Post Migration Factors Affecting Mental Health of Asylum Seekers and Refugees in Western Europe

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POST MIGRATION FACTORS AFFECTING MENTAL HEALTH OF ASYLUM SEEKERS AND REFUGEES IN WESTERN EUROPE

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by

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List of abbreviations

AI	artificial intelligence
CEAS	Common European Asylum System
EU	European union
HIC	high-income countries
IOM	International Organization for Migration
IPV	intimate partner violence
GBV	gender-based violence
GP	general practitioner's
LMIC	low- and middle-income countries
LGBTQI+	lesbian, gay, bisexual, transgender, queer and intersex
MHPSS	mental health and psychosocial support
m-Integration	mobile integration
NGOs	nongovernmental organizations
QOL	Quality of Life
PM+	program management plus
PTSD	post-traumatic stress disorder
RCT	randomized control trails
SWL	satisfaction with life
SH+	self-help plus
SDGs	sustainable development goals
UMR	unaccompanied minor refugees
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Glossary of terms

Anxiety disorders: feeling of unease, such as worry or fear that can be mild or severe. Fear is often associated with automatic arousal necessary for fight or flight by immediate danger, but anxiety is usually associated with muscle tension and vigilance in preparation for avoidant behavior or future danger. It is the main symptom of several mental conditions such as posttraumatic stress disorder, panic disorder and phobia(1,2).

Asylum Seeker: An individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker (3).

Depressive disorders: Persistent sadness, emptiness or irritable mood and a lack of interest or pleasure in previously satisfying or enjoyable activities. The disorders are differ by the duration, timing or the etiology (2,4).

Mental Health: A state of mental well-being that enables individuals to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community(5).

Mental Health and Psychosocial support: Any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders(6).

Migrant: A person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons(7).

Post-traumatic stress disorder (PTSD): An intense physical and emotional response to thoughts and reminders of the event that last for at least a month after the traumatic event. The symptoms of PTSD fall into three broad types: re-living, avoidance and increased arousal(2,8).

Refugees: People outside their country of origin because of feared persecution, conflict, violence, or other circumstances that have seriously disturbed public order, and who, as a result, require 'international protection'(3).

Undocumented migrant: There are several definitions for undocumented migrants in different countries and regions. According to the International Organization for Migration, a non-national person who enters or stays in a country without the appropriate documentation. Undocumented migrants can have documentations that proofs their identity but they do not have the documents for the right to enter or stay in the country, or such documents are fraudulent. Or they do not hold any identity documents or any documents that proof their right to enter or stay in the country(3,7).

Uncompanioned minor refugees: Children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so(3).

Abstract

Background: Refugees are usually exposed to several stressful factors before, during, and after migration and this can lead to mental disorders such as PTSD, depression and anxiety. Several research studies point to the high impact of post migration factors on mental health problems among refugees. Therefore, there is a need to analyze the post migration factors affecting the mental health of refugees and asylum seekers in Western Europe more in depth. As such, the findings can be used by policy makers and mental health practitioners in Western Europe settings to improve specific interventions for refugees and asylum seekers geared toward supporting their mental health.

Methodology: This study employed a literature review approach. The researcher explored the post migration factors affecting mental health of refugees and asylum seekers in Western Europe and analyzed the findings according to Bronfenbrenner's socioecological model.

Results: The researcher explored the post migration factors affecting mental health of refugees in Europe, and linked it with all levels of the model. These factors are often linked to negative life events, gender norms and poor community integration with poor accessibility to mental health activities. Poor community integration in turn influences the refugees' living conditions and language skills, mental health service utilization, employment, education, and socioeconomic level. Poor integration and the prevalent gender norms increase violence and discrimination. Also, individual and relationship factors such as being a minor, absence of a partner, family separation and poor social networking are linked to poor mental health problems. Moreover, complicated and lengthy asylum policies are major factors negatively influencing mental wellbeing among refugees and asylum seekers.

On the other hand, practices such as self-help plus and program management plus, m-Integration, peer-monitoring and social activities like sports club showed positive impact in facilitating refugees' community integration and providing them with mental health support.

Conclusion and recommendation: There is a need for a reconsideration of asylum polices especially for the vulnerable groups like children, women, and IPV victims. Furthermore, multisectoral research and programs in community integration and gender norms is needed. This will lead to the improvement of the refugees' and asylum seekers' mental health.

Keywords: mental health, refugees, asylum seekers, post migration factors, western Europe.

Word count: 13,207

Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), almost 84 million persons were forcibly displaced in 2021 and 31 million were refugees or asylum seekers from low and middle income countries (LMIC)(9). Due to the "healthy migrant effect" that suggests that in comparison to the migrants' home communities, migrants in general are usually healthier, more risk takers and more prepared for stressful factors (10). Thus, high-income countries (HIC) benefit from refugees and migrants in general who participate in the economic cycle, social services and easily integrate into the new communities (11,12). However, refugees and migrants face several stressful factors after arriving to these HIC. So, how do these factors affect their psychosocial health and life in general?

As a humanitarian worker with the International Organization for Migration (IOM) in Yemen, I have interacted with many refugees, migrants, and displaced people suffering from many mental health problems. Unfortunately, I have noticed these mental health problems also exist in Europe; thus, from a public health interest, I would like to understand the reasons behind these problems.

This literature review intends to identify the post migration factors affecting the mental health of refugees and asylum seekers in Western Europe. The results will provide recommendations for policymakers and practitioners to formulate strategies to reduce the psychological suffering within the refugees' settlement context. It will also support asylum workers and policy makers to reduce the negative effects of the stressful factors in post migration contexts in Western Europe.

Chapter 1: Background

Chapter one provides an introductory background information of the study. It consists of the demography of the study area, the current migration policy and situation, the targeted population, the mental health issues and the available services for refugees.

1.1 Demography

The European Union (EU) is a political and economic union of 27 countries that are located in Europe. EU countries are considered as HICs with high living standards. As the gross domestic product in the highest country is 262 euro for Luxembourg and the lowest is 52 euro for Bulgaria(13). It has over four million km^2 land and 447.7 million population in 2022. The largest countries in terms of population size are Germany (83 million), France (67 million) and Italy (58 million) with almost 20% of the population of over 65 years old and 0.6% of the population who are refugees. The most frequent origin of these refugees are from Syria, Afghanistan, Iraq, Pakistan and Turkey(13,14).

According to the United Nations Statistics Divisions, Western Europe countries are Austria, Belgium, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Norway, The Netherlands, Portugal, Spain, Sweden, Switzerland, and the United Kingdom(15,16).

1.2 EU refugees' policy

EU countries are globally known as a tolerant community following the refugees' convention to provide protection under The Common European Asylum System (CEAS) to forced migrants who escape war and persecution. The 1951 Refugees Convention and 1967 protocol states that refugee is " a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him— or herself of the protection of that country, or to return there, for fear of persecution.". This convention contains some rights including the right not to be expelled except under strict conditions, the right not to be punished for illegal entry, and the right to work, to get an education, and to be eligible for housing. It also includes having access to public assistance and legal court and to have freedom of movement within territory and freedom of religion and the right to be issued an identification document. Moreover, the 1967 protocol removes the time and geographical limits that were present in 1951 convention(17–20).

The CEAS consists of four principles which are: (1) the reception condition directive which ensures that all EU members cover the basic life needs of the

refugees. (2) The asylum procedure directive which sets the right for asylum applicants to complete the entire process of application and interviews for fair, quick and quality asylum decision. (3) The qualification directive which is to assess the asylum status to get the protection for refugees to reduce the disparities of acceptance among EU members (21,22). However, reports show differences in asylum acceptance from one country to another. For example, over 50% of Iraqi asylum seekers got accepted in Germany but only 0% got accepted in Greece, which proves that asylum seekers do not have the same chance of recognition in all EU countries(23). (4) The Dublin regulation, which enhances the protection of asylum seekers during all the asylum processes and creates a system to detect early problems in the reception system before they develop into a crisis. This system allows authorities access to the registered asylum seekers' fingerprints for ten years to determine the responsible country for the asylum seeker's profile (21,22).

Nevertheless, the Dublin regulation created challenges related to the system of fingerprints storage. As the asylum seeker will be accepted in the first EU country of his/her entry and will be refused in any other EU country. Thus, the Dublin claim raises several fairness and justice issues among asylum applicants(22,24).

EU established the CEAS to follow common criteria and mechanism for asylum applications. This criteria include three principles: "family unity of the asylum, the issuance of visa or residency, and the illegal/legal entry in the first country"(21). In addition, the CEAS defines those fitting for the refugees' criteria as a person who cannot return to his/her country of origin due to a well-founded fear of persecution based on: race (or ethnicity), religion, nationality, political opinion, or being part of specific social group(19). After the acceptance of an asylum seeker’s application, EU hosted countries should follow the integration migration policies(17,25,26).

1.3 EU and the migration crisis

Europe has struggled from the "migrant crisis" in 2015 as more than one million persons arrived mainly from Syria, Iraq and other LMICs seeking for asylum(27). Thus, many western countries have tightened the acceptance of asylum claims especially if the applicants are not from war or political violent countries(28,29). The European council decided to support the frontline countries such as Italy, Spain and Greece by transferring the asylum to other EU countries such as Sweden and Germany. This decision was taken to spread the influx of refugees more equally over Europe(30). In 2016, EU agreed with Turkey to return any asylum seekers who arrived in the Greek islands(31) and a similar agreement was done with Libya to block migrants from Africa(32).

Later on, the transferring of asylum seekers became one of the laws and the host country could force the asylum seekers to leave the country and this was considered as a law that was against asylum rights(32–34). After that, the law

was modified to allocate the asylum applicants according to the number of applicants on the entry country to other EU countries with low percentage of applicants(35). However, most of the refugees are in Western European countries while Eastern European countries prefer to follow the pushback measures(14,36–38).

Covid-19 pandemic has had an impact on decreasing the flow of migrants to Europe (39). However, after the pandemic, the numbers started to increase even more than before. In 2021, Western Europe received 630,600 asylum seeking applications which is the largest number since 2017(40,41). Also, Europe responded to the Ukrainian crisis by accepting more than four million and a half Ukrainian refugees who arrived in western European countries, and got access to services without any need for asylum procedures or official papers(42,43).

A point to be noted is also that the "migration crisis" has driven Western Europe to come up with quick responses which also puts asylum seekers and refugees at risk to poor mental health status.

1.4 Mental Health Definition

The World Health Organization (WHO) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"(5). Mental health is one of the three components of the health, next to physical and social well-being, according to the health definition from WHO (44).

Mental health well-being is more than the absence of mental issues; it includes the acceptance of abilities, dealing with life pressures and living a productive life(45). Positive mental health includes resilience (coping with hardship), salutogenesis (like optimism) and quality of life which according to the WHO is " an individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives and in relation to the goals, expectations, standards and concerns''(46,47)

In addition to the individual traits such as thoughts, feelings and behavior, there is also evidence that the contextual factors influence mental health such as the exposure to hardship times such as fear or sadness and have a major influence on mental health as well. (48). Due to the exposure to persistent fear and sadness, refugees are a vulnerable group to three mental disorders which are post-traumatic stress disorder (PTSD), depression, and anxiety(49–51).

1.5 Refugees and Mental Health

Due to the global demographic change, there is almost 13% increase in the reported mental health conditions in the last 15 years, as the cases reached to

792 million persons in 2017 which is equivalent to more than 10% of the global population (3,4). This causes almost 1 in 5 years lived with disability (3). Almost all people who were exposed to emergency situations such as war and political violence experienced psychological distress and 22% of this distress progresses to mental disorders (5). Mental health deteriorates if the person has to forcefully flee their home in search of safety (6).
Refugees and asylum seekers are usually exposed to several stressful factors before, during and after their migration journey. This can lead to mental disorders such as depression, anxiety, and PTSD(52). According to a study that was done among Iraqi refugees in Western Europe, it was found that almost 43% of Iraqi adult refuges experienced depression and 25% suffered from PTSD(53). A meta-analysis study of the prevalence of the common mental health disorders among Syrian adult refugees in high income western countries found that 40% suffered from anxiety, 30% suffered from depression and 30% suffered from PTSD(54).

Not surprisingly, refugees and asylum seekers usually experience pre-migration difficulties that may affect their mental health. Such difficulties are war, imprisonment, torture, genocide, starvation, physical and sexual violence, witnessing violence, homelessness and lack of healthcare(55). The harsh journey, separation from family members, crossing points and smugglers' interception can also be added to the stressful factors during the migration journey(52,56). Several research correlate the significant impact of post migration problems with mental health problems of the refugees. Such problems are discrimination, detention, denial of health, education and the work rights' and delaying or rejection of asylum request(55,57).

Resettlement into a safe country does not necessarily correlate with the improvement of the mental health status of the refugees(58). A systematic review of refugees in HICs concluded that the presence of pre, during and post migration risk factors increase mental health disorders (59). Another study generalized the influence of the pre and post migration factors on PTSD, depression, and anxiety but specified depression as post migration outcome in the host country(60). A cohort study among Syrian refugees in Germany concluded that the psychological distress remains high even after long residency time in the host country which confirm the importance of mental health services for refugees(61).

1.6 Mental Health Services

Due to the significant needs for mental health services for the refugees and asylum seekers, the provision and use of Mental Health and Psychosocial support (MHPSS) is recommended by the WHO. Such services are child friendly spaces, community services or even specialist psychological counseling such as cognitive behavior therapy or the prescription of psychotropic drugs(57).

Theoretically, all asylum seekers and refugees in Western European countries have access to healthcare which is covered by public or private health insurance.

Health insurance is compulsory for all refugees, and the health service should be started by the general practitioner's (GP) visit to access the health standard package. The standard package includes mental healthcare such as individual psychological consultation(62,63,72,64–71). Often, asylum seekers will receive vouchers and will be exempt from paying a small prescription fee for medical drugs while refugees will receive insurance cards and can apply for remission if their income is below certain threshold(57,62). However, the socioeconomic variations in different EU countries, different healthcare system and different numbers of refugees in each country make the provision of the service across all the EU countries challenging(73).

Chapter 2: Problem Statement, Justification, Objectives and Methodology

This chapter consists of the problem statement, justification, study objectives, study methodology, and the selected conceptual framework.

2.1 Problem statement

According to the WHO Migration and Health Program, the prevalence of mental disorders among refugees usually shows high variation compared to the host population(51). It has been found that depression ranges from 5-44% among refugees in comparison to 8-15% in the host populations, and anxiety ranges between 4-44% among refugees and 5% in the host population. These huge ranges for mental health disorders are influenced by several factors such as the presence and etiology of the disorders, ways of measuring, the study type, and the study population(51). Not surprisingly, several studies concluded that PTSD is always substantial and has higher rates among the refugees compared to the general population. These ranges reach to 4.4% in the host population and 86% in the refugees(12,51,55).

Several papers concluded that refugees are more resilient compared to the host community and tend to use different coping strategies to react to the pre, during and post migration stressors. However, these coping strategies are influenced by other individual factors such as age and marital status as well as other external factors such as gender, living conditions and social connections(12,55). A qualitative study in The Netherlands related to adolescent refugees who were all diagnosed with PTSD showed poor social networking is one of the factors that are linked to poor mental health in The Netherlands(74). The same results were concluded in a study in Germany done on refugees from Afghanistan and Syria(75).

Nevertheless, the consequences of these mental health disorders increase over time after resettlement and lead to other problems such as inability to find job, or not feeling accepted by the host community(52). A pilot study among asylum seekers in The Netherlands concluded that refugees' mental health problems are more related to post-migration stressors compared to the past traumatic adversity(76). Therefore, there is a need to know and analyze the post migration factors affecting the mental health of the refugees and asylum seekers to improve their psychosocial conditions within their settlement contexts as well as to find best practices and projects that can help health and refugee professionals in MHPSS to reduce the adverse effects of stressful factors among the refugees and asylum seekers in the post migration context.

2.2 Justification

In order to reach to sustainable development goals (SDGs) by 2030, supporting refugees with their mental health will not only be contribute to SDG3 which is to "ensure healthy lives and promote well-being for all at all ages". but also mental health will have a direct effect on the other SDGs such as end poverty (SDG1), ensure quality education (SDG4) and promote descent work (SDG8)(77). It is important that refugees' voices should be well presented in the world, while keeping in mind the post-migration risks they face. Forced migration is usually a complex process that frequently has a negative impact on the asylum seekers and refugees' mental health. As the right for mental health is a human right for all, all refugees should live a mentally healthy life(78).

Furthermore, research recognizes the significant impact of pre and during migration problems on mental health of refugees and asylum seekers,(79) but little is known about the association between post migration problem and mental health. Such problems include discrimination, detention, and delay or rejection of asylum request(55,57).

Although there have been studies on the post migration factors in different countries, there is often no specific and updated literature review paper that specifically studies all these post migration factors and their consequences on refugees and asylum seekers’ mental health in Western Europe.

In addition to that, there are papers that recommend the need for research that address the influential factors for the improvement of refugees and asylum seekers' mental health services in Western Europe(53,58). One systematic study which needs further research was done among first generation migrants (including refugees) and searched the risk factors and prevalence of mental disorders address the lack of papers for the post migration factors affecting mental health. Another policy review concerning Syrian refugees in several countries in Europe, including Germany and Sweden concluded that to better understand the mental health of the refugees, there is a need to address their mental health factors at each phase of migration(53,58). However, there is no research done on which post migration factors are associated with mental health problems among refugees in Western Europe.

Thus, this thesis explores the post-migration factors that influence refugees and asylum seekers’ mental health in Western Europe. It aims to provide policy makers and relevant stakeholders who are interested in the refugees' field and the public health services in Western Europe to improve the refugees' mental health and wellbeing.

2.3 Objectives

2.3.1 General objective

To describe the post migration factors influencing the mental health of refugees and asylum seekers in Western Europe in order to improve their mental health and wellbeing.

2.3.2 Specific objectives

- To identify the individual, family, and community post-migration factors that influence mental health among different groups of refugees and asylum seekers in Western Europe.
- To examine what lessons and good practices exist for improving the mental health of the refugees and asylum seekers in Western Europe.
- To provide policy makers and relevant stakeholders who are interested in the refugees and asylum seekers' field services with recommendations to improve refugees' and asylum seekers' mental health in Western Europe.

2.4 Methodology

A literature review was conducted by reviewing papers published in peer reviewed journals retrieved from databases like Elsevier, Medline, Springer, Embase and PubMed. Then, google and google scholar search engines were used to sort out peer-reviewed and grey literature, after which snowballing was done to identify articles related to refugees, asylum seekers, mental health, and post migration factors.

Relevant articles that use quantitative, qualitative or mixed research methods were used to identify the post migration factors affecting mental health of refugees and asylum seekers in Western Europe. In addition, grey literature was reviewed from WHO, UNHCR, IOM, World Bank, WHO, and the Agencies for the Reception of Asylum Seekers and Refugees in EU.

2.4.1 Inclusion and exclusion criteria

Articles published in English within the last ten years were included; however, some important policy documents that go back to more than ten years have been included as well. The included papers are related to post migration factors that affect mental health of refugees and asylum seekers in the EU Western European countries. For the purpose of this research, the researcher excluded only migrants or undocumented migrants as the definition of these two groups are different within the EU countries (see glossary) (7,21,80).

Papers that focus on Eastern and South – Eastern Europe and any countries that are not under the EU countries were excluded. Thus, the excluded Western European countries are Iceland, Italy, Liechtenstein, Luxembourg, Monaco, Switzerland, and the United Kingdom. As these excluded countries have different social context and different asylum rules and policies. Articles with access to only their abstracts have been excluded as well.

2.4.2 Search strategy, terms and combinations

Different keywords were used to collect data for this literature review. About 300 published and grey literature and peer-reviewed articles were retrieved. However, after screening the abstracts and considering the above-mentioned inclusion and exclusion criteria, some resources were excluded. The key terms were combined using Boolean operators AND, OR, NOT, NOT AND. The search was based on the specific objectives as well as the target group, geographical area, mental health problems, and post migration context.

The first objective was searched based on peer reviewed journals and selected from PubMed, VU data bases, Elsevier, Springer and Google Scholar. The searched term was different post migration factors affecting mental health conditions of refugees and asylum seekers living in Western Europe. Information was also taken from several NGOs official websites like CEAS, UNHCR, WHO and IOM. The second and the third objectives search also covered best practices and programs for mental health improvement by expanding the articles globally in high resource settings and similar to Western Europe context. At the end, recommendations were drawn from the analysis of the evidence and the reviewed resources and articles.

The exact keywords like mental health, refugees, asylum seekers, post migration factors, Western Europe, and search strategies are displayed in the below tables (table 1 & 2).

Table 1: showing the search strategy summary

S/N	objective	Search engine/ database	Types of literature	Used keyword
1	To identify the individual, family and community post-migration factors that influence mental health among different groups of refugees and asylum seekers in Western Europe.	Google scholar, google, PubMed, Elsevier, Springer	- Peer-reviewed articles - Published articles - Journals - Grey literature - National/international reports include - European Union - International Organization for Migration (IOM) - World Bank - World Health Organization (WHO) - United Nations High Commissioner for Refugees (UNHCR)	Mental health, refugees, asylum seekers, refugees, western Europe, age, sex, marital status, negative life events, refugees policy, migration policy, migration crisis, mental health services, residency status, living conditions, camps, refugees centers, language, educational level, employment status, socioeconomic factors, family, friends, peers family separation, intimate partner violence, loneliness, social network, violence, integration, isolation, discrimination, asylum application process, Dublin claim, asylum policy.
2	To examine what lessons and good practices exist for improving the mental health of the refugees and asylum seekers in Western Europe.			Mental health programs, refugees, asylum seekers, western Europe, high-income countries, inclusion programs, integration programs mental health programs

Table 2: showing the combination of the key words and Boolean Operators

Keyword	OR	"Refugees"	"Asylum seekers"	"Post migration factors"	Western " Europe"	"mental health"	**"interventions'**
Synonyms					**AND**		
		Forced migrants	Asylum request	Individual factors	Germany	Mental wellbeing	Mental health preventions
		African refugees	Forced flee	Personal factors	Austria	Mental illness	Mental health programs
		Middle eastern refugees	Documente d asylum	Relationship factors	West Europe	Mental disorders	Mental health and psychosocial support
		Refugees crisis		Family factors	European Union	Mental distress	Professional mental health support
		Migrants crisis		Community factors	Sweden		Community mental health support
		Fled Refugees		Society factors	Finland		Mental health in emergencies
		Displaced people			France		
		Displacement in humanitarian settings			Belgium		
					Ireland		
					Denmark		
					Italy		
					Netherlands		
					Spain		
					Malta		
					Luxembourg		

2.4.3 Limitations of research

The study has some limitations related to the language of the articles used in this review because only articles written in English were reviewed. As a result, some vital information might be missing from Western European countries which were published in non-English language. In addition, the review is based on the information extracted from the available literature, and many mental health cases were not fully reported due to the mental illness stigma which could constitute a high risk of reporting bias in the findings. Also, discovering the true causality between the post migration factors and mental health is another challenge since mental health status is influenced by many pre and during migration factors and cofactors that are not covered in this paper. Another limitation is the socioeconomic variation among the various EU states, different services, different numbers of asylums applicants and different cultural contexts, which make it hard to tailor the upcoming findings for all states.

2.5 Conceptual framework

Various conceptual frameworks were developed to understand the relationship among different determinants that can contribute to mental health problems. Three conceptual frameworks were examined to analyze the post migration factors related to mental health among refugees in Western Europe: "Socio Ecological Model"(81), "The refugee mental health framework"(82), and "The mental health of civilians displaced by armed conflict:"(83).

This literature review tends to choose Bronfenbrenner's "Socio Ecological Model"(81) as in figure1. This framework can be adapted for the refugees' population to have a holistic picture of the post migration factors that have an impact on their mental health. This framework has been used by a variety of studies to understand the factors that influence refugees mental health in different contexts and conditions(84–86). An example of such a paper is a study done in Jordan on Syrian female refugees which was published in 2022(84).

"The refugee mental health framework"(82), and "The mental health of civilians displaced by armed conflict:"(83) modules were not chosen according to the study objectives. "The refugees' mental health framework"(82) was not selected as the application of this framework is specific and applicable to establish services and address the gaps for refugees in a systemic and equitable way and to develop policies and programs for refugees' mental health. "The ecological model of refugee distress"(83) provides a space to describe pre, during and post environmental migration stressors in a superficial way and naming them as " the political violence factors". Thus, it was not used as it is not focused on the post migration factors. However, it categorizes in a detailed way the outcomes of the psychosocial effects of displacements from the individuals, relationship, community and society levels and how a consequence at one level impacts the other level(83).

Figure 1: The socio-ecological conceptual framework with the post migration factors for refugees' mental health as per this literature review

Individual

- Age
- Marital status

Relationship

- Family separation
- Intimate partner violence
- Social networking

community

- Community integration
- Living condition
- Occupational status
- Educational level
- Gender
- Violence
- Discrimination
- Health-seeking behavior

Societal

- Asylum policies
- Negative life events
- Poverty

Chapter 3: Results in line with the framework

3.0 Introduction

In this chapter, Bronfenbrenner's socio-ecological model has been applied to analyze the influencing factors on refugees. It has been taken into account that the factors are inter-related and complex(81).

Different factors affect asylum seekers and refugees' mental health within Western Europe and the high-income countries in general. According to the socio-ecological model, these factors are interrelated and include individual, relationship, community and society factors. This chapter explains the following factors, in line with the model taking into account the complexity and interlinkages among the factors.

3.1 Individual factors

This level explains the following factors according to the model used: age and marital status.

3.1.1 Age

The literature review showed contradicting opinions about age in relation to mental health(87). For example, a study among Syrian refugees in Germany(88) mentioned that young refugees are more vulnerable to depression and PTSD, which is similar to the results from a study in Austria(89). On the other hand, a study among adult Yugoslavian refugees (18-65 years) in Germany and Italy correlated anxiety with the younger participants and PTSD and mood disorders such as depression with the older participants(90). Other two studies among refugees in Sweden correlated the older refugees with more mental health suffering(91,92). Nevertheless, a study among 214 adult Syrian refugees in Germany concluded that there is no correlation between age and the post migration stressors(93). Similar results were found among African refugees in Sweden(94).

Refugee minors face more hardship in pre, during and post migration compared to adult refugees. As they do not only deal with new cultural and societal changes but they deal with other complicated migration process and procedures. A meta-analysis study among minor refugees (less than 18 years) in Europe showed up to 53% had PTSD, 33% suffered from depression and 32% suffered from anxiety(95). A systematic review among refugee minors (11-18 years) in Europe showed minors of 16 to 18 years had more mental disorders compared to those of a younger age(86). The study suggests more caring is needed for those of older age for future issues such as employment and stable residency(86).

Similar results to the study mentioned above were found in The Netherlands, as minors who fled when they were younger than 3 years old had lower mental problems compared to the older adolescents(96). Another study among unaccompanied minor refugees (UMR) reported the highest incidence of PTSD was among the older age (16-18 years). The study related this to the possibility of more post traumatic stressors in the older age compared to the younger ones (97). However, another study showed no correlation between mental health with age differences among adolescent refugees in Germany(98).

Thus, the relation between age and mental health among adults cannot be taken as conclusive as it differs from one study to another. However, some findings conclude that refugee minors are affected more with mental health disorders than the adults. This is logical as minors in general are unlike adults who are independent and have more life experience which make them resilient to life stressors (87).

3.1.2 Marital status

Like many other individual social determinants, some studies linked the presence of a partner to the individual's mental wellbeing in a positive or negative way, while other studies did not.

A cross sectional study of refugees in Germany correlated the absence of a partner to lower quality of life(QOL) (99). WHO defines QOL as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". Other two studies in Sweden associated losing or leaving the partner behind to poor mental health in the refugees and host community groups. These refugees seemed to lose love, support, safety and appreciation with the loss of their partners(91,100). On the other hand, refugee participants who lost their partners in war showed more symptoms of mental grief(91).

A limitation of all the above mentioned studies is that these studies do not include forced marriage or marriage for the purpose of traveling to Europe(91,99,100). Forced marriage is especially difficult for refugee women who will depend financially and legally on the partner(101). Forced marriage could be a cause of other psychological problems such as depression, anxiety, lack of trust, low self-esteem, social isolation or even suicide (102,103). Moreover, some asylum women came to Europe in irregular way with the support of a "journey husband" who is a one of the smugglers to facilitate the journey for women. For example, a qualitative study in Spain mentioned the emotional abuse from the "journey husband" and his disappearance after the journey(104).

Apparently, the most striking post migration factors affecting refugees and asylum seekers' mental health at the individual level are those of a minor age and those who do not have a partner.

3.2 Relationship factors:

This part divides the relationship factors into three parts: family, intimate partner violence, and social networking.

3. 2.1 Family

Family is defined as those members of the household who are related to a specified degree, through blood, adoption or marriage(105). Family connection has direct effect on mental health of refugees based on different co-factors(106,107). Family provides love, care, safety, appreciation and support to cope with problems without the expectations of getting something in exchange just like the relationship among friends and acquaintances (108–110). In this section, the partner will be included as one of the family members and under the relationship layer.

A cohort study of refugees in The Netherlands concluded that family and social support is one of the three mechanisms besides employment and good living conditions that help refugees in coping with psychological issues such as PTSD, depression and anxiety(111). Another cross-sectional study in Sweden correlated the presence of mental illness in refugees with family separation. As refugees are often separated from their families due to conflict, war or persecution (91). Furthermore, Muller et al's study showed significant increase in the prevalence of PTSD, depression, and anxiety among UMR. The causality of these results are linked to the loss of family members, experience of hunger, and personal attacks (98).

A quantitative study in Germany correlated the presence of a partner, adult children and the family presence with good mental health (with 10%, <5%, <5% statistically significance). On the other side, it showed a negative correlation with family geographical separation(1.70), which is worse when all the nuclear family is outside Germany(-4.15)(106). The writer explained these results to be due to the value that family gives to a person's life. On the other hand, family distance leads to inaccessibility to social support and the fear of possible harm to them in the home country(106). Another study among torture survival refugees in Germany mentioned worrying about family in Iraq as their main post migration distress(112). Furthermore, these results are correlated with similar results for refugees in Germany(99,113). As Miller's study concluded the impact of family separation was not only on mental health but it was also on the quality of life in General(83).

3. 2.2 Intimate Partner Violence

Intimate Partner Violence (IPV) is an issue and a risk factor for mental health. It is defined as the exposure to physical, sexual or psychological violence from the current or previous partner of any gender(114). This section will cover IPV only

as it is linked to the relationship part; community section will consider the community's violence factor.

In any population, IPV is considered as a risk factor for mental health disorders such as PTSD and depression(115,116). Female refugees are usually exposed to IPV in the post migration phase due to the absence of the protective network, language barrier to seek help and the economic or residence dependency on the partner(103,115–119).

Two hundred and twenty in depth interviews among refugees and asylum seekers in The Netherlands and Belgium mentioned 332 acts of sexual violence after arriving to Europe and the majority of these acts were done by partners(103). A quantitative study of over 3,900 refugees in Denmark mentioned women’s exposure to IPV by men and related such acts to women's poor mental health These acts are usually linked to the experience of other gender based violence (GBV) incidences before migration or the lack of social support after migration(118). Three qualitative studies in Italy, Sweden and Germany mention participants' poor mental health behind experiencing psychological violent partner after migration (120–122). Another qualitative study on women exposed IPV in Germany correlating it directly with their suffering from PTSD(101). These results are also similar to the results from the host population (123,124). Nevertheless, a systematic review in western countries concluded that IPV among refugees is a reaction from other underlining causes such as previous traumatic experiences which the assailant cannot cope with (125).

3.2.3 Social network

Social network is the number of the surrounded people, the strength of communication between people and their impact on mental health(126). Friends and social networking give the support to refugees and people when needed(95,126). A study among UMRs concluded that friends from the same cultural context support when it came to dealing with the current life changes while friends from the new culture facilitate the integration process(95). Furthermore, a cross sectional study of refugees in Sweden showed better mental health for refugees who regularly contacted friends compared to the other group who did not. Also, results showed a positive correlation between refugees who spend time engaged in social activities with their mental health compared to the other group who did not socialize with people from their culture or the new country (127). A report from Italy correlated poorer social connection with stronger signs of PTSD in refugees(128). In addition, another study in Finland showed poor mental health in refugees who have poor communication with their friends(65).

Nevertheless, a quantitative study for long settled Yugoslavian refugees in Western Europe showed an independent association between social isolation and temporary residence status in relation to mood and anxiety disorders (90). Another study among adolescent refugees and asylum seekers who live longer

than 3 years in The Netherlands and strong social network showed no correlation between PTSD symptoms to satisfaction with life(SWL)(129). The study correlated these outcomes to other factors based on the social network, refugees' reactions to the stressors, and residency status. It seemed that those who have social support perceived better SWL. Thus, adolescent refugees may be more optimistic for reframing their experiences in a positive way. However, the results showed negative relationship between SWL and living without residency for 3 years and the difficult living conditions as a post migration stressor – which leads to lack of optimism for the future (this point will be covered in the next layer-). (129,130).

Loneliness is a negative feeling of having low social network. Loneliness differs from social isolation, as it is possible to be surrounded with people but you feel alone(131,132). Studies consider social connection as one of the positive factors for the mental health of all people, especially the displaced people. This social connectivity can come from family, friends, professionals and wider circle from people of the same cultural background(95,107,133,134).

Refugees usually deal with loneliness and the experience of loss of family members or friends due to migration and asylum seeking(135). A systematic review of 22 studies of refugees and asylum seekers in Western Europe correlated loneliness to the suffering from PTSD, depression and anxiety. The results also correlated loneliness with other post-migration difficulties such as mistrust, discrimination and community integration(58). A cross sectional study among 326 refugees in Germany indicated that loneliness is negatively correlated with the availability of social support and positive quality of life in general(131).

From these findings, it can be seen that the relationship factors that affect mental health of refugees during post migration are family separation and IPV. Other factors such as, loneliness and poor social network also cause negative impact on mental health and are also linked to other post migration factors such as community integration, discrimination and loss of a close person.

3. 3 Community Factors:

This part focuses on the community factors such as community integration, living conditions, language skills, occupational status, educational level, health seeking behavior, gender, violence, and discrimination within the refugees' community and the host community.

3. 3.1 Community integration

Several papers describe integration as a personal or public approach, involving structures or processes(136–138). Ager and Strang's Integration Framework defines personal approaches as related to individual experience in language, culture and security/stability situation, while public approaches can be related to employment, housing, education, health, and social networking. However, all these approaches come on the base of rights, residency status and

citizenship(139). At the policy level, integration is a goal of the European governments for how refugees become part of the host community(136–138). Refugees status will be influenced by the integration policies and result in different outcomes such as economic condition, employment status and social support(137). This will be covered in the next layer of the framework.

Forced migration has a strong impact on the integration or isolation even after arriving to the new host country(107,140). It is essential for refugees to build new social network in the settled country. This is challenging, as some of the countries prefer to house the refugees in economically deprived communities, causing them to be more isolated(107,137). A systematic review in Europe concluded that there is significant association between lack of social integration with poor quality of life, anxiety, depression and PTSD and vice versa(58). Furthermore, Hajak et al’s systematic study correlated the lower presence of integration activities with the increase of psychological symptoms. Nevertheless, four papers showed no correlation between mental health and the refugees' interaction with German people(113). Another study in Sweden also showed that there was no improvement in social integration of refugees who stayed longer than six years connecting it to mental health improvement. However, this poor mental health improvement also linked to other post migration factors such as family separation and poor social network(141). This is also correlated with another study that mentioned that community integration was not improved even after staying for long period of time(142).

The base of community integration is the provision of residency status for refugees and asylum seekers(139). Stable residency status has a positive effect on the mental health of refugees – which will be emphasized in the below sections-(111,113,143,144). For example, a study to measure health related quality of life among over 6,800 refugees in Germany showed a positive outcome in refugee's physical and mental quality of life after changing their residency status(145).

However, some studies show no improvement in mental health after changing the residency status(146).For instance, a cohort study among 200 Syrian refugees that followed them for 1.5 year concluded the long duration of the procedure it took to obtain their residency status increased their symptoms of PTSD, anxiety and depression which confirms the importance of therapeutic interventions for refugees (61). Another systematic review concluded that refugees with temporary protection visa had higher rates of mental distress and deterioration in the community integration compared to the other refugees who did not. The researchers correlated this with the feeling of uncertainty about the future of the legal progression which is important for community integration(147).

3.3.2 Living conditions

Several papers correlated good housing conditions with the legal status which impacts better quality of life for refugees. The residency status determines part of the living conditions which varies from country to country under the EU members according to the economic and welfare status of the country(143). Walther et al's study of more than 4,300 refugees in Germany showed a significant correlation between stable residency status and good housing conditions with decrease in psychological distress and improved quality of life(144). Another study of 510 refugees in asylum centers in Sweden showed the same correlation of the good housing condition with decreasing symptoms of PTSD, depression, and anxiety (50).

Another systematic review of refugees and asylum seekers in Germany correlated poor mental health with risk factors such as living in shared places and temporary residence permission(113). A systematic review of accessibility of health services in Western Europe correlated the availability of accommodation with the accessibility of mental health services(72). It also correlated with a cohort study in The Netherlands that showed that the recent residency permit holders with better housing conditions had a significant decrease in psychological symptoms compared to the other refugees(111).

3.3.3 Language

Studies among refugees in Western Europe correlated the ability to speak and communicate in the host country's language with social and economic integration. This will have an indirect impact on their mental health as it happened in Denmark(148), Germany (93,149) Sweden(150), and The Netherlands(151). Walther et al specifically correlated better German language skills to better mental health and quality of life(144). A systematic review in Western Europe found in five papers the correlation between language literacy, social integration and better mental health. The study considered post migration stressors a consequence of poor language skills among refugees , thus indicating that language is a factor of post migration distress(58). Along the same lines, a systematic review among refugees specifically correlated poor language fluency in the host country to depression(60).

3.3.4 Occupational status

Occupational status and labor market participation is one of the challenges that refugees face, as the migration place and time are not in the refugees' control. In addition, occupational status is related to other cofactors such as the residency status, validation of work experience, and education from their home country. Thus, employment status makes an impact on refugees' mental health outcomes(142,152).

A systematic review of refugees in Germany correlated in seven articles having a job with a lower prevalence of PTSD, mood, anxiety and better quality of life(113). Furthermore, Bogic et al's cross sectional study associated the mood disturbance (including depression) to unemployment(90). Sidorchuk et al's study showed an association between unemployment and psychological distress regardless of gender and migration status(153). In addition, Steel et al associated employment specifically with post migration integration(94). However, Jannesari et al's systematic review showed no correlation between employment and mental health. This result could have been affected by the residency status cofactor as all the included population who were included in this study were asylum seekers and not permanent resident refugees(154).

3.3.5 Educational level

Studies consider low educational level as a cofactor for mental health relating it to the integration process. Refugees struggle to complete their education or get higher degree due to many barriers such as poor socioeconomic conditions, lack of residency status, poor language skills, missing documents or completing the certificates' validation process(58,92,155). A cross sectional study among refugees and asylum seekers indicated that lower educational level is independently associated with mood disorders, anxiety and PTSD(90), while another study in Ireland showed independent correlation between low level of education in asylum seekers compared to refugees with high level of education (155). Moreover, Sleijpen et al's study among adolescent refugees mentioned that they got hope from education, as it is a way for higher socioeconomic status and empowering their life in future(95).

Nevertheless, a population based study among refugees in Sweden concluded no association between low educational level and mental disorder such as anxiety, depression and PTSD(92). The study explained this by the buffering effect of higher education. The buffering effect theory holds that higher education helps buffering or shielding individuals from the negative impact of stressful events. However, this theory is cancelled out as the overqualified refugees experience loss of status which makes a negative impact on their mental health(92).

3.3.6 Health Seeking Behavior

Despite the significant needs and the availability of services of mental health among refugees and asylum seekers, MHPSS utilization among refugees and asylum seekers is still very low(57,78,156). For example, only 20% of Iraqi refugees with PTSD sought mental health care in the Netherlands(157). However, a cohort study among adolescent refugees in Sweden found an increase in reaching mental health outpatient services in refugees who stayed longer in Sweden(158). Another study in Germany found higher utilization of MHPSS among

refugees with higher educational levels. This study suggested for further investigation on these results among refugees who receive equal services(159).

There are several barriers and factors for reaching to the services as reported by several research. Stigma of mental health problems seemed to be as the main barrier for seeking mental health services among refugees(76,160). Other barriers are poor language, cultural barrier, unawareness of the European health system and healthcare providers as well as the lack of health system trust among refugees(52,78,156).

One of the reasons is the long waiting list in Denmark(161), Germany and Italy(90). In addition, the same refugees' group in Germany and Italy reported their inaccessibility to transportation cost and poor language skills. Therefore, language is a significant barrier for mental health services. Renner et al considered poor language skills as a barrier for mental health services, mentioning that feelings are hard to explain even in the mother tongue not only in foreign language(162). Similar results were reported in other studies such as those done in Denmark(161), Italy(163), Germany(86), and Sweden(164).

Another barrier for low utilization of MHPSS services is the cultural concepts when reporting the mental disorder. Laban et al study mentioned that refugees' patients usually came complaining about non-specific pain instead of mental disorder(118). Same results were concluded in a systematic study among middle eastern female refugees in Europe(165).

3.3.7 Gender

Different studies correlated gender as a possible factor for mental health problems among refugees in the post migration phase(87). Studies in Sweden(91), Germany(88) and Italy(90) correlated women refugees with more mental disorder outcomes in comparison to men. These results are also present in non-refugees populations and was explained by the gender norms for men and women and was not related to the biological differences between male and female, as it is more acceptable for women to show mental problems than for men(87,90,166). A systematic review of UMRs in Europe concluded same results that girls have more incidence of depression and PTSD in comparison to boys(97). Another study in Germany among Iraqi refugees who have been subjected to torture and rape showed high rates of PTSD in women compared to men(112).This could be explained by women's psychology as they are more likely to ask for help for their health needs than men, or it could be because girls and women are more vulnerable and may have been negatively affected in the pre, during and post migration phases(91,97,112,167,168).

Based on the common gender power dynamic, refugee women experience gender violence such as rape, forced abortion, forced marriage and sexual trafficking(169) (This will be explained in detail in the next part). A systematic review concluded that women who struggle with sexual assault and rape suffer from higher degree

of PTSD compared to men(170). In addition to all the points mentioned above, women who experience sexual attacks find difficulties in making revelations during asylum applications in Europe due to fear of rejection from her community and the fact that sexual issues tend to be a taboo subject in the conservative communities(170,171).

On the other hand, a cross sectional study among 420 African refugees residing in Sweden showed more traumatic events, postmigration stress and PTSD symptoms in men more than women. This stress is related to poor economic conditions, discrimination against them, and healthcare inaccessibility. However, the women participants, in this study, showed higher depression symptoms compared to men(94).

Another cross-sectional study of over 1,200 Syrian refugees in Sweden divided them according to the mental disorder severity using self-reported data on trauma violent and non-violent exposure. The results correlated women with higher prevalence of PTSD, depression and anxiety disorders. However, regarding to the men who did suffer from those disorders, it was found that they suffered more from the symptoms. The study predicted that this could be due to the fact that the men participants had experienced more adverse pre migration events such as internment in asylum camps or more physical attacks(92). In addition, some studies correlate male sex to other mental disorders after resettlement such as substance use disorders and it is considered as coping mechanism for the stressful events that men face(90).

3.3.8 Violence

Violence occurs in the pre, during and post migration phases from partner, family members, strangers or migration professionals(103,117,119,125). This part will cover only violence from non-partner as the IPV has already been covered in the relationship part in 3.2.2 section. Schrijver et al's study among 223 interviews showed that the 69% of the mentioned cases who reported violence from non-partner, the victims were also women(103). Another study among refugees in eight European countries mentioned that 58.3% of the respondents from both sexes are victims of violence. However, women are victims of physical violence while men are affected by emotional violence(172). The pre and during migration traumatic events increase the possibility of post migration violence and vulnerability(104).

A report from Doctors of the World which had data from nine European countries indicated that asylum seekers are high victims of violence and this confirms the refugees' vulnerability to violence compared to the host population(173). In a field study among asylums in 25 camps in Denmark, The Netherlands and Sweden in 2017, all participants mentioned kind of physical or psychological violence that happened to them after arriving to Europe and some of the cases were from European people which was shocking for asylums seekers who considered Europe

as a "secure environment". A quote from a woman who had been raped by a policeman after arriving to Europe illustrates this: "I had traveled to Europe because I thought it valued freedom and security, but I experienced none of that here. I left Syria to avoid what I suffered on my journey here". The experience of post migration violence makes negative impact on mental health and leads to a decrease in community integration(174). It should be noted that the papers that mentioned these findings are underestimated as many of the studies' participants did not want to disclose their personal experiences since they are in the asylum process(119,172–174).

3.3.9 Discrimination

Discrimination is a global behavior against people based on their gender, nationality, religion or ethnicity(175). Several studies suggested that feeling accepted in the settled country makes a positive impact on the refugees' mental health and quality of life(61,100,142). For example, a cross sectional study in Austria showed a positive correlation between discrimination stressors and mental disorders(89). Similar results were concluded in studies done in Sweden(120,141), Austria(89), Germany(176) and Italy(122).

Furthermore, another study among refugees with PTSD showed higher percentage (71%) of discrimination compared to the other refugees who did not suffer from PTSD (27%)(177). In addition, a systematic review in six Western European countries considered feelings of discrimination as one of the barriers for mental health services and support(57). However, all the mentioned discrimination factors are correlated with other factors such as gender, living environment, employment and residency status in the host country(62,120,122,176,177).

Even though all refugees are considered as a vulnerable group and face discrimination from the host community, there are some groups who are more vulnerable than these refugees such as lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+). A systematic review of 21 studies among over 200 LGBTQI+ refugees in Europe mentioned discrimination and different types of violence as their main pre and post migration stressors in addition to several other mental health difficulties such as mistrust, fear, anxiety, grief and suicidal thoughts. This discrimination happens from other refugees from their origin or from European people such as asylum professionals or neighbors(178). In addition, a study on LGBTQI+ refugees in Germany showed that they experienced higher discrimination in the post migration phase in comparison to the pre migration phase. This can worsen their mental health conditions as they reject their identity and it also complicates their integration in the new community(179).

To sum up, the community factors that influenced mental health seems to be linked mainly to the community integration factor and gender norms. Poor community integration leads to other factors like discrimination, violence, poor

living conditions, unemployment, low educational level, low MHPSS utilization and poor language skills. Language skills can be considered as a barrier to factors such as unemployment, low educational level or low MHPSS utilization. Gender is also an influential factor that impacts other factors such as gender inequities, violence, and discrimination.

3.4 Societal Factors:

This part of the results emphasizes the process of asylum application, negative life events and poverty linking them to the mental health of refugees and asylum seekers.

3.4.1 The asylum policies

The asylum procedures, interviews, progress and the waiting time all have an impact on refugees' mental health. Several research papers considered asylum procedures as one of the post migration stressors since asylum seekers wait for a minimum of six months and stay up to years for the outcome of their claims with movement restriction(88,91,142). In addition, they do not have access to the labor market, education, and are away from their family and friends. All these factors will have an impact on refugees' life and their mental health(21). A study in Denmark correlated the longer period of asylum waiting to fewer chances of employment in 3.2% for each year(180).

Georgiadou et al mentioned the asylum duration as one of the factors for mental disorders(88). Another study in Germany among traumatized asylum seekers the impact of interviews showed a significant decrease in post-traumatic avoidance factors and increase in intrusions(181). Furthermore, the poor living conditions inside the detention centers such as shared rooms with strangers made a negative impact on the mental health. A study in Malta mentioned 80% of decline among asylum's mental health residents after arriving to the detention center and these results differ from center to another according to the conditions in the centers(73). It is to be noted, all these factors are differed from country to another according to the available system and policies in each European country(142).

Furthermore, the Dublin claim make a negative impact on asylum integration by delaying the procedures and creating the feeling of unacceptance from the selected country(21,182). In some cases, refugees will choose another country to apply for asylum so as to unite with family members or to avoid racism or to be close to relatives, but their application will be rejected from the Dublin claim. As a result, the person will return to the entry country or will be hidden in the preferred country afraid of police professionals, thereby being excluded from the ability to work, study, or integrate in the community(182).

Another factor to be taken into consider is the integration policy itself which makes an impact on mental health of refugees as different EU countries follow different

integration policies. The inclusive model gives citizenship on the basis of residence or at birth and it is multicultural, whereas the assimilation model gives residency by adhesion to republication values and restricts the cultural acceptance, and the exclusionist model gives residency by ancestry with few integration abilities(183). Research shows lower mental wellbeing for refugees living in exclusion integration policies and better in inclusion integration policies(136,183).

3.4.2 Negative life events

All refugees and asylum seekers experienced negative life events; however, there are some refugees who experience additional traumatic life events after arriving to the host country such as homelessness, human trafficking, unfair asylum procedures, actual death, sexual violence or financial difficulties (119). A study among over 200 refugee women who had survived human trafficking showed severe PTSD symptoms. Furthermore, the longer the trafficking time the higher the symptoms(184). A study among 223 refugees and asylum seekers in Belgium and The Netherlands showed almost 57% of the participants had experienced sexual violence after arriving to Europe. Moreover, the majority of this violence is from partners or asylum professionals(103).

A longitudinal study of refugees in Germany compared PTSD, depression and anxiety symptoms in 6-12 months period for people who had been exposed to new stressful events after resettlement in Germany compared to another group. The results showed a significant increase in the mental disorders of people who had new stressful life events compared to the other refugees' group who had not (130). The same results were concluded from 385 asylum seekers in 15 supported centers in Italy(185).

3.4.3 Poverty

Poverty among the HIC refers to the inability of the family to secure accommodation and other basic materials such as food and clothes(186). It is also considered as one of the outcomes of forced migration for asylum seekers and refugees around the world(142,186). Regardless of the refugees' socioeconomic status back home, they will often leave most of their properties such as businesses, houses, savings and even their certificates and official papers. For these reasons they will not be able to find jobs or get back their stipend for living. Thus, many of the refugees and asylum seekers stay in poor situation for years(142,186).

Unfortunately, refugees' socioeconomic conditions are strongly related to the asylum policies in the European countries, while these policies itself are considered as "poverty producing machines" to reduce the future asylum claims(187). Such policies are staying in the refugees centers without the right to work during the asylum application process and receiving only a low financial support

rate(186,188). Thus, poor refugees' households usually depend on welfare or social networks to cover their necessities(186).

Poverty is placed in a vicious cycle in the mental health, as it can be a factor or a consequence of the psychosocial state of people(189) as the development of the mental health for individuals is shaped by social, environmental and economic conditions(189). From a psychiatric treatment perspective, financial issues are considered as one of the two main postmigration stressors besides family separation(190). A study among minor groups in Berlin linked the low socioeconomic status with poor mental health(191). Another study among refugees in Sweden indicated poverty as one of their post migration stressors in addition to the feeling of isolation, discrimination and family separation(91). Bogic et al's study correlated the same results that is poverty with depression, anxiety and PTSD(60). Hynie's critical review showed the relationship between income, residency status, access to education and employment as all factors that make an impact on refugees' mental health(142).

To sum up, the asylum policies seem to be a predominant factor influencing mental health of refugees as well as they play an important role in increasing poverty. As asylum policies are long and complicated procedures, they restrict asylum seekers to work or study before accepting their claims. These policies and procedures could lead to unfair asylum results and impact other factor because if the claim is rejected then this will impact other factors such as community integration which in turn be a barrier to the labor market and may lead to poverty.

Chapter 4: Existing Programs and Best Practices

It can be seen from what was mentioned before that refugees come to western countries in diverse groups with higher incidence of mental disorders(88,141,177,192). Different groups of refugees have different needs that range from prevention, promotion or treatment. Even HICs find difficulties in covering all these needs of refugees(57,157). The WHO Regional Office for Europe describe four areas for interventions based on evidence-based and success stories. These interventions start with social integration covering all the basic needs such as food, housing, residency status, and occupation for all arrived asylum seekers. In addition, it takes into consideration the social activities for migrants and refugees such as sports, clubs or school activities for children(51).This is similar to UNHCR's recommendation for the host countries. As UNHCR recommended integrating MHPSS into the whole government's system through a variety of sectors such as health, education, social affairs and employment to ensure of the communities' participation with the host community and refugees for better accessibility, acceptability and sustainability of the services(193).

The second area is to overcome mental health utilization barriers by providing services tailored to the refugees' needs by taking into consideration the fear of discrimination and the cultural contexts of refugees' communities.

The third one is to facilitate full benefit of the services after reaching the healthcare providers by overcoming barriers such as the language barrier, maintaining confidentiality and meeting expectations. The fourth is to treat refugees and asylum seekers with severe mental disorders. As many refugees have been exposed to trauma and developed mental disorders, many have resilient skills that can support them in the social integration(51).

A literature review for the best practices was done based on searching for all the outlined factors as the socioecological framework. The programs below are some evidenced-based programs that show positive impact on mental health for refugees and asylum seekers in different high-income countries and similar to Western Europe contexts. Nevertheless, the researcher did not find published sources for the best practices for all the defined factors. Herewith are some of best practice' examples linked to one or more post migration factors.

4.1 Peer monitoring Programs

Peer monitoring is group of two or more individuals who act as peers and one is a monitor to enhance personal development, capacity building and success. Studies in Australia show the positive impact of these programs among female refugees to gain more confidence, social networking, finding jobs, and educational opportunities and reducing poverty. In addition, it added noticeable impact of

gender empowering and changing the gender norms which are known contributors to mental health and wellbeing(194,195).

4.2 m-Integration

Mobile aided integration through artificial intelligence (AI) have supported refugees' a lot by developing apps to support communication, translation, mapping, learning, banking and government services(196). A study among asylum seekers and refugees in Greece searched for the impact of using mobile integration (m-Integration) applications for the community integration and better mental health. The results found positive impact on social integration by learning the language, better accessibility to health services and improvement in the mental health status. The language support is associated with 4% increase in the community integration and 0.8% in better health outcomes. Furthermore, AI helps by professionally teaching the language through translation and pronunciation as well as it presents the health conditions and symptoms according to the user's needs; hence, all these lead to better mental wellbeing(196).

4.3 Self-Help Plus

WHO established mental health interventional programs that are specifically for prevention or promotion as well as for treatment refugees'. Such a program that is for prevention is Self-Help Plus (SH+) which is a stress management package to cope with life adversity such as poverty, violence, conflict and forced migration(197,198). SH+ consists of five audio recorded sessions and an illustrated book to teach the skills to 20-30 persons by non-specialist facilitator. Thus, it can be considered as a base for a specific mental health intervention(197,198).

Several randomized control trails (RCT) found SH+ to be a psychological support for preventing disorders. As the concept of the program is to cope with difficult thoughts through mindfulness approaches without letting negative feelings dominate(197,198). A pilot RCT among 65 female refugees in Uganda to measure the effect of SH+ identified positive changes in their psychological distress, flexibility and depression after the intervention(199).

Nevertheless, another RCT among 459 refugees in five Western European countries showed significant difference after two weeks of SH+ follow up but no difference after six months follows up. The researchers connected this result to the lack of practice of the skills among the participants or the lack of participants' blindness in the trail. However, the study mentioned several limitations such as the sample size, group heterogenicity, exclusion criteria, losing of follow up and the study duration. Thus, the participants suggest for other RCT for SH+(200).

4.4 Program Management Plus

Furthermore, Program Management Plus (PM+) was established for refugees suffering from common mental disorders such as depression, anxiety and stress(201). It is based on cognitive behavior therapy and problem-solving therapy strategies through sessions from non-specialist facilitator(156,201). It is feasible, efficient, community acceptable and showed positive impact on the participants' mental health(156,201).

RCTs was done among Syrian refugees in the middle east and The Netherlands with mental distress symptoms. The trial showed improvement and effectiveness among participants' mental health which support the individual PM+(156,202). These results correlated with Switzerland's RCT(203). Another study concluded similar results about the effectiveness of PM+ for group treatment instead of individuals. However, all these results consider the importance of cultural adaptation and the consideration of "mental disorders stigma" among the group participants(204).

4.5 Sports clubs

There is no doubt that sports have been associated with positive physical and mental health for people and for refugees as they specifically increase the feeling of community engagement and integration. In sports, different cultural groups -both from refugees and host community- can play together with limited verbal communication. Research on sports clubs concluded that the impact among refugees for learning the new language, social networking and raising self-confidence came as a result of the feeling of achievements. The benefit is salient among refugees groups who suffer from mental disorders or social isolation due to discrimination, gender norms or poverty(205,206).

A study of the impact of a tennis club on the refugees' community integration found its positive impact on the integration but it should be conducted in safe space and be focused on having fun rather than learning skills(206).

Another study on sports clubs in similar European context in Australia identified the benefits and the barriers of these clubs among refugee minors. The barriers were linked to membership and transportation cost and gender norms for girls' participation. The sport club benefits were usually linked to the physical and mental health of the participants such as self-esteem, leadership and feeling of success. Furthermore, the sport club for children was integrated in school activities which make teachers give additional support to children who are isolated through extra hours coaching. In addition to other successful parts, such activities opened the doors for refugee minors for international scholarships and opportunities(205).

Chapter 5: Discussion

5.0 Overview of findings

As discussed under the results section, this literature review identified various individual, relationship, community and societal post migration factors affecting mental health of refugees and asylum seekers in Western Europe. The review results for the lessons and good practices revealed some points of attention that can be taken into account when developing new programs/ reviewing mental health programs for improving the mental health of the refugees and asylum seekers in western European countries; thus, this paper can make evidence – based recommendations.

5.1 Individual factors

In this thesis, the most important factors affecting mental health among refugees are minor age and absence of the partner. Refugee minors are a vulnerable group in the post migration context compared to the adult refugees. specifically, minors aged 16-18 years have more mental distress compared to the younger minors (less than 16 years old). Minors in this age have concerns about their future life as refugees and their available opportunities for getting good education, occupation and a stable life.

The other factor at the individual level that has a negative effect on the mental health and quality of life is the absence of the partner. The partner is known to provide the love, support, safety and appreciation to deal with post migration stressors. These results are similar to the results among refugees in Turkey(207) and Jordan(84). Those factors are also interlinked with the other outlined layers such as IPV and social network. As in some cases, the partner's presence could cause violence to the victim which will deteriorate the victim's mental health status. Also, people in young age are affected from poor social networking.

5.2 Relationship factors

Most of the evidence reported positive and negative effect of the relationship factors on the mental health of refuges in the post migration settings. Despite suffering from severe trauma or mental illness, refugees who are united with their families showed lower incidence of mental disorders in comparison with refugees who are away from their nuclear family. Worrying about family and the inability to reunite with them is the most mentioned post migration factor as the case of the Iraqi torture survivors in Germany indicated (112). Same results were also found in a study among Iraqi refugees in Australia(208).

On the other hand, relationship factors could cause a negative impact on the mental health if the partner is a victim of violence. These results are similar to other two studies done in Jordan(84) and the United states(209). It is to be noted that IPV cases are usually low in reporting due to fear of disclosure or because of cultural beliefs which may lead to continuation of the violence. However, the findings link IPV to community factors for the importance of women empowerment and gender equity. Furthermore, as concluded from papers that some of the violence cases are outcomes of the assailant's underlining mental health issues such as pervious traumatic experience. This leads to the conclusion that the assailant and the victim are both in need for MHPSS. The same conclusion was found in other research in Switzerland(210).

Social networking with people from the same cultural background or from the new country has a positive impact on the refugees' mental health of all ages. Nevertheless, loneliness and poor social network have been linked directly to mental health difficulties. Furthermore, social networking is also linked to other relationship and community migration factors such as community integration, discrimination from the host country and refugees' society or loss of close person.

5.3 Community factors

It seems that community integration and gender norms from home country are predominant factors behind mental health among refugees and influence all the other community factors. The residency status plays a crucial role in all the other community factors, as getting a stable residency status will make an impact on having good housing conditions; on the other hand, waiting for asylum outcome leads to staying months or even years homeless or in poor living conditions which may lead to negative impact on the mental health of the asylum seekers and refugees. These findings are also similar to the findings from Greece(49) and Turkey(211).

Moreover, according to findings, poor language skills are a consequence and a factor that affect community integration and have been linked to people who have more post migration stressors. Nevertheless, individuals who have poor language skills and find difficulties in learning the culture cannot create new network, or access the MHPSS services and fail to find a job, or educational opportunities and all these make an impact on their mental condition.

Moreover, another important factor that cannot be neglected is the occupational status of the refugees after arriving in Europe. Findings correlated good occupational level with better mental health for refugees but Sengoelge et al's paper concluded the opposite on the buffering effect. Many qualified refugees cannot integrate in the labor market because they cannot prove their papers' validity in the host country leading them to work in low status jobs or making them unable to find a job which may increase poverty and make a negative impact on their mental health as well as make them feel unwelcomed by the host country.

These results are also present among refugees in Canada(212) and Australia(213).

Another factor is all kinds of violence and discrimination that refugees face in general and the vulnerable groups face in particular. Such vulnerable groups are women, URMs, and LGBTQ+ groups who are affected by the host community and the refugees' communities too. The negative impact of these factors among asylum and refugees is as deep as the violence they face in the pre and during migration phases and can lead to slow their integration process, especially if this incidence was from asylum professionals who should be considered as trusted people who should provide safety and security. Another point to consider is the over-consideration of these groups in comparison to the other refugees which could also create more violence and discrimination against them instead of supporting them. These results were also found among refugees in Canada(212).

Both men and women are affected by the post migration factors and in need for MHPSS. However, the majority of the studies relate the higher need of women for MHPSS to gender discrimination. The findings showed a higher incidence of depression and PTSD among women compared to men especially if they were victims of GBV such as rape. These results are similar to results from refugees in Turkey(214) and Canada(215). In addition, the rejection and stigma that women may face from her own community after the violence makes her more vulnerable and in need for support from the host country.

These community findings are significant in tackling the post migration factors for refugees in Western Europe by emphasizing the need for women empowerment as crucial to improving the mental health of refugees. This can happen by developing the woman’s self-autonomy to help her make all life decisions as well as by raising her knowledge about her rights in the new community. Also, there is a need to make vulnerable groups such as women or any person who has faced or continues to suffer in unfair life situations in Europe aware of how and where to report such cases.

All these community findings highlight the needs for community-based interventions programs aiming to strengthen community integration starting from language classes for accessibly to the labor market, and school and mental health services. Programs such as m-Integration- should also be easily accessed and used –by taking in consideration the cultural and economic barriers. In addition to the implementation of community engagement program by the host community and refugees to minimize the discrimination and increase cultural acceptability, integrating students in schools as well as in the sports clubs showed positive impact of community integration and mental health in the long term.

5.4 Society factors

This review findings reveal the impact of several post migration factors such as policies and how they affect the mental health of refugees and asylum seekers in western Europe. The importance of fair asylum policies and asylum rights to get citizenship cannot be neglected. The findings show the impact of asylum policies and their impact on acceptance of the asylum claim which influence getting residency and integration into the community. The community integration is framed from policies that involve the individual and public efforts for learning the language and culture as well as providing secure situation, good housing conditions, occupational opportunities and support for building new social life.

Also, one of the key interlinked post migration factors for refugees are the negative life events such as human trafficking, homelessness and unfair asylum procedures. Many of these events affect negatively on the mental health of the refugees and are linked to other relationship, community or personal factors. Also, such events make the asylum process and interviews hard to be followed due to the inability to concentrate and provide documented evidence which cause unfair asylum decisions and worsen the mental health of these vulnerable refugees.

In addition to the impact of the Dublin claim that restricts the rights of the asylum seekers based on their mode of arriving to Europe without considering their asylum profile there is also the asylum process based on the Dublin policy which requires. asylums seekers to apply again and again while at the same time living in poor conditions and having restrictions on all life activities including education, employment and traveling ability. Such policies purposely put refugees in poor situation as a pushing mechanism for future asylum claims. All these policies do not consider the mental health of the refugees and the ones who are negatively affected by them more are the ones who are in need for MHPSS. To effectively improve the mental health of asylum seekers and refugees, it becomes necessary that policy makers improve the asylum policies and rules and consider asylum rights and human needs.

All these policy findings highlight the needs for improving the rules and regulations for the refugees in Europe. These improvements should cover the integration policies that cover the residency status, the validity of refugees' documents, and the language fluency. They also raise ethical questions regarding asylum and refugees' rights and dignity in the asylum centers and the host country. Taking into consideration the pre and during migration factors that led the refugees to bear all the suffering to get accepted in the new community, there is a need to reconsider such policies.

5.5 Best practices

As mentioned in the findings of the refugees' groups and different needs of the refugees in Europe, all human basic needs should be covered for all asylum seekers and refugees after arriving. Such needs start from protection, safety, shelter, food, water and sanitation. Poor community integration and gender norms, in addition to individual and relationship factors like minor age, absence of partner, traumatic life event, IPV, family separation and poor social network all are considered as post migration factors that are linked to poor mental health among refugees. Furthermore, the appraisal of the analyzed best practices and factors showed that using peer-monitoring, m-Integration and social activities such as sports club make an impact on refugees' integration in the community and are considered as coping solution for the above-mentioned individual, relationship and community factors. However, the literature review had challenges to find best practices for all the factors specifically for gender norms, discrimination, health seeking behavior and labor market integration pointed to the needs for future programs and interventions for all the summarized factors.

In addition to the other practices and interventions for mental health prevention and promotion or for the treatment of people who already suffer from mental health such as SH+ and PM+, these community programs showed positive impact for the support of the refugees and asylum seekers who are in need for MHPSS and can be implemented in asylum centers. These programs should be tailored by taking into consideration the context of the refugees' communities and should be easy to be reached by asylum seekers and refugees after arriving.

Also, the impact of the integration policies on the mental wellbeing of the refugees and asylum seekers in Europe should not be neglected as they are a critical point to improve their mental health. The inclusive model has better impact on the mental health and life satisfaction in comparison to the exclusion and the assimilation models. Policy makers should take into consideration all of these policies as a human right need for refugees and asylum seekers.

5.6 Review Limitation

The limitation of this review is the diverse factors and the confounding factors influencing mental health in general and the finding of this study. Furthermore, the limitation is also related to the limited articles that linked mental health in the post migration context of different refugees and asylum seekers groups in all the selected EU member states. In addition, the variations in the socioeconomic levels among different EU member states which lead to different services, integration policies and different cultural and community acceptance acts as a limitation to this review. These limitations make it hard to tailor specific analysis and recommendations specifically for different refugees' groups and different countries. Thus, this paper included papers from Western European countries as it is similar in social and economic situation.

Another limitation is the under reporting of many factors relating to the gender norms such as GBV and IPV or even the general mental health factors like mental health stigma. Also, many of the identified factors are not clearly linked to the post migration phase only and can be linked to life prior migration and during migration, and for some studies this is unclear. Moreover, the appraisal is based on the information extracted from the available literature and many factors were not fully reported which could constitute a high risk of reporting bias in the findings. In addition, due to regional and cultural disparities, the results might not be transferable to all Western European contexts.

The socio-ecological model is used to organize the findings in this review. The model uses the best approach to get the best result for the target people, like refugees and asylum seekers. It is relevant because it identifies various factors and cofactors affecting mental health of refugees or any group of people and links the factors at different levels. However, the application of this model seems to be for a homogenous group who have similar cultural contexts and not for a heterogenous group with several contextual differences as the case of refugees in this paper. Thus, some factors are under-presented and could be presented better like community integration and discrimination.

Chapter 6: Conclusion and Recommendation

This review concludes that factors affecting mental health of refugees and asylum seekers in Western Europe cross all levels of the socioecological model such as unfair and complicated asylum policies, presence of gender norms, and poor community integration. Mental health and community integration activities are inadequate, unacceptable or inaccessible. These factors influence the living conditions and language skills, which impact the inaccessibility of MHPSS, getting employment and education opportunities that are linked to poverty. Thus, there must be multi-layered intersectoral interventions involving all the socioecological levels for better public health status considering the refugees who are already in need for specialized mental health response.

Refugees become more vulnerable if they have personal and relationship factors such as being a minor, not having a partner or family, having negative life events or experiencing IPV. Gender norms should be considered for their impact on violence or discrimination. Thus, it is crucial to overcome these factors by gender empowerment and different social activities such as peer monitoring programs and sports clubs tailored to different refugees' groups. Furthermore, the literature review showed a gap in the available programs that tackled all the included factors. Thus, awareness raising and innovative community programs for these factors will make good impact on refugees' mental health and wellbeing.

Asylum polices and the Dublin claim impacted the asylum acceptance, getting residency and community integration especially for those who suffer from mental health or faced undesirable life events. Hence, for better mental health, there is a need for a reconsideration of the integration policies in each country and the implementation of polices for asylum claims' acceptance. In addition, considering the benefits of SH+ and PM+ as successful programs and practices to improve the mental health of the refugees and asylum seekers, they can be used in Western Europe while taking into consideration the different socioecological layers in the framework as evident from previously implemented projects within the refugees' communities. These results can be implemented to improve the mental health of refugees in the post migration context in Europe and the following are some recommendations.

6.1 Recommendation

Policy

- CEAS and governmental offices for asylum and refugees in Western Europe countries can improve the asylum and migration policies for better community integration and better public health conditions for refugees. These policies cover the acceptance of asylum claims, accessibility to the labor market and education, accommodation and family reunion, Hence, all these points will participate in improving the refugees' mental health conditions.
- Governmental offices for asylums and refugees in Western Europe countries should facilitate the labor market integration of the refugees by facilitating policies for refugees' documents and accreditations for the long-term benefit on mental health of refugees and poverty prevention.
- The Agencies for the Reception of Asylum Seekers and Refugees in Western Europe countries should ensure protection of human rights, and dignity among asylum seekers and refugees as well as raise the awareness of asylum seekers and refugees' rights among the asylum community and the asylum professionals in the centers, borders and governmental offices.
- Asylum professionals in the asylum centers should give more consideration and improve the current rules by taking into consideration the special needs of asylum seekers who are minors, or already suffer from negative life events or mental illness during the asylum procedures and interviews so as not to worsen their mental health and lose the trust of these vulnerable groups as these groups need to be treated with empathy during the whole process.

Interventions

Governmental offices for asylum and refugees should ensure that all refugees and asylum seekers have access to different services and activities by considering all the possible factors:

- Community-based integration programs are adapted to different groups' needs, time and contexts to facilitate the integration process in the community through learning the language for occupational and educational improvement as well as for the accessibility to mental health services while taking into consideration the special needs of the vulnerable groups, such as homosexuals and women.
- Community-based gender and women empowerment project, awareness raising of human rights, and reporting any violence or discrimination incidences in safe way to ensure better mental health for all people by taking into consideration the community’s acceptance and the cultural

sensitivity of gender topics, without over consideration them to avoid sensitivities and more discrimination.
- Awareness raising among the refugees and the host community and the advocacy of the labor market integration of the refugees to reduce the socioeconomic inequity between refugees and the host community to ensure better community integration and mental health wellbeing.

Governmental offices for asylum and refugees and ministry of health offices in the Western European countries should ensure that all refugees and asylum seekers have access to mental health programs and utilize these programs which are adapted to different groups' needs, time and contexts for improving their mental health, prevention of mental illness as well as treatment or first aid support for refugees and asylum seekers in Europe while taking into consideration the special needs of the vulnerable groups such as minors, LGBTIQ+ and women.

Research

- Governmental offices for asylums and refugees in Western Europe countries should evaluate the present community integration programs and activities (including language classes, labor market integration, school integration and the other community-based activities) for their impact for better community integration and mental wellbeing by doing comprehensive multisectoral research taking into consideration the different socioecological levels.
- Governmental offices for asylums and refugees in Western Europe countries should do multisectoral research on gender issues related to the refugees in the post migration contexts such as GBV, human trafficking, forced marriage and IPV cases in order to provide protection and security for these victims taking into consideration the safety of the participants and victims.
- There is a need from the governmental offices for asylums and refugees in Western Europe, ministries of health, refugees international and national NGOs to make more efforts to identify the individual, relationship community and social factors that affect the mental health of refugees in the post migration context in Western Europe, in order to develop approaches appropriately adapted to their different cultural contexts and needs.

Reference list

1. National Health Service - The United Kingdom. Overview - Generalised anxiety disorder in adults [Internet]. [cited 2022 Aug 7]. Available from: https://www.nhs.uk/mental-health/conditions/generalised-anxiety-disorder/overview/
2. American Psychiatric Association. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FIFTH EDI T ION DSM-5TM. Library of Congress Cataloging-in-Publication Data. 2013.
3. UNHCR. UNHCR "refugees" and "migrants." Refug migrants. 2018;(2018):7–19.
4. World Health Orgaization. Depression [Internet]. 2019 [cited 2022 Aug 7]. Available from: https://www.who.int/health-topics/depression#tab=tab_1
5. The World Health Organization. Mental health: strengthening our response [Internet]. https://www.who.int/. [cited 2022 Apr 20]. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
6. (UNHCR) TUNHC for R. Psychosocial support global strategy - technical sheet: mental health and refugees. Heal Ment Support Psychosoc. 2021;
7. IOM. Glossary on Migration No. 34. Internatioal Migr Law [Internet]. 2019;234. Available from: http://medcontent.metapress.com/index/A65RM03P4874243N.pdf%5Cnhttp://www.epim.info/wp-content/uploads/2011/01/iom.pdf
8. (CDC) C for D and C. Coping with a Traumatic Event What Is a Traumatic Event? What Are Some Common Responses? [Internet]. Available from: https://www.cdc.gov/masstrauma/factsheets/public/coping.pdf
9. UNHCR - Refugee Statistics [Internet]. [cited 2022 Mar 2]. Available from: https://www.unhcr.org/refugee-statistics/
10. Sserwanja Q, Kawuki J. Migrant Health: Healthy Migrant Effect and the Need to Prioritize Migrant Health. Asian J Med Heal. 2020;(June):11–6.
11. Migrants and refugees are good for economies [Internet]. Nature. 2018 [cited 2022 May 4]. Available from: https://www.nature.com/articles/d41586-018-05507-0
12. Abubakar I, Aldridge RW, Devakumar D, Orcutt M, Burns R, Barreto ML, et al. The UCL–Lancet Commission on Migration and Health: the health of a world on the move. Lancet. 2018;392(10164):2606–54.
13. Council of the European Union. Life in the EU [Internet]. [cited 2022 Jul 13]. Available from: https://european-union.europa.eu/principles-countries-history/key-facts-and-figures/life-eu_en
14. Norwegian Refugees Committee. A few countries take responsibility for most of the worlds refugees [Internet]. 2022 [cited 2022 Jul 13]. Available from: https://www.nrc.no/shorthand/fr/a-few-countries-take-responsibility-for-most-of-the-worlds-refugees/index.html

15. United Nations Western Europe. Statistics and Country Information - [Internet]. 2021 [cited 2022 Jul 13]. Available from: https://unric.org/en/info-point-library/online-databases/statistics-and-country-information/

16. United Nations Statistics Divisions (UNSD). Standard Country or Area Codes for Statistical Use [Internet]. [cited 2022 Jul 14]. Available from: https://unstats.un.org/unsd/methodology/m49/

17. Kaya A. The Netherlands : from multicultural to assimilation. In: Islam, Migration and integration. 2009. p. 116–40.

18. Council of the European Union. Asylum applications in the EU - Consilium [Internet]. 2022 [cited 2022 Jul 13]. Available from: https://www.consilium.europa.eu/en/infographics/asylum-applications-eu/

19. UNHCR - The 1951 Refugee Convention [Internet]. [cited 2022 Jul 13]. Available from: https://www.unhcr.org/1951-refugee-convention.html

20. United Nations High Commissioner for Refugees (UNHCR). The 1951 Convention and its 1967 Protocol. UNHCR. 2011;16.

21. Asylum Information Database (AIDA). The implementation of the Dublin III Regulation in 2020. European Council in Refugee and Exiles. 2021.

22. Williams R, Bodil M, Keller S, Lambert J, Sargentini J, Terricabras J. Beyond Dublin: a discussion paper for the greens/EFA in the European Parliament. Greens EFA. 2015.

23. Asylum EUA for. EUAA publishes a COI report on Iraq: Targeting of Individuals [Internet]. 2021 [cited 2022 Aug 1]. Available from: https://euaa.europa.eu/news-events/euaa-publishes-coi-report-iraq-targeting-individuals

24. Schuster L. Dublín II y eurodac: Examinando las (in)intencionadas(¿?) consecuencias. Gender, Place Cult. 2011;18(3):401–16.

25. Albada K, Hansen N, Otten S. Polarization in attitudes towards refugees and migrants in the Netherlands. Eur J Soc Psychol. 2021;51(3):627–43.

26. European Comission. COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGION. Action Plan Integr Incl 2021-2027. 2016;(2020):1–23.

27. NEWS B. Migrant crisis: Migration to Europe explained in seven charts - BBC News [Internet]. 2016 [cited 2022 May 4]. Available from: https://www.bbc.com/news/world-europe-34131911

28. Press U. As Humanitarian Situation in Syria Worsens, Emergency Relief Coordinator Tells Security Council 'Failure Each Year Cannot Be Our Strategy' [Internet]. 2022 [cited 2022 Jul 24]. Available from: https://press.un.org/en/2022/sc14779.doc.htm

29. Humanitarian UNICEF. Current L-3 and L-2 Emergencies [Internet]. 2019 [cited 2022 Jul 24]. Available from: https://www.corecommitments.unicef.org/level-3-and-level-2-emergencies

30. Council of the European Union. Extraordinary meeting of the European Council (23 April 2015) - Consilium [Internet]. [cited 2022 Jul 23]. Available from: https://www.consilium.europa.eu/pl/press/press-releases/2015/04/23/special-euco-statement/
31. Council of the European Union. EU-Turkey statement, 18 March 2016 - Consilium [Internet]. [cited 2022 Jul 23]. Available from: https://www.consilium.europa.eu/en/press/press-releases/2016/03/18/eu-turkey-statement/
32. Jubany O. The Local Governance of Immigration and Asylum: Policies of Exclusion as a Battleground [Internet]. Springer Link; 2019. Available from: http://www.palgrave.com/gp/series/14044
33. Union C of the E. Proposal for a Regulation of the European Parliament and of the Council establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a [Internet]. [cited 2022 Jul 23]. Available from: https://ec.europa.eu/transparency/documents-register/detail?ref=COM(2016)270&lang=en
34. International Organization for Migration. Libyan judiciary prepares to combat human trafficking | International Organization for Migration [Internet]. [cited 2022 Jul 24]. Available from: https://www.iom.int/news/libyan-judiciary-prepares-combat-human-trafficking
35. Council of the European Union. REPORT on the proposal for a regulation of the European Parliament and of the Council establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Memb [Internet]. [cited 2022 Jul 23]. Available from: https://www.europarl.europa.eu/doceo/document/A-8-2017-0345_EN.html
36. UNHCR. Problem of tolerance in political sphere of Estonia And Latvia.
37. News E. Helme: Estonia will not accept even one asylum seeker | News | ERR [Internet]. ERR news. 2019 [cited 2022 Jul 13]. Available from: https://news.err.ee/990044/helme-estonia-will-not-accept-even-one-asylum-seeker
38. Human Rights Watch. Violence and Pushbacks at Poland-Belarus Border [Internet]. 2022 [cited 2022 Jul 13]. Available from: https://www.hrw.org/news/2022/06/07/violence-and-pushbacks-poland-belarus-border
39. Paliamant E. Asylum and migration in the EU: facts and figures | News | European Parliament [Internet]. 2022 [cited 2022 May 4]. Available from: https://www.europarl.europa.eu/news/en/headlines/society/20170629STO78630/asylum-and-migration-in-the-eu-facts-and-figures
40. politico. Europe asylum applications up by a third in 2021: Report – POLITICO [Internet]. [cited 2022 Apr 20]. Available from: https://www.politico.eu/article/europe-asylum-applications-up-by-a-third-in-2021-report/

41. Paliamant E. Annual asylum statistics - Statistics Explained [Internet]. 2022 [cited 2022 May 4]. Available from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Annual_asylum_statistics#Number_of_asylum_applicants:_increase_in_2021
42. Project global detention. THE UKRAINE CRISIS Double Standards: Has Europe's Response to Refugees Changed? - Global Detention Project | Mapping immigration detention around the world [Internet]. 2022 [cited 2022 May 4]. Available from: https://www.globaldetentionproject.org/the-ukraine-crisis-double-standards-has-europes-response-to-refugees-changed
43. NEWS B. How many Ukrainians have fled their homes and where have they gone? - BBC News [Internet]. 2022 [cited 2022 May 4]. Available from: https://www.bbc.com/news/world-60555472
44. World Health Orgaization. Health consititution [Internet]. [cited 2022 Feb 8]. Available from: https://www.who.int/about/governance/constitution
45. World Health Orgaization. Mental Health [Internet]. 2022 [cited 2022 Feb 8]. Available from: https://www.who.int/health-topics/mental-health#tab=tab_1
46. Corey L. M. Keyes. Mental Health Is a Complete State: How the Salutogenic Perspective Complete the Picture. Emory University - Department of Sociology; 2013.
47. The World Health Organization. The world Health Organization Quality of Life Assessment (WHOQOL): position paper from the world health organization. Pergamon. 1995;41(10).
48. Stansbury JP, Ried LD, Velozo CA. Unidimensionality and bandwidth in the Center for Epidemiologic Studies Depression (CES-D) Scale. World Heal Organ. 2006;86(1):10–22.
49. van de Wiel W, Castillo-Laborde C, Francisco Urzúa I, Fish M, Scholte WF. Mental health consequences of long-term stays in refugee camps: preliminary evidence from Moria. BMC Public Health. 2021;21(1):1–10.
50. Leiler A, Bjärtå A, Ekdahl J, Wasteson E. Mental health and quality of life among asylum seekers and refugees living in refugee housing facilities in Sweden. Soc Psychiatry Psychiatr Epidemiol [Internet]. 2019;54(5):543–51. Available from: http://dx.doi.org/10.1007/s00127-018-1651-6
51. World Health Orgaization. Mental health promotion and mental health care in refugees and migrants (Technical guidance on refugee and migrant health). 2018;40. Available from: http://www.euro.who.int/__data/assets/pdf_file/0004/386563/mental-health-eng.pdf
52. Priebe S, Giacco D, El-Nagib R. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Heal Evid Netw Synth Rep 47 [Internet]. 2016;ix-pp. Available from:

http://www.euro.who.int/__data/assets/pdf_file/0003/317622/HEN-synthesis-report-47.pdf?ua=1

53. Close C, Kouvonen A, Bosqui T, Patel K, O'Reilly D, Donnelly M. The mental health and wellbeing of first generation migrants: A systematic-narrative review of reviews. Global Health [Internet]. 2016;12(1):1–13. Available from: http://dx.doi.org/10.1186/s12992-016-0187-3

54. Nguyen TP, Guajardo MGU, Sahle BW, Renzaho AMN, Slewa-Younan S. Prevalence of common mental disorders in adult Syrian refugees resettled in high income Western countries: a systematic review and meta-analysis. BMC Psychiatry [Internet]. 2022;22(1):1–15. Available from: https://doi.org/10.1186/s12888-021-03664-7

55. McColl H, McKenzie K, Bhui K. Mental healthcare of asylum-seekers and refugees. Adv Psychiatr Treat. 2008;14(6):452–9.

56. Black J. Focus on the Overseas Route to the Canary Islands. 2021;1–16.

57. Satinsky E, Fuhr DC, Woodward A, Sondorp E, Roberts B. Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. Health Policy (New York). 2019;123(9):851–63.

58. Gleeson C, Frost R, Sherwood L, Shevlin M, Hyland P, Halpin R, et al. Post-migration factors and mental health outcomes in asylum-seeking and refugee populations: a systematic review. Eur J Psychotraumatol [Internet]. 2020;11(1). Available from: https://doi.org/10.1080/20008198.2020.1793567

59. Giacco D, Laxhman N, Priebe S. Prevalence of and risk factors for mental disorders in refugees. Semin Cell Dev Biol [Internet]. 2018;77:144–52. Available from: https://doi.org/10.1016/j.semcdb.2017.11.030

60. Bogic M, Njoku A, Priebe S. Long-term mental health of war-refugees: a systematic literature review. BMC Int Health Hum Rights. 2015;15(1).

61. Borho A, Viazminsky A, Morawa E, Schmitt GM, Georgiadou E, Erim Y. The prevalence and risk factors for mental distress among Syrian refugees in Germany: a register-based follow-up study. BMC Psychiatry. 2020;20(1):1–13.

62. Kohlenberger J, Buber-Ennser I, Rengs B, Leitner S, Landesmann M. Barriers to health care access and service utilization of refugees in Austria: Evidence from a cross-sectional survey. Health Policy (New York). 2019;123(9):833–9.

63. Yiannakopoulos Y, Etherlands LUN, Omania NOR, Pain SLS. Legal Report on Access To Healthcare in 17 Countries Belgium-Canada-France-Germany-Greece-Ireland-Italy-Luxembourg-Netherlands-Norway-Romania-Slovenia-Spain-Sweden-Switzerland-Turkey-United-Kingdom. 2016.

64. Andersen MH, Kruse A, Frederiksen HW, Ahmadi A, Norredam M. Health status of refugees newly resettled in Denmark. Dan Med J. 2020;67(12):1–10.

65. Kaur S. Barriers Faced by Refugees to Access Health Care Services in Finland [Internet]. LAU REA University of Applied Sciences. 2021. Available

from: https://urn.fi/URN:NBN:fi:amk-2021060915356

66. Informations pour les personnes exilées. I am a refugee, what are my social rights ? | Informations pour les personnes exilées [Internet]. [cited 2022 Jul 13]. Available from: https://domasile.info/en/i-am-a-refugee-what-are-my-social-rights/

67. Germany Visa. Health Insurance for Refugees/Asylum Seekers in Germany - Germany Visa [Internet]. [cited 2022 Jul 13]. Available from: https://www.germany-visa.org/insurances-germany/health-insurance/refugees-asylum-seekers/

68. Medical services asylum seekers. Medical services and entitlements for asylum seekers [Internet]. [cited 2022 Jul 13]. Available from: https://www.citizensinformation.ie/en/moving_country/asylum_seekers_and_refugees/services_for_asylum_seekers_in_ireland/medical_services_and_entitlements_for_asylum_seekers.html

69. Fullman N, Yearwood J, Abay SM, Abbafati C, Abd-Allah F, Abdela J, et al. Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: A systematic analysis from the Global Burden of Disease Study 2016. Lancet. 2018;391(10136):2236–71.

70. UNHCR Italy. Health Services - UNHCR Italy [Internet]. [cited 2022 Jul 13]. Available from: https://help.unhcr.org/italy/services/health/

71. Organization WH regional office for E. Joint report on a mission of the Ministry for Energy and Health of Malta, the International Centre for Migration, Health and Development and the WHO Regional Office for Europe. 2015.

72. Ledoux C, Pilot E, Diaz E, Krafft T. Migrants' access to healthcare services within the European Union: A content analysis of policy documents in Ireland, Portugal and Spain. Global Health. 2018;14(1):1–11.

73. Lebano A, Hamed S, Bradby H, Gil-Salmerón A, Durá-Ferrandis E, Garcés-Ferrer J, et al. Migrants' and refugees' health status and healthcare in Europe: A scoping literature review. BMC Public Health. 2020;20(1).

74. Sleijpen M, Mooren T, Kleber RJ, Boeije HR. Lives on hold: A qualitative study of young refugees' resilience strategies. Childhood. 2017;24(3):348–65.

75. Walther L, Amann J, Flick U, Ta TMT, Bajbouj M, Hahn E. A qualitative study on resilience in adult refugees in Germany. BMC Public Health. 2021;21(1):1–17.

76. Slobodin O, Ghane S, De Jong J. Developing a culturally sensitive mental health intervention for asylum seekers in the Netherlands: A pilot study. Intervention. 2018;16(2):86–94.

77. English LM, Mayo P. Lifelong learning challenges: Responding to migration and the Sustainable Development Goals. Int Rev Educ [Internet]. 2019;65(2):213–31. Available from: https://doi.org/10.1007/s11159-018-9757-3

78. Roberts B. Health Policy and Systems Responses to Forced Migration. Bozorgmehr K, Biddle L, Razum O, Roberts B, editors. Springer Netherlands; 2021.

79. Ibrahim H, Hassan CQ. Post-traumatic stress disorder symptoms resulting from torture and other traumatic events among Syrian Kurdish refugees in Kurdistan Region, Iraq. Front Psychol. 2017;8(FEB):1–8.

80. European Commission. Statistics on migration to Europe [Internet]. 2021 [cited 2022 Jul 14]. Available from: https://ec.europa.eu/info/strategy/priorities-2019-2024/promoting-our-european-way-life/statistics-migration-europe_en#RefugeesinEurope

81. URIE BRONFENBRENNER. Toward an Experimental Ecology of Human Development. Cornell Univ. 1977;(48):513–31.

82. Kanagaratnam P, Pandalangat N, Silver I, Toner B. A mental health framework from the voices of refugees. Int J Soc Psychiatry. 2021;

83. Miller KE, Rasmussen A. The mental health of civilians displaced by armed conflict: An ecological model of refugee distress. Epidemiol Psychiatr Sci. 2017;26(2):129–38.

84. Brooks MA, Meinhart M, Samawi L, Mukherjee T, Jaber R, Alhomsh H, et al. Mental health of clinic-attending Syrian refugee women in Jordan: associations between social ecological risks factors and mental health symptoms. BMC Womens Health [Internet]. 2022;22(1). Available from: https://doi.org/10.1186/s12905-021-01584-y

85. (CDC) C for D and C. The Social-Ecological Model: A Framework for Prevention |Violence Prevention|Injury Center|CDC [Internet]. [cited 2022 May 15]. Available from: https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

86. Scharpf F, Kaltenbach E, Nickerson A, Hecker T. A systematic review of socio-ecological factors contributing to risk and protection of the mental health of refugee children and adolescents. Clin Psychol Rev [Internet]. 2021;83:101930. Available from: https://doi.org/10.1016/j.cpr.2020.101930

87. Nesterko Y, Jäckle D, Friedrich M, Holzapfel L, Glaesmer H. Factors predicting symptoms of somatization, depression, anxiety, post-traumatic stress disorder, self-rated mental and physical health among recently arrived refugees in Germany. Confl Health. 2020;14(1):1–12.

88. Georgiadou E, Zbidat A, Schmitt GM, Erim Y. Prevalence of mental distress among Syrian refugees with residence permission in Germany: A registry-based study. Front Psychiatry. 2018;9(AUG):1–12.

89. Leitner S, Landesmann M, Kohlenberger J, Buber-Ennser I, Rengs B. The Effect of Stressors and Resilience Factors on Mental Health of Recent Refugees in Austria. Vienna Inst Int Econ Stud. 2019;(November).

90. Bogic M, Ajdukovic D, Bremner S, Franciskovic T, Galeazzi GM, Kucukalic A, et al. Factors associated with mental disorders in long-settled war refugees: Refugees from the former Yugoslavia in Germany, Italy and the

UK. Br J Psychiatry. 2012;200(3):216–23.

91. Tinghög P, Malm A, Arwidson C, Sigvardsdotter E, Lundin A, Saboonchi F. Prevalence of mental ill health, traumas and postmigration stress among refugees from Syria resettled in Sweden after 2011: A population-based survey. BMJ Open. 2017;7(12).

92. Sengoelge M, Johnson-Singh CM, Mittendorfer-Rutz E, Vaez M, Saboonchi F. Identifying subgroups of refugees from Syria resettled in Sweden based on multiple trauma exposures: A latent class analysis of trauma history and mental health outcomes. J Psychosom Res [Internet]. 2019;125(June):109814. Available from: https://doi.org/10.1016/j.jpsychores.2019.109814

93. El Khoury SJ. Factors that impact the sociocultural adjustment and well-being of Syrian refugees in Stuttgart–Germany. Br J Guid Couns [Internet]. 2019;47(1):65–80. Available from: https://doi.org/10.1080/03069885.2018.1520196

94. Steel JL, Dunlavy AC, Harding CE, Theorell T. The Psychological Consequences of Pre-Emigration Trauma and Post-Migration Stress in Refugees and Immigrants from Africa. J Immigr Minor Heal. 2017;19(3):523–32.

95. Sleijpen M, Boeije HR, Kleber RJ, Mooren T. Between power and powerlessness: A meta-ethnography of sources of resilience in young refugees. Ethn Heal. 2016;21(2):158–80.

96. Goosen S, Stronks K, Kunst AE. Frequent relocations between asylum-seeker centres are associated with mental distress in asylum-seeking children: A longitudinal medical record study. Int J Epidemiol. 2014;43(1):94–104.

97. Mohwinkel LM, Nowak AC, Kasper A, Razum O. Gender differences in the mental health of unaccompanied refugee minors in Europe: A systematic review. BMJ Open. 2018;8(7):1–6.

98. Müller LRF, Büter KP, Rosner R, Unterhitzenberger J. Mental health and associated stress factors in accompanied and unaccompanied refugee minors resettled in Germany: A cross-sectional study. Child Adolesc Psychiatry Ment Health [Internet]. 2019;13(1):1–13. Available from: https://doi.org/10.1186/s13034-019-0268-1

99. Georgiadou E, Schmitt GM, Erim Y. Does the separation from marital partners of Syrian refugees with a residence permit in Germany have an impact on their quality of life? J Psychosom Res [Internet]. 2020;130(August 2019):109936. Available from: https://doi.org/10.1016/j.jpsychores.2020.109936

100. Tinghög P, Al-Saffar S, Carstensen J, Nordenfelt L. The association of immigrant- and non-immigrant-specific factors with mental ill health among immigrants in Sweden. Int J Soc Psychiatry. 2010;56(1):74–93.

101. Pogarell A, Garthus-Niegel S, Mojahed A, von Verschuer C, Rokyta U, Kummer W, et al. Community Case Study on Trauma-Specific Treatment and Counseling for Refugee Women Exposed to Intimate Partner Violence.

Front Psychiatry. 2019;10(December):1–8.

102. Conway P. Forced marriage. Airl Bus. 1999;1999(11):54.

103. Keygnaert I, Vettenburg N, Temmerman M. Hidden violence is silent rape: Sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Cult Heal Sex An Introd. 2015;14(5):189–206.

104. Jim M, Esperanza L, Hern M, Fern C. Understanding Violence against Women Irregular Migrants Who Arrive in Spain in Small Boats María. Healthcare. 2020;8(299):1–13.

105. Boudart M, Djega-Mariadassou G. Methods of projecting households and families: Chapter 1. Concepts and Definitions. Kinetics of Heterogeneous Catalytic Reactions. The United Nations; 2015. p. 1–37.

106. Löbel LM. Family separation and refugee mental health–A network perspective. Soc Networks [Internet]. 2020;61(January):20–33. Available from: https://doi.org/10.1016/j.socnet.2019.08.004

107. Strang AB, Quinn N. Integration or Isolation? Refugees' Social Connections and Wellbeing. J Refug Stud. 2021;34(1):328–53.

108. Sapin M, Widmer ED, Iglesias K. From support to overload: Patterns of positive and negative family relationships of adults with mental illness over time. Soc Networks [Internet]. 2016;47:59–72. Available from: http://dx.doi.org/10.1016/j.socnet.2016.04.002

109. Bilecen B, Cardona A. Do transnational brokers always win? A multilevel analysis of social support. Soc Networks. 2018;53:90–100.

110. Sierau S, Schneider E, Nesterko Y, Glaesmer H. Alone, but protected? Effects of social support on mental health of unaccompanied refugee minors. Eur Child Adolesc Psychiatry [Internet]. 2019;28(6):769–80. Available from: https://doi.org/10.1007/s00787-018-1246-5

111. Lamkaddem M, Essink-Bot ML, Devillé W, Gerritsen A, Stronks K. Health changes of refugees from Afghanistan, Iran and Somalia: The role of residence status and experienced living difficulties in the resettlement process. Eur J Public Health. 2015;25(6):917–22.

112. El Sount CRO, Denkinger JK, Windthorst P, Nikendei C, Kindermann D, Renner V, et al. Psychological burden in female, iraqi refugees who suffered extreme violence by the "islamic state": The perspective of care providers. Front Psychiatry. 2018;9(NOV):1–10.

113. Hajak VL, Sardana S, Verdeli H, Grimm S. A Systematic Review of Factors Affecting Mental Health and Well-Being of Asylum Seekers and Refugees in Germany. Front Psychiatry. 2021;12(March).

114. Matthew Breiding, Kathleen Baseli, Sharon Smith, Michele Black RM. Intimate partner violence surveillance: Uniform Definitions and Recommended Data Elements. Natl Cent Inj Prev Control Centers Dis Control Prev. 2015;2.

115. World Health Organization. Global Plan of Action.to strengthen the role of

the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children [Internet]. 2016. Available from: https://www.who.int/reproductivehealth/publications/violence/global-plan-of-action/en/

116. Ferrari G, Agnew-Davies R, Bailey J, Howard L, Howarth E, Peters TJ, et al. Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services. Glob Health Action. 2016;9(1).

117. Sethi D, Lazdane G. Sexual Violence Against Refugee Women on the Move To and Within Europe. 2016;(March). Available from: http://www.euro.who.int/__data/assets/pdf_file/0018/319311/9-Sexual-violence-refugee-women.pdf?ua=1

118. Singhammer J, Bancila D. Associations between stressful events and self-reported mental health problems among non-western immigrants in Denmark. J Immigr Minor Heal. 2011;13(2):371–8.

119. De Schrijver L, Vander Beken T, Krahé B, Keygnaert I. Prevalence of sexual violence in migrants, applicants for international protection, and refugees in europe: A critical interpretive synthesis of the evidence. Int J Environ Res Public Health. 2018;15(9).

120. Sharareh A, Carina B, Sarah W. The health of female Iranian immigrants in Sweden: A qualitative six-year follow-up study. Health Care Women Int. 2007;28(4):339–59.

121. Ahmad A, Benson-Martin J, Jahn A, Beiersmann C. A Qualitative Study into Perception, Experience, and Response of Intimate Partner Violence among Syrian Refugee Women in Heidelberg, Germany. 2022;1–17.

122. Napolitano F, Gualdieri L, Santagati G, Angelillo IF. Violence Experience among Immigrants and Refugees: A Cross-Sectional Study in Italy. Biomed Res Int. 2018;2018:15–8.

123. Stöckl H, Penhale B. Intimate Partner Violence and Its Association With Physical and Mental Health Symptoms Among Older Women in Germany. J Interpers Violence. 2015;30(17):3089–111.

124. Lagdon S, Armour C, Stringer M. Adult experience of mental health outcomes as a result of intimate partner violence victimisation: A systematic review. Eur J Psychotraumatol. 2014;5.

125. Timshel I, Montgomery E, Dalgaard NT. A systematic review of risk and protective factors associated with family related violence in refugee families. Child Abus Negl [Internet]. 2017;70(June):315–30. Available from: http://dx.doi.org/10.1016/j.chiabu.2017.06.023

126. Stewart DE. Social determinants of women's mental health. J Psychosom Res. 2007;63(3):223–4.

127. Id EM, Grahn M, Zdravkovic S, Id CC. Social relations and mental ill-health among newly arrived refugees in Sweden : A cross- sectional study. PLOS Glob PUBLIC Heal [Internet]. 2022;1–9. Available from: http://dx.doi.org/10.1371/journal.pgph.0000362

128. “A domanda risposta”, Facchini (Altreconomia): “Sui migranti abbiamo ‘già dato’? Ma dove, ma quando?” | Vie di fuga [Internet]. [cited 2022 Jul 20]. Available from: https://viedifuga.org/a-domanda-risposta-facchini-altreconomia-sui-migranti-abbiamo-gia-dato-ma-dove-ma-quando/

129. Sleijpen M, Haagen J, Mooren T, Kleber RJ. Growing from experience: An exploratory study of posttraumatic growth in adolescent refugees. Eur J Psychotraumatol. 2016;7.

130. Schock K, Böttche M, Rosner R, Wenk-Ansohn M, Knaevelsrud C. Impact of new traumatic or stressful life events on pre-existing ptsd in traumatized refugees: Results of a longitudinal study. Eur J Psychotraumatol. 2016;7(1).

131. Belau MH, Becher H, Kraemer A. Loneliness as a mediator of social relationships and health-related quality of life among refugees living in North Rhine-Westphalia, Germany. BMC Public Health [Internet]. 2021;21(1):1–10. Available from: https://doi.org/10.1186/s12889-021-12303-5

132. Loneliness and Social Isolation | Issues in Society [Internet]. [cited 2022 Jul 20]. Available from: https://spinneypress.com.au/product/loneliness-and-social-isolation/

133. Torres JM, Casey JA. The centrality of social ties to climate migration and mental health. BMC Public Health. 2017;17(1):1–10.

134. Afifi TO, MacMillan HL. Resilience following child maltreatment: A review of protective factors. Can J Psychiatry. 2011;56(5):266–72.

135. Stainton A, Chisholm K, Kaiser N, Rosen M, Upthegrove R, Ruhrmann S, et al. Resilience as a multimodal dynamic process. Early Interv Psychiatry. 2019;13(4):725–32.

136. Malmusi D, Palència L, Ikram UZ, Kunst AE, Borrell C. Inequalities by immigrant status in depressive symptoms in Europe: the role of integration policy regimes. Soc Psychiatry Psychiatr Epidemiol. 2017;52(4):391–8.

137. Kearns A, Whitley E. Getting There? The Effects of Functional Factors, Time and Place on the Social Integration of Migrants. J Ethn Migr Stud. 2015;41(13):2105–29.

138. da Lomba S. Legal status and refugee integration: A UK perspective. J Refug Stud. 2010;23(4):415–36.

139. Ager A, Strang A. Understanding integration: A conceptual framework. J Refug Stud. 2008;21(2):166–91.

140. Strang AB, Baillot H, Mignard E. ‘I want to participate.’ transition experiences of new refugees in Glasgow. J Ethn Migr Stud [Internet]. 2018;44(2):197–214. Available from: https://doi.org/10.1080/1369183X.2017.1341717

141. Sundvall M, Titelman D, DeMarinis V, Borisova L, Çetrez Ö. Safe but isolated – an interview study with Iraqi refugees in Sweden about social networks, social support, and mental health. Int J Soc Psychiatry. 2021;67(4):351–9.

142. Hynie M. The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. Can J Psychiatry. 2018;63(5):297–303.

143. Cratsley K, Brooks MA, Mackey TK. Refugee Mental Health, Global Health Policy, and the Syrian Crisis. Front Public Heal. 2021;9(August):1–20.

144. Walther L, Fuchs LM, Schupp J, von Scheve C. Living Conditions and the Mental Health and Well-being of Refugees: Evidence from a Large-Scale German Survey. J Immigr Minor Heal [Internet]. 2020;22(5):903–13. Available from: https://doi.org/10.1007/s10903-019-00968-5

145. Grochtdreis T, König HH, Riedel-Heller SG, Dams J. Health-Related Quality of Life of Asylum Seekers and Refugees in Germany: a Cross-Sectional Study with Data from the German Socio-Economic Panel. Appl Res Qual Life. 2022;17(1):109–27.

146. Kaltenbach E, Schauer M, Hermenau K, Elbert T, Schalinski I. Course of mental health in refugees-a one year panel survey. Front Psychiatry. 2018;9(AUG):1–12.

147. Turrini G, Purgato M, Ballette F, Nosè M, Ostuzzi G, Barbui C. Common mental disorders in asylum seekers and refugees: Umbrella review of prevalence and intervention studies. Int J Ment Health Syst. 2017;11(1):1–14.

148. Rytter M. Made in Denmark: Refugees, integration and the self-dependent society. Anthropol Today. 2018;34(3):12–4.

149. Green M. Language Barriers and Health of Syrian Refugees in Germany. Am J Public Health. 2017;107(4):486.

150. Foged M, Werf C Van Der. Access to Language Training and Local Integration of Refugees. CReAM Discuss Pap Ser. 2022;(April).

151. Di Saint Pierre F, Martinovic B, De Vroome T. Return Wishes of Refugees in the Netherlands: The Role of Integration, Host National Identification and Perceived Discrimination. J Ethn Migr Stud. 2015;41(11):1836–57.

152. Niemi M, Manhica H, Gunnarsson D, Ståhle G, Larsson S, Saboonchi F. A scoping review and conceptual model of social participation and mental health among refugees and asylum seekers. Int J Environ Res Public Health. 2019;16(20).

153. Sidorchuk A, Engström K, Johnson CM, Kayser Leeoza N, Möller J. Employment status and psychological distress in a population-based cross-sectional study in Sweden: The impact of migration. BMJ Open. 2017;7(4).

154. Jannesari S, Hatch S, Prina M, Oram S. Post-migration Social–Environmental Factors Associated with Mental Health Problems Among Asylum Seekers: A Systematic Review. J Immigr Minor Heal [Internet]. 2020;22(5):1055–64. Available from: https://doi.org/10.1007/s10903-020-01025-2

155. Toar M, O'Brien KK, Fahey T. Comparison of self-reported health & healthcare utilisation between asylum seekers and refugees: An observational study. BMC Public Health. 2009;9:1–10.

156. De Graaff AM, Cuijpers P, McDaid D, Park A, Woodward A, Bryant RA, et al. Peer-provided Problem Management plus (PM+) for adult Syrian refugees: A pilot randomised controlled trial on effectiveness and cost-effectiveness. Epidemiol Psychiatr Sci. 2020;

157. Lamkaddem M, Stronks K, Devillé WD, Olff M, Gerritsen AAM, Essink-Bot ML. Course of post-traumatic stress disorder and health care utilisation among resettled refugees in the Netherlands. BMC Psychiatry. 2014;14(1).

158. Manhica H, Almquist Y, Rostila M, Hjern A. The use of psychiatric services by young adults who came to Sweden as teenage refugees: A national cohort study. Epidemiol Psychiatr Sci. 2017;26(5):526–34.

159. Bozorgmehr K, Schneider C, Joos S. Equity in access to health care among asylum seekers in Germany: Evidence from an exploratory population-based cross-sectional study. BMC Health Serv Res [Internet]. 2015;15(1):1–12. Available from: http://dx.doi.org/10.1186/s12913-015-1156-x

160. Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D, et al. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. Lancet [Internet]. 2016;387(10023):1123–32. Available from: http://dx.doi.org/10.1016/S0140-6736(15)00298-6

161. Jensen NK, Johansen KS, Kastrup M, Krasnik A, Norredam M. Patient experienced continuity of care in the psychiatric healthcare system—a study including immigrants, refugees and ethnic Danes. Int J Environ Res Public Health. 2014;11(9):9739–59.

162. Renner A, Hoffmann R, Nagl M, Roehr S, Jung F, Grochtdreis T, et al. Syrian refugees in Germany: Perspectives on mental health and coping strategies. J Psychosom Res. 2020;129.

163. Griffiths G, Tarricone I, Berardi D, Donegani I, Fioritti A, Maisto R, et al. The provision of mental health services to immigrants and refugees in Italy: The barriers and facilitating factors experienced by mental health workers. J Psychopathol. 2017;23(2):79–86.

164. Mangrio E, Carlson E, Zdravkovic S. Understanding experiences of the Swedish health care system from the perspective of newly arrived refugees. BMC Res Notes [Internet]. 2018;11(1):1–6. Available from: https://doi.org/10.1186/s13104-018-3728-4

165. Tahir R, Due C, Ward P, Ziersch A. Understanding mental health from the perception of Middle Eastern refugee women: A critical systematic review. SSM - Ment Heal [Internet]. 2022;2(June):100130. Available from: https://doi.org/10.1016/j.ssmmh.2022.100130

166. Howard LM, Ehrlich AM, Gamlen F, Oram S. Gender-neutral mental health research is sex and gender biased. The Lancet Psychiatry. 2017;4(1):9–11.

167. Gottvall M, Vaez M, Saboonchi F. Social support attenuates the link between torture exposure and post-traumatic stress disorder among male and female Syrian refugees in Sweden. BMC Int Health Hum Rights. 2019;19(1):28.

168. Carod-Artal FJ. Social determinants of mental health. World Heal Organ. 2017;33–46.

169. UNHCR. Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons [Internet]. UNHCR website. 2003. 158 p. Available from: http://www.unhcr.org/pages/49c3646c1d9.html

170. Vallejo-Martín M, Sancha AS, Canto JM. Refugee women with a history of trauma: Gender vulnerability in relation to post-traumatic stress disorder. Int J Environ Res Public Health. 2021;18(9).

171. Granero-Molina J, Jiménez-Lasserrrotte M del M, Fernández-Sola C, Hernández-Padilla JM, Sánchez Hernández F, López Domene E. Cultural Issues in the Provision of Emergency Care to Irregular Migrants Who Arrive in Spain by Small Boats. J Transcult Nurs. 2019;30(4):371–9.

172. Keygnaert I, Dias SF, Degomme O, Devillé W, Kennedy P, Kováts A, et al. Sexual and gender-based violence in the European asylum and reception sector: A perpetuum mobile? Eur J Public Health. 2015;25(1):90–6.

173. Chauvin P, Simonnot N, Vanbiervliet F, Vicart M VC. Access to healthcare for people facing multiple vulnerabilities in health in 26 cities across 11 countries. Report on the social and medical data gathered in 2014 in nine European countries, Turkey and Canada. Dr World. 2015;(May):138.

174. Dempsey KE. Spaces of violence: A typology of the political geography of violence against migrants seeking asylum in the EU. Polit Geogr [Internet]. 2020;79(January):102157. Available from: https://doi.org/10.1016/j.polgeo.2020.102157

175. Edge S, Newbold B. Discrimination and the health of immigrants and refugees: Exploring Canada's evidence base and directions for future research in newcomer receiving countries. J Immigr Minor Heal. 2013;15(1):141–8.

176. Haase A, Rohmann A, Hallmann K. An ecological approach to psychological adjustment: A field survey among refugees in Germany. Int J Intercult Relations [Internet]. 2019;68(February 2017):44–54. Available from: https://doi.org/10.1016/j.ijintrel.2018.10.003

177. von Haumeder A, Ghafoori B, Retailleau J. Psychological adaptation and posttraumatic stress disorder among Syrian refugees in Germany: a mixed-methods study investigating environmental factors. Eur J Psychotraumatol [Internet]. 2019;10(1). Available from: https://doi.org/10.1080/20008198.2019.1686801

178. Nematy A, Namer Y, Razum O. LGBTQI + Refugees' and Asylum Seekers' Mental Health: A Qualitative Systematic Review. Sex Res Soc Policy [Internet]. 2022; Available from: https://doi.org/10.1007/s13178-022-00705-y

179. Golembe J, Leyendecker B, Maalej N, Gundlach A, Busch J. Experiences of Minority Stress and Mental Health Burdens of Newly Arrived LGBTQ* Refugees in Germany. Sex Res Soc Policy [Internet]. 2021;18(4):1049–59. Available from: https://doi.org/10.1007/s13178-020-00508-z

180. Hvidtfeldt C, Schultz-Nielsen ML, Tekin E, Fosgerau M. An estimate of the

effect of waiting time in the Danish asylum system on post-resettlement employment among refugees: Separating the pure delay effect from the effects of the conditions under which refugees are waiting. PLoS One. 2018;13(11):4–8.

181. Schock K, Rosner R, Knaevelsrud C. Impact of asylum interviews on the mental health of traumatized asylum seekers. Eur J Psychotraumatol. 2015;6.

182. Bartel A, Delcroix C, Pape E. Refugees and the Dublin Convention. Borders Glob Rev. 2020;1(2):40–52.

183. Meuleman B. The influence of macro-sociological factors on attitudes toward immigration in Europe. A cross-cultural and contextual approach. Status Publ [Internet]. 2009; Available from: https://lirias.kuleuven.be/handle/123456789/244575

184. Zimmerman C, Hossain M, Guzun N, Tchomarova M, Ciarrocchi RA, Kefurtova A, et al. The Health of Trafficked Women : A Survey of Women Entering Posttrafficking Services in Europe. Am J Public Health. 2008;98(1):55–9.

185. Crepet A, Rita F, Reid A, Van Den Boogaard W, Deiana P, Quaranta G, et al. Mental health and trauma in asylum seekers landing in Sicily in 2015: a descriptive study of neglected invisible wounds. Confl Health [Internet]. 2017;11(1):1–11. Available from: http://dx.doi.org/10.1186/s13031-017-0103-3

186. Lukasiewicz K. Exile to Poverty: Policies and Poverty Among Refugees in Poland. Int Migr. 2017;55(6):56–72.

187. Allsopp J, Sigona N, Phillimore J. Poverty among refugees and asylum seekers in the UK. IRIS Work Pap Ser [Internet]. 2014;1–46. Available from: http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/iris/2014/working-paper-series/IRiS-WP-1-2014.pdf

188. Mayblin L, James P. Asylum and refugee support in the UK: civil society filling the gaps? J Ethn Migr Stud [Internet]. 2019;45(3):375–94. Available from: https://doi.org/10.1080/1369183X.2018.1466695

189. Knifton L, Inglis G. Poverty and mental health: policy, practice and research implications. BJPsych Bull. 2020;44(5):193–6.

190. Bruhn M, Rees S, Mohsin M, Silove D, Carlsson J. The range and impact of postmigration stressors during treatment of trauma-affected refugees. J Nerv Ment Dis. 2018;206(1):61–8.

191. Rapp MA, Kluge U, Penka S, Vardar A, Aichberger MC, Mundt AP, et al. When local poverty is more important than your income: Mental health in minorities in inner cities. World Psychiatry. 2015;14(2):249–50.

192. Keskimaki I. 14.M. Workshop: Health policy responses to the European “refugee crisis.” Eur J Public Health. 2020;30(Supplement_5):278–9.

193. United Nations High Commissioner for Refugees (UNHCR). Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations. United Nations High Comm Refug [Internet]. 2013; Available

from: https://www.unhcr.org/protection/health/525f94479/operational-guidance-mental-health-psychosocial-support-programming-refugee.html

194. Gower S, Jeemi Z, Wickramasinghe N, Kebble P, Forbes D, Dantas JAR. Impact of a Pilot Peer-Mentoring Empowerment Program on Personal Well-Being for Migrant and Refugee Women in Western Australia. Int J Environ Res Public Health. 2022;19(6).

195. Gower S, Jeemi Z, Forbes D, Kebble P, Dantas JAR. Peer Mentoring Programs for Culturally and Linguistically Diverse Refugee and Migrant Women: An Integrative Review. Int J Environ Res Public Health. 2022;19(19).

196. Drydakis N. Mobile applications aiming to facilitate immigrants' societal integration and overall level of integration, health and mental health. Does artificial intelligence enhance outcomes? Comput Human Behav [Internet]. 2021;117:106661. Available from: https://doi.org/10.1016/j.chb.2020.106661

197. JoAnne E. Epping-Jordan, Russ Harris, Felicity L. Brown, Kenneth Carswell, Claudette Foley, Claudia Garc la-Moreno, Cary Kogan M van O. Self-Help Plus (SH1): a new WHO stress management package. World Psychiatry [Internet]. 2016;15(3):294–5. Available from: doi:10.1002/wps.20355

198. Au T, Brown F, Carswell K, Gray B, Epping-Jordan J, Foley C, et al. Self-Help Plus (Sh+) a Group-Based Stress Management Course for Adults Generic Field-. World Health Organization; 2021.

199. Tol WA, Augustinavicius J, Carswell K, Brown FL, Adaku A, Leku MR, et al. Translation, adaptation, and pilot of a guided self-help intervention to reduce psychological distress in South Sudanese refugees in Uganda. Glob Ment Heal. 2018;5.

200. Purgato M, Carswell K, Tedeschi F, Acarturk C, Anttila M, Au T, et al. Effectiveness of Self-Help plus in Preventing Mental Disorders in Refugees and Asylum Seekers in Western Europe: A Multinational Randomized Controlled Trial. Psychother Psychosom. 2021;90(6):403–14.

201. Dawson KS, Bryant RA, Harper M, Kuowei Tay A, Rahman A, Schafer A, et al. Problem Management Plus (PM+): A WHO transdiagnostic psychological intervention for common mental health problems. World Psychiatry. 2015;14(3):354–7.

202. de Graaff AM, Cuijpers P, Acarturk C, Bryant R, Burchert S, Fuhr DC, et al. Effectiveness of a peer-refugee delivered psychological intervention to reduce psychological distress among adult Syrian refugees in the Netherlands: study protocol. Eur J Psychotraumatol [Internet]. 2020;11(1). Available from: https://doi.org/10.1080/20008198.2019.1694347

203. Spaaij J, Kiselev N, Berger C, Bryant RA, Cuijpers P, de Graaff AM, et al. Feasibility and acceptability of Problem Management Plus (PM+) among Syrian refugees and asylum seekers in Switzerland: a mixed-method pilot randomized controlled trial. Eur J Psychotraumatol. 2022;13(1).

204. Acarturk C, Uygun E, Ilkkursun Z, Yurtbakan T, Kurt G, Adam-Troian J, et

al. Group problem management plus (PM+) to decrease psychological distress among Syrian refugees in Turkey: a pilot randomised controlled trial. BMC Psychiatry [Internet]. 2022;22(1):1–11. Available from: https://doi.org/10.1186/s12888-021-03645-w

205. Block K, Gibbs L. Promoting social inclusion through sport for refugee-background youth in Australia: Analysing different participation models. Soc Incl. 2017;5(2PracticeandResearch):91–100.

206. Doidge M, Keech M, Sandri E. 'Active integration': sport clubs taking an active role in the integration of refugees. Int J Sport Policy Polit [Internet]. 2020;00(00):1–15. Available from: https://doi.org/10.1080/19406940.2020.1717580

207. Cantekin D. Syrian Refugees Living on the Edge: Policy and Practice Implications for Mental Health and Psychosocial Wellbeing. Int Migr. 2019;57(2):200–20.

208. Nickerson A, Bryant RA, Steel Z, Silove D, Brooks R. The impact of fear for family on mental health in a resettled Iraqi refugee community. J Psychiatr Res [Internet]. 2010;44(4):229–35. Available from: http://dx.doi.org/10.1016/j.jpsychires.2009.08.006

209. Nilsson JE, Russell EB. Accultration, Partner Violence, and Psychological Distress in Refugee Women from Somalia. J Interpers Violence. 2008;23(2002):1654–63.

210. Spiller TR, Schick M, Schnyder U, Bryant RA, Nickerson A, Morina N. Somatisation and anger are associated with symptom severity of posttraumatic stress disorder in severely traumatised refugees and asylum seekers. Swiss Med Wkly. 2016;146:w14311.

211. Alemi Q, Stempel C, Baek K, Lares L, Villa P, Danis D, et al. Impact of Postmigration Living Difficulties on the Mental Health of Afghan Migrants Residing in Istanbul. Int J Popul Res. 2016;2016:1–8.

212. Chen C, Smith P, Mustard C. The prevalence of over-qualification and its association with health status among occupationally active new immigrants to Canada. Ethn Heal. 2010;15(6):601–19.

213. Leitner SM, Landesmann M. Refugees' integration in the Austrian labour market: Occupational mobility and job-skills mismatch [Internet]. 2020. Available from: https://www.econstor.eu/handle/10419/237675%0Ahttps://www.econstor.eu/bitstream/10419/237675/1/1735454508.pdf

214. Alpak G, Unal A, Bulbul F, Sagaltici E, Bez Y, Altindag A, et al. Post-traumatic stress disorder among Syrian refugees in Turkey: A cross-sectional study. Int J Psychiatry Clin Pract. 2015;19(1):45–50.

215. Guruge S, Roche B, Catallo C. Violence against Women: An Exploration of the Physical and Mental Health Trends among Immigrant and Refugee Women in Canada. Nurs Res Pract. 2012;2012:1–15.