Refugee Mental Health:

Research and Intervention

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Abstract

This report outlines international and Scandinavian research on interventions for refugee mental health and presents a new initiative for the promotion of psychosocial health for newly arrived refugees in Sweden. It is argued that research has identified varying levels of refugee distress which warrants not only medical responses but preventive psychosocial public health initiatives as well. It is further argued that research has pointed to the importance of intersectoral cooperation and that psychosocial interventions can and should contribute to: the promotion of resilience and building of personal resources; the strengthening of mental health literacy; the reduction of social stigma attached to mental ill-health; and the promotion of trust, social support and social networks. It is also noted that research results indicate that psychosocial interventions should be trauma-informed as well as culturally tailored and anchored, and that they should provide individuals with possibilities for further support beyond the realms of the implementation of the intervention.

Partnership Skåne's in-depth programme for psychosocial health, targeting newly arrived migrants in Skåne, Sweden, is presented as a preventive initiative that could align itself with many of the intervention requirements presented by international and Scandinavian research. The programme aims to promote resilience and makes use of Civic and Health Communicators, a valuable resource with an established trust from and knowledge of the target group. This resource as well as experiences from Partnership Skåne's Civic and Health Communication, provide the programme with knowledge for cultural tailoring and the circumvention of social stigma and distrust. It is concluded that the strengths of the project rely on careful subsequent evaluation of pilot testing and consideration of possible challenges connected to unprecedented intersectoral cooperation; the assurance of a trauma-informed environment, high requirements on support systems for the communicators; as well as the recruiting of participants.

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List of abbreviations and acronyms

ADAPT   Adaptation and Development after Persecution and Trauma

CHC   Civic and Health Communication

CROP Groups   Culture-Sensitive and Resource Oriented Peer Groups

IM   IM Swedish Development Partner[a]

MHPSS   Mental Health and Psychosocial Support

MILSA   Knowledge-based support platform for migration and health[b]

NAD   Network, Activity, Participation[c]

PM+   Problem Management Plus

PMLDs   Post Migration Living Difficulties

PREMO   Prevention Model for Psychosocial Health

PS   Partnership Skåne

RHPCC   Refugee Healing Partnership for Coordinated Care

TRT   Teaching Recovery Techniques

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[a] IM is a Swedish abbreviation and stands for "Individuell Människohjälp"
[b] MILSA is a Swedish acronym combining the Swedish words for migration and health
[c] NAD is a Swedish abbreviation and stands for "Nätverk – Aktivitet – Delaktighet"

Part I: Refugee mental health research

Introduction: resettled refugees and mental health

The UN Convention relating to the status of refugees defines a refugee as someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion [1]. With this definition in mind, it is unsurprising that much research on resettled refugees has focused on how the adversities inherent in the refugee definition have affected the mental health of people who flee their homes. Studying for instance PTSD, depression, anxiety and suicide, international research reaches diverse results regarding the prevalence of mental ill-health amongst refugee groups. Indeed, scholars continuously note that estimates of mental ill-health prevalence have been widely varying, depending on studied groups, symptoms and outcomes, sample size and methodology [2-6]. The heterogeneity of refugees is also emphasised as well as the difficulty in making sweeping conclusions on the prevalence of mental ill-health without a sub-group perspective [7,8].

Nevertheless, much of the international research results points to the fact that refugees or refugee subgroups are particularly vulnerable to mental ill-health [3,9-14]. Swedish research has also noted how newly arrived refugees suffer from poor mental health [15-19], often to a greater extent than national or regional averages [20-24]. The prevalence of mental ill-health is attributed to factors that are common or unique to the refugee experience, such as pre- or perimigration experiences in the category of cumulative exposure to trauma [13,25]. The argument is often made however, that postmigration factors present in the resettlement process, at the very least play an equally influential role for the mental health of a refugee [18,19,26,27]. Such arguments are made taking into consideration postmigration risk factors such as long asylum processes or temporary residence permits [17,20,28-30], discrimination and racism [7,15,19,20,31], isolation and lack of social networks [15,19,20,32,33], economic instability [7,15,33,34], housing problems [15,34], or difficulties entering the labour market [18,19,34,35]. Asserting the importance of postmigration factors enables a constructive perspective as these factors may be addressed by policies and health promoting interventions in the receiving country [26,27].

Terminology considerations

As the following report uses the terms *refugee*, *migrant*, *immigrant*, and *newly arrived* throughout, some initial clarification should be made. The research outlined has studied different groups, and it should not be assumed that the referenced results are easily comparable. Indeed, national legal contexts influence the categorisations and terms used to describe studied populations in migration research. When referring to research here, terms will be cited as stated in the particular study. Otherwise, the definition of refugee used in this paper is the above-mentioned UN definition. In the Swedish context, the term 'newly arrived' (nyanländ) is often used without adding 'migrant' or 'refugee', and commonly denotes an individual who has received a residence permit as a refugee or as a person in need of subsidiary protection, and as a family member of such individuals. A newly arrived person is registered in the Swedish establishment programme, which spans from two to three years [36].

The following sections will further exemplify and discuss research on migration and mental health, building a theoretical foundation to better understand the empirical case that is presented in part II of this paper; Partnership Skåne's in-depth programme for psychosocial health.

The spectrum: from mental ill-health to resettlement stress

Plenty of scholars have theorised on the post migration phase, aiming to illuminate conditions that affect the well-being of resettled migrants and refugees. From this, a growing flexibility in the conceptualisation of refugee mental health has emerged, proposing that clinical mental ill-health that calls for professional treatment is neither inescapable nor the only possible outcome of refugee and resettlement hardship. As Ryan and colleagues argue, the dominating theoretical approach in refugee mental health has been a 'medical model', with a focus on pathological conditions, diagnosis of disorders and treatment of symptoms through pharmacological or psychotherapeutic interventions. This, they assert, is certainly important yet only a part of the picture when trying to understand the well-being of refugees [37]. Thus, alternative models of explanations have emerged.

For instance, during the 90s and forward Berry presented the 'acculturation framework', nowadays a well-referenced sociocultural conceptual framework for immigrant adaptation and well-being [37]. The concept of acculturation and acculturation stress marks another way of thinking about migrant health, implying that there is more to consider than pathological medical diagnoses. Acculturation is explained by Berry as the changes that groups and individuals experience when they come into contact with another culture. The acculturation framework outlines four scenarios in which acculturation takes on different forms, based on the extent to which value is placed on cultural maintenance on the one hand and contact or participation with the host society on the other hand [26,38,39]. Building on this framework, Berry connects the acculturation scenarios to the well-being of the immigrant, stating that an acculturation experience may be seen as a source of difficulty or opportunity, and that an experience perceived as a source of difficulty is a stressor. Depending on the consequences of such stressors and one's ability to cope with them, the immigrant experiences various levels of stress. If acculturation experiences pose no problem for the individual, changes to align oneself with one's new context will follow smoothly in what Berry calls *behavioural shifts*. If there are greater levels of conflict and the experience is perceived as problematic yet controllable and surmountable, the individual is experiencing *acculturative stress*. When acculturation experiences create problems that cannot be controlled or surmounted, the individual is experiencing *psychopathology* [38].

It is noteworthy however, that this conceptual framework was created with migrants as a whole in mind. Although internationally resettled refugees comprise a sub-group included in the migrant definition [5], it is not unlikely that refugees experience unique stressors as the challenges of acculturation felt by immigrants as a whole are added to specific refugee experiences. These include repression, political violence, forced family separation, stressful asylum processes and concerns for the people and the society that is left behind [8,9,26]. Connecting the acculturation framework to refugees, Williams and Berry acknowledge this added burden of risk factors that makes refuges an at-risk population especially suitable for public health interventions. Nevertheless, they assert that "although refugees are at risk from numerous factors, many of these factors can be controlled or their impact moderated" [26, p. 636].

Writing on post conflict populations and trauma, Silove also emphasise the possibilities of mitigating the effects of potentially traumatic experiences through both clinical and psychosocial interventions. Silove's *Adaptation and Development after Persecution and Trauma (ADAPT)* model takes into consideration both post conflict societies as well as resettlement contexts for refugees and is permeated by a multi-layered socioecological perspective of the interplay between individual, group

and societal needs for recovery. It postulates that five psychosocial pillars are necessary for stable societies, and that these pillars are disrupted by mass conflict. Therefore, mental health and psychosocial interventions must aim to strengthen these pillars, which comprise 1) safety and security, 2) bonds and networks, 3) a sense of justice, 4) roles and identities, and 5) existential meaning. In keeping with Berry, Silove notes that the collective or individual response to stressors of mass conflict can be maladaptive/pathological or adaptive/normative [40]. He also refers to a *survival risk group* and a larger *adaptive risk group* - the former experiencing severe impairment that warrants psychological attention whilst the latter may experience symptoms of mental ill-health but is capable of self-directed recovery with adequate social support and opportunities [41].

Thus, with the emergence of theories that incorporate multifaceted refugee mental health needs, concepts such as acculturative stress, resettlement stress and other variations have become widely used as they conceptualise distress not only as pathological but also as a normal response to the major life changes that refugees experience [37]. Renner and colleagues, for instance, emphasise the need for interventions aimed at "everyday problems and acculturative stress rather than post traumatic symptomatology" [42, p. 11]. Another example is provided by Knefel and colleagues, as they study the effects of the WHO-developed method *Problem Management Plus (PM+)* for Afghan refugees in Austria. The scholars point to refugee specific mental distress that is different from common mental disorders, and note that trauma-focused therapies have proved efficient in reducing symptoms of PTSD, depression and anxiety, but that there are a limited number of studies that consider other aspects such as daily functioning or quality of life. To cover the variety of difficulties that refugees may face, the authors evaluate an application of an adapted version of PM+. The intervention aimed to address mental health problems as well as *PMLDs - post migration living difficulties*, which can be a source of stress that warrant lower-intensity treatments but can also contribute to common mental disorders that require more advanced treatment [43].

In other words, if it is possible to experience poor mental health to varying degrees there should also be a variety of health promoting approaches in response to this. As determinants of health are connected to social, environmental and economic factors, mental health is not exclusively the responsibility of the health sector and medical treatment [44]. A recent intervention perspective that takes this into account is presented by Im and colleagues as they propose a framework to align interventions in response to the multi-layered mental health needs of refugee communities. They note that "mental health issues other than common disorders that are critical to social functioning (e.g., adjustment disorders and acculturative stress) are not well understood, nor are they routinely integrated into mental health services" [6, p. 2]. Using a multitier mental health and psychosocial support (MHPSS) model with origins in humanitarian settings, they propose an adaptation to the American refugee resettlement context. In line with arguments presented by the summarised research so far, the model presupposes that refugees have varying mental health needs to which different societal sectors should respond. The model includes four tiers that complement each other whilst catering to different target groups: *tier 1, Social Adjustment and Integration*, is for all refugee newcomers; *tier 2, Family and Community Support Systems*, is for refugee newcomers who need added psychosocial support for cultural and social adjustment and healthy coping; *tier 3, Bereavement and Trauma Healing*, is for refugee newcomers who have common mental disorders or trauma-related mental, behavioural, or emotional health issues; and lastly, *tier 4, Specialised Mental Health Treatment*, is for refugee newcomers who need specialised care for psychiatric and mental illness

treatment. The four tiers constitute what the authors refer to as a *Refugee Healing Partnership for Coordinated Care (RHPCC)*, implying interconnectedness and sectoral cooperation [6].

The Swedish establishment programme

A newly arrived refugee in the ages of 20-65 who has been granted a residence permit for more than 12 months normally partakes in the Swedish establishment programme. Its activities include language training, a civic orientation course, and other courses and activities to promote labour market establishment. Participation enables an individual to seek financial aid from the Swedish Social Insurance Agency.

In keeping with Im and colleagues' macro perspective focusing on sectoral interdependence, Ekblad and colleagues argue that in order to promote the empowerment of vulnerable groups, there is a need for collaboration between the societal sectors that are to serve them. The authors evaluate a university course on local intersectoral cooperation for refugee mental health, completed by employees from sectors active in the Swedish establishment programme. The results confirm the significance of cooperation in the field of refugee reception and that collaborative learning is of importance to achieve this goal [14]. Further, studying the mental health-promoting possibilities of the establishment programme, Lindencrona and Ekblad emphasise the importance of comprehensive strategies focusing on intersectoral coordination. With reference to Silove's ADAPT model and its socioecological underpinnings, the authors note the importance of a refugee's resettlement environment and the consequential influence that the Swedish establishment programme activities may have on refugee mental well-being [45]. In a retrospective medical journal study and interview study of asylum seekers and their kin, Ekblad and colleagues makes further use of the ADAPT model as an analytical tool. They find that the model's five psychosocial pillars resonate with the informants' testimonies, implying the importance of attachments, safety and security, identity and roles, human rights and existential meaning[d]. In line with Silove's perspective on adaptive and maladaptive responses to potential trauma, the authors conclude that a refugee's environment influence whether reactions to previous threats, violence and separations will lessen or re-emerge. To prevent maladaptive responses, the resettlement environment must create security and safety, as well as conditions for recovery from potentially traumatic experiences [46].
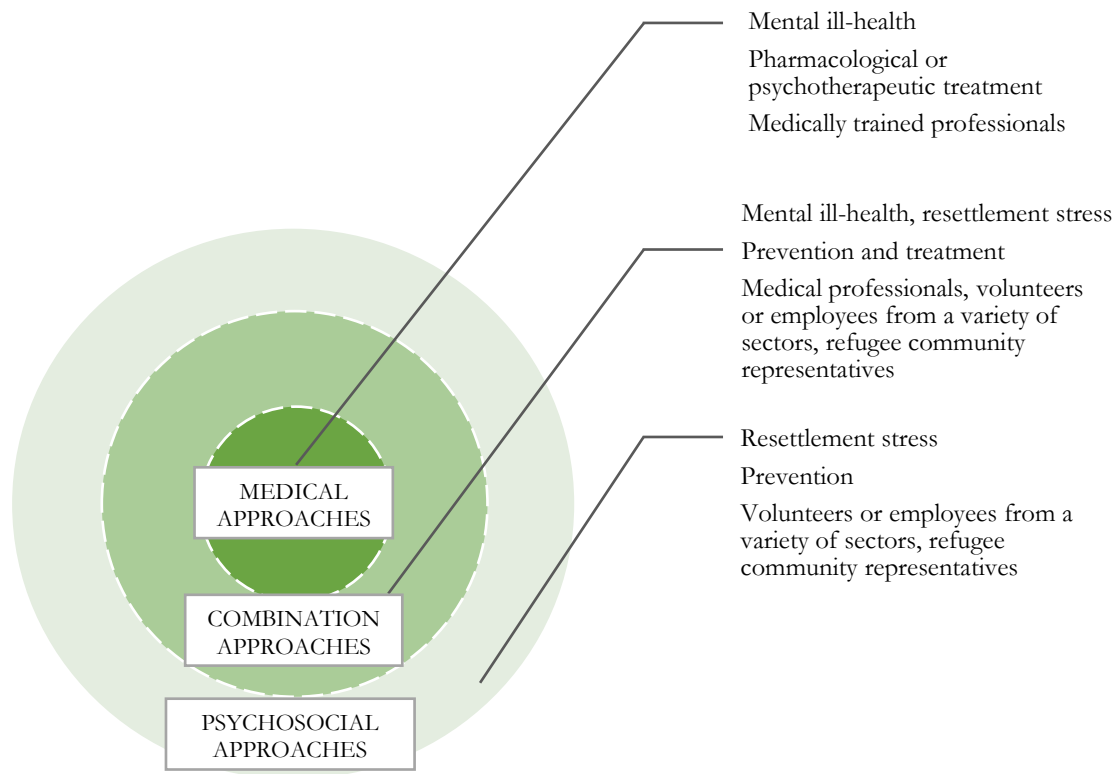
Thus, an emerging focus on *preventive* approaches can be noted. Indeed, Weine asserts that calls for building capacities for preventive approaches to refugee mental health have grown with the concern for those who are suffering from poor mental health but not presenting symptoms, and also for those who are not suffering but are having individual or family difficulties. This shift from a treatment focus to a preventive focus entails an emphasis on *resilience*, a concept that has been applied on individual, family and community level and refers to an adaptive capacity leading to a positive trajectory in the face of adversity. Weine suggests that preventive mental health interventions for refugee families in resettlement can operationalise resilience by building on *protective resources*, that is, family and community characteristics that can stop, delay or diminish mental health problems [47]. Another example of this resource focus is presented by Ryan and colleagues, who argue for a *resource-based model of migrant adaptation*, which describes "the process

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[d] The ADAPT model as presented by Silove has been revised throughout the years. Ekblad and colleagues' study was published in 2012 and thus refers to an older version of the model.

through which individuals seek to satisfy their needs, pursue their goals and manage demands encountered after relocating to a new society" [37, p. 7]. At the core of the model is an individual's resource pool, comprised by personal physical or psychological resources, as well as material, social and cultural resources. The pre-migration, flight, and post-migration phases all affect this resource pool, and psychological stress is likely to arise when one's context places constraints on or depletes existing resources whilst offering few opportunities for resource gain [37]. In their study on *Teaching Recovery Techniques (TRT)*, Sarkadi and colleagues refer to Silove's previously mentioned adaptive risk group, asserting that there is a demand for interventions that can address the needs of this group on a community level by strengthening personal resources. This can be done by teaching necessary skills for mental ill-health symptom reduction, and in this application of TRT, employees from both inside and outside the health sector were trained to provide group sessions based on tools from cognitive behavioural therapy designed to reduce PTSD and depression symptoms [48].

Placing interventions on the spectrum

The research outlined so far has several aspects in common. Firstly, it points to a transition from a medical to a preventive psychosocial approach, or rather to an inclusion of the latter in the attention span of refugee and migrant research. Secondly, it is possible to see a transition from the refugee as an object to a subject. This is implied by the voluntary characteristic of preventive interventions and the help to self-help approach of resource and resilience building that presupposes the co-creation of the intervention between service provider and target group. It thus places power and decision making with individuals from the target group. The value of self-perceived influence and agency is noted, for instance by Ikonen's qualitative study on newly arrived migrants in Sweden. The study presents how they experience a lack of influence over their establishment programme, which contributes to a feeling of powerlessness and hopelessness [19]. Lastly, the research has illuminated the complexity of refugee mental health and hence the importance of positioning an intervention in its context. Therefore, Model 1 outlines a theoretical map of refugee mental health interventions by defining their presuppositions in terms of challenges experienced by target groups, intervention characteristics, and intervention provider:

Mental ill-health

Pharmacological or psychotherapeutic treatment

Medically trained professionals

Mental ill-health, resettlement stress

Prevention and treatment

Medical professionals, volunteers or employees from a variety of sectors, refugee community representatives

Resettlement stress

Prevention

Volunteers or employees from a variety of sectors, refugee community representatives

MEDICAL APPROACHES

COMBINATION APPROACHES

PSYCHOSOCIAL APPROACHES

Model 1: A theoretical map of refugee mental health interventions
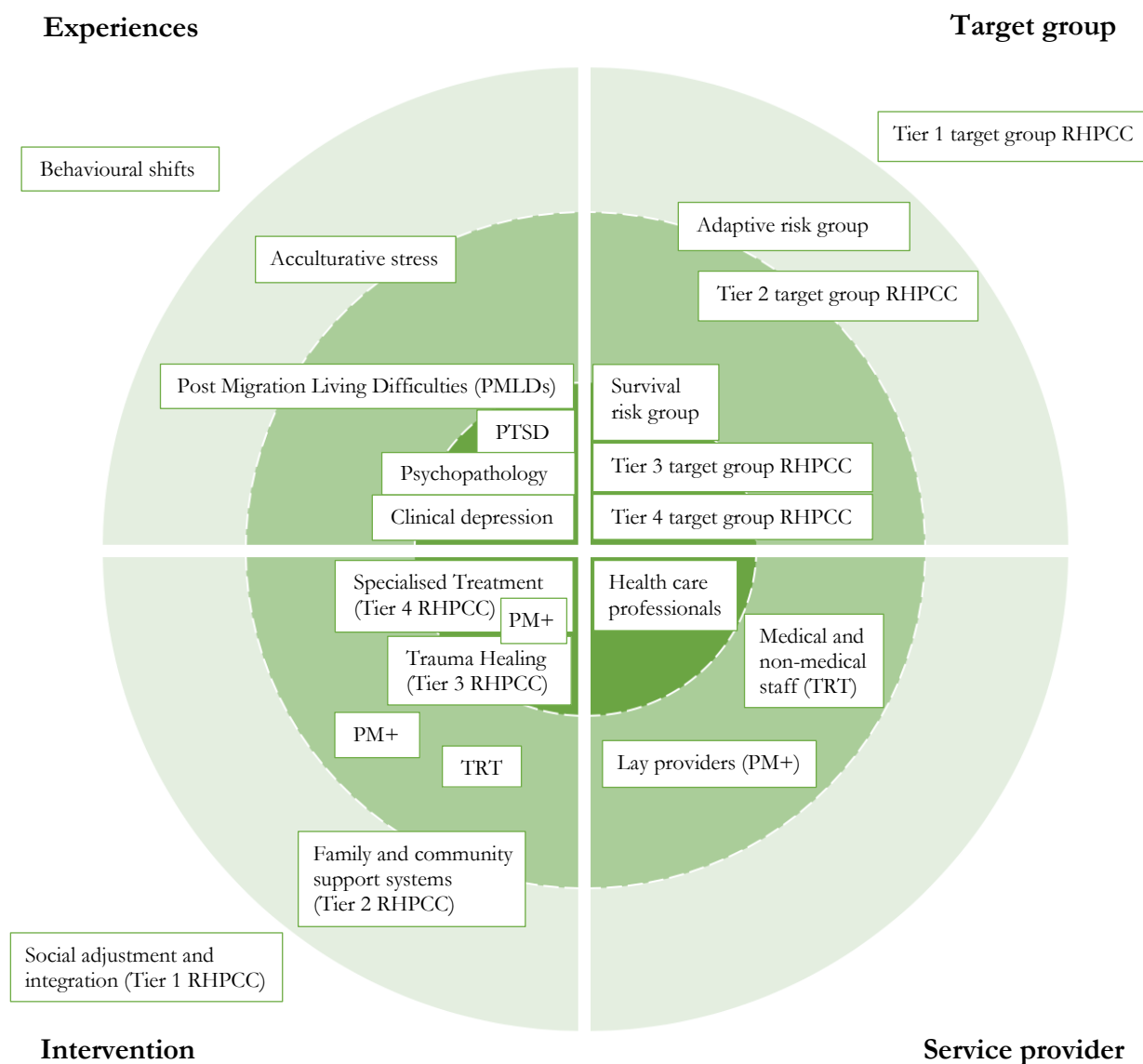
The model depicts three spheres in which various aspects of refugee mental health initiatives can be placed. The core circle represents medical approaches described by the exemplified research. The target group here, for instance, would be suitable for Im and colleagues' Tier 3 and 4 of the multitier RHPCC model. This target group is comprised by refugee newcomers who have common mental disorders or trauma-related mental, behavioural or emotional health issues, and those who need specialised care for psychiatric treatment [6]. The target group here could also be Silove's survival risk group, which experience severe impairment that warrant psychological attention [41]. Interventions of this inner circle are also suitable for acculturation difficulties described by Berry as psychopathology [38]. The interventions that are considered appropriate are pharmacological or psychotherapeutic treatment, and they should be provided by medically trained professionals. Interventions of the inner circle aim to treat established conditions and they are not preventive in the sense of postponing or hindering the emergence of symptoms. Nevertheless, they can surely be preventive in the sense that they avert further deterioration of mental health and build resilience towards other undeveloped conditions.

Counterbalancing the core of medical approaches is the outermost circle of psychosocial approaches. It caters to a larger target group that would correspond to Im and colleagues' Tier 2 target group, i.e. refugee newcomers who need additional psychosocial support for cultural and social adjustment and healthy coping [6]. This target group may also be referred to as Silove's adaptive risk group that experiences symptoms of mental ill-health but is capable of self-directed recovery with adequate social support and opportunities [41]. The interventions of this outer circle are suitable for those who experience Berry's acculturative stress [38], or lower levels of Knefel and colleagues'

post migration living difficulties (PLMDs) [43]. A range of interventions can be appropriate for this target group, however they do not include medical or psychological treatment. This connects to the providers of the interventions, who are not medically trained professionals but volunteers or employees from other sectors, or refugee community members. The interventions are preventive and focus on resource-building and resilience as advocated by Ryan and colleagues [37] and Weine [47].

The middle circle represents combination approaches in which medical treatment or involvement by medical professionals is paired with prevention and possible involvement of volunteers or refugee community members. Examples include the Teaching Recovery Techniques (TRT) intervention evaluated by Sarkadi and colleagues. As descried previously, employees with and without medical background were trained in this intervention to facilitate sessions that were aimed for Silove's adaptive risk group [48], most appropriately placed in the outer circle of the theoretical map. At the same time, the aim of the sessions was to reduce medical symptoms of PTSD and depression that are situated in the inner circle of the theoretical map. As such, aspects from both the inner and the outer circle of the theoretical map were combined. It is also possible that one intervention, such as Problem Management Plus (PM+), is adapted in ways that makes it suitable in different parts of the theoretical map. When evaluated by Knefel and colleagues, PM+ was provided by psychologists with the objective of reducing symptoms of common mental disorders and associated stress via PMLDs [43]. As developed by WHO, PM+ can also be implemented in the context of humanitarian crisis by non-specialist lay-providers under specialist supervision to adults impaired by stress [49]. The former would thus be appropriately placed in the inner circle of medical approaches, whilst the latter fits better in the middle circle of combination approaches.

Overarching systems of coordinated interventions are likely to span across the theoretical map. Indeed, their very logic rests on the assumption that the circles are interconnected and that their interventions are complementary. Im and colleagues' multitier RHPCC model is an example of this, where the psychosocial and medical approaches are seen as interdependent and their separation therefore unwanted. Only by looking at the model's interventions separately can they be placed in different circles of the theoretical map. Additionally, such overarching systems may include basic interventions for all refugees, whom - due to their status as newcomers - require resettlement support but do not necessarily have mental health needs. Indeed, they may experience what Berry describes as behavioural shifts, i.e. acculturation that poses no major problem for the individual's well-being [38]. Tier 1 of the multitier model is an example of such an intervention, which includes basic services and security such as food and shelter, vocational training and social services [6]. Such interventions are likely to counteract mental ill-health as they satisfy basic needs and encourages personal development, but it is not their primary purpose. As such, they are most appropriately placed outside the circles of the theoretical map. In Model 2, the theoretical concepts and empirical examples described in the summarised research are placed onto the theoretical map.

Experiences

Target group

Behavioural shifts

Tier 1 target group RHPCC

Acculturative stress

Adaptive risk group

Tier 2 target group RHPCC

Post Migration Living Difficulties (PMLDs)

Survival risk group

PTSD

Psychopathology

Tier 3 target group RHPCC

Clinical depression

Tier 4 target group RHPCC

Specialised Treatment (Tier 4 RHPCC)

PM+

Health care professionals

Trauma Healing (Tier 3 RHPCC)

Medical and non-medical staff (TRT)

PM+

TRT

Lay providers (PM+)

Family and community support systems (Tier 2 RHPCC)

Social adjustment and integration (Tier 1 RHPCC)

Intervention

Service provider

Model 2.1: A theoretical map of refugee mental health interventions – empirical examples applied

Accessibility of and barriers to mental health support

The research outlined in this paper has pointed to the multifaceted needs of resettled refugees and calls for additional approaches to compliment the medical model. It is valuable therefore to know what factors in particular that can be accommodated for by additional psychosocial approaches. In terms of western classical health care and mental health services, research has illuminated aspects that specifically affect the well-being of resettled refugees in high-income countries. Many scholars have proposed that help-seeking behaviours differ between resettled refugees and native populations, noting that appropriate help-seeking for health care is low amongst refugees and that certain barriers obstruct their access of care [7,47,50-53].

The summarised research has presented arguments for resource building approaches for refugee mental health. One such personal resource that is commonly addressed in research as contributing to well-being and to constructive help-seeking behaviour is health literacy, the extent to which one can understand and make use of health-related information [23,52]. Mental health literacy then, refers

to "knowledge and beliefs about mental disorders and their recognition, management or prevention" [54, p. 182] and thus denotes the ability to recognise disorders, having knowledge on how to seek mental health information, having knowledge of risk factors, self-treatment and professional help available, and having attitudes that promote recognition and appropriate help-seeking [54]. A health literacy survey performed in eight European countries suggested the presence of a social gradient, as the subgroups within the studied population that displayed a lower level of health literacy also suffered from financial deprivation, low social status and low education [55]. International and Swedish research has proposed that health literacy and mental health literacy is found to be low amongst immigrants [23,30,32,52,56,57]. Consequently, recommendations for refugee or immigrant health interventions often include the promotion of health literacy and mental health literacy [11,16,23,34,52,58].

Additionally, difficulties for resettled refugees to navigate the western healthcare system has been presented as a contributor to differences in help-seeking behaviour [57,59]. Linguistic barriers may also contribute to lower help-seeking amongst immigrants [20,53,57,60], and it has been proposed that immigrants who lack fluency in the majority language are less likely to be targeted by health promotion initiatives [61]. Additionally, it has been argued that definitions of mental ill-health and ways of expressing and perceiving mental distress varies between cultures [33,62,63], and that for many refugees mental health problems may be attached to shame or stigma and a perceived social distance to people with mental health problems [51,64-66]. Therefore, the acknowledgement of possible mental health problems may be less likely, resulting in lower levels of help-seeking. Indeed, Renner and colleagues argue that refugees have mental health needs that may differ from the average population and that mental health interventions need to be culturally congruent in the sense that they consider different perceptions of grief, religious differences, ethnic identity and specific practices, culture related expectancies, illness metaphors and culture specific symptoms and their meanings [42].

Similarly, the difference between *targeting* and *tailoring* health promotion strategies has been emphasised by Hyman and Guruge, who propose that tailoring mental health initiatives is preferable as it implies the development of health information that is consistent with the characteristics, needs and cultural beliefs of a particular group. They further propose the use of *link* or *lay elders*, that is, trained personnel from the ethnocultural group, to increase the relevance of health messages and to reduce barriers to behaviour change [61]. Advocating for community-based approaches for preventive mental health interventions for refugee families, Weine similarly asserts that in his past 20 years of intervention research for refugee mental health he has found that ethnicity, culture and social context must be attended to in intervention development. He summarises key intervention characteristics to strive for, of which *acceptability* and *culturally tailored* refer to the fit of the intervention with the characteristics of the targeted group's cultural background. He further argues for community collaborative approaches which involve community members as partners in building preventive interventions, to counteract acceptability issues such as stigma and distrust [47].

By revisiting Im and colleagues' multitier model described previously, one also finds similar considerations. Writing on their adaptation of the RHPCC model to the refugee resettlement context, Im and colleagues address the issue of cultural awareness. For the success of a multitier model in which medical and psychosocial approaches come together, the authors assert the

importance of a two-pillar approach where trauma-informed and culture-informed care is mainstreamed across the tiers. Refugee resettlement agencies that provide introduction programmes in Tier 1 or psychosocial support in Tier 2, may often be equipped with resources for cultural competency, but may lack mental health knowledge and a trauma-informed approach. The opposite may be said about mental health services whose treatment services are provided in Tier 3 and 4. The health professionals here are likely equipped with knowledge on how trauma affects mental health, but they may lack experience in working with refugee populations or may lack culturally relevant tools for assessment and practice [6].

The two-pillar approach aims to address the blind spots and capacity gaps at each tier so that all levels of support are both *trauma-informed* and *culture-informed*. Indeed, the authors state that the absence of a trauma-informed approach, often more common in Tier 1 and 2, may result in retraumatising environments, emotional distress and stigmatisation. As seen in Model 2, Tier 2 corresponds to the outer circle of the theoretical map. The absence of culture-informed care then, often more common in Tier 3 and 4 that corresponds to the inner circle of the theoretical map, may uphold barriers such as inaccessibility and stigma [6]. In line with these arguments, it is possible to place the strongest trauma-informed skills at the inner circle of the medical approaches, gradually subsiding as one moves outwards. Conversely, the strongest culture-informed skills move in the opposite direction, being the strongest in the outer circle of psychosocial approaches. The intent of initiatives such as the two-pillar multitier model is then to strengthen skills where they are weak, assuring the presence of trauma-informed skills at the outer circle and culture-informed skills at the inner circle, for the prevention of retraumatising environments, inaccessibility and stigma.
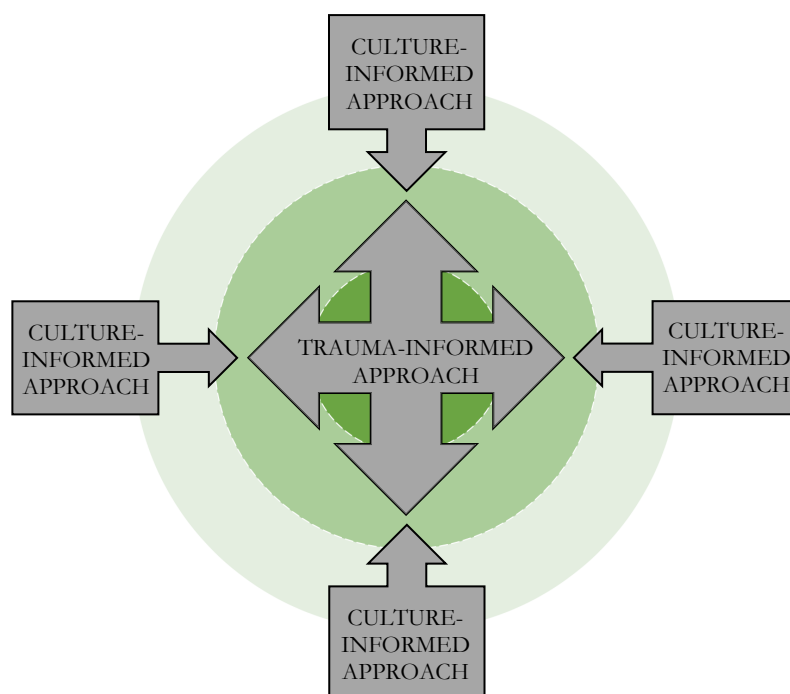
Model 3: Mainstreaming trauma-informed and culture-informed competence

As regards the role of culture for the mental well-being of resettled migrants however, it may be mentioned that cautionary arguments have been presented as well. For instance, in Shahnavaz and Ekblad's rare study on Swedish mental health care professionals' own perceptions of cultural competence and cultural awareness, the authors propose that there is a pitfall in an over-confidence in cultural training. They argue that there is a complex interaction between psychiatric problems and cultural factors, which constitutes a source of uncertainty to understand culturally diverse patients in the resettlement context. They note that although conducive for the understanding of the culturally diverse, the impact of cultural training should not be overestimated. For instance, an extreme focus on intercultural similarities or differences are both equally unhelpful. The former, often accompanied by ethnocentric tendencies, could lead to cultural blindness in which one is unable to see the varying preconditions that members of different communities face. The latter, in turn, may lead to exaggerated categorisation on the basis of culture, religion and ethnicity and could thus lead to stereotyping. Further, an overconfidence in the knowledge that comes with a shared immigrant background or one's taught intercultural competence, could blind an individual to connections that involve other factors than culture [67]. Indeed, this perspective correlates to Ryan and colleagues' critique of Berry's acculturation framework as an 'overculturalised' view of the migrant adaptation process. The result of such overculturalisation could be that issues not directly linked to culture are underplayed. In cases when people migrate or flee to settings culturally similar to their own, it is possible to note factors that should be regarded as influencing mental well-being, such as loss of social networks; family separation; unemployment; poor living conditions; or prolonged asylum processes leading to a sense of meaninglessness in day-to-day life [37].

Social support and social networks

Social capital defined as trust in other people and societal institutions, is often connected to the well-being of refugees and immigrants. For instance, Östergren states that one's level of trust in societal institutions will affect the propensity to turn to them for help and the way you perceive and receive their information. Your trust in people around you will affect the extent to which you are willing to partake in society and build relationships that are important for your mental well-being [68]. Results from surveys mapping the health of newly arrived refugees in the southernmost region of Sweden show that the majority of the studied population did not trust people in general [23,30,58,69] and that trust in certain societal institutions, particularly primary health care, was low [23,58]. Resettled refugees have been reported to be less likely to discuss their health problems and less likely to believe in the usefulness of professional help [70]. Indeed, one of the main themes discovered in Shannon and colleagues' qualitative study of 111 refugees from four different ethnocultural groups, was the belief that talking about one's emotional distress with health professionals does not help. The study also identified a lack of trust in interpreters and a belief that what one said in an interpreted conversation could be gossiped about in the community [64]. Hadgkiss and Renzahoz's systematic review of 32 studies on asylum seekers' health status and service utilisation also found a lack of trust in health care institutions and interpreters [57] - a result that is echoed in Swedish research as well [23,71].

Connected to trust is another aspect of social capital, namely the intra- and interrelationships between people of different groups or communities, also known as bonding social capital within and bridging social capital between groups or communities [72]. Research has illuminated the fact that social participation and social support is lacking for resettled refugees and that self-perceived

loneliness is high [13,35,58,69]. Studies have also pointed to the fact that such conditions contribute to poor mental health [15,18,24]. Having established these connections between trust, social relations and well-being, it is unsurprising that many scholars argue for health promotion initiatives that aim to enhance the social capital of migrants - focusing on trust, social support and network building [15,58,68,69,73]. For instance, in Sundell Leceröf's dissertation on health promotion for recently settled migrants in Sweden, it is concluded that social capital as social networks, community participation and trust in other individuals and authorities seems to be a protective factor for mental health [16].

Tinghög and colleagues similarly call for initiatives to reduce and prevent poor mental health by enhancing newly arrived immigrants' own resources and their resilience, by facilitating their participation in society, access to information and to social networks [24]. Indeed, in studies that qualitatively investigate the perspectives of newly arrived migrants in Sweden, being provided with a social context is perceived as a substantial advantage of the Swedish establishment programme. This however, seems to be a balancing act as the multitude of introduction activities may also be simultaneously perceived as intense and time-consuming, leading to the feeling that one has to prioritise between equally important activities and that it is hard to combine one's family life with the programme [19,74].

In intervention research on mental health, social support in a group setting has been presented as enhancing protective factors amongst resettled refugees. In their study on the effectiveness of working with Teaching Recovery Techniques (TRT) with unaccompanied minors, Sarkadi and colleagues observe the positive characteristics of a group conversation. They conclude that the participants who partook in group counselling experienced a feeling of community, trust and social support in the group, and that sharing in a group contributed to a feeling of decreased loneliness and a relieving sense of normalisation of problems [48]. Evaluating Culture-Sensitive and Resource Oriented Peer (CROP) Groups as a community-based intervention for Chechen asylum seekers, Renner and colleagues attribute the study's positive results partly to the supportive group setting. Importantly, an explanation provided for the loss of positive effects at the follow-up evaluation was the perceived loss of social support as the groups were no longer active [42]. This may point firstly to the potential of the group setting and secondly to the importance of continued support beyond the realms of the immediate intervention.

Similar tendencies were found in Eriksson-Sjöö and colleagues' study on self-perceived health-related quality of life among newly arrived Arabic-speaking refugees who participated in a group-based health promotion intervention in Sweden. The researchers argue that "many who have experienced trauma and torture seem to appreciate the opportunity to testify to their experiences both by filling in questionnaire and by sharing them with others in similar situations" [71, p. 122]. The study results indicate that the participants experienced better health and quality of life, but the authors also note a stress stemming from not knowing whether one would receive further support after the intervention [71].

The research outlined so far has presented arguments in favour of certain characteristics of mental health promotion for resettled refugees. They are summarised below.

- *Preventive* psychosocial mental health promotion is important to complement medical approaches and to better respond to resettlement stress that does not warrant the latter.

- *Intersectoral cooperation* is a prerequisite for the success of any mental health promoting initiative that caters to vulnerable groups.

- Preventive mental health promotion should build *resilience* and strengthen *personal resources*.

- Mental health promotion should enhance *mental health literacy*.

- Mental health initiatives should be *culturally tailored* and *anchored*, without language barriers and with considerations of cultural conceptions and practices.

- Psychosocial mental health initiatives should be *trauma-informed* to avoid retraumatising environments.

- Mental health initiatives should reduce or circumvent *social stigma* and *distrust*.

- Mental health initiatives should promote *social support* and *access to social networks*.

- Structures for *continued support* beyond the specific intervention should be established.

Part II: A psychosocial initiative for refugee mental health

The context: Swedish initiatives for refugee mental health

The remainder of this report will present and discuss a specific initiative for refugee mental health, a mission initiated by the Ministry of Health and Social Affairs and launched by the County Administrative Board of Skåne through Partnership Skåne. From a public health perspective, The Swedish government has acknowledged the need for intensified nation-wide work with the promotion of mental health. The government has also recognised the additional vulnerability for mental ill-health experienced by newly arrived migrants and has therefore made available funds for national, regional and local projects for the promotion of mental health resources for this particular group [75-78]. Described below are a few examples of national, governmentally supported projects, followed by a presentation of Partnership Skåne's initiative for psychosocial health.

Mission Mental Health is the result of an agreement between the Swedish government and the Swedish Association of Local Authorities and Regions. Mission Mental Health is financed by The Ministry of Health and Social Affairs and includes several nationwide projects for promotion of mental health with various target groups. One such project, launched specifically for the promotion of refugee mental health, is Health in Sweden. The project's objective is a knowledge gain for health care professionals who come in contact with resettled refugees. Health in Sweden aims to educate employees in Regions on topics such as health information to migrants; migration and mental health; interventions for trauma treatment; as well as how to better use the first health check-up that is offered to all newly arrived refugees as a mental health screening opportunity. The project is based on peer education with the idea of 'training trainers', leading to a dissemination of knowledge to colleagues of education participants. All regions in Sweden have participated in the project and to date, 20 000 employees have been trained [75-77].

Also under the auspices of Mission Mental Health is the project Mobilising for Mental Health, which includes various sectors and focuses on intersectoral cooperation. It has previously been noted that scholars such as Im and colleagues as well as Ekblad and colleagues argue that intersectoral cooperation is essential for the success of refugee mental health promotion. Similarly, Mobilising for Mental Health was launched with an awareness that mental health should be promoted broadly and by different societal sectors. The project aims to create conditions for a broad and long-term development in the field of mental health, and includes but is not exclusive to work with newly arrived migrants. It is a collective arena that aims to contribute to mainly four processes: 1) to *connect* various actors, preferably from different sectors, and complement already existing networks, 2) to *encourage engagement* amongst those who already work with mental health, as well as those who do not, 3) to *provide meeting points*, for instance with education or workshops based on specific themes or target groups, and 4) to *support cooperation*, for instance through matchmaking between various actors and with dissemination of method material and working tools [79].

The Ministry of Health and Social Affairs has also given mandate to civil society as regards refugees and the promotion of mental health. The Swedish Red Cross for instance, has received funds for the development of their health promoting activities for newly arrived migrants and asylum seekers [80]. The Swedish Red Cross has a long experience of both treatment and activities for social support. The organisation has six treatment centres in Sweden, in which people who are suffering from

trauma linked to war, torture or migration can receive help. They also offer services such as searching for lost family members and support in connection to family reunification, as well as sessions for Swedish language training [81].

Partnership Skåne's initiative for psychosocial health

As evident by the aforementioned examples, mental health initiatives that have been supported by the Swedish government can be implemented on a strategic or operational level, include one or several societal sectors, and can focus on prevention as well as treatment. The remainder of this paper will focus on a coming initiative for psychosocial health which is also financed by The Ministry of Health and Social Affairs [78]. Its focus is preventive and although administered by the County Administrative Board of Skåne, it requires the participation and cooperation of various societal sectors.

Background: Partnership Skåne and Civic and Health Communication

In Partnership Skåne (PS), organisations that are responsible for the reception of newly arrived migrants in Skåne, the southernmost region of Sweden, come together to jointly develop methods for addressing prioritised needs where regional cooperation and coordination of resources is necessary. PS's work is administered by the County Administrative Board of Skåne and includes partners from all over the country connected to the public sector, academia and civil society. One of PS's main activities is the Civic and Health Communication (CHC). It is an introduction to Swedish society for newly arrived migrants, facilitated by Civic and Health Communicators (henceforth referred to as communicators) and provided in several Swedish counties. In Skåne, the Welcome to Skåne pilot project implemented in 2017-2019 also provided CHC participants with the opportunity to visit societal arenas for a deeper, more practical understanding of Swedish society. Researchers from Swedish universities within the PS network continuously evaluate the projects included in PS's work. Westerling and colleagues, Wångdahl and colleagues and Daryani and colleagues have, for instance, indicated that rates of self-estimated mental health, health literacy and social participation have increased after completion of the CHC [82,83] and the Welcome to Skåne [30] programme.

MILSA educational platform is an education programme designed especially for the CHC, where communicators are trained in pedagogy and how to create dialogue about Swedish society connected to topics such as health and health literacy, mental health, sexual and reproductive health and rights, parenting, democracy, and more. The communicators speak the same language as the CHC participants, and have personal experience of migration and of being a newcomer in Sweden. The communicators are established in Swedish society and thus able to act both as a member of the migrants' community, as well as a representative of and link to Sweden. It has been reported that the communicators enjoy a great deal of trust and appreciation from the CHC participants [74]. In line with Weine's arguments, the communicators are thus involved as refugee community members, counteracting acceptability issues, stigma and distrust [47]. One can also claim that the communicators represent what Hyman and Guruge refer to as link or lay elders, trained personnel from the ethnocultural group, which contributes to the cultural tailoring of an initiative [61].

*An in-depth programme for psychosocial health and well-being*

PS has been conducting method development connected to refugees' mental health and well-being since 2015. One such initiative involves in-depth programmes for parental support and for psychosocial health and well-being, which will be offered to participants of the CHC on a voluntary

basis. The focus of this report will remain on a pilot project for the initiative for psychosocial health, which stems from a previously developed method in PS's work called Prevention Model for Psychosocial Health (PREMO). The logic of the method was the matching of appropriate interventions in relation to the needs of a newly arrived refugee. These interventions ranged from being matched with civil society activities that promote social participation; partaking in support groups in which migrants could talk about psychosocial health; receiving PTSD treatment from the Red Cross's section for refugee health; and developing one's knowledge on migration and mental health. As such, the PREMO method catered to both the target group of the inner and outer circles of the theoretical map, pairing prevention and treatment.

PS's new in-depth programme for psychosocial health is developed with a logic similar to the PREMO method, with central focus placed on the part of PREMO that included a support group for conversations about mental health. It has been noted that from a socioecological perspective, several scholars have argued that in terms of refugee well-being, personal resources matter but do not exclude the importance of an individual's surrounding environment. This environment must create conditions that supports the ability to adaptively respond to previous experiences of threats, violence and separation [40,45,46]. In keeping with such findings, PS's support group is planned as a part of a larger structure, which in turn is comprised by combined efforts for a strengthening environment. Model 4 builds on the experiences from PREMO and illustrates an example of the in-depth programme and its surrounding structure in Malmö: the CHC represents the foundational civic orientation (as seen in the bottom part of Model 4), which is complemented by the in-depth programme which includes the support group for mental health and well-being (seen in the middle part of Model 4), as well as local civil society resources (seen in the top part of Model 4). Cascading of this model to other parts of Sweden is possible, where the programme may be implemented with other local resources, creating different structures for a strengthening environment.

As seen in Model 4, the strengthening environment of the in-depth programme in Malmö is constituted by NAD, My Path and Rådrum. *Network, Activity, Participation (NAD)* is a method designed to match newly arrived migrants with local civil society organisations based on their interests. Participation in such activities provides opportunities for social interaction, to practice Swedish and to improve health and recuperate. NAD is operated by the Network for civil society organisations in Skåne. *RådRum* is an open house-style counselling service available in several cities in Skåne. It is operated by IM Swedish Development Partner (IM) and it offers counselling for migrants who need support to navigate Swedish society. Through sessions with a volunteer advisor, migrants can receive help in finding solutions to different daily life problems. It may be to get in touch with the correct authority, the right person or with filling in forms. RådRum aims at enhancing an individual's ability to exercise personal rights, facilitating social inclusion and increasing opportunities to access labour markets and to participate in civil society. *My path* is a method for individually tailored support that is operated by Save the Children. In My Path, individuals have access to a supportive environment for guidance and advice concerning their well-being or more practical everyday issues. Through recurring individual conversations or group discussions, the participants of My Path work together with Save the Children employees, creating goals and individual plans. The method is based on self-empowerment and Save the Children employees work to strengthen a person's own ability to find solutions.

These resources provide the supporting environment of the in-depth programme with different possibilities. NAD creates pathways to civil society, Rådrum provides accessible, impromptu and practical support, and My Path offers individually tailored and more private support during an extended period. With the mutual goals of increasing social participation, making social networks available and strengthening existing personal resources, these local resources complement each other by working towards similar goals with different means. As stated previously, research points to the importance of social participation and social networks for the well-being of refugees [15,58,68,69,73], and scholars have argued for interventions that strengthen personal resources [24,37,47,48].
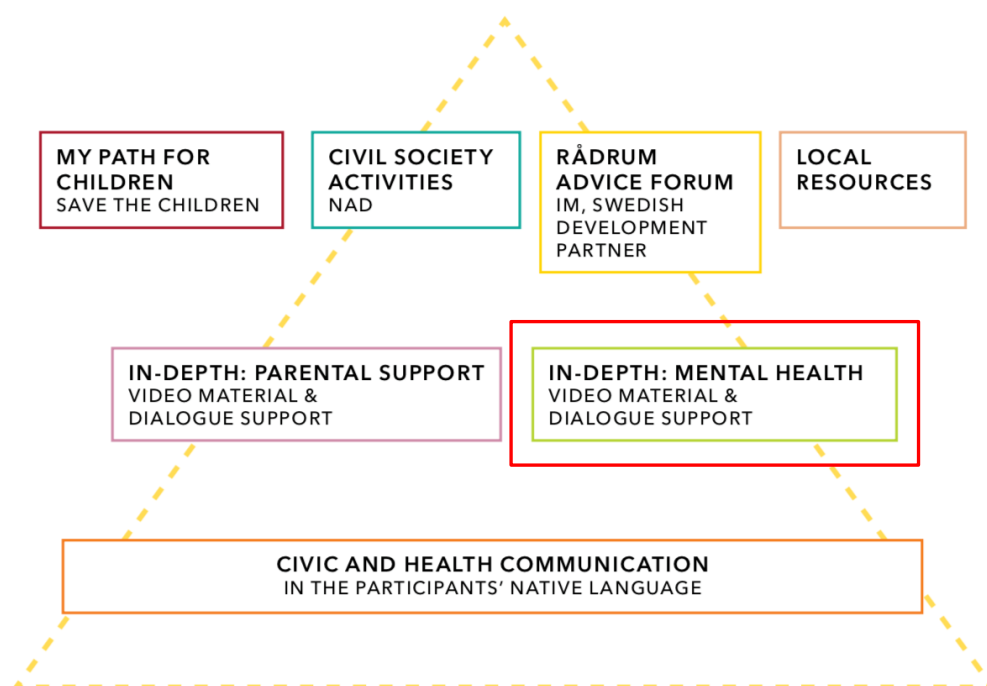
Model 4: Efforts for a strengthening environment [84]

The in-depth programme will depart from the support group (highlighted in Model 4) that serves as an informal conversation forum facilitated by two communicators. Three short films featuring experiences of newly arrived migrants as well as perspectives from experts are used in order to prompt and facilitate group conversations. The films address issues such as identity change or loss; loneliness; coping with grief and worries for those left behind; facing new norms and values; stress connected to the migration process; and coping with refugee specific traumas. The short films aim to enable conversations in which the participants themselves decide how personal they want to be and how much they want to share. Indeed, the characters presented in the films may serve as proxies for general conversation about themes commonly experienced by refugees. The voluntary participation and the flexibility of the conversations promote the co-creation of the conversation forums by the communicators and the participants. This signifies the previously mentioned changed role of the resettled refugee from an object to a subject. The informal conversation forums can also be seen in the light of arguments presented in the summarised research results that highlight positive aspects of group initiatives such as a sense of community, trust and social support [42,48,71]. This becomes especially important as additional research results point to a disproportionate lack of trust [23,69] and feeling of loneliness [13,35,58,69] within the target population of this initiative.
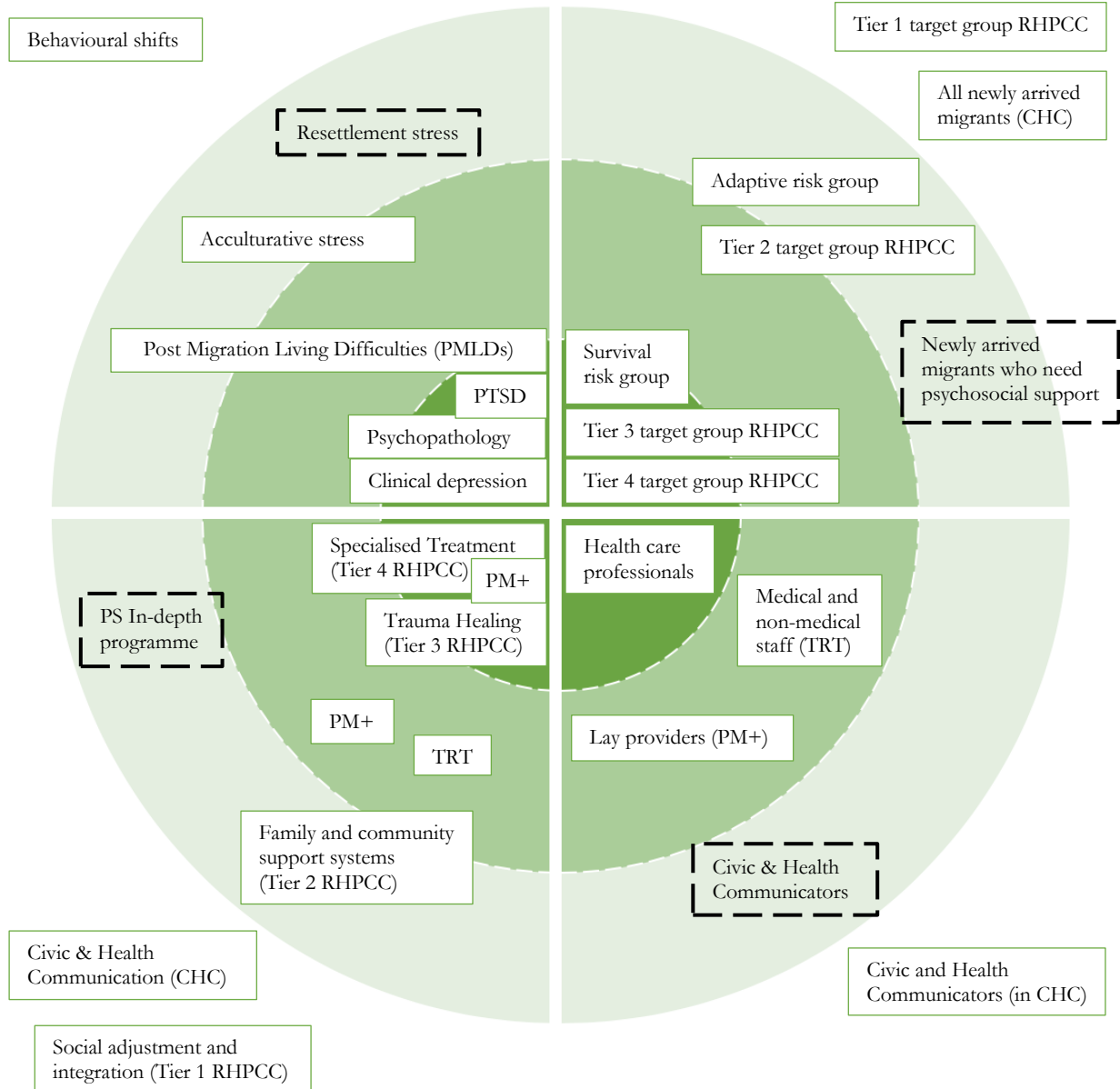
The short films are complemented by tools for dialogue and reflection support, which are made available to the communicators in an in-depth education focusing especially on the communicator's ability to facilitate discussions on sensitive topics related to mental health. MILSA education programme graduates can participate in the in-depth education, which teaches them methods for leading the in-depth programme's support group and its discussions about mental health, well-being and stress management. The education also teaches a trauma-informed approach through Tranforming Care sessions organised by Save the Children. Hence, in accordance with Model 3, this is an example of the mainstreaming of a trauma-informed approach into sectors that are more commonly culture-informed. Indeed, with knowledge and experience from the MILSA education programme, the CHC, and their own migration background, the communicators have unique culture-informed skills. It is possible but cannot be assumed that they also have trauma-informed skills. In line with Im and colleagues' arguments, such skills should therefore be strengthened to counteract retraumatising environments for the in-depth programme participants [6].

The in-depth education also aims to strengthen the communicators' ability to understand and manage their own reactions to participants' expression of emotions; create an understanding of different cultural views on mental health; and create knowledge on how to promote coping, reconciliation, and acceptance. It is possible here to note two important aspects of the education that connects to the presented research. One, developing one's knowledge on different cultural views on mental health corresponds to the noted importance in research of varying cultural perceptions and that such variations should be considered in health care and mental health interventions [6,33,42,47,61,63]. Two, the promotion of coping, reconciliation and acceptance also connects to the strengthening of personal resources, the importance of which is argued for by Ryan and colleagues [37] and Weine [47].

The edited version of Model 2 illustrates the positioning of the in-depth programme on the theoretical map. It is appropriately positioned in the outer circle, being a preventive approach provided by trained refugee community members in their profession as Civic and Health Communicators. It caters to those who experience more distress than Berry's unproblematic behavioural shifts [38], but who's experience can still be placed within the realms of what is a normal response to the major life changes that refugees experience. They could for instance be included in Berry's group that experience acculturative stress [38], or in Silove's adaptive risk group [41]. It is noteworthy however that by assuming a macro perspective and taking into consideration the whole structure surrounding the in-depth programme (see Model 4), it is much like Im and colleagues' multitier RHPCC model and the PREMO method, more of an overarching system of coordinated interventions that span across and outside the theoretical map. For instance, the supporting environment of the in-depth programme should include cooperation with health care and medical support, appropriately placed in the inner circle of medical approaches. Additionally, the foundational CHC is placed outside the circles of the theoretical map, as it caters to the target group of all newly arrived migrants with a residence permit and aims to develop knowledge about Swedish society rather than to offer psychosocial support.

Experiences   **Target group**

Behavioural shifts

Tier 1 target group RHPCC

All newly arrived
migrants (CHC)

Resettlement stress

Adaptive risk group

Acculturative stress

Tier 2 target group RHPCC

Post Migration Living Difficulties (PMLDs)

Survival
risk group

Newly arrived
migrants who need
psychosocial support

PTSD

Psychopathology

Tier 3 target group RHPCC

Clinical depression

Tier 4 target group RHPCC

Specialised Treatment
(Tier 4 RHPCC)

Health care
professionals

PM+

Medical and
non-medical
staff (TRT)

PS In-depth
programme

Trauma Healing
(Tier 3 RHPCC)

PM+

Lay providers (PM+)

TRT

Family and community
support systems
(Tier 2 RHPCC)

Civic & Health
Communicators

Civic & Health
Communication (CHC)

Civic and Health
Communicators (in CHC)

Social adjustment and
integration (Tier 1 RHPCC)

Intervention   **Service provider**

Model 2.2: A theoretical map of refugee mental health interventions – empirical examples applied
   The components of Partnership Skåne's in-depth programme for psychosocial health are marked by dashed squares

Part III: Summary and discussion

As research findings have been presented and the structure of Partnership Skåne's in-depth programme for psychosocial health explained, it is possible to summarise the connections between the two, and note that the programme could provide newly arrived refugees with several possibilities for mental health promotion. As the programme is in its pilot phase and yet to be implemented and evaluated, some lessons are also to be learned and some possible challenges to take into consideration should be noted. The following section will therefore 1) reiterate the previous list of summarised research results, 2) briefly repeat and concretise how the in-depth programme corresponds to these findings, and 3) present possible limitations and challenges of the in-depth programme.

Potential and possibilities

As stated, the research presented in this paper has presented arguments in favour of certain characteristics of mental health promotion for resettled refugees. They are reiterated below, followed by a brief summary of the discussion so far.

- *Preventive* psychosocial mental health promotion is important to complement medical approaches and to better respond to resettlement stress that does not warrant the latter.
- *Intersectoral cooperation* is a prerequisite for the success of any mental health promoting initiative that caters to vulnerable groups.
- Preventive mental health promotion should build *resilience* and strengthen *personal resources*.
- Mental health promotion should enhance *mental health literacy*.
- Mental health initiatives should be *culturally tailored* and *anchored*, without language barriers and with considerations of cultural conceptions and practices.
- Psychosocial mental health initiatives should be *trauma-informed* to avoid retraumatising environments.
- Mental health initiatives should reduce or circumvent *social stigma* and *distrust*.
- Mental health initiatives should promote *social support* and *access to social networks*.
- Structures for *continued support* beyond the specific intervention should be established.

<u>The in-depth programme is a preventive initiative that aims to promote resource building</u>

The in-depth programme is an example of an important psychosocial complement to medical mental health interventions. The programme is not therapeutic but, as stated, focuses on strengthening the personal resources of the participants – which has been argued for in the outlined research. The in-depth programme presents an opportunity to accommodate the larger group of refugees referred to in research as in need of psychosocial support but not medical or psychological treatment. It aims to provide social support and opportunities that will make this group capable of self-directed recovery as proposed by research.

<u>The in-depth programme is likely to contribute to enhanced mental health literacy</u>

Health literacy is part of the Civic and Health Communicators' education for the Civic and Health Communication (CHC), which creates competency that the communicators can bring with them to the in-depth programme and apply to issues of mental health. As the in-depth programme creates dialogue about and present experts' perspectives on themes such as resettlement stress,

mental ill-health and coping, it is likely that the conversations there will create better knowledge of risk factors, self-treatment and professional help available and strengthen programme participants' ability to recognise symptoms and seek mental health information. Additionally, increased mental health literacy expressed specifically as attitudes that promote recognition and help-seeking may be another way to reduce the social stigma that is sometimes attached to mental ill-health.

Conditions that enable cultural tailoring and anchoring are in place

As stressed previously, the support group of the in-depth programme makes use of a valuable resource, namely the Civic and Health Communicators. Knowing the participants from the Civic and Health Communication (CHC), sharing their language and having their own previous experience as newcomers in Sweden, they have a valuable and unique knowledge of the target group as well as a shared frame of reference. The communicators have a dual role as partly representatives of the participants' community and partly ambassadors of Swedish society. As such, they may act as the 'link elders' proposed in research, anchoring the programme and creating acceptability in the community. Cultural tailoring is facilitated by a learning process through the continuous communication between CHC participants, the communicators and researchers in Partnership Skåne. This enables opportunities to tap into the understandings, expectations and needs of the target group for better adaptation of interventions.

Measures have been taken for the prevention of retraumatising environments

Research has pointed to the dangers of an overconfidence in cultural competency and the importance of strengthening a trauma-informed approach amongst providers of psychosocial initiatives. In keeping with such findings, the communicators will complete an in-depth education in which a trauma-informed approach is a part. Another theme of the communicators' in-depth education is how to identify participants' needs for support and how to safely refer participants to the appropriate supporting resource. For instance, if participants have mental health care needs beyond the competence of the communicators, there should be possibilities for guidance towards professional health care. Another aspect that is in place to prevent retraumatising environments is that as a preventive mental health intervention, the in-depth programme encourages the participant to act as a subject with whom the decision-making power lies in terms of both participation and as co-creators of the group conversations. Put simply, in-depth programme participants have the power to choose if they want to participate as well as how and if they want to talk about their resettlements stress.

The in-depth programme can reduce or circumvent social stigma and distrust

An additional advantage of a preventive initiative outside the realms of traditional health care is the possibility to recruit participants by avoiding stigma-inducing concepts such as 'treatment', 'therapy' or 'mental ill-health'. The focus in this approach is on opportunities and the strengthening of personal resources, as advocated for in the exemplified research. Indeed, the acceptability of a preventive intervention can be enhanced by a resilience approach because there is an explicit assumption that participants have resilient properties such as strengths and personal resources. The support group also offers a forum in which to engage in discussions on mental health in one's own language, with a trusted facilitator in a safe context. The Civic and Health Communicators enjoy a high level of trust from the participants of the Civic and Health Communication, as opposed to interpreters and parts of health care to which research has noted low trust.

The in-depth programme can harvest the advantages of group approaches noted by research, namely normalisation of problems, a decreased sense of loneliness and the feeling of community, trust and social support. Additionally, the in-depth programme places the individual in a supporting structure. The programme is planned to establish a continued supporting environment for the participant, which is in line with research results pointing to the importance of maintaining the feeling of support and development post intervention. The Civic and Health Communicators serve as a links between the participant and local resources such as NAD, My Path and Rådrum - activities that can provide continuous support as well as promoting social capital.

Possible limitations and challenges

As stated, the in-depth programme has potential to contribute to the promotion of refugee mental health. An awareness of the programme's possible limitations and challenges is needed to fulfil this potential, and some of them are therefore considered below.

Unprecedented intersectoral cooperation

The in-depth programme requires intersectoral cooperation as it brings together for instance county administrative boards, municipalities, public health care, civil society, and academia. Although structures for such cooperation are in place within Partnership Skåne, the in-depth programme is a new initiative calling for new collaborative pathways and links that are not yet established. Additionally, the supporting environment may vary depending on location, making general guidelines a challenge. Much responsibility as well as organisational freedom will be placed on local cooperation, which in turn requires an ability from local actors to identify their own strengths and need for support. This connects to the issue of continued support, which has been stressed by research as important for the well-being of refugees. It will be integral to carefully map the possibilities and challenges of continued support after the completion of the in-depth programme, in order to avoid the experience of abandonment for programme participants.

High requirements for communicators' skills warrant high requirements for their support system

The Civic and Health Communicators who facilitate the in-depth programme's support group are expected to fulfil several important requirements. These include, to name a few, local awareness for appropriate referral of participants; the ability to lead conversations on sensitive topics; an awareness of one's own professional role and its boundaries; the ability to support participants without moving into the area of therapy; and the ability of dealing with situations in which participants display strong emotions. Added to the importance of the task itself, i.e. helping resettled refugees towards better mental well-being, such requirements can comprise a daunting task. Consequentially, the support provided for the communicators needs to be in parity with the requirements placed upon them. Their guidance and tutoring should be well planned and able to support them as they aspire to fulfil the requirements of their task.

The importance of a trauma-informed approach

An example of the above stated requirements that is worth mentioning in length is connected to the trauma-informed approach and the ability to identify health care needs. Although the in-depth education teaches the communicators a trauma-informed approach and the programme itself is

preventive and places itself apart from medical treatment and therapy, two issues should be raised here. One, it is impossible to guarantee that mental health care needs do not emerge in this setting. Therefore, the communicators need to be equipped with tools to manage acute needs and to appropriately refer individuals to other interventions. Even if such tools are reassured by the in-depth education, a remaining challenge may be the assessment of further health care needs. In other words, there will be a responsibility placed on the communicators to identify, interpret and categorise the emotional needs of the participants. Additional challenges can also arise if health care needs are in fact identified but the programme participant is hesitant to receive professional help. Therefore, the guidance and support that is provided for the communicators must be able to help them with these difficult tasks as well. Two, another issue that will be important for the avoidance of retraumatising environments is the formation of groups. Group dynamics may be very influential as regards the group atmosphere and the participants' experience. Evaluation is thus needed for development and possible redirection, to look closer at issues such as size, division of men and women, etc.

<u>Recruiting</u>

The in-depth programme is formed to be appealing to the target group by taking into consideration issues of trust, social stigma and community representation as described by the outlined research. Nevertheless, the practical details of recruiting participants are currently being formed and some considerations can be noted. In terms of recruitment and target group, the in-depth programme is arguably faced by a challenge as it should not appeal to those who need treatment but nevertheless tap into a motivation to deal with resettlement stress. In other words, there should be *some* recognition of challenges or difficulties for those who are targeted by the initiative, but the overall message should be one of possibilities and positivity. This is a fine line to walk, which may induce conceptual unclarity as regards the initiative promotion. As argued, the in-depth programme is an example of how resettled refugees are assigned the role of subjects rather than objects. This places the decision-making power with them, which in turn makes the appeal of the programme increasingly important. The reported 'activity fatigue' amongst newly arrived immigrants becomes relevant here, as individuals who feel that they juggle an abundance of mandatory activities could be assumed as less tempted by what is perceived as an additional time-consuming activity, especially if its purpose is unclear. The focus and intention of the programme as well as the role of the communicators should therefore be expressed very clearly to facilitate participation and prevent unmet expectations from participants.

Concluding remarks

This report has discussed research on interventions for refugee mental health. It has presented research findings and a new initiative for the promotion of psychosocial health for newly arrived migrants in Sweden, arguing that this initiative could align itself with many of the intervention requirements presented by international research. With careful consideration of strengths, limitations and challenges – as well as thorough subsequent evaluation and possible redirection – Partnership Skåne's in-depth programme for psychosocial health has the potential to make a real difference in the lives of newly arrived migrants who experience resettlement stress.

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