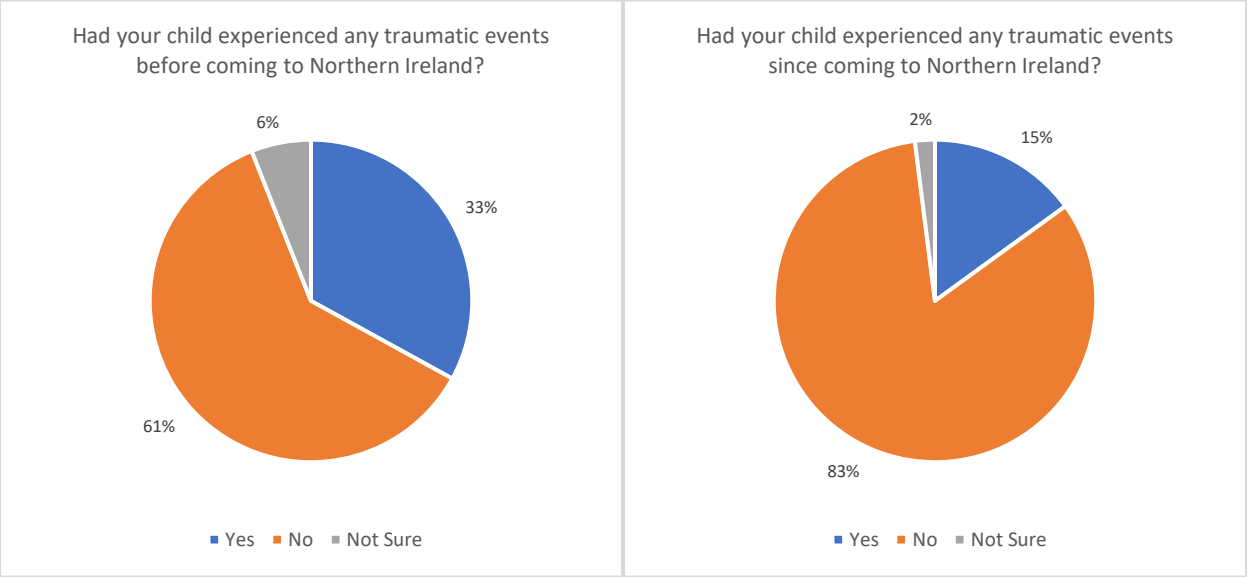


Figure 5: Pupil experiences of trauma

Whilst not fully representative[7] these results give an indication of the frequency of traumatic events in the lives of Syrian refugee students. While parents reported that 33% of their children experienced trauma pre-migration, and 15% post-migration, their responses to questions on school experiences (*Figure 6* below) suggest that trauma is not proving to be a barrier to education for most Syrian pupils.

However, responses to an open question on how trauma experiences had impacted integration and learning highlighted significant parental concern for some pupils who had become fearful and withdrawn due to experiences of violence, the loss of or separation from family members, and interrupted education. Some examples of responses are recorded below:

> "My son is isolated and does not mix with anyone at school" [parent of boy, 11]
>
> "Yes, and the reason is her separation from her brother and his children in Lebanon two years ago. She always thinks about them and is afraid for them" [parent of girl, 15]
>
> "Affected them badly and a feeling of fear of anything … sorrow and difficulty in integrating with others" [parent of girl, 11]

[7] Parent/carer sample accounts for approximately 15% of the children and young people who have come to NI via the VPRS scheme.

> "He experienced the fear of being killed and the fear of planes and missiles every day" [parent of boy, 17]

As outlined in the Introduction (Chapter 1) and in our Scoping Review (Chapter 2), there are likely to be cultural differences in the understanding and reporting of trauma. Explanatory models of mental illness are culturally bound, and Western ideas on mental health may not always be acceptable to non-Western communities. Our research methods did strive to address this (e.g. by carefully considering the definition of trauma and piloting with advisors from the Syrian community) but it remains something we cannot fully account for.

We did not feel it ethically appropriate to probe further in an online survey so did not explore the nature of the trauma, or whether the trauma was real, perceived, directly suffered by the pupil or witnessed happening to someone else. Focus groups or interviews with Syrian parents and pupils (as was our original intention) could explore these issues in more depth and with more sensitivity. Members of the Syrian community expressed to our research team that they would value this opportunity in the future, so schools have a better understanding of what some pupils have been through. Further research could explore other post-migration experiences beyond 'trauma', such as poverty, racism and social isolation (Rutter, 2006).

Coping and School Support

The final section of the survey questionnaire asked respondents to assess their children's ability to cope with the various difficulties they faced at school, the ways that schools were currently supporting their children, and how schools might be able to better support them. The figure below summarises responses to these questions.

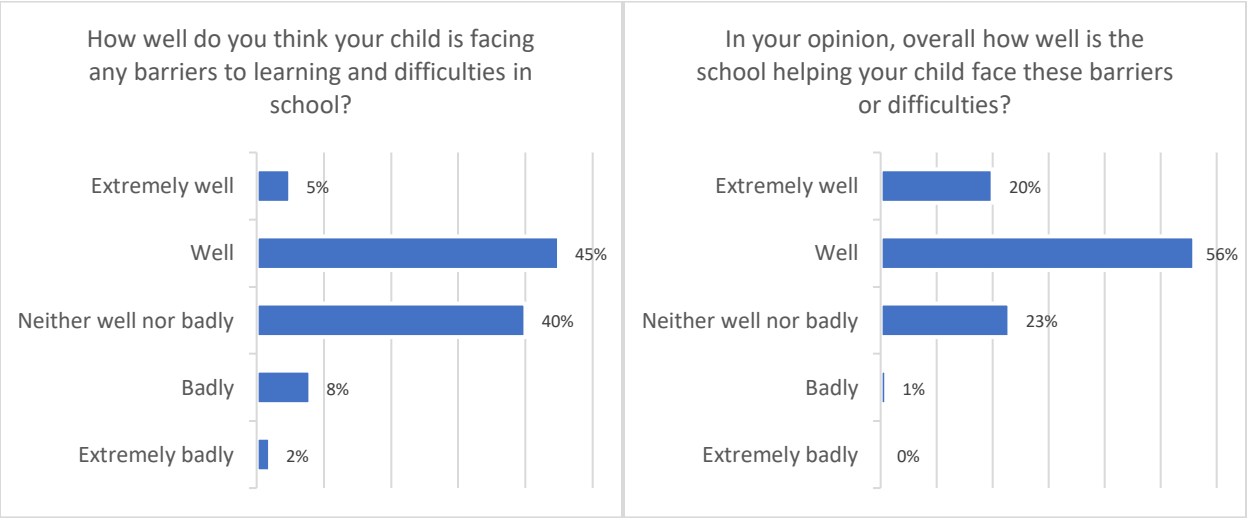


Figure 6: Pupil ability to face barriers to learning, and school support

Following these questions, respondents were asked an open question inviting them to specify the ways that their children's schools were helping them. Most common answers (in order of frequency) included: providing language learning support (n=10); providing individual learning support (n=8), including remotely (n=2); and caring and attentive staff (n=8). Some reported bilingual/Arabic language teaching and learning materials (n=3), and others 'being treated the same' as other pupils from Northern Ireland as being particularly helpful (n=3). Two respondents reported forms of mental health support in place.

Respondents were then asked what the school could do to improve their children's experience. Again, the most common responses centred on providing English language (n=11) and general learning support (n=6). A significant number of responses also generally referred to encouraging (n=4), valuing (n=1), addressing shyness (n=2) and treating children well (n=3). Only one respondent suggested mental health support.

In the final question, parents were asked to rank a set of options for school-based interventions to support their children. The results are summarised below, and show that 'Individual or group therapy to reduce distress related to trauma', 'Advice for parents on helping their child with trauma or loss', and 'Linking school staff to other professionals to find the best ways to help' were most highly ranked, though not by a large margin.

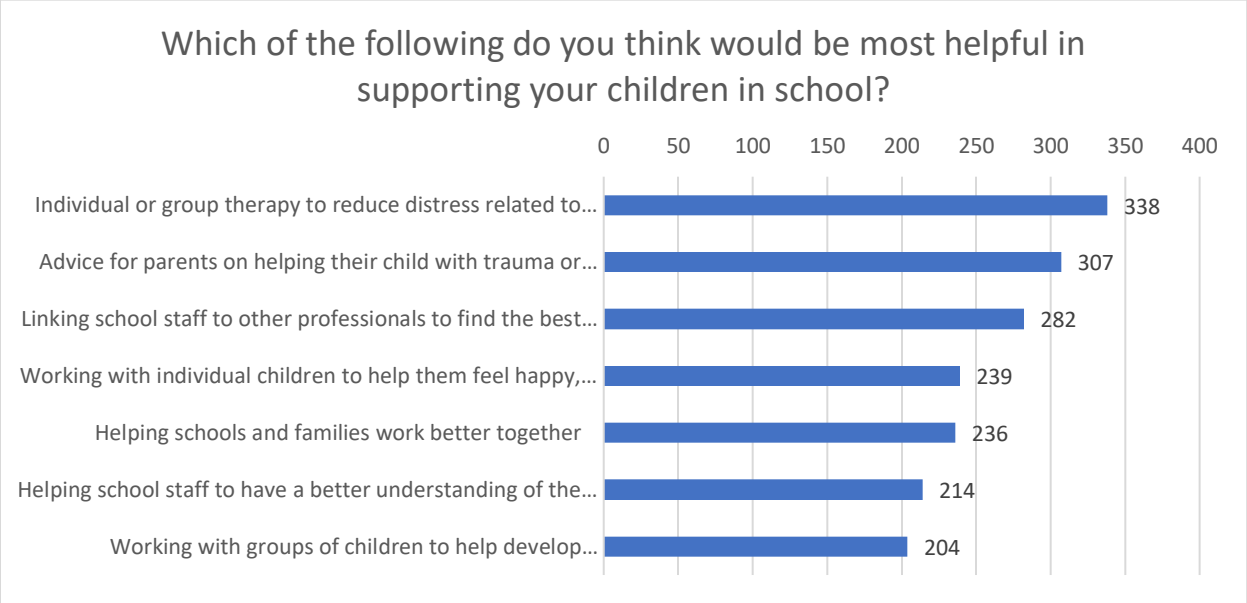


Figure 7: Parents' ranked choices of school-based interventions to support Syrian refugee pupils

Pupil Survey: Findings and Discussion

Demographic Data

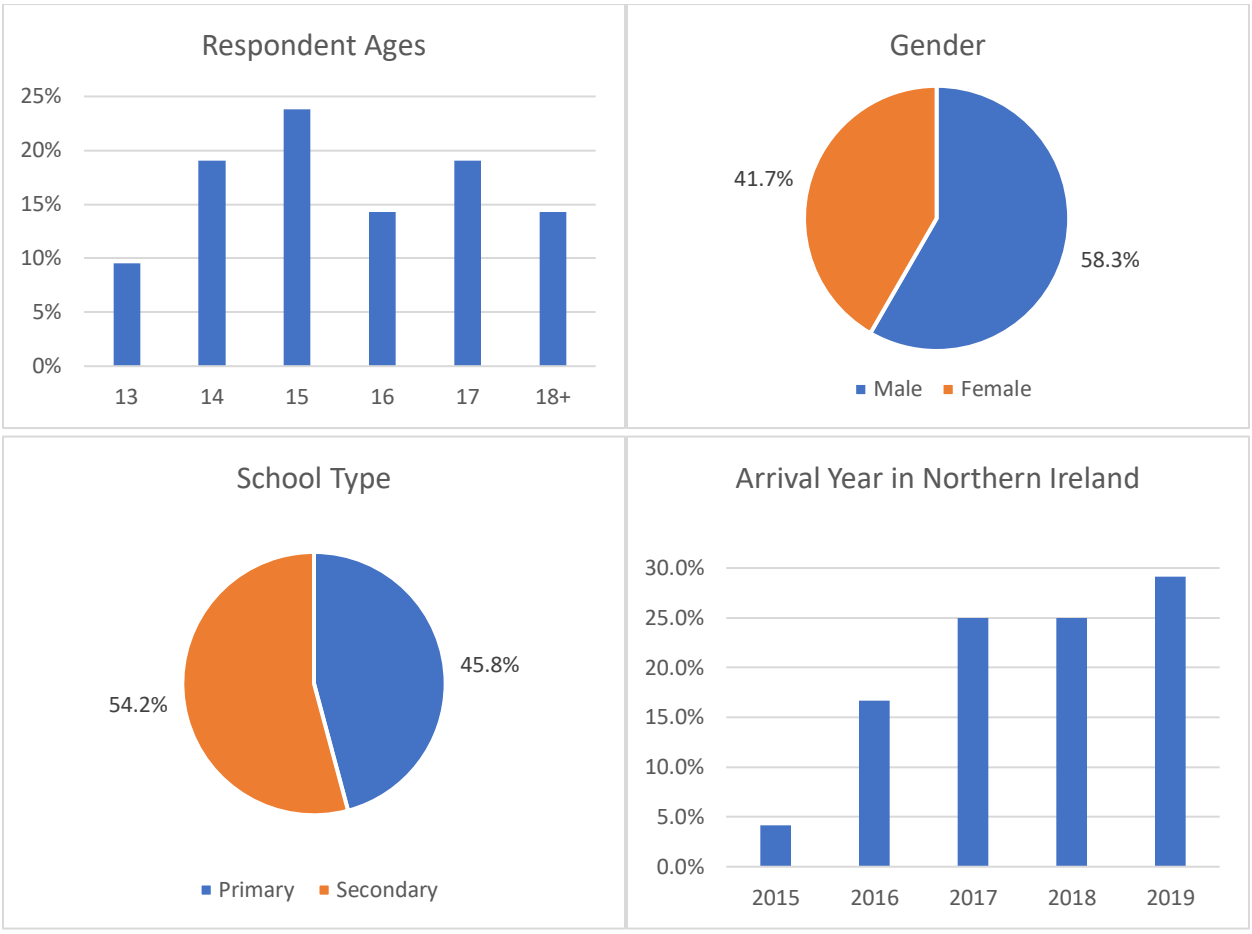


Figure 8: Pupil respondents' age, gender, school type and arrival year in Northern Ireland

The four charts contained within figure 8 give an overview of the demographic data of the 25 pupil respondents. There is clearly some confusion here (possibly due to translation or literacy difficulties) as reported ages indicate an entirely post-primary school-aged sample, but almost half of respondents said they attended primary school. As discussed above, in some cases it was clear that an adult had completed the survey on behalf of their child. Both for this reason, and because of the low number of responses (n=25), the findings from the pupil survey should be understood not to be representative of the wider VPRS pupil population.

Pupil views on their school experiences

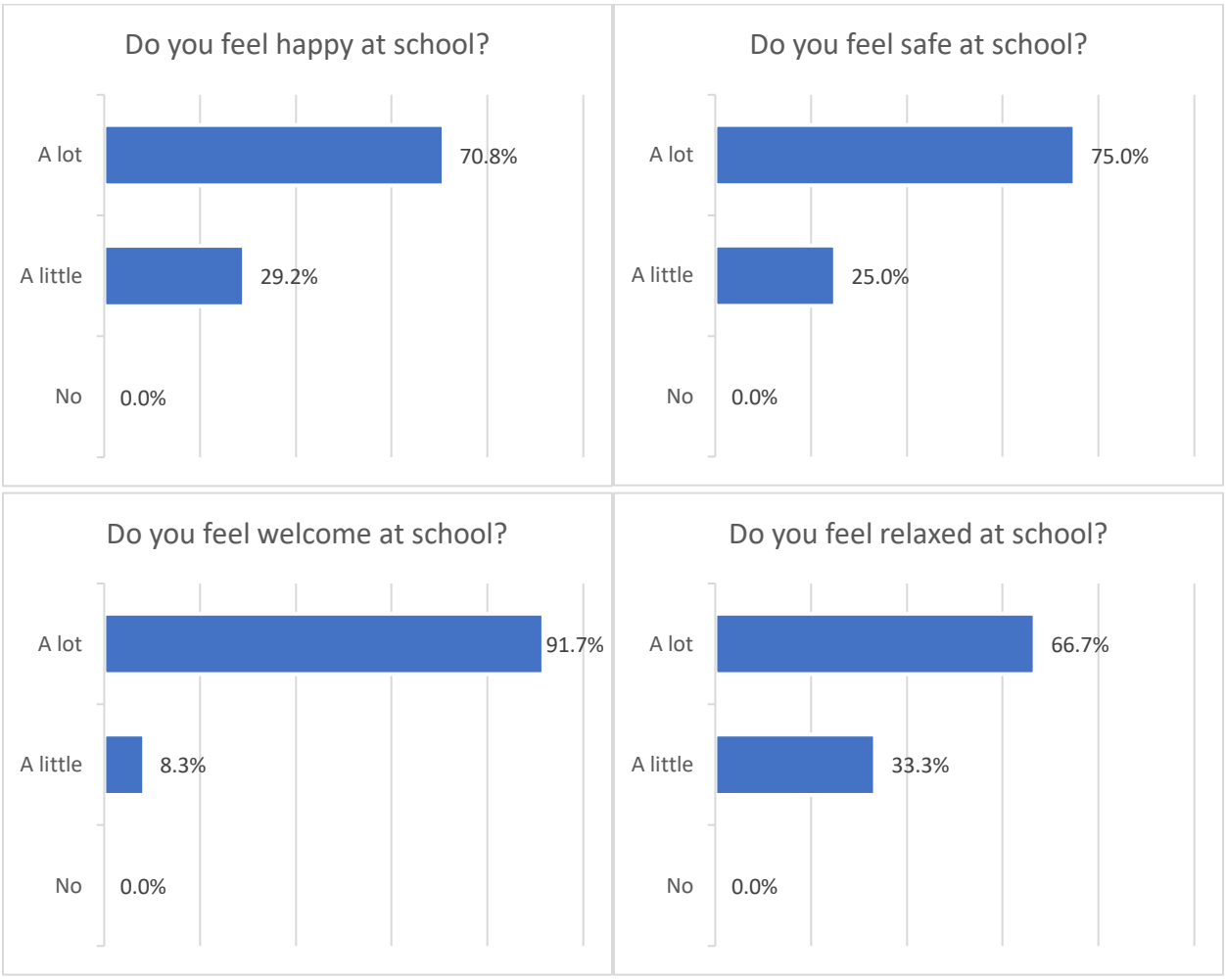
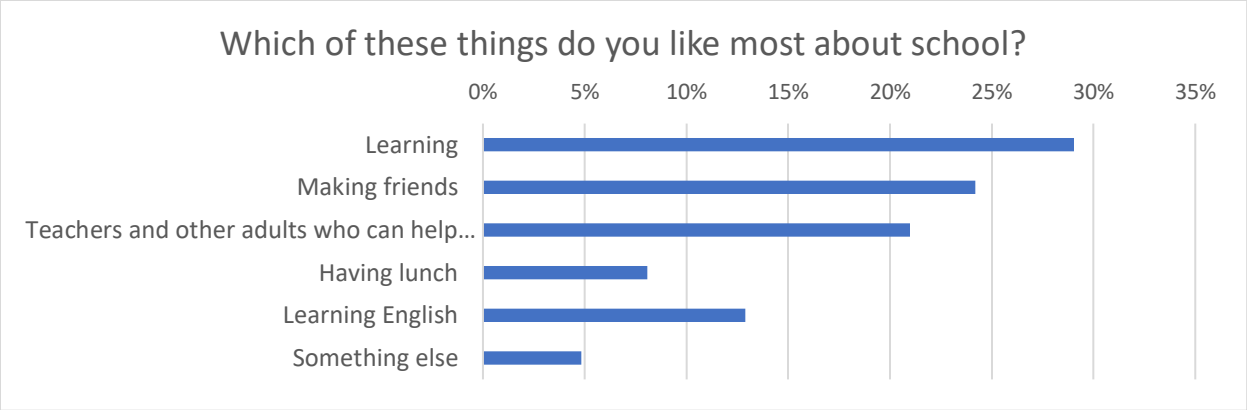


Figure 9: Pupil respondents' Happiness, Safety, Welcome and Relaxed

Figure 9 above summarises respondents' answers to simple questions about their feelings at school, which appear mostly positive particularly for 'welcome'. In answer to the subsequent question, "What makes you feel like this?", pupils were more forthcoming with negative experiences, for example:

> I can't make friends and I feel I'm being discriminated against sometimes
>
> Fears of my lack of experience with the language

Difficulties with English (n=4) and consequently making friends and learning (n=3) were the most common negative comments, whilst positive comments cited the welcoming nature of people at the school (n=6), support and care (n=4).



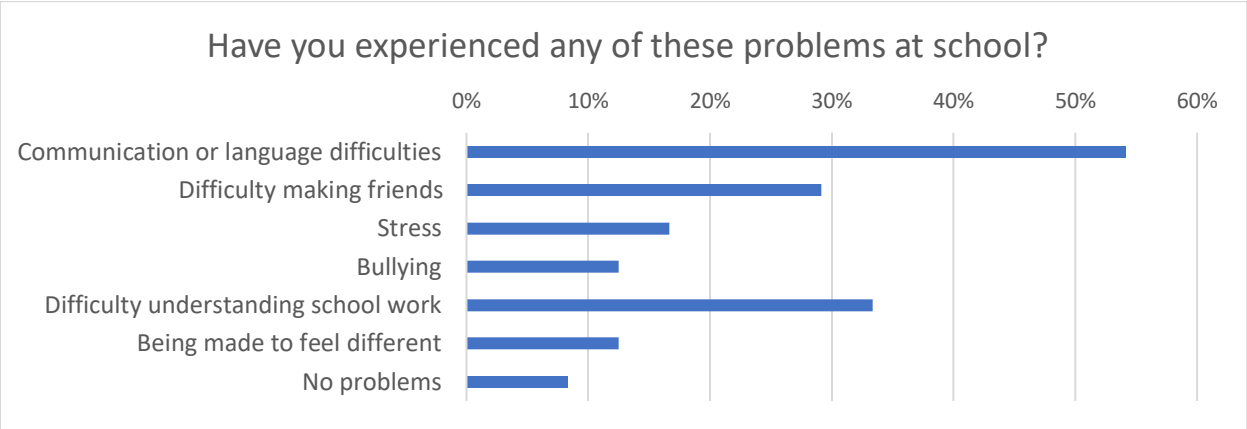


Figure 10: Pupil enjoyment and problems at school

The data summarised in figure 10 above demonstrates the centrality of communication to developing relationships and academic learning, the key concerns of respondents at school. Between 10 and 15% reported experiencing "stress", "bullying" or "being made to feel different". Only under 8% of respondents said they experienced "no problems" at school.

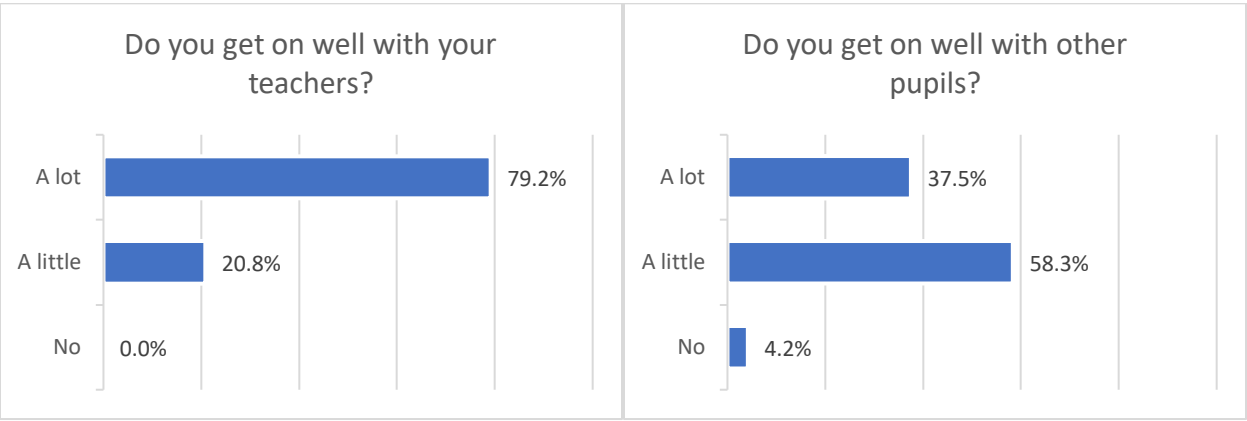


Figure 11: Pupil relationships with teachers and other pupils

Figure 11 above summarises pupil estimations of their relationships with teachers and other pupils, and indicates how on average Syrian pupils had better relationships with their teachers than with other pupils.

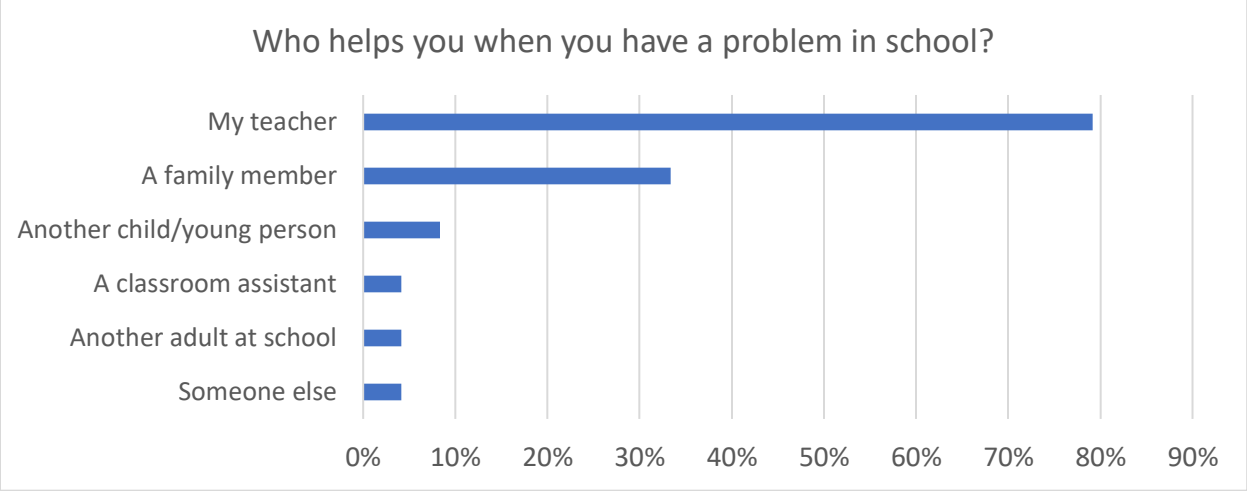


Figure 12: Who helps when a pupil has a problem at school

In this final multiple-choice question, we wanted to find out who Syrian pupils felt they could rely on to help them in school. Perhaps unsurprisingly given the positive relationships reported in figure 12 above, 79.2% of respondents identified their teacher. Only a small minority, under 10%, identified another adult or pupil at school, or a classroom assistant, whilst 33.3% identified a family member.

Strengths and Challenges

The final section of our survey asked pupils to reflect on their experiences before and since arriving in Northern Ireland. It was deemed unsuitable to ask such a potentially complex question to primary-school aged children, so these questions were only asked to respondents that said they attended post-primary school (n=13).

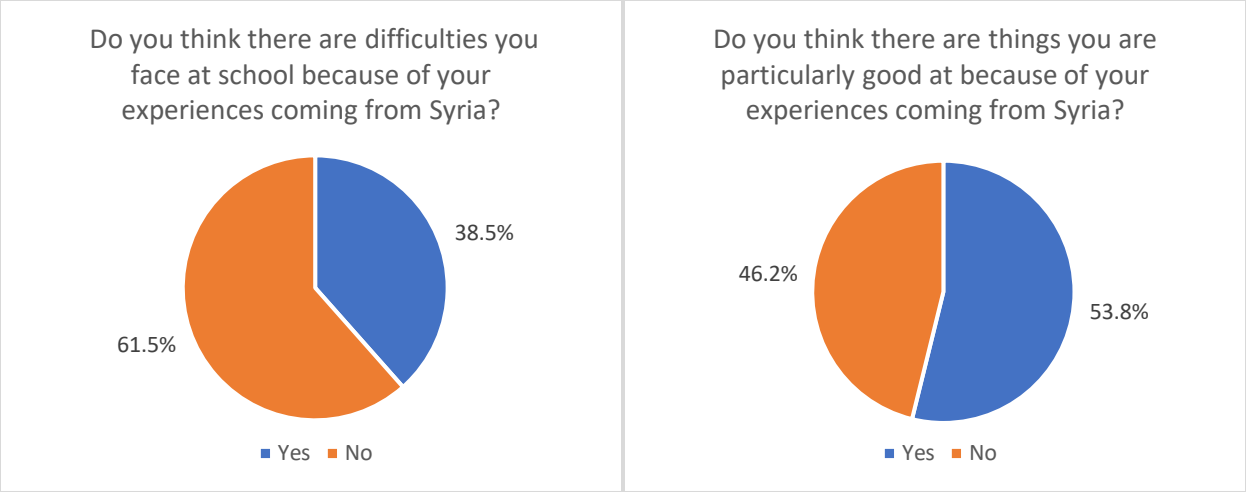


Figure 13: Pupil respondents' strengths and challenges due to 'coming from Syria'

The responses summarised above tell us a little about pupils' perceptions of the relevance of their experience as immigrants/refugee to their schooling. These closed questions were followed by an open question, the responses to which were more instructive. Four of the five explained how they thought adverse experiences had benefitted them in terms of maturity, resourcefulness, patience, and interest in learning. For example:

> "War taught me patience, it helps me to be patient while doing my homework. I was strong when I explained my very difficult journey from Syria to here, and what I saw in terms of dead bodies, bombing, and clashes in front of my class students and the teacher. I felt happy, safe and proud to be in front of the students with such audacity" (18, female)

> "There was a Spacetoon channel in Syria in my childhood, and I always followed it and was attached to it almost even now. It eased me the burden of the war and helped me to be attached to my studies more as it presented the information in an interesting and exciting way, and because as defined about Spacetoon channel, it is the life of an Arab child" (15, male)

> "What we faced in Syria and the difficulties make us more conscious and makes us look older than our age" (15, male)

The final, open question of the survey asked pupils what extra support they thought refugee children and youth need in Northern Ireland schools. Almost all responses to this mentioned language support, either through English language support, Arabic/Bilingual learning and teaching staff, or facilitating cultural learning and social integration.

Chapter 4: Teacher Focus Groups

Method

To investigate the support requirements of teachers and schools, and any barriers to education, resulting from the sequelae of previous trauma, we carried out four focus groups with teachers from schools across Northern Ireland.

Teachers were recruited through several channels. Teachers who had previously taken part in an Intercultural Education Service (IES) survey and indicated interest in taking part in a focus groups were contacted directly. A call also went out from the lead researcher's Twitter account and individual teachers known to the research team were approached directly.

16 teachers agreed to take part in the focus groups and completed consent forms. Focus group participants represented seven primary schools, seven post-primary schools, one pre-school and one special school. Seven schools were Catholic-maintained, eight controlled, and one integrated. Our sample included twelve women and four men. The most common role was teacher (mostly literacy, English, or EAL, n=7), followed by Principal (n=5), Vice Principal (n=3), and SENCo (n=2). Some participants had multiple roles.

Focus groups were carried out remotely via Microsoft Teams. Sessions were recorded with participants' consent and automatically transcribed using a voice-to-text transcription software. Transcripts were checked against the original recording and corrected by one researcher, who was also present at all focus groups. The transcripts were subsequently coded by the same researcher using the qualitative data analysis package MaxQDA and following the principles of thematic analysis (Braun & Clarke, 2006). Thematic analysis is a "method for identifying, analysing and reporting patterns (themes) within [qualitative] data" (Braun & Clarke, 2006, p. 79) by organising and describing a data set in detail. To this purpose, the full qualitative data set is initially coded in close detail. Codes are then merged and combined into thematic clusters, followed by a second round of coding to ensure new codes still match the content of the coded segments. Coded segments are then compared within and across codes to develop themes.

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followed by a second round of coding to ensure new codes still match the content of the coded segments. Coded segments were then compared within and across codes to develop themes.

Findings and Discussion

Barriers to education resulting from sequelae of previous trauma

Participants in our teacher focus groups reported that VPRS children in their schools had experienced a wide range of traumatic events related to living in a war zone, displacement, and living in camps. Many were also aware of the potential trauma associated with resettlement in a culturally different society and coping with a different language. Teachers often lacked detailed information on their pupils' traumatic experiences beyond a very vague idea, and some schools took a "trauma by default" approach, arguing that "if they have been through camps and whatever, there must be [trauma]" (FG1-4, PS Principal). This contrasts with the views expressed in our parent survey, where 33% of parents reported that their children had experienced traumatic events before coming to Northern Ireland. As discussed in Chapters 1, 2 and 3, parents and teachers may define trauma in different ways.

Teachers had noticed a range of symptoms and sequelae of trauma among their VPRS pupils, including, among others, attachment issues, avoidance symptoms, aggressive behaviour, and being quiet and withdrawn. Aggressive behaviour in boys was noted and sometimes explained as cultural difference. Some teachers reported that each child was unique in their resilience and response to trauma, and that siblings sometimes presented quite differently. It was also repeatedly noted that some children didn't display any obvious symptoms, and some teachers concluded that they were "fine":

> "I have to be honest with you, the kids that we're seeing, there's only really that one child of third year that I'm really concerned about. I mean, what we've seen, I don't know the depths of the trauma, and really what was causing it. But it could just be like a, a teenager with a few issues(…) a lot of the other kids, the girls in particular, they are absolutely fantastic. I mean, there's no issues there. (…) Some of the issues, actually, are to do with cultural issues. (…) I'm not convinced that/ because (…) many of them got out of Syria at quite an early stage. I'm not really convinced that there's major, major trauma issues there. (FG2-2, PP EAL teacher)

Several teachers discussed barriers to learning resulting from sequelae of previous trauma in relation to individual pupils, many of which were related to children's perceptions of safety. It was repeatedly noted that helping VPRS pupils feel safe in school was a key priority and an essential condition before learning could take place, but that building the necessary trusting relationships could take a long time, as in the following quote discussing outcomes of an art therapy intervention for VPRS pupils:

> "I think it depends on the pupil. For some of them, it's been very effective. And others, it has (…) flagged up those issues with transitioning to different areas, like being with different people. (…) At the minute they've had eight-week sessions, the ones who are coming from that refugee background, you know, the first eight weeks is building their relationships. And then it's moving into more outcomes. But the fact that we're able to build those relationships with the therapist is a big outcome for them in the first place." (FG3-5, SP Vice Principal).

Several teachers reported that VPRS pupils in their care had experienced difficulties settling in to school and would run away when scared or stressed:

> "That wee one I was telling you about, who's in (…) foster care, his initial reaction was flight, because he didn't understand, he hadn't been in school before. So, he didn't understand what was happening, his automatic reaction was to run, or if he fell or hurt himself, he just ran, because he hadn't built up the trust yet. So, we did a lot of chasing him for the first wee while, he just found it very hard." (FG3-3, PS Principal)

One teacher reported that her pupil would sometimes hide to avoid going into class:

> "The other wee boy in his year group, when he arrived the parents [said] he's very [tearful] but just ignore him, he has to grow up and he has to get on with it. And we would find him on the corridor sometimes and not going into class, and he'd be maybe hiding behind a wall on the corridor. He used to come up to me in the morning time he would come up here to my room, [his] safe room, as opposed to going into class, and that's why we are a wee bit worried about him (FG1-3, PP English teacher)

As in the case quoted above, some pupils developed a strong attachment to an individual member of staff and to a specific "safe place", such as a trusted teacher's office, which could sometimes create barriers to learning. One Vice Principal (FG3-5, SP Vice Principal) found that pupils would sometimes form strong relationships with only one key person and struggle when this person wasn't there. This problem was particularly acute during the Coronavirus pandemic, where staff changes were more frequent than usual, so helping pupils develop strong relationships with more than one member of staff was a key challenge.

Attachment to one individual could also interfere with pupils' ability to attend class or to avail of additional teaching and trauma support. One English teacher (FG1-3, PP English teacher) reported that a Syrian boy in her school preferred to come to her room, where he felt safe, instead of going into class. Two teachers found that some of their pupils didn't want to take part in additional support offered to them, as they felt uncomfortable leaving their trusted teacher.

> "We're able to fund art therapy, specifically through VPRS this year, to provide that for our refugee pupils. It's interesting, because it flagged up a lot of the attachment things I was talking about before, like, they don't like to go to a separate room, they don't like to be taken away from their teachers, like it actually made that a lot more, you know, at the forefront of our minds, it's attachment issues, but they're certainly able to have that time and that one-on-one attention through the art therapy." (FG3-5, SP Vice Principal)

> "We used Interlingua last year, (…) an Arabic speaking teacher came in once a week and worked with the two girls we had, it was a connection to their language and they liked seeing her once a week. Now, it didn't work with the wee boy, he just didn't like going out of the room, we've talked before about going to different settings, he didn't want to go. But the girls definitely got something out of an Arabic speaking person coming into school that was just for them." (FG3-3, PS Principal)

Attachment issues and separation anxiety also interfered with some pupils' ability to make friends and mix with local children, as they preferred to stay close to their siblings. This, in turn, had an impact on their English language development:

> "Last year, we had a family who joined us, and the three children have actually experienced quite severe trauma in their lives before they came here. (…) they are so emotionally dependent on each other. And they have to be near each other, understandably, because of the trauma. (…) that in itself is inhibiting their learning of the English language, whereas children before, who had to be independent, and pick up and make friends are actually picking up things a lot quicker. (FG3-4, PS Principal)

Teachers also reported suspensions following aggressive behaviour, and difficulties concentrating on schoolwork as a result of trauma. Withdrawal from class due to challenging behaviour also emerged as a general trend.

Language

Data both from our teacher focus groups and from our parent and pupil surveys has clearly shown that language difference affects VPRS pupils, their families, and school staff in many ways, including pupils' emotional wellbeing, access to mental health services, communication between schools and parents, and teachers' ability to support their pupils' recovery from trauma. This reflects research in Second Language Acquisition (SLA) among Syrian refugees outside Northern Ireland (Al Masri and Abu-Ayyash, 2020).

Teachers in the focus groups noted that some of the Syrian children were quiet and withdrawn at school. The teachers showed an awareness of the concept of the Silent Period that is widely accepted to be part of SLA. This phenomenon of a period characterised by nonverbal behaviour has been variously explained as a sign of non-productive engagement in active second language learning, psychological distress about the new language, and incomprehension, and it can be understood to last from several weeks to an entire year (Roberts, 2013). However, Roberts (2013, p. 32) in a review of research relating to the Silent Period, concludes that the extent and quality of the evidence base for widely held assumptions about the Silent Period by scholars and practitioners is 'extremely limited'. Interestingly one of the teachers used the word 'mute' to describe Syrian pupils he worked with, associating this with language acquisition. For example, he noted that

> ‘the younger one was actually able to pick up the language much quicker and easier than the boy who was in my class. First of all, he stayed quite mute for a longer period of time. And whether or not again that's a personality or a confidence thing, or trauma is just, maybe the younger child was in a busier classroom and maybe had to stand up for himself a bit more and had to come out of the shell quicker’. (FG2-3, P6 Teacher).

Toppleberg et al. (2005) discussed the complexities involved in distinguishing between quiet behaviours associated generally with language acquisition, and trauma related difficulties such as selective mutism. Notably, Toppleberg et al. (2005) highlighted poor support for second language learning in the classroom, negative views of the pupil’s home language, ‘the high linguistic and cognitive demands resulting from sudden immersion in a second language; and feeble parent–school relationships’ (Toppleberg et al., 2005, p. 594) as triggers of selective mutism in vulnerable children.

As outlined in the parent and pupil surveys in Chapter 3, language was at the heart of the most commonly experienced problems at school. Language barriers affecting integration and learning were highlighted across all data sets. While the teachers in the focus groups highlighted the rich learning opportunities that the presence of the Syrian pupils in the school community offered, and often mentioned that they were confident, conscientious, and determined to succeed academically, a prevalent view emerged that from the perspective of the school, acquisition of English was of primary importance. This informed decisions that, temporarily at least, narrowed engagement with the school curriculum, in some cases to literacy, numeracy and science. Pupils were withdrawn from class, particularly from Religious Education, languages, and history, to work on English language skills. For example, one teacher reported that:

> “Mostly what we do to be honest with you is we take the children out of subjects that we think that, you know, realistically our priority has to be developing their English skills, so we may take them out/ for example, if they have never done French before, we'll take them out of that subject, because we think they've maybe got enough to do to learn the English language. And maybe something else that we think is not going to work out well for them, so maybe.. it could be technology and design, but just depends on where their strengths and whatever lie. So we do a withdrawal on that basis.” (FG1-1, PP Principal).

Another teacher said “they obviously don't do all the subjects. We withdraw them from subjects like French, History, that sort of thing.” (FG1-3, PP English Teacher). One teacher expressed the view that studying topics like The Victorians was irrelevant to the Syrian pupils. In the participating Catholic Maintained schools, Religious Education was considered to be a beneficial curriculum area. The subject content was discussed with families (including world religions, ethical and moral issues, and Old Testament topics relevant the Quran) and families were encouraged to consent to pupil participation. Several pupils did join Religious Education classes and chose the subject at GCSE level, although others chose to withdraw from church related aspects such as sacrament preparation. Even when the pupils’ standard of English had improved,

in some schools the pattern of withdrawal continued. In one school the pupils were placed together in a room to work with a classroom assistant who had completed relevant training.

Teachers highlighted creative activities, art and sport as important for Syrian pupils and their families. One teacher pointed to the successful involvement of several pupils in a local Gaelic club and another described art sessions offered by an Arabic speaker to which parents were invited. Informal learning experiences like this were considered to be beneficial for learning English and developing home-school and community relations. Teachers reported that Syrian pupils' experiences and feelings were explored to some extent through the 'pastoral curriculum', PDMU, Learning for Life and Work, Geography, World Around Us, Circle Time, Literature and Literacy, classroom discussions and writing. Creative writing, story, art and poetry were considered to be particularly helpful. Teachers expressed awareness of a need to approach topics such as War and The Middle East sensitively and when engaging with current affairs through television programmes such as Newsround. These teacher experiences resonate with Capstick and Delaney's (2016) recommendation of creative language activities in the classroom as a means of offering supportive psycho-social interventions.

Both our parent and pupil surveys, and the teacher focus groups, have shown that language barriers can put significant strain on children's and young people's mental health, as they can lead to feelings of inadequacy, loneliness, and frustration:

> "I'm thinking particularly of a young lad in our school, he's year nine (…) and during this lockdown period he has really regressed. And he has not participated at all. He's found things very, very difficult. I've had to kind of cajole him and make calls home to try and get him involved. So, and he's also said, you know, people are going to think I'm stupid, because if he's having to type something, he hasn't got the skills to communicate what he wants to say. So, ach, it is very difficult for him and, um... yeah, I think we just need to be supportive and just keep hanging in there. But like that he's withdrawing." (FG3-1, PP Literacy teacher)

Perhaps due to the language barrier, schools and teachers appear to have limited knowledge of an individual pupil's history and background. This may affect their ability to support trauma recovery. Uncertainty over pupils' possible traumatic experiences and feelings forms a key theme throughout our teacher focus group data. While focus group data points to a range of factors, such as parents' and pupils' reluctance to share traumatic experiences with school staff and cultural differences in attitudes to mental health, language was clearly a key barrier in this regard. Teachers often need to rely on physical and behavioural symptoms and sequelae, and on guesswork, to help them meet their pupils' emotional needs, as in the following quote by a focus group participant who had unwittingly triggered a panic attack by seating a pupil away from their siblings at lunchtime:

> "They are very good at concealing how they're feeling until they're put out of their comfort zone. And then that's when you see it, and they can't express it, obviously, with their language, but I

> dread to think what it's actually they are internalising, and what they haven't actually yet processed for themselves. (…) Who knows what's going on for them, you know, because I could see it physically that day, just in the sheer panic (…). But as I say, we don't know what's going on for them. (…) But the other children, again, who haven't got the physical damage, I don't know what trauma, because they aren't able to express it in the same way. But [they] come across as being happy and enjoying their time in school." (FG3-4, PS Principal)

Communication between school and parents was mentioned as a major problem by several teachers. Parents' English skills are often poor and schools lack fast and easy access to language services, as interpreters are not always available at short notice and most schools in NI do not have any Arabic-speaking staff. In one case, teachers felt that "it was too difficult to try and communicate" with the family to adjust the settling-in schedule of a young child who was distressed. Instead, the child spent several weeks closely attached to one member of staff, until they settled (FG3-2, PRE nursery teacher). Several teachers also reported difficulties communicating with parents on issues relating to mental health and special needs, although these difficulties were largely attributed to cultural differences, rather than language barriers.

Language barriers can also have an impact on access to mental health services. While several focus group participants had referred pupils for counselling, one teacher reported that their school's counsellor refused to treat EAL pupils due to the language barrier:

> "But our counsellor/ I would imagine most counsellors don't really want to touch EAL children, because their English isn't good enough to express their feelings. So, our counsellor, whenever I tried to refer on, if we had a child with significant difficulties, impact of significant trauma, didn't want to go near him, because for her, there's just/ there's a language barrier, so how do you make that work?" (FG4-1, PP Head of English)

While we cannot generalise based on this one case, it suggests that VPRS pupils sometimes experience discrimination based on their language when trying to access mental health services, and that this discrimination is not always recognised as such by school staff.

Schools employ a number of strategies to manage language barriers and their impact on VPRS pupils' mental health and educational outcomes. Many of our focus group participants were keen to employ Arabic-speaking staff to improve communication with parents and to enable children to be "fully involved in the school community" (FG2-2, PP EAL teacher). However, they often found that "it's tremendously difficult to get someone that speaks Arabic in Northern Ireland" (FG2-2, PP EAL teacher). Three schools had been able to employ Arabic-speaking classroom assistants – in two cases the mother of former or current pupils – who also assisted with day-to-day communication between parents and staff. One school had contracted an Arabic teacher via a private language school, who provided Arabic lessons to some of their VPRS pupils.

In the absence of Arabic-speaking staff, schools employ a range of strategies to communicate with pupils and parents. Several focus group participants reported using translation apps, such as Google Translate, to communicate with parents and children on a day-to-day basis, but some worried about the quality of the translation. Interpreters and translators were also used, but several participants felt that availability and the delay involved in organising these services put a strain on everyday communication. Two teachers reported using pupils as interpreters: one school asked a child to translate a conversation with their parent, resulting in a different message being conveyed. The other school used more advanced pupils to translate in school on a day-to-day basis as part of a "buddying system". Both teachers found these solutions problematic. As highlighted in Jones et al. (2018) research suggests that translating in high stakes situations such as hospital appointments can be stressful for children. It is possibly stressful also in the context of home school dialogue, particularly given cultural differences.

In an effort to help pupils learn English more quickly, some schools actively manage and restrict newcomer pupils' relationships with other pupils who speak their language. For example, one teacher stated that:

> We separated them in the form classes so that they're not all in one form class. Within each form class, we try to ensure that they're in each part of the room, that they can't just speak to each other, that they have to engage with other people. Whether it's right or not, we try to just encourage them to speak in English when they're in school. (FG2-2, PP EAL teacher)

Others take the opposite approach and employ a "buddying system", matching newcomer pupils with another pupil who speaks their language and serves as a "crutch" (FG1-1, PP Principal) while their English skills are limited. One teacher argued that matching two newcomer pupils with each other is beneficial even if they don't speak the same language, "because they have an understanding, there's more of an empathy there" (FG4-4, PP EAL coordinator).

However, regardless of the approach taken, there was often an underlying notion that friendships with other Syrian pupils were problematic, while friendships with local children were beneficial and desirable. Friendships between VPRS pupils were often described in pejorative terms, such as "insular", "cliques", "hanging together as a group", "segregated", or "influenced", and seen as a barrier to learning English and to integration. In contrast, friendships with local children were described in much more positive terms as "spreading out", "engaging" "joining in", "mixing", or "broadening out". VPRS pupils were often described as not integrating with local children, but their reasons were not always taken into consideration.

It is important to highlight that, as well as a barrier, linguistic diversity in learning can also be a valuable resource for improving VPRS pupils' emotional wellbeing and schools have harnessed the beneficial effects of language through a range of projects. Two teachers reported offering Arabic-language activities to support VPRS pupils' wellbeing. One school contracted an Arabic teacher through a private language school to work with some of their VPRS pupils:

> "We used Interlingua last year. And again, it's a service where they speak/ it was an Arabic speaking teacher came in once a week and worked with the two girls we had, it was a connection to their language, and they liked seeing her once a week. (…) The girls definitely got something out of an Arabic speaking person coming into school that was just for them." (FG3-3, PS Principal)

Another school hired an Arabic-speaking teaching assistant to run a weekly Arabic language and art club for Syrian pupils. For the second half of each session, non-Arabic-speaking pupils were also invited into the class to learn about Arabic art and language and to create art together. For the last 15 minutes, Syrian parents were invited to join the class to see their children's work, mingle with other parents, and informally discuss any issues or questions with the help of an interpreter. The teacher reported that this scheme had had positive effects on the school's relationship with Syrian parents, Syrian families' integration, and VPRS children's confidence.

Two teachers reported letting VPRS pupils share their language, culture, and, in one case, even traumatic experiences with other pupils in a circle time setting and stated that this had a positive impact on confidence. One of the participants in our pupil survey confirmed this, stating that:

> "I was strong when I explained my very difficult journey from Syria to here, and what I saw in terms of dead bodies, bombing, and clashes in front of my class students and the teacher. I felt happily safe and proud to be in front of the students with such audacity" (female, 18 years)

Another school taught the other children in the class about Syria as part of their welcome procedure, using maps and pictures and teaching them some phrases in Arabic. This approach does not give VPRS pupils as much agency and control over their story and may instead risk stereotyping them and making them feel different. The teacher felt that while the purpose of the welcome procedure was inclusivity, it might be problematic:

> "You know, it was all about that inclusivity, but I suppose at the back of our mind, it occurred to us that, you know, that might be difficult as well for the children while we're welcoming them in, but we're referring back to their homeland and where they came from, and obviously, there could be issues of separation and of trauma also. But we try to do that in a sensitive way and build the children's confidence and (…) welcome the children in. (FG4-2, PS Vice Principal and SENCo)

There is a need for building teacher capacity in Northern Ireland, including in Initial Teacher Education, to understand more fully the challenges and opportunities of linguistic diversity for all pupils, including Syrian refugees and their families. Urgent curriculum review and development are also needed in order to take account of the experiences and needs of all children in schools where increasing numbers of pupils are multilingual, and bring Northern Ireland in line with other UK regions (Jones, 2020).

Support requirements

Throughout the focus groups, teachers highlighted a number of problem areas, which should be targeted for additional support. These include improved support services to assist schools in

dealing with problems relating to teaching and supporting newcomer pupils affected by trauma; improved access to training; and measures to remedy the negative effects of language barriers on learning and mental health.

Several focus group participants highlighted the support received from the Intercultural Education Service (IES). Many were particularly appreciative of the VPRS Support Officer from the EA/IES, whom they described as approachable, proactive, and supportive. Several participants reported that they were in regular contact with this officer and highly valued having a designated contact that they "would feel confident going to" (FG2-1, PS Vice Principal):

> "You just know that you can lift the phone, and they said ring me any time or send me an email. So, you know that the support is there, or that they can signpost you in the right direction. So that's been very helpful." (FG4-2, PS Vice Principal/SENCo)

Specifically, participants mentioned the value of intensive initial support, often recalling long phone calls or meetings with the VPRS Support Officer. Helpful practical resources, such as teaching resources and pre-translated letters and forms, were also mentioned.

However, the focus group data also indicates that the existing support is insufficient to address the extent of needs at Northern Irish schools. Despite the positive feedback on the support that is already available, a key theme in the focus group data is a sense of being lost:

> "Support-wise, we feel that we have found our own way." (FG1-4, PS Principal)

> "You are kind of on your own, you know? I feel like we kind of felt our way in the dark a wee bit and, I suppose, yes, if you phoned up and you asked for a particular question, but there was no strategy-led approach, you know? You are not given a roadmap and expect this and do that and if you get to there and you need this, you know? That just doesn't happen. (…) You make up your own roadmap and are hoping that it's sufficient. (FG1-1, PP Principal)

Focus group participants felt that it was mostly up to schools to look for and find the support they needed, and that "there's an element of constantly searching for things and having to start from scratch that's very hard" (FG2-1, PS Vice Principal).

> "I think sometimes the schools themselves have to find something. You know, like you have to find a project or training for your staff as opposed to maybe it being some/ like, if we look at some of the services that as a SENCo we would access, you know, the only service that I can think would relate to trauma is the Post-Primary Behaviour Support, which we would use, but there's nothing really specific for trauma." (FG1-2, PP SENCo)

> "A lot of it is left to schools to manage, you know, in my experience, and a lot of it is down to the staff, upskilling the staff as best you possibly can." (FG4-3, PS Principal)

Because of the perceived lack of support from authorities, several participants felt that they often had to rely on instinct or personal experience, rather than expertise, which made them feel inadequate and worried about the quality of their provision:

> "It really feels like everybody is having to start from scratch and trying to find things and things can be a bit ad hoc. So, you never really see like you are delivering excellent or even very good lessons across all curriculum subjects. Because you have the language barrier, you don't have all the resources that you need, you don't know where to go to get them all." (FG2-1, PS Vice Principal)

> "Regarding the teaching and doing everything else, I don't know if I'm doing it right. I don't know if there's more I can be doing. There are some resources, but you're just trying to go on your natural teaching instinct a lot of the time on how to deal with these children." (FG3-3, PS Principal)

Several participants reported finding support through alternative channels. One school twice hired private consultants to deliver newcomer and trauma training. Another focus group participant stated that she often came across useful information by chance through conversations with colleagues at other schools:

> "I'd have to say that I think the success of things that we have made in some areas in our school has been more through not the traditional channels. It's been having conversations with friends in other schools, maybe who have Syrian pupils, and then outside the Education Authority and other channels, (…) contacting another school in the area to chat, and I know that they have a Syrian teaching assistant (…), so we brought him to our school, but that's all stuff that's kind of has happened more by chance and by conversations, rather than it being something that we knew we could tap into." (FG2-1, PS Vice Principal)

In fact, colleagues were widely seen as an extremely valuable source of expertise and information. One participant (FG2-3, PS teacher) had taken part in a local training event with other teaching staff who had VPRS children in their schools, which involved sharing experiences and best practice, as well as planning a unit of work together. He found the experience highly beneficial. Another participant had been able to share best practices with other schools as part of his school's application for School of Sanctuary status. He felt that sharing ideas and experiences had been "invaluable in terms of developing the provision for our newcomer students" (FG4-4, PP EAL Coordinator). Participants widely agreed that creating opportunities to connect with each other and share experiences and best practice with other schools and teachers would be very helpful. Many participants were extremely keen to take part in the study for this reason alone:

> "I think this is brilliant. Even just the community that's being created with other professionals, even allowing this dialogue is a really good start, which wasn't there before. I think it's brilliant, even just to facilitate this." (FG4-1, PP Head of English)

> "It's actually really nice to hear the shared experiences of everybody, even though we're all coming from different sectors, I find it really beneficial to hear some of the experiences that everybody else has had. So, thank you for sharing." (FG3-5, SP Vice Principal)

In addition to more opportunities to share experiences and best practice with other schools, participants reported that they needed more guidance on what to expect, where to find support, and how to navigate processes and procedures (a "road map"). Standardised teaching resources and priority curricula for newcomer children, as well as demo lessons, were also suggested as helpful measures for improving staff confidence and ensuring that children received relevant, high-quality provision.

Training

While we didn't systematically collect data on the range and extent of trauma training received by senior management and teaching staff in Northern Irish schools, qualitative focus group data suggests that training experiences vary widely between and within schools. Some of our participants had received extensive training, including nurture, Theraplay, trauma-informed practice (TIP), Tree of Life, ATTACh, and Women's Aid Helping Hands training, as well as EAL, newcomer, and intercultural training, and a range of unspecified training courses. Others hadn't attended any training at all. There was a general consensus that more training was needed to help schools support pupils recovering from trauma, including but not limited to VPRS pupils.
Within schools, access to training also varies depending on role. Our sample consisted mainly of members of senior management teams and teachers with specialist roles, such as SENCo or EAL coordinator, many of whom had received at least some training on subjects relating to trauma or newcomer pupils. However, this is not the case for all teaching staff in Northern Irish schools.

Insufficient availability of relevant training was also mentioned. One school sourced trauma consultancy services from England, as the relevant expertise could not be found in Northern Ireland, although the Safeguarding Board had since contacted the school and offered training on trauma-informed practice, which the Principal in question felt could be a suitable alternative. Several teachers expressed interest in gaining School of Sanctuary status for their schools, but had been unable to participate in the scheme, which had only been rolled out to Belfast and Derry/Londonderry at the time.

Teachers felt that trauma training was relevant for all schools – particularly in the wake of the COVID pandemic – and should be available as standard. Focus group participants also stressed the importance of whole-staff training to ensure that all staff children interact with are adequately qualified to meet their needs. This is particularly striking in the following quote from a primary school principal:

> "My school haven't had any specific training. And I think it is necessary, especially if your child comes into school, and they want teachers dealing with it. But the child, as I was saying, could run. So, all the teachers need trained, not necessarily if you get a child in your class, because these children, you know, down the corridor at break time, lunch time, in the playground, I really think

> it's important that all staff and all schools get this training, because there are more and more children coming. And I know we're talking about trauma, we don't really know what kind of trauma is coming out of the whole COVID situation, you're going to have more and more children that need support that we as teachers aren't qualified to give. But we're the ones that are at the frontline. We're the ones that see them every day. So, we do need more support to help us make the right decisions, rather than make things worse, unintentionally. (FG3-3, PS-Principal)

A bespoke "train the trainer" model was suggested to allow more staff to benefit from trauma training on a limited budget and to ensure sustainability:

> "So, if we can create something bespoke to [our school], and alongside IES, then we can deliver next year, maybe with a little bit less support. So, we're just constantly building capacity and skill and constantly improving our practice, because that I think a lot of people have alluded to in this focus group, and a lot of the things that we're seeing within the refugee children, a lot of our other pupils are coming with that trauma background as well. So, it will be beneficial, the experience that we're getting from this will be beneficial across all classes and supporting many pupils" (FG3-5, SP Vice Principal)

Several focus group participants reported that they or their staff needed training to better recognise and identify the symptoms of trauma. As the following quote from a primary school principal shows, this is particularly important for the more subtle symptoms:

> "My teachers are getting there with the understanding of what trauma is and how it impacts the child. But unless they can see it physically, sometimes they don't realise that it's there. So, it's really about educating all teachers and all professionals, classroom assistants about how this affects all children. And it's not always visible. And it's not always behavioural either. And, yeah, so it's something that really needs to be pushed forward and expedited, as far as I'm concerned" (FG3-4, PS-Principal)

Furthermore, principals whose schools had received trauma training through the Safeguarding Board or from private consultancies reported that this had been vital in helping them and their staff "understand" trauma on a deeper level, changing their attitudes towards trauma and enabling them to adjust how they responded to pupils affected by trauma, and to develop appropriate strategies and policies:

> "I think even completing the trauma-informed schools training (…) really does make you sit back and think and recognise even why their decision-making processes might be the way that they are and their presentation might be, and I suppose it does allow you to go back and talk with that trauma-informed language even to your staff about what's acceptable and what needs to be thought about in a different context and how we react to certain things. (…) [So, I would like to see] projects (…) that really allow you to see the what, the why and the how, so that you can begin to form your responses and your attitudes and your plan, and maybe that's a bit what we are missing." (FG1-1, PP-Principal)

Training was also seen as vital to improving staff confidence and addressing the feelings of inadequacy discussed above. This was true both for trauma training, as in the quote below, and for teaching support:

> "We haven't had any specific trauma training, which I think would be useful for our staff. We kind of just use the strategies we've always used rather than like specific strategies, our staff are very empathetic and they're very people-centred, so I think naturally they do what is needed for the pupils. But I think for their own confidence and our confidence to know that we're providing the best support for them, just to know that we are doing the right things, specific training on trauma would be really useful." (FG3-5, SP-Vice Principal)

Teaching support could include demo lessons, which several participants would have appreciated as a means of improving confidence, gaining practical skills, and improving teaching provision for refugee pupils:

> "One thing we would have liked in the very early days (…) is demo lessons. That somebody is prepared to come in and say, this is how you teach this. My staff was very frightened at the start and would have loved that. And we were refused demo lessons, and I know that other schools (…) had done that before, and I think for my staff to develop confidence, if somebody had come in and even team-taught or done a demo lesson, it would have increased confidence, so certainly I think that's something for new teachers coming in it would be quite an important thing that we can do that." (FG1-4, PS Principal)

In conclusion, the school staff who participated in our focus groups highly valued the support from IES/STARS, and from each other, when this was available. However, a clear message is that more support, guidance and training is required to build capacity in meeting the needs of refuge pupils. In the next chapter we make recommendations as to how this could be developed.

Chapter 5: Key Findings and Recommendations

Based on the results, themes and discussion presented in Chapters 2-4, this Chapter will outline the key findings that relate to our initial aims:

- To better understand the educational experiences of Syrian refugee pupils and explicate the support requirements of teachers and schools.
- To investigate barriers to accessing the educational environment which may have resulted from the sequelae of previous trauma.
- To provide an evidence base to support the service design and delivery of the Schools Trauma Advisory and Referral Service (STARS).

For each Key Finding we make a Recommendation for consideration by EA colleagues. While our Aims (and contract specifications) were focused on informing the development of STARS, the recommended actions arising from these findings may also be relevant to other services within the EA and to partner agencies. Some of these recommendations may already be in place or in development.

Key Finding 1: Language acquisition is the main challenge

Despite our remit and primary focus on trauma, language issues were highlighted by parents, pupils and school staff as the main barriers to accessing the educational environment. It is also the major area in which support and teacher capacity is lacking.

Entering a new educational environment without communication skills in the language of instruction can be very stressful for children and young people. Results from our scoping review, teacher focus groups and parent and pupil surveys all clearly demonstrated that language difference affects VPRS pupils, their families, and school staff in a range of ways. This includes pupils' emotional wellbeing, access to mental health services, communication between schools and parents, and teachers' ability to support their pupils' recovery from trauma.

In relation to trauma support, there is a shortage of Arabic-speaking mental health and teaching professionals in Northern Ireland. Schools usually work with counsellors who do not speak Arabic, or with Arabic-speaking staff who may have little relevant training. Our focus groups have shown that, where available, Arabic-speaking staff can make invaluable contributions to supporting VPRS pupils and improving everyday relationships between schools and VPRS parents. In the absence of Arabic-speaking staff, schools have shown resourcefulness and creativity by employing parents or contracting services from private language businesses. However, language remains a significant barrier to accessing mental health services among refugee communities.

Recommendation 1: Advocate for more language support

While it may not be within the remit of STARS personnel, it is important that we reflect our participants' requests in relation to language learning and accessing the curriculum, e.g. teaching support, demo lessons, high-quality standardised teaching resources (especially high-interest, low-ability resources) and priority curricula for newcomer pupils. Language as a barrier needs to be re-visited in terms of commissioning of services as there is simply not enough capacity in terms of either resourcing or teacher expertise/capacity.

In addition, measures to address the impact of language barriers in accessing trauma support are greatly needed. Counsellors and other mental health staff working with schools need to be adequately trained in supporting pupils with limited English-language skills, to ensure pupils can access the support they need without discrimination

Ideally a designated bilingual family liaison officer would signpost support services to several schools in an area. Key aspects of this role could include liaising between families and schools, providing ad hoc translation services at short notice, and acting as a cultural broker for schools.

Key Finding 2: A strong evidence base for school-based interventions and practices

Our scoping review found a diverse range of potentially beneficial school-based interventions and practices that support refugee children and adolescents' recovery from traumatic experiences worldwide. These included CBT-based and Trauma Systems Therapy interventions, often administered within a multi-modal or multi-tiered programme, as well as a wide array of alternative approaches that harness the beneficial effects of music, art, and play. Some of these are cost and resource-efficient and can be successfully implemented even in areas of disadvantage and with minimally trained staff (e.g. Sirin et al., 2018; Kalantari et al., 2012). In addition, our focus groups highlighted how schools have offered VPRS pupils a range of creative arts interventions involving Arabic language and culture, with reportedly beneficial results (though there is no empirical evidence of this).

Similar to the previous research highlighted in Chapter 1, several studies in our scoping review found that embedding mental health services in schools improved access to mental health support for refugee children and young people (Acosta Price et al., 2012; Ellis et al., 2013; Allison & Ferreira, 2017). Expanding low-threshold mental health services in schools can be an effective way of engaging refugee pupils and their families in mental health service as barriers such as stigma, transport, unfamiliarity etc. are reduced and services are integrated into a system where the target group is already engaged.

The importance of cultural considerations was stressed in several of the studies included in the scoping review and in our previous work providing mental health support to war-affected

children and young people (McMullen and McMullen; 2018; McMullen et al., 2013). Culture ascribes meaning to events and every culture has its own understanding and expression of mental health difficulties and norms for seeking help (McMullen et al., 2020; Summerfield, 1999).

Including advisors from the Syrian (or other refugee) community as part of the intervention team has been shown to be important for participant engagement and to ensuring cultural sensitivity, relevance and acceptability of the intervention to the target community (Cadelli et al., 2020; Acosta Price et al., 2012). This reduces potential to unintentionally cause harm through providing contextually inappropriate interventions (McMullen and McMullen, 2018).

Recommendation 2: Ensure cultural sensitivity and capacity-building in interventions and practices

As STARS currently includes psychologists trained in CBT and other therapeutic modalities, there is potential to offer individual or group therapy in schools. This was the intervention that was most frequently selected by Syrian parents as most needed to support their children (*Figure 7*) In contrast, the findings from the teacher focus groups would suggest that it is the professional development for school staff and capacity-building components of such interventions that may be more relevant for the STARS service.

Either way, it is vital that any interventions/practices are culturally sensitive and contextualised, taking into account the participants' priorities, norms and values. Capacity-building and consultation should highlight the importance of being consistent with community priorities, cultural norms, and values. STARS/IES should continue to partner with members of the Syrian community and other community organisations in the selection, adaptation, implementation and evaluation of interventions.

There is a renewed drive to ensure more collaborative and integrative working between Education and Health sectors[89]. In communication with DE and EA officials, STARS/IES personnel should continue to emphasise the benefits of integrating mental health support for refugee pupils within their school setting.

Key Finding 3: Trauma has impacted some but not all

Our focus group results suggested that there is a default assumption among some school staff that all refugee pupils have experienced trauma and have barriers to learning as a result. However, while a third of parents reported that their children had experienced a traumatic event, this did not seem to be a barrier to accessing the educational environment according to most parents and pupils. As highlighted in Chapter 1, existing research has demonstrated that refugee

[8] https://www.health-ni.gov.uk/mentalhealthstrategy
[9] https://www.education-ni.gov.uk/articles/emotional-health-and-wellbeing

children and young people display resilience, resourcefulness and high functioning despite the adversities they have encountered.

Our data is not fully representative and there are likely to be cultural differences in understanding of trauma as well as potential for stigma and underreporting. As outlined in our Scoping Review, Western ideas on mental health may not always be well understood or acceptable to non-Western communities. Data from our focus groups supports this as school staff highlighted parents' and pupils' cultural differences in attitudes to mental health, and a general reluctance to share about difficult experiences or emotional wellbeing. Language was clearly a key barrier in this regard (as discussed above).

While it was noted by school staff that many Syrian pupils did not present with wellbeing difficulties, others were presenting with signs and sequelae of trauma including attachment issues, avoidance, separation anxiety, and being quiet and withdrawn. Aggressive behaviour in boys was noted and sometimes explained as cultural difference, rather than a result of their previous experiences.

Recommendation 3: Provide psychoeducation for families and school staff

Our data, and anecdotal discussions with the Syrian advisors to our research team, suggested that there is a great need for psychoeducation to develop understanding of trauma, and of mental health and wellbeing in general, within the Syrian refugee community. A transdiagnostic approach, and partnership with Syrian cultural brokers, could help families to understand these difficulties as normal responses to abnormal events. In turn this may reduce stigma and underreporting, and encourage access to appropriate support.

Psychoeducation is also needed for school staff, so that they do not transfer their a priori expectations of trauma onto pupils, but instead are informed and aware of potential indicators and triggers. STARS/IES staff should challenge dichotomous thinking, and promote awareness of intersectionality. Refugees should not be seen as a homogenous group, but should be offered specialist support if needed in terms of race, gender or sexuality (BPS, 2018). Reducing complex experiences to a category of 'trauma' only can distract from attending to other post-migration experiences such as poverty, racism and social isolation (Rutter, 2006; Summerfield, 1999). This advice could be built into a best practice guide (Recommendation 4) and training (Recommendation 5).

Key Finding 4: Schools have a lack of information about refugee pupils

Schools reported a lack of knowledge about refugee pupils' history and background. In the absence of this information, the biographical experiences that they relate to teachers may lead to the default assumption (described above) that trauma has impacted their wellbeing and

learning. Essentially, teachers were often relying on behavioural presentations, and on guesswork, to help them identify and meet their pupils' needs. This is likely to affect a school's ability to support trauma recovery where required.

Recommendation 4: Gather information about prevalence and impact of previous experiences.

The following suggestions may be helpful for IES/STARS in gathering this information:

i. Host pupil and parent focus groups. This was the original aim of the current study but prohibited by COVID-19 lockdown. Focus groups could use our questionnaire data, and the themes from our teacher focus groups, as a starting point to explore these issues in greater depth with refugee families.

ii. Further investigate the prevalence of mental health and wellbeing difficulties among refugee and pupils. For example the Strengths and Difficulties Questionnaire[10] could be distributed to a large sample of VPRS pupils. Alternatively, a range of screening measures that address trauma, stress, anxiety and depression are available from the Children and War Foundation[11].

iii. A consultation approach in cases where schools do identify, through referral to STARS, children with potential difficulties arising from sequelae of trauma. This could yield information about the extent to which communication difficulties between home and school are contributing to under-identification of trauma-based symptoms and/or simply that the advocacy of the STARS personnel is needed due to lack of information-sharing per se. This may lead to greater input to help parents understand the NI school system either by EA IES or Welcome Centre model.

iv. Some assessment of incoming VPRS pupils. For example, a pilot whereby STARS personnel work embedded in the Welcome Centre model[12], where the gathering of information about the needs of refugee families already occurs. This could be supplemented by STARS gathering information about refugee pupils in respect of educational needs above, and relaying this to schools.

Key Finding 5: Schools have had success, but clear guidance is required.

As discussed above, schools have often had to reactively respond to the needs of this population. Reassuringly, our results suggest that this has been effective, as parents' and pupils' reports on school experiences and support were overwhelmingly positive. This concurs with previous positive findings on refugees' school experiences in NI, outlined in Chapter 1. We caveat this by

[10] https://www.sdqinfo.org/
[11] www.childrenandwar.org/resource
[12] Described on p.10- https://www.barnardos.org.uk/sites/default/files/uploads/Barnardos_ANewLifeForMe_web.pdf

highlighting that Syrian parents may not fully appreciate what their children's experiences of school are (e.g. when asked how their children are coping, 40% of parents said 'neither well nor badly' which suggests uncertainty). This is likely to be due to lack of knowledge of the NI school system, difficulties in communication between schools and families and/or genuine lack of awareness of whether their children are having difficulties.

The focus groups with school staff highlighted professional commitment, passion and creativity in using existing knowledge and understanding, and in a sourcing a range of external supports to support Syrian children and young people. In the absence of guidance they have "found their own way" in places, and effectively supported VPRS pupils.

As in previous research (Morgan, 2018; Pastoor, 2016; Szente et al, 2006) a number of the school staff stated that they often had to rely on instinct or personal experience, rather than expertise, which made them feel inadequate and worried about the quality of their provision. This likely leads to the inconsistency of responses outlined in this and previous research from NI (e.g. McMullen et al, 2020, Robertson et al, 2020) rather than responses based on evidence of effective practice. Some school staff in this study did described approaches that may not be helpful (e.g. suspensions, withdrawal from class, projects involving refugee pupils sharing traumatic experiences with fellow pupils, discouraging home language or social interactions).

Recommendation 5: Develop a 'Best Practice Guide' for schools

A 'Best Practice Guide' for supporting refugee and asylum seeking pupils could provide evidence-informed, best practice advice for schools. There are good examples from other areas[13], but a NI-specific, contextualised, guide is needed. Such documentation could continue to be located on EA website and enhanced, developed and publicised (similar to the 'Protecting Life in School'[14] document, which was followed up with a self-assessment audit tool and other resources). A best practice guide for schools in supporting refugee and asylum-seeking pupils should:

i) Include advice on key processes and frequent problems (and how to address them), as well as signposting to relevant services and contacts.

ii) Not be trauma-specific, but instead be a holistic model for understanding the educational needs of refugee pupils, including the links between language learning and wellbeing. STARS personnel could be responsible for parts of this documentation which relate to emotional well-being and potential mental health difficulties which could be sequelae of trauma (signs, symptoms, prevalence).

[13] For example, see the guide from Gateshead Council - https://www.gateshead.gov.uk/media/3285/Education-refugee-Asylum-seekers/pdf/Education-refugee-Asylum-seekers.pdf

[14] https://www.education-ni.gov.uk/publications/protecting-life-schools

iii) Pro-actively model for schools how to use their VPRS/EAL funding.

iv) Support schools to reflect on how their existing resources and skills might meet the needs of their new arrivals (BPS, 2018).

v) Provide advice on communicating with parents, including in relation to previous trauma experiences.

vi) Be supported by a regular newsletter/social media broadcast outlining current opportunities to reduce the time schools spend on searching for resources, training, funding opportunities and support.

Key Finding 6: IES/STARS support is valued and should be extended

Existing support is widely seen as helpful and is appreciated by teachers and schools. Interaction with IES/STARS personnel was consistently described as positive and helpful, but there was a clear call for this to be more widely available and accessible. Below we have made two final recommendations, based on the findings from this research, for the optimal means through which IES/STARS personnel could continue to support Syrian pupils, and other refugee and asylum seeking children and families.

Recommendation 6a: A holistic Intercultural Education Service (IES)

Rather than developing STARS as a bespoke service to respond to trauma, the findings suggest that structuring the IES should be structured holistically. As we understand, this has already been happening over time as the IES service has developed from a primarily language-based advisory/support service to including social work personnel. Now with the addition of educational psychology there is potential for a joined-up, responsive team with diverse expertise. Holistic referral forms could offer a range of supports (e.g. language, trauma, general advice, group work, whole class) with the IES multidisciplinary team convening to consult on cases and formulate responses. Personnel could then move between schools depending on the needs of cases as they arise. An audit of the types of 'referrals'/'requests for support' coming in to STARS and all the other parts of the IES, would be helpful in decision-making and strategic planning.

Our understanding is that the Education Authority is embarking on a wide-reaching SEN strategic development programme. This is to include a range of projects which will address, for example, the development of a multi-disciplinary model of pupil support services, SEND Act Operationalisation as well as a re-examination of multidisciplinary working per se and the service delivery model for the Educational Psychology Service. These may provide a timely context in which the recommendations of this research could be considered. This is also in line with the BPS (2018) guidelines which state that psychologists should 'collaborate and work in partnership with other professionals and agencies to ensure psychological, physical, social welfare, educational, vocational and legal needs [of refugees] are addressed as holistically as possible'.

Educational Psychologists (EPs) would be of vital importance to the IES within this model, given their training in psychological formulation, as well as in addressing the complex trauma presentations among some individuals that are referred. Also, since EPs are experienced in working systemically, they are well equipped to support schools to prepare for the arrival and successful inclusion of refugee pupils. EPs within STARS/IES, through their research and contact with refugee communities, are also well placed to advise other colleagues within the Educational Psychology Service on assessment, intervention and recommendations for refugee pupils who are referred in relation to SEN, EAL, behaviour and wellbeing.

Recommendation 6b: Collaboration and integration of trauma-informed training and practice

Any member of staff may need to support pupils experiencing difficulties related to the sequelae of trauma at any point in the school day. Trauma training should be available for all schools and all staff, regardless of a school's VPRS pupil population or a staff member's role. Our school focus group data indicates that some schools have effectively used knowledge of trauma-informed practice resulting from various training providers, including the IES, the EA Behaviour Support Service training, the Safeguarding Board training and other private companies and charities. This dispersal may be inhibiting access for schools who, as mentioned in the data, have sourced their own training. We recommend collaboration and integration of the various services who are providing this training, so this is more centralised and accessible to schools. Where there are specific training requirements in relation to refugee and asylum-seeking pupils, these could be delivered through the dissemination of the Good Practice Guidance (Recommendation 3).

Local training/networking events that bring together staff from neighbouring schools to connect, share best practice, exchange resources and insights, and build capacity were highly sought-after by teachers in our focus groups. These could be facilitated by IES/STARS through reflective practice groups (e.g. Gibbs, 1988) or group process consultation (e.g. Farouk, 2004), which would be valued by staff and could be an effective and efficient approach to supporting a large number of refugee pupils.

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