STRATEGIES FOR A HEALTH PROMOTING INTRODUCTION FOR NEWLY-ARRIVED REFUGEES AND OTHER IMMIGRANTS

Fredrik Lindencrona

Stockholm 2008
To my family, friends, colleagues and all the great persons from all around the world that I have met during this exciting project
“...refugees present perhaps the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity”

Marjorie A. Muecke 1992
ABSTRACT

From 1980 to 2005 about 340,000 persons have been granted permanent residency in Sweden for refugee or similar reasons. Many countries, including Sweden, have implemented introduction programmes aimed at reducing inequality in critical living conditions between refugees and the host population. From a structural perspective on health promotion, the intended outcomes and the role as everyday environment make such programmes interesting settings for health. This thesis aims to identify the preconditions for and to develop strategies for strengthening the health promoting potential of the Introduction for newly-arrived refugees and other immigrants, and its environment in Sweden. The four papers in the thesis are designed to identify important risk and protective factors for mental health within the Introduction and to consider how structures, processes and practices of the Introduction may promote such protective factors and prevent risk factors both during programme delivery and as a result of it.

In Paper I, 28 professionals with different roles in the Introduction are interviewed about health among the refugees in the programme. The study shows that the most immediate conceptualization of health among staff is that it concerns absence of illness and that the role of the Introduction is to refer those with such problems to treatment in healthcare. However, in narrated everyday episodes about the Introduction, health is something far richer. It includes two levels: personal capacities and qualities in the Introduction and the environment, and threats to each of these levels. Paper II presents path analyses for core post-traumatic stress symptoms (CPTS) and symptoms of common mental disorder (GHQ-s), including socio-demographic variables, pre-resettlement trauma, personal capacity to handle stress, exposures as asylum-seekers and a new instrument to measure resettlement stressors, obtained from 115 persons, mainly from Iraq. The final path models of CPTS and GHQ-s are similar in some respects, such as the importance of personal capacity to handle stress, while in other respects they differ: resettlement stressors are more important than pre-resettlement trauma for explaining GHQ-s, whereas the reverse applies to CPTS. Paper III and Paper IV use information about the structure, process and practice of the Introduction, reported by 83 Introduction unit managers in the same number of local authorities in Sweden. Both studies focus on which building blocks, in the inter-organizational network that provides the Introduction that can explain differences in critical setting qualities. Various combinations of the following five main building blocks affect setting qualities: active management on all levels, systematic evaluation, active network involvement by many organizations, group modes of interaction between managers and staff as well as between staff and participants from all organizations, and conditions in the local authority.

The results are integrated in the Health Promoting Introduction Model, which includes: network building blocks, setting qualities, the health promoting spiral of personal capacities, outcomes and environmental facilitators and long-term health, social and economic outcomes at the individual, group and societal levels. The model should guide policy and the development of practice in this area. It can also provide opportunities for focused research on complex health promoting service delivery systems in general and settings for refugee resettlement support in particular.


Slutsatserna i avhandlingen är att programmet måste ändra sin idé om att man ska ge hjälp åt flyktingar för att kompensera olika brister hos dem. Ett bättre sätt att se på flyktingar är att det är en grupp av personer som kan och vet mycket. De måste få vara med och ta fram vilket stöd som de behöver för att den kompetens och de resurser de har ska användas på bästa sätt. Samarbetet mellan deltagare och personal är viktigt för att programmet ska lyckas. Eftersom det är väldigt olika personer som kommer till Sverige måste programmet bli bättre på att ge rätt insatser åt varje person. Ett bra samarbete mellan olika organisationer i en kommun gör det lättare för flyktingar att få arbete och att etablera sig i samhället, men mer forskning behövs om vilka insatser som leder till olika mål. Att Introduktionen fungerar är viktigt för att hälsan i denna grupp ska förbättras men också för den sociala och ekonomiska utvecklingen av det svenska samhället.
 استراتيجيات من أجل التمهيد النافع للصحة
- ملخص

كان الناس ولا يزالون يتألقون إلى السويد من مختلف بقاع الأرض. تعود ذلك إلى أسباب مختلفة، ولكن العمل والحب من أكثر الأسباب المعادية وراء ذلك على مر السنين. بعد الاستعراض الحب العالمية الثانية بداية الناس تعود إلى هذه هيمنة المفاصل في أوائلهم السهولة. وبالرغم من ارتداية هجرة اللاجئين وأشخاص آخرين يعانون من ظروف مشابهة خلال العقود الثلاثة، فقد نجح سوي فريق أداء من اللاجئين في العلوم في القوى إلى أوروبا. ربما أن عدد هؤلاء قليل للغاية. ولكن نحن نحن أوروبا اللاجئون في عددهم صاحبهم في أي حال يضعف الأغلبية بالресурсات المتاحة عند قوم الأشخاص إلى السويد يضمن معظم اللاجئين منهم، أو من لديه أسباب مشابهة، بطلان لتصحيح الإقرارات الدائمة، ولكن هناك عدد كبير منهم لا يصل على هذا التصريح من التصريح الإقامة الدائمة كلاجئين أو لأن لديهم أسباب مشابهة لأحواللاجئ. يعمال هذا العدد حوالي 0.4% من عدد سكان السويد. كيف تشير الأمور بالنسبة لم، لا يسمح لهم الهجرة إلى السويد.

كانت هذه النظرية تدور حول ما إذا كان الأشخاص الذين يسعهم القضاء في السويد

عندما يمنح المهر تصور الإقامة الدائمة في السويد بسبب اللجوء أو نتيجة للهجرة فإنها بعض اللجوء، فإنه يشجع على المشاركة فيما يسمى البرنامج التمهيدي في البلدية التي يقيم فيها. إن الهجرة إلى السويد لبرنامج التمهيدي هو مساهمة للأطفال الذين يفسرون حقاً المسؤوليات التي يمكنهم من الحصول على عمل، دعم أو الاستمرار في التعليم. إننا نتوقع أن تكون من مشاركة في المجتمعون مختلفين، ولكن الأشخاص الذين تصل إلى السويد، مستقرون وأكثر فروع كبيرة بين أشكال الظروف الاجتماعية عند مقارنة الأشخاص المولودين في بلدان أخرى مع الأشخاص المولودين في السويد. إن مثل هذه الاختلافات تظهر ذات أهمية كبيرة، التي تمكن من تأثير أن هناك فروق بين حال الأشخاص ضمن مجموعات مختلفة من النجاح في السويد عبر تلك الفروق الاجتماعية عن ظروف النشأة أو كود المعبر قدرته على تقديم للمؤسسة. وفي السويد، بما أن البرنامج التمهيدي يجب أن يؤدي على هذه الفروق للحصول على عمل بidable أو تعلم اللغة السويدية. فيما بين أمر على ما يرام بالنسبة للبرنامج التمهيدي. كما نعلم أيضاً أن البيئة الوصولية للمؤسسة، تمر في هذه الظروف الاستثنائية، مثالية لدراسة التهوية لمعرفة ما هو الذي يوفر على سياقة المشاركة في هذا البرنامج. عن طريق عمل مقابلات مع المستخدمين واللاجئين المشاركات ضمن البرنامج التمهيدي، واستجابة لآليات للأمان والمسؤولية عن البرنامج التمهيدي. يجري البحث بصيغة بيومية جيدة بالإضافة إلى ذلك إلى أهدافه إلى الوصول إلى مقارنات.

إن الدراسة التي توصلت إليها هذه الطرقية تقول أنه يجب أن يتم تغيير فكرة البرنامج إذا كما نستطيع في تقدم العمر للأشخاص الذين يتمتعون من مختلف التواصليات الموجودة لديهم. بدلاً من ذلك يجب النظر إلى اللاجئين كمجمعة قادرة وتمكينها من النجاح، يجب أن يمنح لها أرباب العمل الذين تحتاج إليه لكي تستخدم الكفاءات والموارد الموجودة لديهم. أيضًا، فإن الفصل إن اتخاذ ما بين المشاركين والمستخدمين مهم جداً لكي ينجح البرنامج التمهيدي، بينما أنه يوجد فرق كبير بين الأشخاص الذين يسكنون إلى السويد، فيجب أن ينجح البرنامج أولاً فيما يتعلق بمساعدات اللجوء في الحصول على الإعانات، أولاً، حيث يجب أن تكون مبادئ الأدوات الحالية للبرامج المعروفة إلى النجاح، بصرف النظر، إذا كان ذلك في إطار تطوير جديد للمنظمات في بنية ما يمكن أن يسهل هذا الشيء، الأمر بالنسبة للأحياء بالحصول على عمل وترسيخ أفعالهم في المجتمع. يجب علينا أن نقوم بتعبير من الأشخاص عن الإجراءات التي توصلنا إلى أهداف مثلى. إن البرنامج التمهيدي يجب بصيغة معنية بمسؤولية واضحة. مثالاً، لمها، التي تختص الناحية الصحية لهذه المجموعة الرئيسية بالنسبة للتطوير الاجتماعي والاقتصادي للمجتمع السويدي.
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<td>DSM III, DSM IV</td>
<td>Diagnostic and Statistic Manual for the American Psychiatric Association, versions III and IV</td>
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<td>Introduction</td>
<td>The Introduction for newly-arrived refugees and other immigrants</td>
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<td>General Health Questionnaire</td>
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<td>GHQ-s</td>
<td>Symptoms of common mental disorder as measured by the General Health Questionnaire</td>
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1 HEALTH AND MENTAL HEALTH PROMOTION – TRACING THE ROOTS

This thesis concerns how current principles of health promotion can be applied to facilitate the resettlement in Swedish society of newly-arrived refugees and other immigrants. The concept of health promotion was introduced in 1974 by Marc Lalonde, Canadian Minister of Health, in the pioneering report *A new perspective on the health of Canadians* (Government of Canada 1974). While this report can be seen as the starting point for the modern health promotion movement, the ideas underlying the concept can be traced back to ancient times, at least to Greek civilization around the 5th century BC.

Homer has it that humankind acquired the art of healing through Asclepius, a mortal who was taught by Chiron, a centaur. In later Greek mythology, Asclepius is a god with a close relationship to two related goddesses, Hygeia and Panacea (the sources refer to them variously as daughters or spouses of Asclepius), who differed in their approach to healing. Hygeia was the guardian of health and has been linked to preventive or environmental aspects of medicine, while through her knowledge of drugs Panacea became omnipotent as a healing goddess (MacDonald 1998). Notwithstanding Panacea’s dominance, thinkers such as Hippocrates articulated wisdom inspired by Hygeia on the relationship between persons and their social and physical environments that seems sophisticated even from the perspective of modern health promotion (ibid).

Ideas similar to those of medicine as we know it today recurred some thirteen centuries later, during the Renaissance. Before that, in the 13th century, ideas about how to lead a healthy life, with reference to such matters as sleep, exercise and nutrition, were presented in *Regimen Sanitatis Salernitatum*, a book that the medical historian Sigerist claimed to be the most successful medical treatise of all times (ibid).

As medicine developed through history, the distinction was maintained between curative medical treatment and interventions to promote health and prevent disease, with precedence for the former. Today, it can hardly be denied that as a result of technological innovations at first derived from Islamic culture through the crusades, Panacea ideas of curative medical treatment occupy the larger part of the medical field. Concurrently, Hygeia has tended to move her activities to neighbouring land that is often less oriented to biomedicine and illness. She has, however, regained importance as our understanding of the important factors that prevent illness and promote health has grown in the past century and a half. It is the fruits of this development that have guided the theoretical foundation of this thesis, which is an attempt to apply the principles of promotion to new contexts that have not yet been explored for their potential contribution to this worthwhile humanistic endeavour.

1.1 OUTLINE OF THE THESIS

The first four chapters provide an overview of developments in areas of relevance to this thesis. Chapter 1 introduces four ideas that can be considered to be significant underpinning themes in “structurally oriented health promotion” (Poland, Coburn, Robertsson, Eakin and the members of the Critical Social Science Group 1998, 796).
The four ideas, which are lessons learned by health research in a number of disciplines over the past century, provide the theoretical foundation for this thesis and for the more specific theories and principles that are used in it. They are: 1) health is intricately linked to the living conditions in which a person or a group of persons live, 2) the main bulk of factors that determines health lie in the nested levels of the everyday environment, outside the realm of healthcare, 3) adversity and inequality matters for individual and population levels of health, and 4) it is particularly important to understand what leads to health. The rest of this chapter will introduce the field of mental health promotion and mental disorder prevention, a field that has recently regained momentum. Chapter 2 starts with an introduction to research in refugee mental health. It ends with a framework that guides the review of determinants of health and mental health at different levels of social organization that may impact upon the health of refugees and other immigrants. In Chapter 3, Moos’ theoretically and empirically validated integrative model, which addresses the interplay between context, coping, adaptation and health/well-being, is applied to the context of resettlement in Sweden. In Chapter 4 the focus is on possible strategies to address the determinants of health. First, the modern development of health promotion is presented, with particular reference to the Ottawa Charter and subsequent developments. The chapter goes on to introduce research on settings for health and ends with a section about the implementation of complex service delivery.

Chapter 5 presents the aim of the thesis, while Chapter 6 describes the methods used in the studies included in the thesis. In Chapter 7, the main results of the various studies are described, together with an account of two interventions that were based on preliminary results from the studies and tested in four Swedish municipalities. The research material from the implementation of the two studies has been collected but time did not allow any detailed analysis of the data before the thesis was finalized. In Chapter 8, the primary findings are integrated into the Health Promoting Introduction Model and the project is discussed from a methodological perspective. Finally, conclusions are drawn and implications for research, policy and practice are suggested.

1.2 LESSON I: HEALTH IS INTRICATELY LINKED TO THE CONDITIONS IN WHICH A PERSON OR A GROUP OF PERSONS LIVE

Understanding of the intricate and variable role of the social and physical environment for the prevention of ill-health and the promotion of health has grown during the past century and a half. Attempts to understand this relationship have often mirrored the development of the most pertinent public health problems at a particular time in history. Thomas McKeown and others have identified improvements in social and economic conditions as the most important factor behind the marked improvement in life expectancy in the developed world in the last two centuries (e.g. McKeown 1976). There is general agreement with McKeown on two basic conclusions: a) economic effects on material living conditions are critical “root causes” of improvements in population health, and b) innovations in curative medicine cannot account for such changes (Colgrove 2002; Link and Phelan 2002; Szreter 2002). However, new evidence has shown that McKeown ignored the role of active political activity in combating challenging social and economic conditions, as well as more direct interventions to improve basic amenities for health. Szreter have called this ignorance a
“dangerous untruth” since it left the field wide open for arguments, starting in the 1980s, that political action could not achieve anything; on the contrary, public spending slowed down needed economic development (2002). Later evidence has shown that “public health is an intrinsically political subject, and it cannot be divorced from intentional, organized human agency” (ibid, 722). Szreter suggests that McKeown’s disregard of the role of political action may have been an omission rather than a fundamental theoretical idea, because at the time of his first conclusions, in the middle of the 20th century, the importance of political institutions and commitment at all levels was almost undisputed (2002). The belief in the need for global political commitment after the Second World War is evident from the inauguration of several global institutions such as the UN in 1945 and the World Health Organization in 1948.

Thanks to improved social and economic conditions, “degenerative and man-made diseases displace pandemics of infection as the primary causes of morbidity and mortality” in the developed world (Omran 1971, 732). The change has been driven both by active political will and by access to more resources for people to take decisions conducive to health (Link and Phelan 2002; Szreter 2002). Although Omran differentiates between models of how this so-called “epidemiological transition” occurs in different countries and regions, recent predictions indicate that a similar shift is underway and will dominate most low and middle-income countries in the coming 25 years, with HIV/AIDS, unipolar depressive disorders and ischemic heart disease as the three most important causes of the worldwide burden of disease in 2030 (Mathers and Loncar 2006; World Health Organization 2008). However, “the tides of the health transition have not lifted all boats evenly” (Heuveline, Guillot and Gwatkin 2002, 314). In fact, mortality disparities seem to have grown in the second half of the previous century, between as well as within countries, and the excess death rate for the poorest 20% of the world’s population is mainly attributable to infectious diseases. The quality of the physical environment is still a highly salient issue worldwide, with about 17% of the global population lacking access to clean water and 42% lacking access to improved sanitation in 2002 (WHO 2004).

An important contribution to thinking about individual level and socio-structural explanations for health and disease has been provided by Geoffrey Rose (1985; 1992). He realized that since incidence rates vary tremendously over time and between populations, while the genetic distribution of susceptibility does not seem to vary more between than within populations, the characteristics of a person who is particularly likely to fall ill in a given population are not necessarily the same as the characteristics of populations where many get ill. Studying only disease occurrence between people within a population masks shared risk factors that might actually be those that are important for disease burden. For diseases with a high incidence, persons at a relatively lower level of risk compared to others will still be likely to get the disease, only less likely than those with higher risk. This insight led Rose to postulate one of his most important arguments (sometimes called Rose’s theorem): “a large number of people at a small risk may give rise to more cases of disease than the small number who are at high risk” (Rose 1985, 36). The differentiation between causes of incidence and causes of disease has been much discussed in epidemiology. The main argument against Rose has been that all preventive interventions must be based on established disease pathways into the human body (Charlton 1995, 610). For Rose, causes with the greatest
potential impact on disease incidence have priority (Schwartz and Diez-Roux 2001).

The key to Rose’s argument starts in a Durkheimian idea that since populations are
different level of organization to persons, other variables may be at work at this level,
such as “social facts” (Schwartz and Diez-Roux 2001). Given that there are several
nested levels of social and biological organization, “the disease of any individual
incorporates causes at a level of organization above (and below) the individual” (ibid,
437).

In order to address the incidence of a particular disease or risk factor in a population, it
is necessary to have a “population strategy”. A population strategy to prevention
attempts “to control the determinants of incidence, to lower the mean level of risk
factors, to shift the whole distribution of exposure in a favourable direction” (Rose
1985, 36). As stated in Rose’s theorem, even limited levels of change for many people
have the potential to achieve a lot of change for the population. Another important
benefit is that individuals may find it easier to undertake personal change when
everyone else is also subject to the same requirement for change. Change in social
norms can facilitate structural change in the provision of goods and services. However,
the population strategy has one important drawback, often referred to as the
“prevention paradox”, namely that “a preventive measure which brings much benefit to
the population offers little to each participating individual” (ibid, 37). Because of this
paradox, Rose saw the two strategies as complementary and considered that the high-
risk strategy could not be abandoned until there was knowledge of effective measures
to affect the underlying causes of incidence (ibid).

Even today, public health approaches tend to favour the individual high-risk strategy
over the population approach. A re-evaluation of the ideas in 2006, two decades after
they were introduced, concluded that even if some improvements could be attributed to
the high-risk strategy, such as annual reductions in the USA of about 2% and 1%,
respectively, in morbidity/disability in older age and in mortality, such gains have been
hard-won and sustaining or increasing them will continue to demand considerable
resources and attention in a never-ending circle from new recruits of persons at risk
(Doyle, Furey and Flowers 2006). This dominance has contributed to the claim, not
clearly articulated by Rose, that the effects of the individual high-risk strategy might be
positively skewed in favour of the population’s upper socioeconomic strata. While
adaptation to needed changes in behaviour may be comparatively easy for people and
communities with more resources, this is considerably harder for those with fewer
resources. A review of effective policy for tobacco control for socio-economically
disadvantaged groups in six western European countries shows that population
strategies, such as limiting access to cigarettes by raising their price and legislation
against advertising or use in certain environments, are considered to be the most
effective for these groups (Giskes, Kunst, Ariza, Benach, Borell, Helmert, Judge et.al.
2007). Evaluations demonstrate large effects on smoking as well as an overall change
in smoking norms when such strategies are applied (Fong, Hyland, Borland, Hammond,
Hasting, McNeill, Anderson et.al. 2005). Notwithstanding the important
ethical considerations that must be addressed before any public policy decision to
restrict the autonomy of individuals in favour of the common good, these findings
illustrate the necessity of population strategies for public health improvement if
changes that might reduce inequality are to be achieved.
1.3 LESSON II: THE MAIN BULK OF FACTORS THAT DETERMINES HEALTH LIE IN THE NESTED LEVELS OF THE EVERYDAY ENVIRONMENT, OUTSIDE OF THE REALM OF HEALTHCARE

The epidemiological shift was evident in Europe and the rest of the Western industrialized world from around the time of the two world wars (Omran 1971). In the new disease panorama, other models were needed to explain disease occurrence and to guide action against it. When the major diseases could not be attributed to distinct agents, such as microbiological organisms, other disease mechanisms had to be envisioned. One of the more important ideas throughout the 20th century has been the concept of stress, originally introduced by Hans Selye in 1936. Selye, an experimental physiologist, first considered stress as a non-specific physiological defence reaction in experimental animals (Viner 1999). By the 1940s this had been broadened into the definition of stress that still is used: “the sum of all non-specifically induced changes in a biological system” (Selye 1956 quoted in Viner 1999, 392). This concept is ubiquitous in the public debate and in medical and health disciplines today, but that was not the case for decades after the concept’s introduction.

Instead, the 1950s, when the epidemiological shift had been evident for some time in Europe, was dominated by risk-factor modelling of cardiovascular disease, featuring clinical symptoms and markers (Oppenheimer 2006). Oppenheimer suggests that clinical characteristics were more within reach of epidemiology at that time because most of the work was done by clinical doctors and questions about social class and other social concepts were thought to be potentially offensive to the respondents (ibid). However, the multiple risks involved made it obvious that isolating and acting upon a single factor would not suffice to reduce the problem. This insight led to an active search in the 1960s for other risk factors, primarily in the realm of individual psychological (particularly behavioural) factors (Oppenheimer 2006). The focus on individual behaviour was spurred by the development of behavioural medicine, a field of prevention, education, treatment and research where behaviorist psychology is applied to “understand how behaviours affect the development and course of illness” (Weddington and Blindt 1983, 704) with the purpose of treating “medical problems by changing behaviors” (ibid, 708). Later, simple behavioural models were expanded into theoretical models to explain health behaviour based on social cognition, such as the theory of reasoned action (Fishbein and Ajzen 1975) and the health belief model (Becker 1974). In the 1950s the psychologist Richard S. Lazarus and his colleagues were already studying individual differences in motivational and cognitive variables among persons exposed to stress. Lazarus’ ideas challenged Selye’s notion that stress is “determined only by the amount of adaptation provoked by a stressor” (ibid, 403). However, even in the late 1960s, military psychiatrists were still quantifying life events as more or less stressful without consideration for the person-environment interaction or individual variability (Holmes and Rahe 1967). Models based on social cognition or on the individual variability in how stress is handled have guided health education and health psychological research and intervention for the better part of the last quarter-century and are still being applied (Mielewczyck and Willig 2007).
These models are the focus for clinical health psychology, the mainstream approach to how psychology can be used to aid persons with somatic health problems. Interventions based on this approach are often delivered by individual counselling in health care institutions and schools. For example, reviews show that psychoeducational programmes for coronary heart disease patients make an important contribution to the lowering of mortality and morbidity in this group (Dusseldorp, van Elderen, Maes, Meulman and Kraaij 1999). This approach has been a cornerstone of public health activity since around the mid 20th century (World Health Organization 1986a). However, this flourishing development has been accompanied by growing criticism, from inside and outside health psychology, of the clinically-oriented perspective on health behaviour. In particular, the criticism comes from several fields where health and mental health are considered to be much more “an outcome of social, economic and political determinants than a simple consequence of individual behaviour and lifestyle” (Marks 2002, 11).

The focus on the complexities of the nested layers of everyday contexts has been advocated in socio-ecological psychology ever since the 1970s. This field of psychology and behavioural sciences was inspired by general ideas of ecology and human ecology and saw a possibility to “direct their inquiries toward a more complete view of man interacting with both his physical and social environment” (Insel and Moos 1974, 180). An important influence here has been Professor Rudolf Moos from Stanford. In 1974, Insel and Moos reviewed the evidence about human environments and found three underlying dimensions, represented across a variety of environmental inventories, that may characterize different environments: relationship dimensions, personal development dimensions and system maintenance and system change dimensions (1974). Work on characterizing different settings and linking setting qualities to outcomes for participants in these settings has continued and resulted in an integrative model (Moos 2002). Another important example of the socio-ecological perspective is Urie Bronfenbrenner’s ecological systems theory (1979).

The socio-ecological perspective has been important in community psychology, an alternative to mainstream clinical psychology that focuses on “the formal structures of our society—the institutions themselves rather than the people that live in them” (Goodstein and Sandler 1978, 887). A more recent approach is public health psychology, which belongs to a health discourse but differs from clinical health psychology in its clear focus on prevention and promotion rather than treatment. The roots of this approach can be traced back to at least the early 1980s (Tanabe 1982). Public health, community and critical approaches to health psychology all include social, economic and political dimensions at many levels of the environment as critical factors in the study of and action to affect health and health behaviour (Murray and Poland 2006). However, simplifying somewhat, while community psychology helps us to understand and achieve constructive social processes, advocacy and social capital development outside the health care system, public health psychology has been inspired by public health as an active contributor to the development of public policy (Marks

1 This model serves as an important vehicle to organize the ideas in this thesis and will be introduced in detail in Chapter 3.
Psychologists’ interest in public health and public policy can easily be understood in the context of new movements in epidemiology since the 1970s.

Social epidemiology – the study of social, economic and political determinants of public health – has moved from being just a minimal research area in the 1960s to become an area of high importance for epidemiology and public policy (Commission of the social determinants of health 2008). An early contribution to this area was Cassel’s challenge to the traditional disease model in epidemiology. Inspired by stress research, Cassel argued that an adequate disease model needed to include the host environment as a dimension that affects, relatively non-specifically, the host’s susceptibility to a broad range of diseases (1976). The last sentence of his paper shows how he tries to distance himself from the contemporary dominant risk-factor epidemiology perspective. He argues that interventions based on his model of disease “would do more to prevent a wide variety of diseases than all the efforts currently being made through multiphasic screening and multi-risk-factor cardiovascular intervention attempts” (Cassel 1976, 122). Another early contributor to the field was the head of the global commission of social determinants of health within the WHO, Sir Michael Marmot. Interestingly, his early studies in this area used migrating populations with varying risk for coronary heart disease and found that among persons born in Japan and now living in the US those who still kept “traditional values” had a similarly low risk for the disease as people in Japan, while those “acculturated to US values” had levels approaching the general US population. Since this could not be explained by ordinary biomedical risk factors, Marmot and Syme claimed to have found evidence for social factors of heart disease and showed that the social environment needed to be taken into account when explaining variations in disease risk (Marmot and Syme 1976). These ideas led to the paper on social networks and their role for host resistance, by Lisa Berkman and others in 1979, which one of the pioneers in social epidemiology has described as representing the start of the new field of social determinants of health (Syme 2005).

The introduction of the McKeown thesis in the late 1970s made many researchers “mindful of the potential health impact of the entire array of social, political, and economic policy we humans develop […] it is in this broadening of perspectives that public health will find its best response to social conditions that act as fundamental causes of disease” (Link and Phelan 2002, 732). McKeown’s and other people’s ideas had an important influence on the research community, which was concerned about the skyrocketing costs and limited returns of the traditional disease-health care clinical treatment model. This drew attention to the contribution of “interventions and structural changes outside of the health care system” (Evans and Stoddart 1990, 1353). The development of better models to explain population health was one important challenge. A prominent early example is the model presented by Evans and Stoddart in Canada in the paper “Producing health. Consuming care”, where health and function are focused as the most critical issue, affected by disease and a whole set of other factors. Levels of health and function have a strong influence on well-being, the ultimate goal of health policy (ibid). Levels of health in the population are dependent on numerous factors in the nested environment. While many researchers in and outside social epidemiology agree with Evans and Stoddart in seeing many determinants of
health outside the healthcare system as most important for population health, the framework has raised criticism on other grounds (Poland, Coburn, Robertsson, Eakin and the members of the Critical Social Science Group 1998). The critique is essentially the same as that directed towards the McKeown hypothesis, i.e. that wealth does not provide health without active political efforts. According to these critics, if funds are to be “freed” from healthcare, they must be earmarked for other specified health-producing interventions; otherwise this roll-back of public spending is unlikely to confer any health gains.

Traditional epidemiology has not always accepted the radical ideas in social epidemiology. The debate has been quite fierce; social epidemiology has been accused of challenging the anchoring of epidemiological theories in biomedical processes and it has been argued that “stretching borders between epidemiology as a biomedical discipline and sociology only leads to trivial statements, useless for society” (Zielhuis and Kiemeney 2001, 43). Several profiles in social epidemiology, such as Nancy Krieger at Harvard, have defended the subject and argued that it is indispensable because “ignoring social determinants of social disparities in health precludes adequate explanations for actual and changing population burdens of disease and death, thereby hampering efforts for prevention” (2001, 45). Siegrist considers that much progress has been made in this new approach to epidemiology, including such issues as the social gradient for many of the most frequent chronic diseases, the impact of social support, social networks, the effort-reward and the demand-control balance (2001).

1.4 LESSON III: ADVERSITY AND INEQUALITY MATTERS FOR INDIVIDUAL AND POPULATION LEVELS OF HEALTH

More sophisticated models of the relationship between “wealth and health” have been an important feature of the social epidemiological research tradition since the beginning of the 1980s and are still an important area (Commission of the social determinants of health 2008). An early contributor to the understanding of the massive health inequalities in countries in the developed world was the 1980 report by the UK’s Chief Medical Officer, Sir Douglas Black, on inequalities in health. Delivered to government at the time of high-tide Thatcherism, it was not well received and it took more than ten years for the issues to become major topics in health research (Irvine, Elliott, Wallace and Crombie 2006). An interesting debate about inequalities and their role for health, particularly the link between income inequality and population health, became salient during the 1990s. A couple of main models have been introduced to understand how economic conditions and health are related to each other on a population level (Raphael, Macdonald, Colman, Labonte, Hayward and Torger son 2005). The psychosocial hypothesis, with authors like Wilkinson and Marmot as its strongest proponents, sees relative position as a key factor behind income inequality as a population health determinant. According to this hypothesis, raising levels of income inequality “will feed back to the social environment, affecting levels of social prejudice, social distinction, tendencies to exclusion, the exercise of power, and the creation of insecurity, and, finally, to the insidious tendency for some people to be made to appear as inadequate failures in contrast to the successful and wealthy” (Wilkinson 1999, 539-540). The tendency constitutes a social gradient across the whole scale, not just for those at the bottom of the hierarchy, since there is always someone who is relatively better off than oneself (Marmot 2004).
Neo-materialists critique the psychosocial school on three grounds: a) the model ignores class relations and macro-structural dimensions, such as gender and race, that can explain the generation of income inequality and account for absolute and relative deprivation, b) social cohesion, not political change and activism, is foregrounded as a determinant of population health, and c) the de-contextualized conceptualization of social cohesion can be (and has been) used in the US and UK to render communities responsible for their mortality and morbidity – a strategy to “blame the community” (Muntaner and Lynch 1999). The neo-material hypothesis stresses the absolute, not the relative, effects of income inequality that have a disproportionate effect on the most disadvantaged. These effects are caused by “historical, cultural and political economical processes. These processes influence the private resources held by individuals (money to buy housing, healthy food, opportunities to exercise, medical care) and also shape the nature and availability of a health-supportive public infrastructure – the types and quality of education, health services, transportation, environmental controls, food availability, recreational facilities, housing stock, occupational health regulations – that form the structural matrix of contemporary life influencing health” (Lynch, Smith, Harper, Hillemeier, Ross, Kaplan and Wolfson 2004, 21). Much of the same argument is evident in critical health psychology, a new approach to health psychology which actively tries to challenge mainstream conceptualizations of health and well-being that neglect the “political nature of all human existence” (Marks 2002, 15). Critical health psychology takes pains to scrutinize “the aspiration of health promotion programmes that claim to be working towards all people taking an equal share of life chances, opportunities and resources for health” within the context of the whole of society, government and commerce (ibid, 15).

Recognizing the importance of health inequalities and developing theory to understand them is critical for finding appropriate strategies to address them effectively. It is a question of the utmost salience for public policy because socioeconomic inequalities have increased in Sweden in the past decade and have been identified for several disease groups in several countries in Europe (Lundberg and Palme 2002; Mackenbach, Bos, Andersen, Cardano, Costa, Harding, Reid et.al. 2003; Rosvall, Chaix, Lynch, Lindström and Merlo 2006). However, a recent review of income inequalities and population health concludes that the evidence does not suggest that the strong version of the income inequality-population health hypothesis is true, either between countries or as a general phenomenon within wealthy nations (Lynch, Smith, Harper, Hillemeier, Ross, Kaplan and Wolfson 2004). The link is more articulated in some particular cases, such as the level of individual states in the US, but the control of individual and contextual factors that may confound this relationship may not be perfect (ibid). The general conclusion is that there may be some support for a weaker version of the income inequality hypothesis, which in certain contexts does contribute to some outcomes for some. After this review, the psychosocial camp made its own systematic review and came to a different conclusion: that 70% of the studies suggest that “health

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2 Two versions of the psychosocial income inequality hypothesis are identified in the review. The strong version claims that the effect of a transfer of income from A (high income) to B (low income) population health will improve health for both A and B. The weak version suggests that B will gain more than A loses from this transfer and therefore the effects of income inequality on health will be greater for B.
is less good in societies where income differences are bigger” (Wilkinson and Pickett 2006, 1768). The debate is still raging, with new data and interpretations being published by both the psychosocial and the neo-materialist camps and both sides providing evidence for their position, sometimes seemingly at the expense of a full account of findings that support the other side in the debate (Subramanian and Kawachi 2007).

1.5 LESSON IV: IT IS IMPORTANT TO UNDERSTAND WHAT LEADS TO HEALTH

The three previous lessons address various aspects of the relationship between the environment and disease. However, they share the drawback that little is really learned about health. Although the WHO definition of health, stressing well-being rather than illness or injury, dates from 1948, the traditional focus of the public health sciences and psychology has been on what leads to illness and disease. Although highly limited, research on why many people do not fall ill when the conditions they are exposed to predict that they might, has developed in the margins over a couple of decades. In the mid 1970s, Selye elaborated his original idea of a non-specific response to any stressor and proposed a distinction between a good kind of stress (eustress) and a bad kind (distress). However, little was said in terms of their psychological and physiological expression (Lazarus 1993). For Lazarus, an important dimension in any model of psychological stress is coping: “a person’s on-going efforts in thought and action to manage specific demands appraised as taxing or overwhelming” (ibid 8). The research by Lazarus and co-workers over a period of twenty years, from the mid-60s to the late 1980s, produced many important insights into the coping concept: coping is a process with many stages, it is situational, and a distinction can be made between different types, such as problem-focused and emotion-focused coping (ibid).

Proceeding from the ideas about psychological stress and perhaps even more so the ideas about coping, several researchers have tried to establish an alternative view of health and mental health, focusing on the positive connotation of human functioning and experience. Starting in the 1970s, the medical sociologist Aaron Antonovsky set out to understand why, among people who have lived under the most taxing circumstances (such as Nazi concentration camps or war), there is always a certain number who do not present expected negative health consequences. He saw this as the process of developing health, salutogenesis, and contrasted it to pathogenesis, the process of developing pathology or disease. Antonovsky found that people who were able to handle these atrocities were characterized by a sense of coherence, that is, a pervasive, enduring though dynamic feeling of confidence, including comprehensibility, manageability and meaningfulness (Antonovsky 1987). Comprehensibility means that the stimuli to which a person is exposed in life, from the external environmental as well as from within, are structured, predictable and explicable. Manageability concerns the experience that resources are available for meeting the demands posed by these stimuli. Meaningfulness concerns the motivational aspect, that demands are challenges, worthy of investment and engagement (ibid.). Two recent systematic reviews of two decades of research on the role of sense of coherence for health and quality of life (Eriksson and Lindström 2006; Eriksson and Lindström 2007) find that sense of coherence is important for health and quality of life. The
relationships have been studied around the world in general and specific populations, such as refugees, and the instrument for measuring sense of coherence has been translated into more than 30 languages with good validity (Eriksson and Lindstrom 2005). Further, Antonovsky and others (Frommberger, Stieglitz, Straub, Nyberg, Schlickewei, Kuner and Berger 1999; Schnyder, Buchi, Sensky and Klaghofer 2000) have argued that sense of coherence is a stable personality trait, while others have argued that it varies as a consequence of exposures throughout life, such as health problems or low social support (Nilsson, Holmgren, Stegmayr and Westman 2003; Smith, Breslin and Beaton 2003). The study by Nilsson and colleagues shows that high levels of sense of coherence may be less influenced by external factors than low levels (2003). The same study found that sense of coherence may be more prone to change among women than among men. The systematic review arrives at a position in between these poles, arguing that while the concept is reasonably stable over ten years, Antonovsky may have overstated its stability, since this increases over the life-span (Eriksson and Lindstrom 2005).

Some studies have found that family factors from a person’s upbringing, such as participation in decision-making and autonomy as a child, and the family’s level of education, are associated with sense of coherence in adulthood (Sagy and Antonovsky 2000). In other studies, sense of coherence as an adult was not predicted by family factors such as having lived with both parents, having siblings and being exposed to violence in childhood (Krantz and Ostergren 2004); the best predictors in the latter study were work strain, social support, social inclusion and socio-economic position. A third study found that both childhood and adult factors predict sense of coherence (Volanen, Lahelma, Silventoinen and Suominen 2004). Gender differences in sense of coherence are limited; an exception is loneliness, which is associated with sense of coherence in men but not in women. The quality of the relationship to one’s partner is important, as is the quality and extent of social support, paid employment and quality of employment (ibid). This study also included wider contextual issues such as national economic crisis and recession. The predictive value of the concept has been shown to be good overall for health and mental health, as well as for quality of life, with exceptions in some studies where sense of coherence has modest predictive validity (Eriksson and Lindström 2006; Eriksson and Lindström 2007).

In recent years, the fields of well-being and positive psychology have been more in focus for sophisticated research that has produced important knowledge about what determines people’s ability to endure harsh circumstances. Many of these models acknowledge the critical role of various kinds of resources. This is the case in Antonovsky’s theory, where sense of coherence is considered to be strongly connected to what Antonovsky calls general resistance resources, resources of different kinds that tend to result in a high level of sense of coherence (Antonovsky 1987). Another approach is Hobfoll’s conservation of resources theory (Hobfoll 1989; Hobfoll 2002), which identifies different types of resources that can be used by people to handle stress: material resources (e.g. income), energy resources (e.g. availability of health insurance), interpersonal resources (e.g. social support and connection to a community) and work resources (e.g. employment) (Hobfoll and Lilly 1993). Related ideas are found in David Fryer’s agency restriction theory which considers the capacity for agency as a fundamental human resource, that have detrimental mental health effects if
restricted (Fryer 1998a). A recent example of these resources in the context of traumatized persons is that among victims of the WTC terrorist attacks in 2001, resilience can be explained by not losing material resources and having access to interpersonal resources (Bonnano, Galea, Bucciarelli and Vlahov 2007). The general lesson from this and other studies concerning trauma survivors, such as after the Tsunami in 2004, is that the best way of promoting resilience is to use population strategies to focus on the recovery environment, including social support, economic conditions and community capacity, rather than focusing on delivering individualistic psychological treatment (Bonnano, Galea, Bucciarelli and Vlahov 2007; Shalev 2004; Silove and Zwi 2005). Other evidence suggests that the recovery environment is the primary explanation for why Vietnamese refugees improve their mental health over time in Australia, so that after ten years in the country it is better than the mental health of Australians (Steel, Silove, Phan and Bauman 2002). The impressive adaptation refugees show, given the right recovery environment, should be used as an important example in research on resilience. In fact, “because refugees’ experiences with change approach the extreme among human groups, research with resettled refugees could clarify the processes and meanings of human change” (Muecke 1992, 521).

**1.6 MENTAL HEALTH PROMOTION AND MENTAL DISORDER PREVENTION**

The four lessons are drawn in the first place from research on general morbidity or mortality, or on some major somatic public health concern such as cardiovascular disease, cancer or diabetes. In contrast, mental health outcomes have seldom been focused in studies of the relationship between individuals and their multi-level contexts, especially in public health and epidemiology. In recent decades, studies on the role of the social environment have been comparatively limited in psychiatry, which has been more preoccupied with biomedical explanations of human suffering. An important driving force behind this development may have been the wish to have psychiatry accepted as a firmly-established medical discipline, as suggested by this citation from an paper about primary prevention of psychiatric disorders: “psychiatry should reaffirm, first and foremost, its position in clinical medicine” (Roberts 1970, 372). Notwithstanding the positive gains that the development of new medication and other methods has conferred for many persons suffering from mental disorder, given the magnitude of the problem, mental health needs to be treated as a key public health challenge (World Health Organization 2001).

Although discussions about mental health in recent decades have highlighted the identification and treatment of disease, this has not been the exclusive focus throughout history. Ever since the earliest known mental hospitals in Baghdad (AD 918) and Cairo, it has been the case that, at least in certain parts of the world, the more or less intended consequence of institutions that “care” for persons with mental disorder have been to separate them in order to protect society. A new, humanistic, perspective on mental disorder emerged around the turn of the 19th century – the mental hygiene movement. An important impetus for this movement was *A mind that found itself*, a book in which Clifford Whittingham Beers, a former psychiatric patient, describes his experiences as a patient and proposes an agenda for mental hygiene societies (Beers 1908).
Interestingly, the recent momentum for mental health promotion is in many ways strikingly similar to the mental hygiene movement almost a century earlier.

Beer’s book was supported by Adolf Meyer, known by some as the dean of American Psychiatry. In the same year as the book was published, the two of them founded the Connecticut Society for Mental Hygiene devoted to “war against the prevailing ignorance regarding conditions and modes of living which tend to produce mental disorders” (Mandell 2008). The movement spread and Beers was able to lead the formation of the National Committee for Mental Hygiene in 1909 and the International Committee for Mental Hygiene in 1919. The First International Congress of Mental Hygiene was held in Washington D.C. in 1930, with representation from mental-hygiene societies in 25 countries. In 1948 the World Federation for Mental Health was formed. Meyer had presented some ideas in 1915 about the organization of mental hygiene in community mental hygiene districts, where “the services of schools, playgrounds, churches, law enforcement agencies and other social agencies would be coordinated by mental health personnel to prevent mental disorders and to foster sound mental health” (Mandell 2008). These ideas were still influential some 25 years later; if anything, they were more clearly focused on the creation of mentally healthy environments through the coordination of community forces and institutional development and the integration of mental health principles into the practices of social work, nursing, public health administration, education, industry and government (ibid). At this time, more biologically oriented psychiatrists were voicing criticism of the limited evidence for this tradition (ibid).

To unite the two camps, Meyer engaged Paul Lemkau to conduct research on mental disorder with standard epidemiological methods. The studies were based on a biological model of disease, with life events and the environment as precipitating factors for illness. With Lemkau, the mental hygiene movement was firmly established in public health, though it seems to have started to become specialized and withdrawn into activities in the realm of health services, more preoccupied with the treatment of individual patients in specific mental hygiene clinics. While Lemkau did not neglect the need for improvements in the social matrix, he considered that these issues were more suited for other agencies. The role of mental health personnel should be restricted to educating and consulting with other agencies in and outside the healthcare sector. In Sweden, the ideas from the Mental Hygiene Movement were adopted early on; a prominent figure here was Viktor Wigert, a professor of psychiatry whom the Swedish Government appointed to attend the First International Conference in Mental Hygiene in 1930. The Swedish Association for Mental Healthcare (now the Swedish Association for Mental Health, Svenska Föreningen för Psykisk Hälsa), inaugurated in 1931, was given the tasks of promoting mental health through awareness-raising in different settings and sectors of society and contributing to the international development of these issues.

From a marginalized position in recent decades, the conceptualizations of mental health and the actions formulated in the mental hygiene movement have become more central again with the acknowledgement of the need for mental health promotion strategies. With approximately 450 million people worldwide estimated to have a neuropsychiatric condition, this group of diseases accounts for four of the five leading
causes of years of life lived with disability in people aged 15 to 44 years in the Western
world (Williams, Saxena and McQueen 2005). To counter problems of this magnitude,
“our only hope is to develop better proactive strategies for preventing disease and
promoting health, rather than to wait to fix problems after they occur” (Syme 2004, 5).
This insight has generated a “momentum for mental health promotion” (Williams,
Saxena and McQueen 2005), based on the principles in the Ottawa Charter for health
promotion and ideas such as the four lessons presented above. Key principles are: to
target the whole population; to focus on enabling and achieving positive mental health
for individuals, communities and society in general; to function as a multidisciplinary
area of practice; and to deliver programmes that can reduce health inequalities through
empowerment, collaboration and participation (Jané-Llopis, Barry, Hosman and Patel
2005). In this new strategy, mental health promotion “endorses a competence
enhancement perspective and seeks to address the broader determinants of mental
health” (ibid, 9).

Effective evidence-based strategies are now available for all five strategies in the
Ottawa Charter (Jané-Llopis, Barry, Hosman and Patel 2005). First, evidence shows
that building healthy public policy in areas such as access to education, regulatory
policy, the workplace, good quality housing and nutrition is all-important for
population mental health (ibid). Second, research has shown that everyday social
settings, such as home, school, workplace and community, can function as supportive
environments for health (ibid). Third, interventions aimed at strengthening community
action by building networks across local actors have shown success in preventing
violence and drug use, as well as in mental health awareness and stigma reduction
(ibid). Programmes that target resilience and social competence among children, reduce
depressive symptoms for adolescents and help overcome the negative impacts of job
loss and unemployment among adults have shown effects on the ability of these
persons to take control over their health and their environment (ibid). The healthcare
sector can be used effectively to prevent mental disorder. Primary care has a key role as
a provider of mental health services to ensure easy access for new mothers, the elderly
and persons with early signs of psychosis (Jané-Llopis, Barry, Hosman and Patel 2005).
The interventions that are most effective in preventing depressive disorder use more
frequent and longer sessions with various components, focusing on competence
enhancement and delivered by a health care provider (Jané-Llopis, Hosman, Jenkins
and Anderson 2003). Primary care provision of integrated strategies, including
systematic counselling and education together with the availability of adequate
medicine, can reduce the burden of disease caused by depression world-wide by 10–
30% (Chisholm, Sanderson, Ayuso-Mateos and Saxena 2004).

The recognition of mental health as an important public health challenge is evident
among policy-makers, practitioners and researchers (some examples are Herrman 2001;
Mittelmark 2005; Sturgeon 2006; World Health Organization 2001; World Health
Organization 2004). In 2005, WHO, EU and the European Council held a joint
ministerial conference on mental health that resulted in the “Mental Health Declaration
for Europe”, stating that the primary aim of mental health activity is “to enhance
people’s well-being and functioning by focusing on their strengths and resources,
reinforcing resilience and enhancing protective external factors” (World Health
Organization 2005, 1). Twelve separate actions are specified to achieve this aim,
clearly inspired by the principles established within health promotion, such as conducting mental health impact assessments for all policies (with particular attention to vulnerable groups), establishing partnerships, and developing coordination and leadership across regions, countries, sectors and agencies that influence mental health and social inclusion (ibid). The increased interest in mental health in policy circles, and in health promotion and public health in general, is indeed a positive step forward. However, there is a blurring of concepts here – participants in the Ministerial Conference in Helsinki often used the term mental health promotion as a “euphemism for mental disorder prevention” (Mittelmark 2005, 56). Mental Health Promotion and Mental Disorder Prevention differ conceptually and theoretically and the differences lead to different suggested actions. Neither can one of them replace the other. What is needed instead is an appropriate combination of high-risk and population strategies because “the vulnerable population sub-groups with which the mental disorder constellation is occupied require all the attention and care that can be mustered. But we need also mental health promotion for the entire community, and a vision of mental health as a resource for robust living, not merely the absence of mental disorder” (ibid, 57).
2 REFUGEE MENTAL HEALTH DURING RESETTLEMENT: AN INTEGRATIVE ANALYTICAL FRAMEWORK

2.1 REFUGEE AND FORCED MIGRANTS’ MENTAL HEALTH

The global number of refugees and persons displaced within their country of residence because of conflict and natural disaster has been estimated at about 67 million in 2007 (UNHCR 2008b). Refugees\(^3\) are the smaller group (about 11 million) and the refugees and forced migrants who have resettled in the western world make up only about 10% of the total number worldwide (Ingleby 2004; UNHCR 2008b). Of the 36,207 persons who sought asylum in Sweden in 2007, 18,414 were granted permanent residency on refugee or refugee-like grounds (Swedish Migration Board 2008). In this group, a small proportion (6% or 1,113 persons) obtained residency according to the UN Convention of Refugees from 1951. The largest group (55% or 10,208 persons) is persons classified as in need of protection. About 10% were so-called quota refugees, brought to Sweden directly from refugee camps in collaboration between Swedish authorities and the UNHCR. Residency was accordingly granted to 51% of all asylum-seekers to Sweden in 2007. However, in that year as in many previous years, the proportion who were recognized as refugees according to the UN refugee convention was much smaller in Sweden than in most other countries (UNHCR 2008b). The classification of refugees is a political and juridical matter that may have some implications for the life of refugees. However, in view of the subject of this thesis, here the terms refugee and refugee-like denote people who are in situations similar to those described in the 1951 UN Refugee Convention.

Since the 1980s, the number of refugees applying for political asylum in industrialized countries has risen dramatically but even before this shift, services for survivors of torture and other forms of violence existed in several places (e.g. Great Britain and the Netherlands) (ibid). Research on refugee mental health has also increased since the 1980s. Within this field, exposure to trauma, and particular outcomes of this exposure, such as post-traumatic stress disorder, has been increasingly focused in the clinical psychological and psychiatric literature (ibid). The concept *post-traumatic stress disorder* (PTSD) was introduced in the DSM-system in 1980 to account for the symptomatology shown by US returnees from the Vietnam War (ibid). The diagnosis was intended to position symptoms of post-traumatic stress as war casualties instead of the result of the soldier’s background or prior psychological functioning. Its introduction into the realm of psychiatry helped veterans to get access to treatment, recognition and financial assistance, since their symptoms were a result of the service

\(^3\) The 1951 UN Refugee Convention states that “A refugee is a person outside of his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there for fear of persecution” (UNHCR 2008a).
they had done. In less than three decades, PTSD has been successfully and impressively established as a psychiatric disease category. As a result, however, the main perspective in refugee mental health has been firmly grounded in a trauma model where refugees are seen as victims of organized violence (Ingleby 2004). With this perspective, mental health in refugees and forced migrants has been assigned to psychiatry, with curative models grounded in either a biomedical disease model or a psychotherapeutic model, while prevention or promotion perspectives grounded in public or population mental health have still not exerted a systematic influence on the understanding of refugee mental health.

During the past decade, the critique of PTSD’s dominant role in refugee mental health has gained momentum. Several counterarguments have been presented (ibid). First, many symptoms of PTSD are essentially universal reactions to extremely shocking experiences that only become abnormal when they persist over time (Kleber, Brom and Defares 1992; Yehuda 2003). Second, seeing refugees as exposed to only one or more circumscribed traumatic events is often an inaccurate description of their plight. Instead, one needs to consider the whole situation in a society or community where many are being uprooted and exposed to atrocities over a long time and across many areas of life (Ingleby 2004; Silove 1999). Third, it is far too simple to see exposure to traumatic and life-threatening events as causing PTSD in everyone. A considerable proportion of those exposed do not show these symptoms and many exposed show other symptoms (Ingleby 2004; Silove 1999). Fourth, refugees with PTSD symptoms do not necessarily see these symptoms as their most serious problem. In a study of asylum-seekers from Kosovo in Britain, about 50% had PTSD but almost all of them mentioned work, school and family reunification as their major problems (Summerfield 2002).

While it may be far too simplistic to understand refugee mental health solely in terms of refugees as victims of organized violence, PTSD clearly is a problem for at least some refugees. Research results show neurobiological and other biological markers associated with PTSD (Sabioncello, Kojican-Hercigonja, Rabatic, Tomasic, Jeren, Matijevic, Rijavec and Dekaris 2000; Söndergaard 2002). Estimates differ, but a recent systematic review, including studies that deal altogether with almost 7,000 refugees who have resettled in the western countries, found a prevalence rate of 8–10% for PTSD in adults (Fazel, Wheeler and Danesh 2005). Point prevalences for PTSD ranging from 5% to 37% and lifetime prevalences between 18% and 37% have been reported for populations in post-conflict societies after complex emergencies across the world (Mollica, Lopez Cardozo, Ososky, Raphael, Ager, Salama and McDonald 2004). However, PTSD is certainly not the only or even the most prevalent disorder among refugees (Mollica 2000). Based on studies in the western world, 4–6% are estimated to have major depression (Fazel, Wheeler and Danesh 2005). Point prevalences in post-conflict settings range from 39% to 68% (Mollica, Lopez Cardozo, Ososky, Raphael, Ager, Salama and McDonald 2004).

An attempt to integrate ideas about the bio-psycho-social determinants of refugees’ mental health has been presented by Silove and colleagues (Ekblad and Silove 1998; Silove 1999). The main idea in this model is that there exist “five core adaptive systems subserving functions of ‘safety’, ‘attachment’, ‘justice’, ‘identity-role’, and ‘existential-
meaning’ (Silove 1999, 201). These major adaptive systems “have evolved in an orchestrated manner to ensure that under normal circumstances, the interaction of the individual and his/her society occurs in a way that promotes personal and social homeostasis” (ibid, 203). The model was originally developed to account for a broader set of pathways between extreme human rights violations, such as torture and other abuses, and mental health outcomes. The model opens up for, though it does not elaborate, the biological processes, and makes a very significant contribution to theorizing the interplay between mind, community and the larger socio-political context (Porter 2007b). Although some kind of causal interaction between domains is implied, the starting point is the social domain; it is here that the effects of war and forced displacement occur and this process is considered to have a significant biological and psychological impact on those exposed (ibid).

Silove’s model has helped to widen the model of refugee mental health. However, it does have a limitation: since the plight of refugees often involves several stages, considering pre-resettlement as the only relevant focus of refugee mental health seems far too simplistic. If, during resettlement, refugees are considered solely as victims of organized violence during pre-resettlement, the only option for refugee mental health is to be reactive, ex post facto. This focus is liable to overshadow people’s basic needs in the present, as resettling refugees (Ryan, Dooley and Benson 2008). Models of refugee mental health during resettlement need to consider refugees as migrants (Ingleby 2004) and thereby acknowledge the present and future in addition to the past. Indeed, all-cause mortality, as well as distinct health problems, are often more frequent among migrants into industrialized countries than in the rest of the population, although the relationship between migration and mortality can be modified by many factors, such as the reason for migration and social, environmental and economic determinants of health in the resettlement context (Albin, Hjelm, Ekberg and Elmstahl 2005; Carta, Bernal, Hardoy, Haro-Abad and State of mental health in Europe working Group 2005; Porter and Haslam 2005). The author of a recent meta-analysis of research on refugee mental health, including 59 studies with 22,000 refugees and 45,000 persons in relevant but different comparison groups, finds that the studies are “conclusively demonstrating the strong moderating effect of enduring contextual (social domain) variables on refugee mental health” (Porter 2007b, 421). Private and permanent accommodation, external displacement, no repatriation, end of the conflict that caused the flight, less restricted economic opportunities and less loss of socio-economic status are all associated with better psychological outcomes (Porter and Haslam 2005). In sum, “social variables impacting refugee mental health are not limited to discrete, proximal social variables of the sort well modelled by the life-events approach, but also encompass enduring and distal variables” (Porter 2007b, 422).

To understand refugee mental health in the resettlement environment, the contextual factors in different phases of the migration process need to be taken into account. By examining the circumstances in which stress arises and the demands they put on people, ways of transforming these environments can be identified (Ryan, Dooley and Benson 2008). Within the research project where the thesis is a part, a model has been developed that portrays how the current and previous phases in the migration process impact on refugees during resettlement (Lindencrona, Ekblad and Johansson Blight
2005, figure 1, next page). The model is based on stress proliferation, that is, the notion that adversity in subsequent phases tends to accumulate and/or be particularly problematic for those who have already been exposed to stress in earlier phases (Pearlin, Schieman, Fazio and Meersman 2005). This stress process theory has been applied by Morton Beiser to refugees resettlement in Canada (e.g. Beiser and Hou 2001). The first phase in figure 1 concerns exposures before entering the country of resettlement. The effects of traumatization, political prosecution and other reasons for fleeing are a part of this pre-resettlement phase. Important risk factors during this phase include war, racial injustice, discrimination and displacement (Hosman, Jané-Llopis and Saxena 2004). Exposure during the pre-resettlement stage can incur losses in personal, material and social resources, some of them ending when the individual leaves the situation, others persisting longer or indeterminately (Ryan, Dooley and Benson 2008).

Figure 1. A model of the phases of the migration process that impact upon health during resettlement.
(Graphical layout: Gunilla Andersson and Fredrik Lindencrona).

Once a person enters a new country, what happens is affected by political systems, laws and regulations that differ between countries. In many western countries, most refugees become asylum-seekers who stay either in the community or in specific camps while they wait for the application to be processed. Countries differ in the degree of state control over access to important resources, such as employment, housing, healthcare and money (Ryan, Dooley and Benson 2008), all resulting in constraints on an “ordinary” life for asylum-seekers. Particularly salient is the lack of control over what for them is the most important decision, permanent residency (Hunt 2008). Typically, this phase is associated with a further loss of personal, material and social resources, such as status loss, racial injustice and discrimination (Hosman, Jané-Llopis and Saxena 2004; Hunt 2008; Johansson Blight and Lindencrona 2003). Finally, given a positive decision, the resettlement process can start. Permanent residency has a
moderating effect on mental health that is even stronger if the source conflict is on-going (Porter 2007b).

At the same time, the resettlement period is full of strains as life is returned to normal. In this phase, pressing problems can arise from the loss of cultural resources, such as social status, occupational skills and the experience and feeling of being alienated from the rest of the population. People exposed to a considerable loss of resources in early stages may be drawn into a resource-loss spiral that is very hard to leave without outside help (Ryan, Dooley and Benson 2008). Even if the resettlement environment does not always differ between people with more and less resources, respectively, the environment’s impact may be more important for people who are more vulnerable (Søndergaard 2002). Despite these exposures throughout the migration process, it is important to perceive refugees “not simply as passive victims of trauma, but active survivors in a new environment whose characteristics have important effects on their mental health and adaptation” (Porter 2007b, 431). In order to promote mental health among refugees, resettlement policies and programmes need to address several protective factors, such as ethnic minorities’ integration, social participation, empowerment, social services and community network (Hosman, Jané-Llopis and Saxena 2004). Instead of being sent back to countries without a working economy or having to live with this fear, the most important policy directive should be “generous material and legal support to facilitate their transition into active members of the economy of the host countries to which they have been displaced”(Porter 2007b, 431).

2.2 A SOCIO-ECOLOGICAL PERSPECTIVE ON REFUGEE MENTAL HEALTH DURING RESETTLEMENT

Refugee or migrant adaptation has been described as “the process through which individuals seek to satisfy their needs, pursue their goals and manage demands encountered after relocating to a new society” (Ryan, Dooley and Benson 2008, 7). In this context, the five adaptive systems proposed by Silove are not considered simply as being affected by exposure to traumatic events or human rights violations; rather they are used to categorize particular needs, resources and demands that are critical for refugees during resettlement (and most other persons as well). The relevant concern is the factors that are critical for health and disease rather than the specific health outcomes that may result from these factors. The model (figure 2, next page) can therefore be considered as a social consequence model rather than a etiological model because “the goal is to elucidate the ways in which society impacts mental health as distinct from isolating the causes of a particular mental health problem” (Aneshensel 2005, 223). The integrative framework is based on “structurally oriented health promotion” (Poland, Coburn, Robertsson, Eakin and the members of the Critical Social Science Group 1998, 796), in particular the four main lessons presented in Chapter 1.

By analogy with the population strategy proposed by Rose, it can be expected that, through appraisal or other intra-psychological processes, individual variation in susceptibility to negative exposure in each of the five adaptive systems is likely to be more limited than the variation in critical resources emanating from the many levels of the environment (Ryan, Dooley and Benson 2008). A proper understanding of the adaptive systems needs to be accompanied by a delineation of pertinent ecological
levels. These levels help to identify both distal and proximal factors that may influence health and mental health. Without it, only action that changes the perception of the conditions can be developed, not the conditions themselves. Other studies have shown that individual differences interact with sociocultural and ecological differences to explain health outcomes (Porter 2007b).

Figure 2. Refugee mental health during resettlement: An integrative framework. (Graphical layout: Gunilla Andersson and Fredrik Lindencrona).

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The thesis author and his colleagues were commissioned to review available research on public health and integration, from 2000 onwards from Sweden and internationally (Lindencrona, Ekblad and Johansson Blight 2006). The integrated analytical framework was perceived as useful for organizing and interpreting research within this relatively fuzzy field. This model employs a five-level model introduced by McLeroy and colleagues (McLeroy, Bibeau, Steckler and Glanz 1988) to structure the nested environment from where resources and demands can emanate. Besides being an analytical framework, the levels can be used to guide appropriate interventions to help people use their resources and reduce their exposure to threats, adversity and stress. The personal level includes factors that concern the individual’s biological and psychological preconditions. The interpersonal level focuses on the individual’s direct relationships to family, neighbours, colleagues etc. The organizational level attaches weight to how different organizational contexts in which the persons live their lives, such as school, workplace, refugee introduction or other organized settings, can expose them to demands and provide resources. The community level concerns factors in the geographically bounded local neighbourhood or local authority in which schools, businesses, healthcare, local voluntary associations exist and work for the people living in the area. The policy level concerns national and international agreements, laws, rules and regulations that are often implemented in the practice of organizations and communities.
The five health systems are represented at each of these levels, so that existing conditions determined by each can threaten and/or promote the health of newly resettled refugees. Different everyday settings may concern one or more of these areas at the same time. An example is employment. Employment contributes to many health advantages, such as economic resources, broadened social network, possibilities to express creativity, and experience of meaning (Akhavan, Bildt, Franzen and Wamala 2004). Thus, having a decent job will be important for health through its impact upon attachment, security, identity/roles and existential-meaning system. In contrast, laws that restrict the possibility of family reunification are an example of a possible threat to health. Current restrictions on family reunification may be regulated by law and as an organizational practice by migration authorities. Policy and organizational levels therefore block access to attachment needs, with potential impacts on mental health.

### 2.2.1 Attachment

Attachment concerns relationships and emotional bonds with people, objects and certain places, such as a house, a neighbourhood, a city or a country. Access to personal relationships is often, but not always, associated with better health and mental health (Berkman, Glass, Brissette and Seeman 2000; Kawachi and Berkman 2001). Relationships fill many functions. First, they may satisfy important needs, such as intimacy and recognition. Second, access to emotional and instrumental support may be important when a person is exposed to stress (ibid). Third, the ability of a group to build up communal mastery has been shown to be more important than individual mastery for preventing depression and anger after exposure to challenging situations (Hobfoll, Jackson m.fl. 2002).

Migration and resettlement can be very challenging for attachment. In general, people who have migrated to Sweden have less frequent contacts with family, socialize less with neighbours and fewer have a close friend (Vogel and Hjerm 2002). Migrants from an Arabic-speaking country have a significantly lower rate of participation in larger meetings with relatives and private parties (Lindstrom 2005) than people born in Sweden. In a study of Vietnamese refugees in Norway, the authors found that social relationships developed more easily within the Vietnamese group than with other people in Norway. Still, after three years in Norway, only half of those interviewed had recurrent contact with other Vietnamese and only one out of five had such a contact with people born in Norway. More contact outside the Vietnamese group was reported by women and by people who had participated in education in Norway (Hauff and Vaglum 1997). Having contact with persons born in the host country is associated with mental health, at least for men. In a study in Norway of 1500 persons from low- and middle-income countries, those who had been visited at home by Norwegians were less likely to report symptoms of mental distress (Thapa and Hauff 2005). A study in Sweden found that the risk of divorce is often higher for people born elsewhere; the risk for persons born in Chile or Iran was four times higher than for people born in Sweden; the only exception was persons from Turkey, whose divorce rate was lower than for all the other groups (Darvishpour 2003).

Compared with new arrivals, groups that have been in Sweden for more than ten years display an improvement, albeit from a low level. However, the differences compared
with persons born in Sweden largely persist. A positive development is that after 10 years, the proportion of people from any country in Africa, from the former Yugoslavia, and from countries in Southern Europe who report having a close friend in Sweden is almost the same as for people born in Sweden (Vogel and Hjerm 2002).

### 2.2.2 Safety and security

This adaptive system concerns support for and threats to physical survival or the integrity of oneself or a close relative. In the host country, this may refer to fear of being repatriated, or to economic stress and insecurity in the neighbourhood and the local community. International and Swedish studies have repeatedly found a strong relationship between personal economic resources and health (e.g. Lantz, Lynch, House, Lepkowski, Mero, Musick and Williams 2001; Ljung, Peterson, Hallqvist, Heimerson and Diderichsen 2005; Olivius, Ostergren, Hanson and Lyttkens 2004). The same relationship can be detected for different mental health outcomes (Lorant, Deliege, Eaton, Robert, Philippot and Ansseau 2003). This meta-analysis included numerous aspects of socioeconomic status and the general conclusion was that there is sufficient evidence to claim that socioeconomic status has an impact on the occurrence of depression and perhaps even more so on the duration of the depressive episode (ibid.) The impact of socioeconomic status on the burden of disease has been estimated for Sweden (Ljung, Peterson, Hallqvist, Heimerson and Diderichsen 2005). If morbidity and mortality (measured in DALYs) in the 18 largest disease groups were the same as for the most well-educated group in Sweden, the disease burden would be 30% less for women and 37% less for men. The disease groups with the largest avoidable burden are heart disease, depression and neuroses for men as well as women, alcohol dependency and self-inflicted injuries for men and stroke and neck- and back-complaints for women. Moreover, these studies probably underestimate the avoidable burden of disease because they are confined to people in the labour market.

The economic situation of people who have migrated to Sweden is generally worse than for people born in Sweden (Vogel and Hjerm 2002). This report shows that for migrants from all over the world (except the Nordic countries and women from Iran), the percentage with an income below the level of social benefits is often 3–5 times higher than for people born in Sweden. Time-limited employment is more common among all groups of people born outside Sweden than for people born in Sweden; information is not available for every group, but for some the proportion in time-limited employment is 40%. Also, the standard of living is lower for migrants irrespective where they come from; in several groups, the percentage with a low living standard is around 60%. The percentage of people living in overcrowded conditions is about four times higher in many migrant groups than it is for people born in Sweden (ibid.).

In addition to the effects of personal living conditions, the national, regional or local level of adversity seems to be important for health. The issue has been discussed by many researchers in the past decade (Lynch, Smith, Harper, Hillemeier, Ross, Kaplan and Wolfson 2004; Wilkinson 1996). In Sweden, several studies have examined these so-called contextual effects (i.e. effects of the area when individual variation is controlled for) and found a varied pattern of outcomes, ranging from small for self-reported health (Lindstrom, Moghaddassi and Merlo 2004) to large for blood pressure...
(Merlo, Asplund, Lynch, Rastam and Dobson 2004) and intake of anxiolytics (Johnell, Merlo, Lynch and Blennow 2004). Many different dimensions in a neighbourhood may be of interest in explaining these contextual effects, including safety and security. In US studies, good contact with neighbours and others in the community can buffer the experience of insecurity associated with high rates of intentional damage and high rates of criminality in the community (Ross and Jang 2000). Compared with people born in Sweden, more of those persons born elsewhere report being victims of threat and violence in Sweden and report living in an area where intentional damage to property has occurred (Vogel and Hjerm 2002). Another aspect of security – participation in associations and social activities, and trust in others – has been studied by Lindström, who found that men and women born outside Sweden have a lower rate of participation and lower trust than people born in Sweden (Lindstrom 2004). Low participation and low trust predicts lower reported mental and self-reported general health. Contrary to what is often assumed low participation does not correlate perfectly with low trust. High participation/low trust is associated with better reported health than those low in both and poorer reported health than those high in both.

The difference between the proportion of people born in Sweden and those born elsewhere who have an income below the level for social benefits diminishes during the first ten years in Sweden (Vogel and Hjerm 2002). However, after ten years in Sweden, many groups of migrants are still worse off economically than people born in Sweden. A striking finding is that among persons born in the Middle East; this proportion has actually increased after ten years in Sweden. The development of standard of living varies between different groups of migrants. The improvement over ten years is greatest for people from Southern Europe and former Yugoslavia. In the Middle Eastern, Turkish and African groups, the initial level is low and the improvement is limited. Living in overcrowded conditions is still more common among all immigrant groups after ten years. The development over the ten-year period is positive, more so for people from Southern Europe and former Yugoslavia than for other groups. Among those currently employed, it is more common for those from most areas to have been unemployed at some time during the last five years. In some of the larger immigrant groups, about 50% have been unemployed in the last five years.

### 2.2.3 Identity and roles

This adaptive system concerns personal experiences that contribute to or challenge an individual’s view of him/herself and his/her identity. Pre-resettlement experiences of atrocities such as torture can undermine a person’s identity, trust in others and personal control over one’s life. During resettlement, this is often a matter of lacking control over one’s own situation, access to and lack of important roles in society and at home, and lack of respect for the newly resettled and his/her resources. Psychiatric disease seems to be more associated with employment than heart disease is (Sundquist 2002). For men, differences in mental health for different groups (based on country of origin) in the employed population are limited, particularly compared with differences between employed and unemployed. The relative risk of a psychiatric disorder is 2–4 times higher among unemployed than employed, irrespective of whether the people were born in Sweden or elsewhere. The patterns among women are similar, though there is a greater variation in relative risk among the employed (based upon country of origin). In
a population study of people who had migrated to Norway from low- and middle-income countries, lack of paid work was a risk factor for mental health among men as well as women. Experience of having a job application turned down was also a risk for mental health in both groups (Thapa and Hauff 2005). The impact of employment on health among immigrants is strong, but the relationship may be more complicated for women than for men (Johansson Blight, Ekblad, Persson and Ekberg 2006).

A study of burn-out in Sweden found that among employed people, burn-out among people born outside Sweden is about twice as common as among those born in Sweden (Hallsten, Bellaagh and Gustafsson 2002). The differences in the total studied population, which included employed and unemployed, showed the same pattern, only more pronounced. It seems that most jobs in Sweden are better than unemployment but the design of the work environment could be a discriminatory factor that needs further study. More people born outside Sweden have jobs characterized by a combination of high demands and low control, a situation that is particularly harmful for health (Vogel and Hjerm 2002). However, the greatest difference between groups born outside as opposed to inside Sweden is that the former more often work in monotonous and passive jobs where demands and control are both low (ibid). A Swedish study of the health effects of the psychosocial work conditions of migrants and others in Sweden found that work conditions were worse for the refugee group and that the health effects of lacking social support were more marked (Sundquist, Ostergren, Sundquist and Johansson 2003).

There are other roles in society that may affect health. The previous section considered the health effects of participation and trust (Lindstrom 2004). Participation in meetings outside work and participation in political demonstrations are more common for male migrants from all countries except Arabic-speaking countries (Lindstrom 2005; Vogel and Hjerm 2002). Among female migrants, all groups participate less in study circles and union meetings; the same applies to many of the other measured kinds of public participation (ibid).

The area or neighbourhood level of unemployment is another risk factor for disease. An international study that covered neighbourhoods with different types and extent of welfare and other services (e.g. USA, the Netherlands, England, Finland, Spain and Italy) has shown that irrespective of the country and controlled for many individual factors (such as own employment), the differences in all-cause mortality between areas with high and low unemployment rates, respectively, ranged from 15% to 45% (van Lenthe, Borrell, Costa, Diez Roux, Kauppinen, Marinacci, Martikainen et.al. 2005). Snowden (2005) describes how the effects of social disadvantage can be moderated by constructive processes in the local context. When many people work to improve their neighbourhood and when different public and civil support structures exist, the preconditions for the population in the neighbourhood are considerably improved. The development of social norms that encourage solidarity and participation in the neighbourhood may be critical in this process (Kawachi and Berkman 2001). However, current arguments about the value of such social capital have been criticized for insufficient evidence of a link to health outcomes and for presenting “itself as an alternative to materialist structural inequalities (class, gender, and race) and invokes a romanticized view of communities without social conflict that favors an idealist
psychology over a psychology connected to material resources and social structure” (Muntaner, Lynch and Smith 2001, 213).

Participation in society changes quite considerably during the first ten years in Sweden (Vogel and Hjerm 2002). The proportion of people who have participated in a political meeting in the past year increases in some groups of migrants, such as those from Southern Europe, former Yugoslavia and from any African country, while it decreases among people from Iran and Turkey. Discussions of politics with family and friends become more frequent, from a low initial level, in all groups of migrants after ten years in Sweden.

### 2.2.4 Justice and human rights

The core adaptive system justice and human rights concerns experiences of human rights violations such as violence, persecution and torture. Many asylum-seekers, undocumented migrants and newly resettled refugees have had such experiences during the pre-resettlement phase. In a study with asylum-seekers in Sweden, the results showed that exposure to trauma before and after entry to Sweden should be identified (Ekblad and Shahnavaz 2004). Many of the asylum-seekers had been exposed to human rights violations and such exposure was associated with suicidal thoughts. Violations can also happen in the host country, where discrimination on grounds of gender, ethnicity, language, religion, disability or legal status occurs. In fact, all core adaptive systems show evidence of violations of justice as a result of the discrimination that entails important and unjust differences between different groups in Swedish society. The causal chains between discrimination and health have been studied (Krieger 2000). Systematic long-term exposure to discrimination may lead to a situation where the group takes it for granted and accepts it. For instance, studies in the US found that the relationship between unemployment and mental health may be weaker in the Afro-American group. This is because groups that have been exposed to unemployment for a long time may develop a coping strategy that helps them to give employment a less important status as a risk factor for mental health (Rodriguez, Allen, Frongillo and Chandra 1999). In a British study, schizophrenia in ethnic minorities was studied in areas with a higher and a lower percentage of people with a non-white background (28–57 per cent vs. 8–23 per cent) (Boydell, van Os, Mckenzie, Allardyce, Goel, McCreadie and Murray 2001). The rate of schizophrenia in ethnic minorities was lower in areas with a larger proportion of people with a non-white background, despite the lower economic level in these areas. The researchers interpret these findings as suggesting that secure access to social networks in the area can reduce the susceptibility to mental health effects of discrimination.

Evidence of the relevance of the link between public health and human rights has been obtained in various fields of research. Important areas within public health are social epidemiology and health inequality, fields that concern effects of social exclusion and marginalization (Kawachi 2000; Marmot and Wilkinson 1999; Muntaner, Eaton and Diala 2000; Shaw, Dorling and Davey Smith 1999). Human rights and ethics are central issues in health promotion, because well-being is considered to be dependent on

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4 I owe Karin Johansson Blight thanks for the review of research on which the text in this section was based.
social justice. Active work is needed on four issues of social justice: poverty; racial discrimination; lack of access to healthcare; and the tendency to blame victims for their health (Buchanan 2000). Policy changes in migration and border control have made asylum-seekers and other migrants more exposed to threats to health in the phases of asylum-seeking and resettlement (Fekete 2001; Silove 2004). As a consequence of a shift in focus from who needs protection to how national borders can be closed to migrants who are not considered to be in “real” need, border controls have become more restrictive. Several Western countries implement policies – such as detention and restricted access to social care, employment, family reunification and healthcare – that actively seek to fence off asylum-seekers and other migrants from their human right to seek asylum (Silove, Steel and Watters 2000; UNHCR 2001). These policy measures can force people to use unregulated entry routes, such as people smugglers, to obtain protection (UNHCR 2001). The legal position of asylum-seekers can often cause a perceived loss of status and a “state of suspension”, an effect of the longer or shorter waiting period to get permission to stay (Hunt 2008). Stigmatization and distrust of asylum-seekers and refugees have increased with the notion that people can be “illegal” and the identification of asylum-seekers as criminals as a result of people-smugglers, the war against terrorism and the war against trafficking (Fekete 2001). All this exposure may be grounded in a new form of racism, xenoracism, targeting asylum-seekers and refugees as a group (ibid). The tendencies to xenoracism are supported by media’s headlines presenting asylum-seekers as “bogus” and by dehumanizing descriptions associated with environmental disasters, using such words as “streams”, “waves” and “swarms” (ibid).

2.2.5 Existential-Meaning

This adaptive system concerns systems of existential meaning in life. Human rights violations such as torture can lead to a loss of the faith in a meaning in life and humankind. The host country can threaten the sense of coherence or belonging to a belief system by restricting the right to practice religion and culture or by not helping people to avoid social exclusion. Being anchored in a religious or political idea seems to provide an existential belonging that is important for mental health (Brune, Haasen, Krausz, Yagdiran, Bustos and Eisenman 2002). An important dimension for refugees during resettlement is the re-establishment of life as being existentially important and meaningful. Part of this demand may concern the possibilities and challenges involved in establishing intercultural contact. Two Swedish studies on the importance of acculturation for mental health compared persons born in Iran, Chile, Turkey and Poland and found that a low level of mastery of the Swedish language is a risk factor for mental disorder and psychosomatic symptoms (Bayard-Burfield, Sundquist and Johansson 2001; Sundquist, Bayard-Burfield, Johansson and Johansson 2000).

The “acculturation framework” presented by Berry uses the stress-coping models proposed by Lazarus & Folkman (Lazarus 1993) to understand migrant adaptation, based on ideas about the importance of intercultural contact for this process. Four different strategies are proposed in the model, which presents different combinations of answers to two questions: Does the group consider it important to keep its cultural identity and characteristics? and Does the group consider it important to have good relations with other groups? Integration is the strategy represented by answering yes to
both questions and marginalization by two no’s; assimilation is the strategy represented by a no to the first question and a yes to the second, while the strategy of separation is the reverse. The conditions in a particular country, region, locality or setting, such as acceptance of different cultural expressions, affect which strategy is possible (Birman, Trickett & Buchanan. 2005). Although the model has been very important for research on migrants and refugee’s adaptation, the postulated key role of intercultural contact must be questioned in several situations. It is not acculturative stress that is the central problem when, during resettlement, refugees suffer from social and economic strain, insecure legal and material situations, etc. (Ryan, Dooley and Benson 2008). This has been acknowledged in Richard Lazarus’ comment on the acculturation stress framework, headed “Acculturation isn’t Everything” (Lazarus 1997). In one of the few studies in which the full model has been used to look at mental health outcomes, Greenlanders who migrated to Denmark were questioned about parents’ encouragement of their children to maintain Greenlandic traditions in Denmark and whether the parents talk Danish (Koch, Bjerregaard and Curtis 2004). In this group, Berry’s model was not significant. Instead, sociodemographic and socioeconomic conditions had a greater explanatory value.

Meaning and goals may be critical for the mental health for refugees in the resettlement process. Losing major life goals as a consequence of migration may be one of the most important risk factors to mental health (Ryan, Dooley and Benson 2008). This brings us to the protective side of health and mental health as it was postulated by Antonovsky (Antonovsky 1987). Sense of coherence has been studied in immigrant populations from Chile, Iran, Poland and Turkey living in Sweden. In all groups, sense of coherence was associated with mental health. The association was particularly strong in the Iranian group, where the relative risk of having mental distress was 12 times higher among those with a low level of sense of coherence (Socialstyrelsen 2000). Antonovsky’s theory of general resistance resources being linked to mental health outcomes by a sense of coherence is supported in southeast Asian refugees in the US (Ying, Akatsu, Zhang and Huang 1997). In a longitudinal study of mass-evacuated refugees from Kosovo in Sweden, sense of coherence was a mirror image of the increase in depressive and traumatic stress symptoms (Roth and Ekblad 2006). Low sense of coherence is a central factor in explaining risk of suicidal thoughts in asylum seekers in Sweden (Ekblad and Shahnavaz 2004).

The framework helps to answer a recurrent question in public health: “Are public health ends better served by narrow interventions focused at the level of the individual or the community, or by broad measures to redistribute the social, political and economic resources that exert such a profound influence on health status at the population level?” (Colgrove 2002, 728). The integrative analytical framework makes it clear that this question has no simple answer. It may be a matter of where the main determinants of a certain problem are located. Affecting the context does help most people most effectively but it is important to be aware that there may be particularly vulnerable persons for whom such intervention is not enough. For them it is critical that other more targeted interventions are available. An example: providing better access to good jobs will most certainly be critical for health and mental health among most refugees. However, for someone with a severe mental health problem, just providing a job will not suffice to alleviate that person’s problems.
3 THE SWEDISH CONTEXT FOR REFUGEE RESETTLEMENT

The previous two chapters have introduced the main ideas that ground the modern discussion within health and mental health promotion and the specific issues of concern for refugees and other immigrants throughout the migration process. Together with the research presented in Chapters 1 & 2, information about Sweden as a resettlement country, some statistics illustrating the diversity of the persons who have recently migrated to Sweden, and a presentation of the Introduction for newly-arrived refugees and other immigrants will provide the content of a socio-ecological framework to understand the context of refugee resettlement in Sweden. The complex interplay between context, coping and adaptation as portrayed by Moos (2002, figure 3) serves as an organizing model for this framework.

Figure 3. A model of the interplay between context, coping and adaptation (Moos 2002). Permission to reprint has been given by Professor Rudolf Moos.

3.1 THE ENVIRONMENTAL SYSTEM: SWEDISH AS A COUNTRY FOR RESETTLEMENT

Migration has always been important for Sweden’s social and economic development. The major reasons for immigration in recent centuries have been related to work, most often in terms of specific skills such as craftsmen in the mining industry or entrepreneurs starting factories or other businesses. Workforce immigration has been replaced by refugee migration in two major periods, after WWII and from about 1973 onwards. When workforce immigration was reduced after 1973, the main routes to permanent residency in Sweden have been refugee migration and migration of these refugees’ relatives. This development is similar to that in several other European
countries (Sahlberg 2005). Of the almost 9.2 million persons that were living in Sweden on December 31\textsuperscript{st} 2007, 13.4\% were born in another country. Between 1980 and 2007, Sweden has granted 343,230 persons permanent residency on refugee or refugee-like grounds.

Countries have been plotted on the world values chart to show their relative positions on two axes: traditional vs. secular values and survival vs. self-expression values (Inglehart 1997). Countries in protestant Europe generally occupy an extreme position as those most dominated by secular values and self-expression. Among these countries, the most extreme example is Sweden. This is very different from the position of the countries from which refugees come. Of course, particular groups, such as those who become refugees, may not reflect the general value system in a particular country. Differences in fundamental views may even be the reason for migrating.

The political climate in Sweden concerning immigration has shifted in parallel with many other European countries (Sahlberg 2005). Prior to the 1980s, little criticism was voiced about immigration to Sweden. In fact, Chileans fleeing persecution from the Pinochet regime in the mid 1970s were often seen as heroes (Eastmond n.d.). A dramatic shift occurred in the early 1990s when xenophobic nationalism gained ground, with racist violence, portrayal of refugees as a threat to Swedish welfare and the entry into parliament of a new anti-immigration party (Ny demokrati) in 1991 (ibid). Many of those who sought asylum as refugees during the wars and ethnic cleansing in the states of the former Yugoslavia during the 1990s were accused of lacking real grounds for asylum and praxis in asylum determinations was restricted (ibid). Although Ny Demokrati failed to win seats in parliament as of 1994, their political ideas have been picked up, at least to some extent, by other parties. The demand that all immigrants should have to pass a Swedish test in order to obtain citizenship may have contributed to the Liberal party’s large gains in the general election in September 2002, possibly the election in which issues to do with immigration and refugees were more important than ever before, with 10\% ranking them as important for their choice of party (Statistics Sweden 2002). However, despite this gain in voter support, the social democratic alliance won the elections. In 2006, on the other hand, protests against restrictive asylum decisions from many voluntary organizations and religious congregations were followed by a short-term temporary law that allowed undocumented persons and other non-recognized refugees to be granted permanent residency.

The state’s role as intervener and regulator has shaped the field of immigrant inclusion for over 30 years (Brekke and Borchgrenvik 2007). Sweden took a political decision to become a multi-cultural country in 1975. The policy was based on three principles: equality, freedom of choice and co-operation. The equality principle meant that all rights and responsibilities applied to everyone in Sweden; freedom of choice meant an option for the new immigrants to retain their culture; and cooperation represented the desired relationship between groups in society. Since the 1970s, scepticism about multiculturalism as a system that sustains differences between people has grown in several European countries and Canada (Sahlberg 2005). Seeing immigrants as a well-defined, coherent group that need special treatment to adapt to Swedish society has accentuated the differences and the status of these people as outsiders (Brekke and Borchgrenvik 2007; Eastmond n.d.). This has led to a barrier between “us”, the norm,
and “them”, the outsiders, that still persists in Sweden (Eastmond n.d.). In other European countries, recognition of the problems of a multicultural policy has led to a strong, predominately right-wing drive for assimilation, because according to this line of thinking, it is “their values”, “their way of living” and “their culture” that lie at the root of the observed social inequalities between “us” and “them” (Sahlberg 2005).

The Swedish solution was to replace immigrant policy with an integration policy based on three fundamental ideas that stress: 1) the reciprocal process between the individual and society, 2) the emphasis on equal access to power, influence and political resources, and 3) changes in society and not, in contrast to assimilation, in the individual’s identity (Sverige Mot Rasism 2002). Swedish integration policy applies across all areas of society and seeks to create a society for everyone, regardless of ethnic or cultural background. Everyone in this society should have the same rights, responsibilities and possibilities. Society should be founded on diversity and a societal development that is characterized by mutual respect for differences. This needs to be achieved within the premises for society’s fundamental democratic values and everybody, irrespective of their background, shall participate and be jointly responsible.

In order to keep track of and help to create the conditions for this kind of society, the Swedish Integration Board was established in 1998 as part of the policy. Eight years after parliament promulgated the policy, it was the subject of a critical review (Riksrevisionen 2005). As indicated by the report’s title, “From immigrant policy to immigrant policy”, the review found that not much had happened. The new policy’s basic principle was that public policy and its implementation should be based on universal strategies so that everyone could benefit. This had not happened. The primary explanations for this failure were: i) the national government’s instructions to its agencies are often imprecise and do not provide specific guidelines for how the particular agency is to work to achieve integration, ii) there are limitations in the basis for decisions to adapt the general policies, and iii) the national government’s weak control of its agencies’ efforts for achieving integration. The failure of integration policy implementation may also have to do with the original policy formulation, whereby government tried to solve implementation issues by setting up an institution, the Swedish Integration Board, to achieve changes that could only be made by others (Rakar 2004).

If, as is often stated in national and European policy, the final outcome of a successful resettlement period is integration, there is a great need to find working definitions that specify areas acceptable to all stakeholders. Starting from an analysis of a broad set of documents, surveys and interviews with refugees and other stakeholders, four means and markers have been identified for integration in UK: employment, education, housing and health (Ager and Strang 2008). Although these may be critical areas of integration which integration support programmes should be geared to address, they must be underpinned by a foundation in citizenships and rights, which vary across countries (ibid.). While the areas are relevant to many refugees, more intricate relationships between them are often reported (Phillimore and Goodson 2008). These are also critical areas for integration in the Swedish context (as shown in Chapter 2). However, the framework is open to an important critique: it does not include measures for detecting the adaptation of host-country institutions to be all-inclusive, including refugees and other immigrants (ibid.). In Sweden, about 25% of the general population
express a willingness to provide concrete help so that immigrants become established (Swedish Integration Board 2006). There is overwhelming support (about 90%) for active measures by local authorities to help newly-arrived migrants to become part of Swedish society (ibid). In contrast to the integration policy, a majority (60%) is in favour of cultural assimilation and only 10% wholly reject the idea of assimilation (ibid). The report’s extensive findings are summarized in a comment by the Swedish ethnologist Åke Daun, who distinguishes between integration at work and in other social institutions, which is acceptable to the great majority of the general Swedish population, and inclusion in Swedishness (i.e. belonging to the Swedish nation), which seems to be limited to persons with a very limited set of values, traits, religions, etc. (ibid).

Welfare policy provision occurs in traditional areas such as education, labour market, economy, housing, leisure time, transport, care and safety (Vogel and Hjerm 2002). When new refugees enter “the institutional structures of settlement, they do so as clients of the welfare system; as such they confront a complex interplay of national policy and their local implementations” (Eastmond n.d., 5). Welfare is not produced by the public sector alone; two other sources, the market (labour market) and the social network (family, relatives and friends), may also be involved (Vogel and Hjerm 2002). The role of the public sector is to guarantee equality and welfare for everyone by means of regulations, public services and redistribution through taxation and transfers (ibid). The mix between these three welfare providers is a highly politicized subject and it differs between countries as well as across time. The social network predominated in Sweden’s former agrarian society; industrialism generated demands on the market and the public sector. Sweden’s public sector expanded rather dramatically from the 1930s up to the beginning of the 1990s, when a shift back to the market began. The welfare mix creates the institutional frame for people’s demands and options, in a short as well as a longer time perspective. The balance results in a specific type of welfare state in the Nordic countries, the institutional welfare state (ibid). The main producers of welfare in such a state are the public sector and the market. The role of the social network as welfare provider is limited compared with other parts of the world. With the limited role of the social networks, the market and the public sector are heavily interdependent, with a high level of employment funding for generous welfare systems and high-quality public services for the education, healthcare and childcare that are needed to produce a healthy and efficient workforce. This mix is unique internationally and has resulted in relatively low levels of poverty, marginalization and inequality (ibid).

The findings in the previous chapter show that integration policy has not been effective in reducing inequality in welfare indicators between people born in Sweden and those born elsewhere. Three conclusions can be drawn: 1) differences in important welfare indicators between people born in Sweden and other countries are usually sizeable, 2) these differences may decrease over time but still exist after ten years in Sweden, and 3) people from regions from which most refugees come are often those showing up worst in the comparison. National policy formulations from the current and previous Swedish governments (e.g. Integrations- och jämställdhetsdepartementet 2008) express the idea that strategies to overcome structural issues – such as improving access to the labour market and providing relevant and high-quality education in Swedish and other
relevant areas – are necessary to achieve change. However, the Swedish integration policy sector far too often lacks strategies and preconditions for effective implementation (Kadhim 2000). Instead, policy and its implementation are marked more by political declarations than practical results, too few concrete directives, general measures more than consideration of the needs, wishes and capabilities of the variety of individuals for whom the services should be provided, and more of a focus on the refugees than on the actors in the environment (ibid).

These problems are critical not only for persons who migrate to Sweden and for a just and democratic society; they also have important consequences for Sweden’s economic development. In contrast to Canada, which may be rather alone in the world in having an active recruitment idea for immigration, neither Sweden nor most other European countries have started to work strategically on using the potential inherent in immigrants and immigration (Sahlberg 2005). The demographic composition of first-generation immigrants differs from that of the host population, with a larger proportion in working ages (Essén 2002). Immigration is needed to balance the working population’s contraction in relation to the total population throughout the EU in the coming decades (ibid). The necessary increase in immigration depends on the choice of demographic goal but the general conclusion is that even an annual increase of at least 200-400% will not be enough to maintain the working population’s current percentage of the total population (ibid). Improving access for persons born outside Sweden who are already in Sweden may be more important for improving the economic conditions of Swedish society than recruiting new labour from outside Sweden ( Integrations- och jämställdhetsdepartementet 2008). In the first quarter of 2008, when the economic situation in Sweden was favourable, the unutilized labour supply among people 20–64 years old was 15.2 million hours per week, of which 4.4 million hours represented persons born outside Sweden; this means that giving the latter group access to work could reduce the total by more than 25% (ibid). In 2004, Professor Jan Ekberg estimated that about 110,000 persons born outside Sweden or with parents born outside Sweden who are currently outside the labour market could be directly available for employment (ibid). Thus, Sweden has to develop a better capacity to open up access to the labour market for those already in the country. This task is also critical for Sweden to become an attractive country in which to resettle, one of the more important strategic issues in the foreseeable future.

### 3.2 THE PERSONAL SYSTEM: SUPER-DIVERSITY

Studying the UK in general and London in particular, Vertovec finds that the traditional idea of diversity, with one or a few different ethnic groups, is not an appropriate label for the current situation (Vertovec 2007). Today, “super-diversity” is the rule rather than the exception. This super-diversity may refer to diversity in many concurrent classifications, such as country of origin, place of residence, gender, legal status, language, religion, age, transnational networks (ibid). To this list one can add the traditional socioeconomic classifications: educational and work experience and economic assets.

Super-diversity is also evident in Sweden. The percentage of all those living in Sweden who belongs to the group of immigrants varies from 6% to 17%, depending on the
definition. The higher figure includes anyone born outside Sweden as well as persons with both parents born outside Sweden. The lower figure comprises people who are citizens of countries other than Sweden. The geographical spread is marked. In 2007 Botkyrka, a municipality in the Stockholm region, was the municipality with the highest proportion of immigrants, 50.8% with the most inclusive definition, 35.2% born outside Sweden. The municipalities with the highest proportion of persons who are not Swedish citizens are Eda, on the border with Norway, and Haparanda, bordering Finland, with 20% and 28%, respectively. The density of people born outside Sweden is highest, 22%, in the three largest cities, with 28% in Malmö and 21% in both Stockholm and Gothenburg. At the other end, about 10% of the municipalities have 5% or less of their population born outside Sweden.

In the period 2000–2005, between 33,000 and 41,000 people from outside Nordic countries resettled in Sweden each year. At least five specific grounds for resettlement can be identified: need for protection, humanitarian grounds, family bonds, work and education (Statistics Sweden 2006). The most frequent reason is family bonds, accounting for 54–62% of immigrants each year. The second largest in most years is humanitarian grounds, though work came second in 2004 and 2005. Need for protection as a reason apart from humanitarian grounds comes only fourth and was the least common reason in 2004 and 2005. Taken together, however, humanitarian grounds and need for protection, which represent different reasons for recognising refugees, occupy second place in each year during 2000-2005 (ibid).

Refugees in Sweden have always represented a wide range of countries of origin. The countries from which the largest numbers come have varied over the years. In the period 1980–1989 Iranians made up about 1/3 of the nearly 100,000 refugees who resettled in Sweden. Countries as diverse as Poland, Ethiopia, Chile, Iraq and Vietnam each contributed more than 5% in this period. The flow from Iran decreased sharply but was still large in 1990 and 1991. In the period 1990–1999, when almost 160,000 refugees resettled in Sweden, over 25% came from Bosnia-Herzegovina, the great majority of them in 1993 and 1994. Another 10% came from Serbia and Montenegro in 1994. The annual variation in reception is also considerable, with 1993 and 1994 as the absolute peak years, with 36,000 and almost 45,000 refugees, respectively, followed by almost 21,000 and 18,000 respectively in 2006 and 2007. At the other extreme, only about 6,000 were granted residency in 1995, 1996, 1998 and 2004. In the period 2000–2007, 76,000 persons have been granted residency on refugee- or refugee-like grounds. More than 50% of them arrived in 2006–2007. The major groups in this decade, over 1/3 of the total, have come from Iraq. This trend was clearest in the early 2000s and during 2006 and 2007. Still, while almost 60% of the refugees who obtained residence permits in 2007 were from Iraq, the total included more than 60 different countries of origin.

While it is very important not to lose sight of the “super-diversity” perspective, the dominance of refugees from Iraq at the time of this research project makes it relevant to provide a brief description of living conditions in Iraq in the 2000s. UNDP and the Ministry of Planning and Development Cooperation of Iraq conducted a population survey with 22,000 households in Iraq in 2004. The general experience is that Iraq has a historical legacy of good general infrastructure, social services, healthcare and
The level of education in Iraq is high. Overall, 20% of the adult population in Iraq has attended secondary school or higher education as their highest completed education. Income inequality between the richest and poorest segments of the Iraqi population is low compared to the region, but there are clear differences between the situation for men and women in Iraq. The figures among women differ considerably from that for men; 47% of women are illiterate or partly illiterate. Very few people in Iraq are still single after the age of 30. Traditionally, the preferred type of marriage is close kin marriage, e.g. between cousins within the patrilineal clan. This kind of marriage is more common in rural than in urban areas. In many rural areas it accounts for over half of all marriages. The improvement in women’s situation in education and the labour market during the 1970s has been followed by a backlash during the last 15 years. The rolling back of public services where most women work has accentuated the low level of labour market participation for women. The employment rate for women above 15 is estimated to be only 13%, among the lowest in the Middle East region. This is roughly the same level as the ILO’s Labour Statistics from 1987, which showed a labour force participation rate of 11% for women above 15 years, compared to 75% for men.

The population of Iraq shares a number of characteristics with the other countries in the Middle East: a recent history of rapid population growth – driven principally by high fertility rates and comparatively low mortality rates – moderated by significant migration. The percentage of households with a close relative abroad ranges from 22% in the north to 6% in the south and the centre regions of Iraq. As reported by relatives, Europe is the primary region of resettlement (52%) for Iraqis who leave their country. Before they left, about 40% of the men were employed in the private or public sector and 16% were self-employed. Among the women, the largest group were housewives, 47%, but 28% worked in either the public or the private sector, 22% and 6%, respectively. According to their interviewed relatives, almost 2/3 of the men left the country to work or to seek work, while 13% left for political reasons. For women, getting married or following the family were the most common reasons, with 55%, while 11% of the women left for political reasons.

For more than 90% of households in Iraq, a primary school, a secondary school, a health centre, and a place of worship could be reached within 30 minutes from their dwelling with the usual means of transportation (cars, public transport, walking and other means). Generally, the situation in urban regions is much better than in rural regions. In the period 1990-2003, Iraq had approximately 53 physicians per 100,000 inhabitants, about one-third of the level in neighbouring Jordan, Syria, and Lebanon in the same period. However, the quality of these services is not always highly rated. After wars and sanctions, access to good healthcare, infrastructure and other services has deteriorated.

Between 1970–1975 and 2000–2005, life expectancy at birth rose only four years in Iraq compared with 17–20 years for other countries in the region. Infant morality was 32 deaths during the first year of life per 1,000 births. The rates in 1999–2003 were 29 for girls and 25 for boys. Mortality in the first five years of life was 40 (all), 35 (girls), 30 (boys).

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5 All figures in this section come from this source unless indicated otherwise.
and 44 (boys) per 1,000. In 2004, 8% of the Iraqi population self-reported chronic illness. Between 205,000 and 242,000 persons are estimated to live with a chronic health problem directly caused by war. The invasion of Iraq started on 20th March 2003 and was declared over in May the same year. In the aftermath of the 2003 invasion there have been about 20,000 deaths among civilians and military personnel. This war has caused more disability among children, women and the elderly than previous wars. Excess mortality due to the invasion has also been reported by other sources (Burnham, Lafta, Doocy and Roberts 2006; Roberts, Lafta, Garfield, Khudhairi and Burnham 2004). These researchers estimate that the invasion and the period up to September 2004 have caused an excess mortality of 100,000 persons; by July 2006 the figure had risen to 665,000 persons. Exposure to war and other atrocities was also common among earlier groups of Iraqi and Kurdish refugees in the Introduction in Sweden. In the late 1990s about 40% of the male refugees were estimated to have been exposed to torture (Söndergaard 2002). The general conclusion is that from a relatively good position, living conditions in Iraq have declined sharply and are now below many other countries in the Middle East on the UN Millennium Development Goals (Ministry of Planning and Development Coordination and UNDP 2005).

3.3 THE PROGRAMME: THE INTRODUCTION FOR NEWLY-ARRIVED REFUGEES AND OTHER IMMIGRANTS

The way in which resettlement support has been provided to migrants in Sweden has changed over the years. Many of the refugees who arrived after WWII were aided by the local communities to which they came. Later, workforce migrants were sometimes provided with language education and some basic knowledge about Sweden by the companies that employed them. The idea of formalizing support as part of welfare provision arose when refugees and family bonds replaced work as the primary reason for getting permanent residency in Sweden.

Today, the political commitment, funding and infrastructure for providing services to refugees during resettlement are predominately channelled through the Introduction for newly-arrived refugees and other immigrants. This programme is actually an exception to the general integration policy, since it focuses on how to compensate for the specific problems that may be associated with the initial period after permanent residency, such as a lack of language skills and access to the labour market. The labour market board was responsible for refugee resettlement support until 1985. Since then, municipalities receive funding from the national level for service provision for each resettled refugee, including children. The funding is expected to cover 24 months of service provision and economic benefits for the participants. In 2007, there were 23,500 persons who were resettled in the Swedish local authorities and granted permanent residency for refugee or refugee-like reasons, or were family members who had arrived up to 24 months after their relative. While all of them are entitled to Introduction services, no exact figures on participation rates are available; however, most of those concerned are likely to register because economic benefits are conditioned on programme participation. The budgeted transfer from the national level to the local authorities in 2009 is about SEK 4800 million (100 SEK≈10 Euro) for 19,300 expected refugees. The general aim and the specific objectives of the Introduction are presented in table 1. The policy stipulates that each participant shall have an individualised introduction plan. As
the only formal control over the quality of programme implementation the plans shall be sent to the responsible agency (the Swedish Integration Board before 1 July 2007, since then each county’s administrative board, Länsstyrelsen) but there is no routine to check the quality of the plans. Thus, in reality, the national funding level does not exercise formal control of the quality of service provision.

Table 1. General Aim and Specific Objectives of the Introduction. Translation by Fredrik Lindencrona

<table>
<thead>
<tr>
<th>General aim of the Introduction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Society’s Introduction for refugees and other newly-arrived immigrants provides the person with the necessary conditions to become economically self-sufficient and to participate in the Swedish Society</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific objectives for the Introduction:</th>
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</thead>
<tbody>
<tr>
<td>For adults:</td>
</tr>
<tr>
<td>An individual plan for the Introduction has been worked out together with the newly-arrived person</td>
</tr>
<tr>
<td>Adult immigrants have knowledge about the conditions that apply in the Swedish society and work life as well as about the rights and responsibilities of each citizen</td>
</tr>
<tr>
<td>Adult immigrants have such knowledge in the Swedish language that the language can be used as a mean of communication in everyday situations, in work life and in education</td>
</tr>
<tr>
<td>Newly-arrived immigrants have early and, for the person, appropriate contact with Swedish work life and associations in the voluntary sector</td>
</tr>
<tr>
<td>Immigrants in working age, without education that corresponds to Swedish nine-year compulsory school, have started supplementary education/activity in line with their individual preconditions</td>
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</table>

<table>
<thead>
<tr>
<th>For children and adolescents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents that between the ages of 16 and 20 years can participate in and profit from Swedish upper secondary education</td>
</tr>
<tr>
<td>Pre-school children and children in school ages participate in and profit from pre-school and school activities. Their parents have an established contact with the pre-school or school</td>
</tr>
<tr>
<td>The specific needs of children who come on their own to Sweden are provided for</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For elderly and people with health problems and the disabled:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention is paid to the specific needs among the elderly in order for them to profit from the services provided by the Swedish society and participate in society in line with their individual preconditions</td>
</tr>
<tr>
<td>Attention is paid to health problems among the newly-arrived immigrants, both adults and children. Healthcare and/or rehabilitating/habilitating services are provided if needed</td>
</tr>
<tr>
<td>Attention is paid to the specific needs among the disabled in order for them to profit from the services provided by the Swedish society and participate in society in line with their individual preconditions</td>
</tr>
</tbody>
</table>

The few existing evaluations show that the Introduction is not particularly effective in supporting speedy access to employment (Integrations- och jämställdhetsdepartementet 2008). For example, the time from permanent residency to employment is estimated to be about 7-8 years in general and more than 10 years for women (ibid). Language mastery has been considered to be one factor behind labour market access. Having a good level of Swedish has been estimated to confer an improvement of about 10% in the rate of labour market access (ibid). However, after 2.5 years as a student, only about 62% of some 60,000 students in Swedish for Immigrants classes have obtained the grade ‘accepted’. Of these, about half had passed the highest grade. Results in Swedish for Immigrants are closely related to the earlier level of educational achievement. The level of education seems to be more important for labour market access, especially in Sweden, for people born outside than inside Sweden. Among all people born outside Sweden with at least two years of university education, 60% have a qualified job in Sweden. For people born outside Europe who have lived in Sweden for less than 10
years, the figure is lower, only 40%. The level among academics in Sweden is 90% (ibid). It has been suggested that the long and complex path towards employment for immigrant academics is due to a mismatch between the resettlement region and regions where work for academics can be found, to offers of education and work that are not sufficiently qualified for them, and to resettlement support, particularly language learning, failing to provide adequate preparation for employment in a job that requires academic competence (Bjurling 2004).

The problems concerning programme effectiveness may concern the aim and objectives of the Introduction as well as its implementation. The aim addresses the position of the participant in relation to the environmental system after programme completion. The objectives focus one-sidedly on how participants should be helped to overcome the potential problems they may encounter in the environmental system. This client perspective is debatable since it implies limited agency and a deficiency on the part of the refugee (Schierenbeck 2003). In this way the culture of the programme often seems to be part of a deficiency discourse where immigrants are seen as being different from the Swedish majority population and in need of different things to become more like this population (SOU 2006:79). The roots of this perspective have been traced back to when the Swedish Immigrant Board took over responsibility for this programme from the employment service in 1985. After this change, the Immigrant Board contracted service provision with local municipality social administrations and this may have consolidated the perspective of refugees as clients with special needs (Eastmond n.d.). In these early years the Swedish term for refugee resettlement support suggested ‘care’. Notwithstanding the intentions behind integration policy from 1997, the alternative perspective – that the recipient society and its structures also needs to be considered – has had little impact on public policy and general discourses on the Introduction and resettlement services. A further reason for the limited success may be the implementation of the Introduction. Policy in this area is an example of the clarity and distinctiveness of policy formulation being sacrificed for consensus (Kadhim 2000). The lack of clarity has given the executive bureaucracy – governmental, regional or municipal/local authority – considerable freedom to interpret the policy (ibid). Many critical comments have been voiced about the Introduction, including challenges at the policy level, such as a lack of political goals and low priority in the work of political bodies (ibid). Problems have also been noted in the organization of the local systems of service provision, such as the lack of a clear division of labour between organizations, highly unstable and varying resources, constant structural change in organizations and the weak position of participants in relation to decisions about service delivery (ibid).
4 ACHIEVING STRUCTURAL HEALTH PROMOTION

4.1 FINDING STRATEGIES TO ADDRESS THE SITUATION

The previous chapters have provided an overview of research that bears on the theoretical perspective in this thesis: structurally oriented mental health promotion applied to refugee resettlement in Western countries. This chapter focuses on existing ideas about how to develop structural mental health promotion strategies. “The Ottawa Charter for Health Promotion” from 1986 can be considered the first key manifestation of such a perspective. This section will look at how these fundamental ideas have developed during the first two decades after the Ottawa Charter. The second section addresses theory of settings and settings development. The third section introduces ideas about how complex service systems such as the Introduction can be built and critical settings qualities that can influence health in such systems.

4.1.1 Health Promotion: From the Lalonde report to the Ottawa Charter

In 1974 the Canadian Minister of Health, Marc Lalonde, introduced a new vision for health in Canada. It introduced four so-called health fields that are central to the health of the population: human biology, life-style, the environment and healthcare. The report sees reducing mental and physical health hazards for high risk individuals and providing access to good care as the main objectives (Government of Canada 1974). With current available knowledge about social determinants and other evidence of the role of social conditions for health, this report may rightfully be criticised for an unduly individualistic perspective and a neglect of structural impacts on health. It must, however, be acknowledged that the report pioneered the idea, in government and policy circles worldwide, that factors outside healthcare could contribute to the health of the population (Irvine, Elliott, Wallace and Crombie 2006). The report was well received in Canada, but did not have much impact on national politics at the time (Hancock 1986). However, it may have influenced the development of the next milestone in health promotion policy: WHO resolution, WHA 30.43, better known as “Health for All by the Year 2000”.

*Health for All by the Year 2000* was launched as a global movement at the International Conference on Primary Health Care in Alma-Ata 1978. It was based on the shared understanding of the World Health Assembly that hundreds of millions of people in the world had a unacceptable health status and that strategies were needed to tackle this problem. The conference established that “the attainment of health required the action of social and economic sectors as well as the health sector” (Irvine, Elliott, Wallace and Crombie 2006, 75). Expanding and devising a clear role for primary health care was seen as the primary vehicle to achieve improvement in health status. A shift in focus was envisioned, from a reliance on treatment with advanced technologies in centrally located hospitals to community health centres and community health workers. Most activities concerned the health sector, though agriculture, food, industry, education and housing were also included in the health sector concept. As a result, critical means to achieve the goals included collaboration between these areas (ibid).
The Lalonde report was also influential in the development of the Surgeon General’s report “Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention” (US Department of Health 1979). This report acknowledged that despite a 700% increase in healthcare spending over less than two decades, there had been no corresponding improvement in health (ibid). The limited effect was explained by the fact that almost all the increase had been spent on treatment and just a tiny proportion on preventive measures. To mobilise and direct action, the report set up measurable health targets that could be addressed with preventive measures, a decision that gave substance to health promotion and prevention in the US (Irvine, Elliott, Wallace and Crombie 2006). However, while this report still focused traditional individual risk factors, the Black Report in the UK resulted in a more controversial shift of perspective by producing convincing evidence that “poverty and ill health were inextricably linked and that material deprivation was a major determinant of ill health and death” (Irvine, Elliott, Wallace and Crombie 2006, 75). The preparation of the report coincided with a change of government from Labour to Tory and the new prime minister, Margaret Thatcher, was not exactly enthusiastic about the findings. It took more than ten years for the issues to become major topics in health research. However, the ideas did spread to other European governments, such as Sweden and Ireland (ibid).

In 1984, the 32 member states in WHO European Region adopted the European Health for All policy (ibid). While the policy did not have the force of law in the member states, it greatly influenced health policy-makers in Europe (ibid). The strategy included five principles: reduction of health inequalities, empowerment of individuals, participation by communities in policy making, co-operation between local agencies in the health sector, and local agencies providing preventive care (World Health Organization 1993). In all, 38 targets were presented for specific groups, changes in life-styles, environmental improvement, developing systems and encouraging specific countries to develop their own health-for-all policies. A review in the late 1990s found that no country had implemented all the targets despite recurrent monitoring meetings across Europe (Irvine, Elliott, Wallace and Crombie 2006).

4.1.2 Health Promotion: The Ottawa Charter

All the key strategies for achieving the targets of the European Health for All policy resemble the international agreements on health promotion that were debated, decided and ratified in the first International Conference for Health Promotion, arranged by the World Health Organization and the Canadian Government in Ottawa, Canada, in 1986 (World Health Organization 1986b). The final document from this conference, the Ottawa Charter, is the key reference for the modern health promotion movement and will therefore be presented in some detail here. The charter elegantly summarizes many of the ideas and the evidence available at the time concerning determinants of health and it delineates a set of clear strategies that firmly establish a structurally oriented perspective on health promotion. A discussion document from the working group engaged to support the new programme on Health Promotion within WHO Europe in 1984, presents several principles for health promotion (WHO 1986). Many of the principles discussed in that document are included in one way or another in the Ottawa Charter, but the structural perspective in the discussion document is even stronger than in the charter. The first two principles clearly represent this perspective in that they...
declare that “health promotion involves the population as a whole in the context of their everyday life rather than focusing on people at risk for specific disease” and “health promotion is directed towards action on the determinants and causes of health” (ibid, 73).

The conference was intended to be a response to “the growing expectations for a new public health movement around the world” (World Health Organization 1986b) and it declared its role in a longer chain of events, including the Alma-Ata conference, the Health for All strategy and the target setting and debates in the World Health Assembly on the critical role of inter-sectoral action for health. The charter defines health promotion as “the process of enabling people to increase control over, and to improve, their health”\(^6\). To reach complete physical, mental and social well-being, certain critical abilities of groups or individuals are needed: to identify and realize aspirations, satisfy needs and to change or cope with the environment. In this understanding, health promotion differs from prevention of disease since health “is a positive concept emphasizing social and personal resources, as well as physical capacities”. Health promotion transcends sectors and traditional life-styles, to be concerned with well-being. The charter defines eight fundamental conditions and resources that are required for health improvement: 1) peace, 2) shelter, 3) education, 4) food, 5) income, 6) a stable eco-system, 7) sustainable resources, and 8) social justice and equity. Three activities are needed to achieve promotion of health: advocate making conditions favourable for health, enable everyone to achieve their fullest health potential, and mediate between different interests in society for the pursuit of health.

Arguably, the charter’s most important pioneering elements are the first three and the fifth of the five health promotion means of action. They introduce critical activities to support the practical implementation of a structural perspective on health and mental health promotion. The first is to build healthy public policy. This “puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health”. To achieve this goal, legislation, fiscal measures, taxation and organizational change may be necessary. Perhaps the most critical activity is coordinated action because this “leads to health, income and social policies that foster equity”. Inter-sectoral collaboration is needed for developing healthier public services, better environments and the identification of and action against obstacles to the adoption of healthy public policies in non-health sectors. The second action mean is to create supportive environments. This is based upon a view that in modern society, issues are so complex and interrelated that it is neither possible nor desirable to separate health from other goals. The interdependence is fundamental to health promotion since evidence from the socioecological perspective points to the “inextricable links between people and their environment”. The goal for health promotion is to create everyday environments with “conditions that are safe, stimulating, satisfying and enjoyable”. Conducting systematic assessments of the health impact of the rapidly changing environment must be a main activity in order to create supportive environments. The third mean is to strengthen community actions. It focuses on engaging and organizing the community to set priorities, make decisions, plan and implement strategies to

\(^6\) The citations in this section are from the Ottawa Charter unless indicated otherwise.
achieve better health. The heart of this process is “empowerment of communities – their ownership and control of their own endeavours and destinies”. To be successful, community development must identify human and material resources, build social support and develop flexible systems for strengthening public participation and direction of health matters. The last means in the Ottawa Charter is to reorient health services. The rational behind this is that “the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services”. An important action in this work is to “open channels between the health sector and broader, social, political, economic and physical environmental components”. Finally, the vision is “a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person”.

Expanding the view of the healthcare sector’s social responsibilities and making it an integrated partner in work for health is an important activity in a coherent strategy. However, it is important that the reorienting represents a radical shift, not just a continuation of the traditional medical or other individualistic strategies to prevent disease. There is a particular risk of this occurring if this and the fourth means are integrated. From a structural viewpoint on health promotion, the fourth mean differs from the first three and the fifth. The fourth means sees developing personal skill, i.e. “enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries,” as an essential task. Education and learning opportunities can provide people with information to “increase the options available to exercise more control over their own health and over their environments, and to make choices conducive to health”. However, it is often questionable whether the main problem is lack of information. The discussion document developed to consult the newly started health promotion programme within WHO Euro in 1984 cautioned against health promotion programmes being “inappropriately directed at individuals at the expense of tackling economic and social problems” and that “healthism could lead to others prescribing what individuals should do for themselves and how they should behave, which is contrary to the principles of health promotion” (WHO 1986, 75). To tackle these challenges it is important to engage those concerned in describing the problems and to consider the development of personal skills as a strategy that must also involve changing the context because “information alone is inadequate; raising awareness without increasing control or prospects for change may only succeed in generating anxieties and feelings of powerlessness” (ibid, 75).

When the Ottawa Charter was launched, it generally elicited support but critical voices were heard from the US and from third world countries in the Western Pacific and Asia (Green and Raeburn 1988). Green and Raeburn find that the charter positioned the system-oriented social/policy model, emphasizing structural determinants, against the professional health education approach, emphasizing personal choice, lifestyle and individual behaviour. Sole reliance on the first model risked strengthening the role of experts and bureaucrats far too much (ibid). In order to avoid splitting the health promotion field, they favour an integrated approach, focused on enabling communities of people in their everyday life to take control over their health and the determinants of their health. Another set of critiques has focused on the Western value system represented in the charter (De Leeuw and Hussein 1999). However, when the charter is analyzed with Quranic texts, the principles seem to be appropriate in a Sunni Muslim
cultural context. For example, creating supportive environments is the essence of the Quran for a religious Muslim and there are clear references to building healthy public policy in the system of Hisba, with direct references in the Quran. That ideas similar to the Ottawa Charter are represented in the Holy Scriptures does not mean that health and social matters are handled accordingly, as evidenced by the situation in several Sunni Muslim countries (ibid). It does, however, provide an opening for the cultural and religious appropriateness of these issues in other parts of the world and for persons with an Islamic background who immigrate to Sweden. The Ottawa Charter has also been interpreted from the Israeli medical sociologist Antonovsky’s salutogenetic perspective (Eriksson and Lindström 2008). This analysis shows that the sense of coherence theory can be used as an underpinning theory that may guide action in the Ottawa Charter’s five action areas and can be used as a framework for evaluation (ibid). A shared key challenge for health promotion and the salutogenic approach is to form “salutogenic societies” (ibid, 198) based on healthy public policies and the synergy between activities in different arenas of society.

4.1.3 Health Promotion: Developments after the Ottawa conference

The Ottawa Charter ended with a commitment to health promotion where the participants pledged to seven actions. Those of greatest importance to this thesis are, 1) advocate a clear political commitment to health and equity in all sectors, 2) tackle inequities in health produced by the rules and practices of society, 3) enable people and their communities to be critical voices in matters of health, living conditions and well-being, and 4) recognize health and its maintenance as a major social investment and challenge, and address the overall ecological issues of our way of living. The World Health Organization and other international organizations were called upon to advocate the promotion of health in all forums and to support countries in setting up strategies and programmes for health promotion. After the Ottawa conference, another five international health promotion conferences have been held, in Adelaide 1988, Sundsvall 1991, Jakarta 1997, Mexico City 2000 and Bangkok 2005.

The Adelaide conference targeted the first action from the Ottawa Charter, building public policy, while the Sundsvall conference focused on the second, creating supportive environments for health. Jakarta was the first global health promotion conference to include the private sector and was also the first to be held in a developing country. This conference also had a wider representation of countries from the developing world. The conference in Mexico City was concerned with how the equity gap can be bridged. While limited to Europe, the EU/WHO Ministerial conference in Helsinki 2005, on mental health in Europe, was the first high-level conference on mental health promotion and therefore of symbolic and practical importance for the development of health promotion targeted towards mental health. Further discussions of the area of mental health in Europe were held at the conference “Implementing mental health promotion action,” held in Barcelona in 2007. The Commission of the Social Determinants of Health within the WHO and the final report “Closing the gap in a generation. Health equity through action on the social determinants of health” published in August 2008, will likely become another important milestone (Commission of the social determinants of health 2008). In contrast to the other conferences, the Bangkok conference was the first after Ottawa to issue a charter as the final outcome.
The decision to issue a new charter has led to some discussion in the health promotion community. Based on a detailed and critical analysis of the perspective represented in the texts of the Ottawa and Bangkok Charters, Porter claims that the change in discourse between the two is considerable (Porter 2007a). Three main shifts in perspective have been identified, a) from a proactive socio-ecological approach to new capitalism, b) from a clear depiction of social justice and equity in resources to equal opportunity for health, and c) from participatory democracy to global technocracy (ibid.). Porter considers that “Bangkok’s foregrounding of life-and-death health threats” (ibid, 78) may easily take precedence for less developed countries but questions whether it would not do more good to stay with the proactive perspective in the Ottawa Charter where health promoters ask “what kinds of worlds we should build and supporting the building” (ibid, 78). Porter’s critique is not fully accepted but it has helped to fuel a discussion of the ethics and principles of health promotion, a subject that should be of deep concern to the health promotion field (Mittelmark 2007).

The Ottawa Charter is still viewed as the main “ethical cornerstone” of health promotion (ibid). However, although this charter and other statements have been an important part of developments in health promotion, it is not clear exactly what they can contribute (St Leger 2007). Inter-sectoral collaboration has been one main strategy in health promotion, re-iterated from conference to conference. However, participation from other sectors is still too limited in health promotion conferences and in the process of drafting declarations, charters and statements (ibid). Success in inter-sectoral work requires a reciprocal adaptation process between sectors in collaboration. It is exactly this process that defines one of the newer and more important developments in health promotion, “investment for health”. The critical idea behind investment for health is that “health is a crucial social and personal resource that needs nurturing – that needs investment. But it is also true that if we invest in ways that secure positive health and well-being we also bring about social and economic benefits for the whole community/country” (Ziglio 2000, 25). Five key principles summarize this approach: 1) improving and maintaining health is an investment, 2) the determinants of population health should guide the investments, 3) such investment implies reorientation of health services, 4) overall social and economic development, population health impact – as measured by both need reduction and health assets maximisation – is the main measure of the quality of the investments, and 5) investments must reduce inequities and be firmly grounded in a human rights perspective (ibid). While investment for health is a new and promising strategy, the concepts and perspective are in line with existing private sector business discourses and require a lot of technically complex decision-making. The pendulum has swung between attempts to articulate the different perspectives represented in health promotion and attempts to reconcile these differences. The most recent discussion, represented in the critique of the dominant structural perspective in Bangkok Charter (Porter 2007a), suggests that only the future can tell whether the investment for health strategy will lead to such a diversion from earlier visions of the health promotion field that it cannot be reconciled. Articulating the differences in different models of health promotion may create tension in the field, but it is most likely an important exercise to spur development when such complex undertakings as creating supportive environments for health and other health promotion strategies are concerned.
4.2 ADDRESSING SETTINGS AS AN INTERVENTION STRATEGY

The call to articulate different models of settings-based work will be heeded in this section. At first glance, the settings-based approach may seem coherent. First, the health promotion glossary has just one definition of a setting: “the place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being” (Nutbeam 1998b, 362). Second, it is well grounded in the Ottawa Charter and the Sundsvall conference on supportive environments for health. Third, critical insights have been the need for action geared towards policies, the social and cultural environment, to build partnerships, engage people in the setting to achieve change and own the change. Fourth, the competence needed to work through settings has included becoming a change facilitator, working with organizational development, building inter-sectoral collaboration and so forth. Fifth, there is general agreement that settings-based work has had successful outcomes (Whitelaw, Baxendale, Bryce, MacHardy, Young and Witney 2001). However, a close examination shows that settings-based work is a broad concept that encompasses at least five different models: passive, active, vehicle, organic and comprehensive (ibid). The models have different key assumptions about the role of the setting for health and the proper locations for intervention to address and improve this work (ibid).

The first two models are focused efforts to address individual changes in health behaviour and the setting is mostly used as a channel to reach a certain population, such as school for pupils (ibid). The other three models are more or less ambitious efforts to change the setting’s structural characteristics. In the vehicle model, a series of specific projects are seen as catalysts for more radical change. The organic model addresses the capacity of the organization and its staff to address problems, build networks and achieve change, rather than a specific health problem. An even wider approach is represented in the comprehensive model, which stresses the need for a firm establishment of the change process in the top level of the organization; an example is the investment for health strategy which engages the whole organization (or the whole community, region or nation) and all cross-cutting steering principles that work throughout it. While the first two models may represent the traditional idea of settings, they do not identify the health promoting and health damaging properties of the settings themselves (Wenzel 1997). In the three last models, the health promotion strategies are seen as more integrated in activities, steering policies, and organizational, social and cultural dimensions of the setting and its environment. Achieving such comprehensive models may not always be possible. Several challenges have been presented that make this less likely, a) the philosophy cannot be translated easily to practical and tangible activities in the setting, b) other priorities act against the agenda, c) health promoters may be required to show better-known strategies with specific outcomes, d) health promoters may not be considered appropriate agents of change in a new setting, and e) inability to find resources to implement the needed change (Levin and Ziglio 1996; Whitelaw, Baxendale, Bryce, MacHardy, Young and Witney 2001). A significant difference between the first two and the last three models concerns the interdependence of health and the general objectives of the setting in which health promotion strategies shall take place. Without active commitment and inclusion in the decision-making processes from other sectors, implementation of health promotion strategies in those
sectors stands little chance of succeeding (St Leger 2007). However, there are certainly some important issues involved in finding working alliances with other sectors. A key problem is that “new partners may possess little or no sophistication or primary interest in health *per se*. Nevertheless it is their construction of reality that must frame the venue of health promotion action” (Levin and Ziglio 1996, 35). Since the engagement and activity of other critical sectors is necessary, their “analyses of reality, of values, of preferences and of evidence of goals achieved” (ibid, 35) must be considered important to promote negotiation, joint learning and effective settings-based intervention.

This points to the critical need to create a shared understanding between health promotion actors and the main managers and main professional groups in the setting, be they headmasters, teachers, labour market officers, managers, sports coaches, business managers, financial market analysts or any other participants in any setting that may be addressed for purposes of health promotion (Levin and Ziglio 1996; St Leger 1997). The right conceptualization and theory-building require close attention to how the everyday activity of the setting can promote health, as well as what improved health can do to improve the setting’s main activity (St Leger 2007). For example, the chance of succeeding in the development of more comprehensive approaches to school health promotion will be “enhanced if it grounds its arguments in better educational discourse and speaks the language of the sector it wishes to engage” (St Leger 1998, 233). It should also be targeted to strengthen the setting’s capacity to solve other prioritized challenges, such as health promoting school approaches that help schools with problems such as bullying, family breakdown, study motivation and violence (ibid). Different strategies to reach such a shared conceptualization can be envisioned, including using existing health language in the new setting, build on existing concepts in the new setting that represent crucial health concepts, and creating and precisely defining new language that may represent both areas (Levin and Ziglio 1996; St Leger 1998).

An instance of this is a theory on health promoting schools that actively seek to ground health promotion in the setting’s organization, curriculum development and pedagogic practices (Markham and Aveyard 2003). According to this theory, health promoting schools can provide support for human functioning through two essential human capacities: practical reasoning and affiliation. As these capacities are already part of the schools’ main activity, well-functioning education is the basis for good health. To achieve positive functioning for pupils in schools and as an outcome of schooling, schools need to be organized with three strategies in mind. First, they need to be better integrated into the surrounding community. Second, they should focus on broad thematic subjects as the main way of teaching. Third, they need to encourage pupils to manage their learning and engage students in decision-making over curriculum development and other issues. When such ideas are institutionalized and embedded in the school environment, “schools do not need health education classes that focus on healthy lifestyle choices nor teaching staff with specialist health education roles in order to be health promoting” (Markham and Aveyard 2003, 1209).

School health promotion seems to have moved from the more individualistic passive model of health promotion to an organic or comprehensive model of settings-based interventions (Whitelaw, Baxendale, Bryce, MacHardy, Young and Witney 2001). To
make this work, new conditions need to be actively arranged to succeed in implementation, such as negotiated planning and coordination, inter-sectoral action between school, family and community, political and financial support and systematic evaluation (Deschesnes, Martin and Jomphe Hill 2003). The need for policy development, integration of the health promotion strategies into ordinary reform agendas and systematic evaluation has also been advocated in other settings, such as healthy cities (de Leeuw and Skovgaard 2005; Glouberman, Gemar, Campsie, Miller, Armstrong, Newman, Siotis and Groff 2006), health promoting hospitals (Johnson and Baum 2001; Whitehead 2004), and healthy workplaces (Noblet 2003). However, in most circumstances policy development without implementation of the practices in a programmatic approach will do little to change a setting (Crisp and Swerrissen 2003). To achieve sustainable change in the environment of the new setting, health promotion may need to take many aspects of the setting into account, including the institutional or organizational culture, the expectations, attitudes and beliefs of key players, the nature of the practice environment, power issues and organizational structure in the setting, and historical developments within the setting, as well as broader social, economic and political determinants that affect policies and practice of the setting (Poland, Green and Rootman 2000; St Leger 1998; Swerrissen and Crisp 2004).

A recent review of the evidence for the five health promotion actions from the Ottawa Charter concludes that “the most effective interventions employ multiple health promotion strategies, operating at multiple levels (often including all of the structural, social group and personal levels), work in partnership across sectors, and include a combination of integrated actions to support each strategy” (Jackson, Perkins, Khandor, Cordwell, Hamann and Buasai 2007, 79). The review of the evidence show that six cross-cutting actions are necessary to achieve success: a) inter-sectoral and inter-organizational partnerships at all levels, b) community participation and engagement in planning and decision-making, c) creating healthy settings at all levels in the everyday environment, d) political commitment, funding and infrastructure for social policies, and e) awareness of the socio-environmental context (ibid). This review shows that to be effective, settings development often needs to join political will, technocratic competence and community participation at the same time. An interesting example in the area of healthy public policy is strategies to engage the community in healthy public policy development in the community setting (Mittelmark 2001). Comprehensive settings approaches seems to be a promising strategy, though the available evidence on such strategies is still limited (Dooris 2006). There are several reasons for the relative lack of studies in this area, a) the focus has been on specific diseases and single factors rather than a comprehensive settings approach, b) whole system change can rarely, if at all, be addressed with research strategies that are considered of the highest rank, such as RCTs, c) the variety of interventions within a settings approach, d) the paradox that if integration of the health perspective is successful it becomes harder to track the improvements, and e) the challenge to evaluate the whole rather than the parts (ibid). To overcome these problems, research strategies need to “look at the whole and attempt to map and understand the interrelationships, interactions and synergies within and between settings – with regard to different groups of the population, components of the system and ‘health’ issues” (ibid, 60). Because of the complexity in conducting settings evaluation and research, this field needs to be provided with better funding, which might require that appropriate evaluation of whole setting development and other
structural health promotion interventions is understood and encouraged by policymakers and managers (ibid). There is reason to believe that this kind of evaluation and research will have an important role in the future of health promotion because the need for settings development makes “simple, universal rules of evidence untenable” (McQueen and Anderson 2001, 77) and this requires that “participation, context and dynamism, is being brought into the thinking on evaluation design” (ibid, 78).

4.3 IMPLEMENTING COMPLEX SERVICE DELIVERY

A recent review of the systems perspective on settings argues that settings have to be understood as “dynamic complex systems, with inputs, throughputs, outputs and impacts – characterized by integration, interconnectedness, interrelationships and interdependencies between different elements” (Dooris 2006, 56). It is an open system with a strong interdependence with the larger context in which it is embedded. The distinctive approach in settings work is the focus on organization development, based in systems theory, to plan, stimulate and implement appropriate change (Paton, Sengupta and Hassan 2005). One critical requirement for success in achieving successful implementation of comprehensive setting development is to know and understand the context in which the change shall be implemented. Organizations and systems can be classified in many ways. It has been recognized for a long time that a central issue which steers organizational design is the task and the technology that the organization is created to carry out (Thompson [1967] 2003). The main aim and the objectives of the Introduction are compatible with several of the determinants of health and mental health, such as participation in society, employment or further education and language mastery. The socio-environment both within the setting and in which the setting is embedded should be a critical concern for any settings development strategy. A critical challenge for service provision concerns the “super-diversity” of participants in terms of who they are, their needs and aspirations. Resettlement being a dynamic process, participants’ trajectories throughout the programme may be quite diverse. This situation requires the on-going identification and development of the available and needed resources among the participants in order for them to reach the goals. Different competencies may be needed to identify these resources within different areas and different organizations are responsible for providing the different kinds of services that are needed. Because of the need for services to be compatible with each other for each participant, continuous interaction between different organizations and their staff at the local level may be critical.

While inter-sectoral and inter-organizational collaboration has often been considered a central strategy for health and mental health promotion, less attention has been paid to understanding settings themselves as complex service systems or, to use another phrase, whole service-implementation networks. When the setting itself consists of several interdependent organizations, as is the case with the Introduction, a detailed understanding of how inter-sectoral action can help achieve health promoting ends is necessary. Under these circumstances the appropriate choice is intensive technology. Intensive technology signifies “that a variety of techniques is drawn upon in order to achieve a change in some specific object, but the selection, combination and order of application are determined by the object itself” (ibid, p. 17). Intensive technology requires reciprocal interdependence, which is the most demanding type of
interdependence because “actions of each position in the set must be adjusted to the actions of one or more others in the set” (ibid, p.55).

Clearly, interdependence is critical in the Introduction, which always includes services other than the Introduction unit, but where the boundary of the open system is drawn differs between municipalities. It is a hierarchical system where the national level provides funding and policy directives to municipalities with or without a contract. The contract provides just a low level basic funding; the remaining economic compensation to the municipality is based on the number of persons who have resettled in the municipality that has registered in the programme. At the local level there is considerable variation in implementation. Usually the municipality has organized a particular unit within either the social or some other administration. In most municipalities, the Introduction includes language schools, either provided by the municipality itself or out-sourced. In many, but not all, municipalities the national employment offices (Arbetsförmedlingen) are also included in the Introduction. When they are not, they often become the next agency to be involved in the resettlement support system after the Introduction has ended. Besides these three central actors, local implementation can vary. Focusing on the connections in such a system may be critical for the creation of health (Ziglio, Hagard and Griffiths 2000).

While research on whole service-implementation networks is limited in health promotion, some research is available elsewhere, particularly in public administration and management. The general view in this field is that whole networks are indeed important because they may help to solve a particular problem: how high-quality coherent service packages for multi-problem clients can be produced and delivered from public services working in specified functional areas with scarce and strictly specified resources and different professional ethos and training (Provan and Milward 2001). The best description of the Introduction is that it functions as a whole network, i.e. a group of “organizations connected in ways that facilitate achievement of a common goal” (Provan, Fish and Sydow 2007, 482). Organizations in a whole network have substantial operating autonomy and the relationships between them are non-hierarchical. Whole networks can be more or less formally established, governed and goal-directed and include many types of linkages and flows between the organizations (ibid.). The review of the limited empirical literature on whole networks concludes that research on whole networks has been mostly preoccupied with how well networks function compared to other mechanisms of coordination, such as hierarchies or markets, but the available evidence shows that such networks may often improve performance (Provan, Fish and Sydow 2007).

A critical question in the new field of whole network research is what constitutes appropriate measures of success (Provan and Milward 2001). Although earlier attempts aimed to develop a universal model for evaluating collaboration (Gray and Woods 1991), there is still no consensus on this issue. In any case, to be maximally relevant, appropriate measures may need to be adjusted to the particular situation. When the Introduction is considered as a health promoting setting, some relevant measures of success can be identified. Health promotion theory helps us to see that the context in which refugees and immigrants live seems to hold most of the determinants of health and mental health. More particularly, Moos’ model shows that any population strategy
to address refugees’ health and mental health has to address the transitory conditions (i.e. the programme) and the environmental system. In line with Markham and Aveyard’s theory of health promoting schools (2003), settings and their environment can provide two interrelated pathways to health. The first pathway concerns the determinants of health within the setting and in the general environmental system at the time of programme delivery. The second pathway concerns the outcomes of programme participation that are resources which help people cope with and improve the environmental system. These resources function as determinants of health. The first pathway will be called the programme environment pathway and the second, the instrumental outcome pathway. It is likely, but not necessary, that these two pathways are interrelated. They may have many factors in common. In order to be health promoting, the programme and the environmental system must provide the optimal conditions in terms of relationship dimensions, personal growth dimensions and system maintenance and change dimensions at the time of programme delivery (Moos 2002). Most likely, a health promoting introduction would also need to address the instrumental outcomes pathway so that the right conditions are in place to reach important goals. Given these two pathways, four critical areas may tentatively be considered important to turn the Introduction into a health and mental health promoting setting for refugees during resettlement.

4.3.1 Organizing for flexibility to overcome “one-programme-fits-all”

The value of a particular service can be increased by adapting the service more closely to the particular participant (Edgren 1998). Thus, if the “super-diversity” of participants is to be taken seriously, the programme must be able to find the right combination of services for each participant. In order to succeed, the Introduction needs to provide a broad and appropriate set of services that can be combined in a flexible way to meet the variety of needs among different clients and for the same client over time (Alter and Hage 1993; Provan and Milward 2001). This requires both availability of all the capacities that may be needed, and the appropriate custom combination of selected capacities, as required by the individual participant (Thompson [1967] 2003, 18). The ability to provide such a variety of service combinations has been called adaptive efficiency (Alter and Hage 1993). According to Alter and Hage, the degree of adaptive efficiency is strongly related to the level of coordination in a whole network (ibid). The same authors have developed a model to operationalize coordination as a performance measure of the whole network. They argue that full coordination is achieved only if three requirements are met. The first requirement, comprehensiveness, is defined as “whether all necessary resources and services are in fact present in the system” (Alter and Hage 1993, 83). A large variety of services means that the network in total provides a broader range of services that can be drawn on to achieve a better match to the variety of needs among clients and for the same client over time. The second requirement, compatibility, concerns a subset of services that specifically assures that “components are linked together in some coherent manner, that is, there is a fit between need and service, and services and technologies are provided to users in a meaningful and appropriate sequence” (ibid, 87). The third requirement, accessibility, concerns specific services that help clients with certain needs, such as health problems or functional disabilities, to have full access to all services (ibid.). With a higher capacity for variation the diversity in needs of each participant can more easily be satisfied.
which makes service participation more meaningful to the participant (Edgren 2006). The most meaningful services are also often the ones that are most likely to lead to critical outcomes for the participant. Providing the right service for each participant will therefore both affect health through the programme environment pathway and the instrumental outcome pathway. In Moos terminology, the pathways will provide opportunities for personal growth and system maintenance and control (2002). There is also an ethical requirement to provide the right services that connects this critical area to the next; “without an opportunity to articulate their own experiences in their own terms and to identify their own priorities in terms of service provision, refugees may be the subject of institutional responses that are influenced by stereotypes and the homogenizing of refugees” (Watters 2001, 1710).

4.3.2 Shared decision-making

Three distinct types of relationships can be identified in the Introduction: between participants in the programme, between participants and staff, and between staff within and between different organizations in the programme. Each provides different possible beneficial relationship dimensions (Moos 2002). However, from a structural health promotion perspective, the last two types should be in focus because they provide the greatest opportunity for impact and sustainable change. Contemporary models of the role of professionals and clients consider clients less as passive recipients and more as active participants in creating appropriate services (Edgren 2006). A critical competence among professionals is then the ability to tune into and understand the needs of the participants (ibid). The relationship between professionals and participants can provide the interpersonal context that is critical for personal growth and system maintenance and control (Moos 2002). A key to the health promoting potential in this relationship is the possibility it has of adjusting the balance between the demands put on a participant and the control he or she is allowed to have over the services that are delivered to him or her (Karasek and Theorell 1990). Providing the opportunity for participants to express agency over their own planning process and services provided, while at the same time getting adequate support such as guidance and emotional support, can enable increased control and allow the production of meaningful services together with, rather than to, programme participants (Edgren 1998; Fryer 1998a). The professional and inter-organizational interactions around a particular client do not take place in a vacuum. Rather, many hurdles may have to be cleared before this kind of relationship can be established since policy conflict is often “located in the struggles between individual workers and citizens who challenge or subject to client-processing” (Lipsky 1980, 12). Thus, the possibility of achieving constructive interaction requires the implementation of certain organizational measures.

4.3.3 Client outcomes

Key outcomes of the Introduction are strengthening the capacity to participate in society, getting employment or continuing in further education and gaining language mastery. The instrumental outcomes pathway to health states that the Introduction can promote health and mental health by affecting all these important determinants of health and mental health. The outcomes represent important changes in relationships between the participant and his/her environmental system. Certain exposures are different for someone in employment as opposed to unemployment and achieving
mastery of the language opens up entry to society more than for someone with limited language skills (see Beiser and Hou 2001 for an application in the case of refugees). The improved situation achieved by reaching these outcomes may also provide resources that can be used to cope with new challenges in life. As such, these key determinants are dimensions of personal growth (Moos 2002). However, a critical analysis of these outcomes shows that the programme cannot perform well on these outcomes simply by strengthening the resources held by participants. Another important issue is how to affect the accessibility and recognition of participants’ resources among important actors in the environmental system. Making refugees’ resources visible to the right employers and lowering thresholds for entry into other arenas of society might be some examples.

4.3.4 Learning, synergy and continuous improvement

As networks are organizational forms in permanent transition, the network’s ability to learn from its interactions is central to improvement of operations (Agranoff and McGuire 2001; Knight 2002). Effective network learning can have positive effects on network processes and continuous improvements, resulting in success over time. Network learning is similar to synergy, a process that concerns how networks are able to make effective use of their available resources (Lasker, Weiss and Miller 2001). There are some specific dimensions of synergy. One of them concerns the learning that can occur as a result of people contributing different kinds of knowledge and perspectives to the discussion of an issue. This interaction can lead to creative new ideas and a comprehensive understanding of a particular situation or person. However, synergy involves not just thinking comprehensively but also acting comprehensively, by coordinating a variety of reinforcing services, strategies, programmes, sectors, and systems (ibid). The problem with synergy is that diversity is perhaps its most critical precondition, while diversity can also lead to conflict, stagnation or breaking up of the collaborative relationships (Eriksson, Lindencrona, Olsson and Puskeppeleit 2007).

4.3.5 Critical conditions for implementation success

The great expectations of whole networks do not mean that they are always able to deliver. In fact, it has been estimated that less than 50% of networks survive their first year and many that do, fail to develop action plans or implement interventions (Lasker, Weiss and Miller 2001). The challenges involved in making collaboration work are so many that researchers have recommended it should be attempted only when it is essential (Huxham 2003). As noted, however, in many instances it is indeed necessary, either because there are no alternatives or because collaboration is mandated. The research on critical success factors in whole networks is still in its infancy, with “only a marginal understanding of whole networks, despite their importance as a macro-level social issue” (Provan, Fish and Sydow 2007, 512). Different researchers have presented different critical success factors for achieving successful coordination of interdependent organizations. Broadly, it seems that whole networks have to overcome structural, procedural, financial and professional barriers, as well as perceived threats to status, autonomy and legitimacy (Hultberg, Glendinning, Allebeck and Lonroth 2005). Provan, Fish and Sydow find that two main factors: network structure (including network development and resource acquisition) and network governance may be interesting issues to consider when explaining outcomes of whole networks. Another
review studying the outcome of community coalitions has found that critical factors are enhancing community member competencies, building new relationships, strengthening intra-coalition operations, and promoting the design and implementation of effective community-based programmes (Foster-Fishman, Berkowitz, Lounsbury, Jacobson and Allen 2001). Lasker and colleagues consider resources such as money, skills and convening power, heterogeneity and level of involvement of partners, relationships among partners, governance and leadership, and the qualities of the external environment as important determinants of synergy and partnership functioning (Lasker, Weiss and Miller 2001). Finally, Page identifies six strategies for achieving needed change in service-implementation networks: i) establishing clear missions and goals, ii) embracing accountability to funders and other stakeholders, iii) redesigning production processes to enhance flexibility and responsiveness to clients, iv) developing administrative systems to support the new production processes, v) developing incentives to motivate staff to perform according to the new system, and vi) changing organizational culture (2003). In an application to two different networks providing health and human services, Page finds that the first two strategies are easier to implement than the remaining four (ibid). Based on the different reviews above, it can be concluded that the level of any measure of network performance is likely to be determined by a constellation of factors.
5 AIM

This thesis is part of a larger research project, “Health Promoting Introduction”, commissioned by the Swedish Integration Board and the European Refugee Fund. Associate professor Solvig was responsible for this project and PhD-candidates Karin Johansson Blight and Fredrik Lindencrona conducted different parts of the project. Parts of this larger project target different groups, such as children, youth and adults of both genders. The four objectives of the project were to: 1) survey the extent, and the way in which municipalities consider physical and mental ill health amongst newly-arrived immigrants during the introduction period, 2) increase knowledge of the relationship between perceived health and access to the Swedish labour market and integration in society among newly-arrived persons in the municipalities’ introduction programmes, 3) identify the psychosocial determinants that may affect the newly-arrived persons’ health, negatively and positively, and 4) develop a model, focusing on the psychosocial health of newly-arrived persons, that can be used for collaboration between different departments within the public sector, private sector, voluntary sector and the newly-arrived immigrants in the municipalities. The project included three main parts: a) “Is mental ill health a barrier to employment?”, b) “Health and Integration with a focus on discrimination, racism and ethnocentrism amongst school children” and c) “Strategies for a health promoting Introduction for newly-arrived refugees and other immigrants”. In addition to these parts, the research group was commissioned by the Swedish Integration Board to publish a review of Swedish and international research in the broad field “Public health and Integration” (Lindencrona, Ekblad and Johansson Blight 2006).

This thesis concerns part (c), primarily objectives 3 and 4 above. The specific aim is to “identify the preconditions and to develop and test strategies for strengthening the health promoting potential of the Introduction for newly-arrived refugees and other immigrants and its environment”. Starting in 2001, the project has been arranged according to a model showing the stages of research and evaluation in health promotion intervention projects (figure 4, next page) (Nutbeam 1998a). At this time, the project has proceeded through the stages of problem definition, solution generation and innovation testing into the fourth phase, intervention demonstration. The main publications from the project at this time concern the first two stages, which are therefore the focus of the thesis. However, two intervention strategies will be presented in Chapter 7 to show how the results have guided practical action in stage three. In addition to the four papers included in this thesis, the project has generated a methodological paper (Lindencrona, Johansson Blight and Ekblad 2002), a theoretical paper (Johansson Blight and Lindencrona 2003), a Masters thesis in Public Health (Broström 2002), and two book chapters, one about inter-sectoral collaboration (Eriksson, Lindencrona, Olsson and Puskeppeleit 2007) and the other prepared for a ministerial conference on mental health in post-conflict societies (Ekblad, Johansson Blight and Lindencrona 2004).

5.1 GENERAL AIM AND AIMS OF EACH PAPER

The general aim of the thesis is to identify the preconditions and to develop strategies for strengthening the health promoting potential of the Introduction for newly-arrived
refugees and other immigrants and its environment. From this general aim, two more specific aims can be identified:

1) to identify important psychosocial risk and protective factors for mental health, particularly within this setting and its environment

Papers 1 and 2 are designed to identify important risk and protective factors for mental health within the Introduction and its environment. More specifically, the aim of Paper 1 is to illuminate how resettlement staff construct refugees’ health in everyday situations in the Swedish resettlement programmes. In Paper 2, path models are produced for two outcomes: symptoms of common mental disorder and symptoms of core post-traumatic stress among refugees during resettlement. The path models focus on resettlement stressors, but these are considered in the light of earlier exposure to traumatic experiences along the stages of the migration process before resettlement, a person’s capacity to handle stress and relevant socio-demographic variables.

2) to examine how the organization, process and practice of the Introduction for newly-arrived refugees and other immigrants can be developed to strengthen the health-promoting potential of this setting and its environment

Papers 3 and 4 aim to contribute to the understanding of structures, processes and practices that characterize networks that provide different opportunities to promote protective factors, and prevent risk factors, both during programme delivery and as a result of it. With such knowledge, the design of networks can be improved, with potential effects on their success rate (Keast, Brown and Mandell 2007). The specific aim of Paper 3 is to examine whether group modes of interaction in networks within the health and human service sector are related to differences in network performance and client outcomes. In Paper 4 the aim is to construct and test path models for different dimensions of network performance, with variables derived from previous research summarized within three sets of explanatory variables: core agency capacity, network characteristics and modes of interaction.

Figur 4. Six-stage development model for the evaluation of health promotion programmes (Nutbeam 1998). Permission to reprint has been given from Professor Don Nutbeam.
### 6 METHOD

The four main publications on which this thesis is based contribute together to the general aim of the thesis but are designed to illuminate different aspects of this aim; moreover, different methods have been used to reach the intended aim of each paper. Papers I and II are separate studies, while Papers III and IV use the same material. Table 2 presents an overview of the methodological characteristics of all four papers.

Table 2. An overview of the methods used in Paper I – IV.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Paper I</th>
<th>Paper II</th>
<th>Paper III</th>
<th>Paper IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four different local authorities</td>
<td>The Introduction programme in seven different local authorities</td>
<td>All Swedish local authorities with a reception of at least 25 persons in 1998-2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus</td>
<td>Staff’s construction of refugees’ health</td>
<td>Pathways to mental health outcomes</td>
<td>Effects of group methods of coordination on network performance measures</td>
<td>Pathways to different network performance measures</td>
</tr>
<tr>
<td>Design</td>
<td>Qualitative individual and group interviews</td>
<td>Questionnaire</td>
<td>Questionnaire</td>
<td></td>
</tr>
<tr>
<td>Respondents</td>
<td>28 staff and managers</td>
<td>124 persons</td>
<td>83 heads of Introduction units</td>
<td></td>
</tr>
<tr>
<td>Test of the procedure</td>
<td>Interview questions could be revised on-goingly</td>
<td>Series of pilot tests</td>
<td>Pilot test with nine different types of municipalities</td>
<td></td>
</tr>
<tr>
<td>Instruments and Measures</td>
<td>Open-ended interview questions, simple interview guide</td>
<td>GHQ-12 and CPTS New questionnaire: Resettlement stress Pre-resettlement trauma Sociodemographics</td>
<td>New questionnaire</td>
<td></td>
</tr>
<tr>
<td>Ethical approval</td>
<td>The Regional ethical committee at Karolinska Institutet</td>
<td></td>
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<td></td>
<td>KI 01-070</td>
<td>KI 02-173</td>
<td>KI 01-070</td>
<td></td>
</tr>
<tr>
<td>Analytical method</td>
<td>Constant comparison in accordance with grounded theory</td>
<td>Factor analysis Path analysis</td>
<td>ANOVA ANCOVA Spearman’s Mann-Whitney U</td>
<td>Multiple regression Path analysis</td>
</tr>
</tbody>
</table>
6.1 METHODOLOGY IN PAPER I

Data collection for Paper I was conducted during spring-summer 2001 in four different local authorities around Sweden. All local authorities had received a diverse group of refugees and had long experience of delivering the Introduction. The four local authorities were chosen to get a relevant variation in type of local authority, population size, refugee reception and proportion of non-Swedish citizens. Through a stakeholder analysis (Brugha and Varvasovszky 2000), the organizations most involved in the local introduction were identified. In each local authority, staff working in different services involved in the Introduction and some managers were recruited. All participants were interviewed by the author of this thesis in pre-existing groups or individually, depending upon whether they worked together or primarily by themselves. Five group interviews with two to seven persons in each and six single-person interviews were conducted. Among the 28 persons there was a variety in organizational belonging (nine in the local authority’s Introduction unit or similar, thirteen in language school, five in employment-related services and one was a supervisor at a traineeship location, gender (eight men and twenty women), and age. Fewer than five were born outside Sweden. Interviews took place in the offices of the interviewed and lasted between one and two-and-a-half hours. Generally, group interviews were longer than single-person interviews. The interviews concerned two broad areas, a) a general description of the structures, policies, actors and processes of the Introduction as understood by the interviewees, and b) episodes of everyday interactions where health was involved. The topic in the latter part of the interview was “Tell me about some episodes or events in your daily work that are in some way related to health among the participating refugees”. In order not to bias what interviewees considered as “episodes of health”, the interviewer interfered as little as possible when these stories were told. Sometimes the construction of health in the episode needed clarification; in group interviews this was most often requested by other participants, who helped their peer to clarify the meaning. Overall, ethical principles of protection of psychological and physical integrity, discretion and informed consent guided the research process (Holme and Solvang 1996).

All interviews were tape-recorded and transcribed. Data were analysed in a stepwise process inspired by grounded theory, particularly in terms of the phenomenological description of the categories and themes and the constant comparative method (Glaser 1998) through which the material could be clarified. In the first step the complete material was read through until both authors became acquainted with it. This made it clear that the material included two types of data: general ideas, thoughts and comments that referred to health in general, and more specific material that concerned health in everyday episodes within the Introduction or its environment. The focus of the analysis is the latter part of the data, while the more general material is used to contrast and clarify the constructions of health within the everyday episodes. The second step focused on the everyday episodes in order to identify the construction of health used in these episodes. It soon became clear that the episodes could point to either the personal level or the setting, the Introduction and its environment. Often both ecological levels were included in one episode. The episodes indicated both promotive aspects and threats to health. Together, these two dimensions categorize the episodes into: positive
dimensions of health at the personal level, threats to health at the personal level, 
dimensions of the setting and its surroundings that promote health, and dimensions of 
the setting or its surroundings that are threats to health. In the third step, when the 
classification scheme was decided, each episode was assigned to one or more of these 
categories, depending upon its construction of health. Not all episodes had a direct 
statement of the type “health means…”; instead, the constructions were embedded in 
the narrative. Each category included several different constructions of health. The 
fourth step made it possible to formulate a model to summarize the categories about 
health at the personal level. The model includes the categories in step three but links 
them to three overarching themes, so-called health spheres that could be threatened by 
different categories. The validity of the model has been tested, first by inviting the 
study participants to read citations and the main findings and to comment upon these, 
second by using the models to discuss the setting as a health-promoting environment 
with staff in several situations. Although only around one out of three of the study 
participants responded to our invitation to comment upon the material, those who did 
were satisfied with our interpretations and found the model useful. The usefulness of 
the model has also been reported by professionals and managers in the Introduction and 
its environment in the many presentations of the model that have been made.

6.2 METHODOLOGY IN PAPER II

The material used in paper II was the last material of the three studies in the thesis to be 
collected. It was collected as a baseline before the intervention period (in stage 3, figure 
4, page 55). Arabic, Sorani or Bosnian speaking refugees, by far the majority of 
refugees at the time of the study (2002-2004), who had been received in any of seven 
Swedish local authorities were invited to the study. The intention was to include all 
participants with these languages who could be reached during the many occasions 
when the thesis author was present in the specific local authority. A majority of the 
participants (83%) were recruited by the first author in existing classes of Swedish for 
Immigrants or related classes within the Introduction programme, about two months 
after the programme starts for each participant. The remaining 17% of the participants 
were recruited during approximately the same time in the programme among persons 
who were asked to participate in an intervention to improve the process of programme 
planning. According to consultations with professionals at the intervention sites, few of 
the participants declined participation when asked, but some staff may have applied 
bias in their recruitment. This tendency was counteracted by the first author giving 
supervision to the programme staff that were to recruit the participants, though this may 
not have been enough to eliminate all bias. However, in terms of age and gender the 
sample is similar to Arabic-, Sorani- or Bosnian-speaking refugees resettled in Sweden 
during the study period. The final sample included 83% born in Iraq, 62% were men 
and the mean age was 34 years (SD: 9.3 years). The mean length of stay in Sweden for 
those included was 12 months (SD: 8.1 months, Min-Max: 2-48 months). More than 
half of the participants (62%) lived with relatives. The mean time to obtain a decision 
on the asylum claim was 404 days in 2003 (Råbergh 2004). Three persons were 
excluded because they had been in Sweden for much longer than the rest of the sample 
(7-14 years). From the remaining 121 persons, another 21 were excluded from at least 
one analysis because of internal missing items. Because of missing data, the number of 
persons included in each analysis varies. Internal missing was handled with different
imputation techniques: person mean for the established GHQ-12 scale, which showed high internal consistency, and regression imputation for the resettlement stressor scales. Excluded persons reported a slightly higher occurrence of exposure to pre-resettlement trauma than those included.

Paper II was based on a new questionnaire that includes explanatory variables and scales for symptoms of common mental disorder (GHQ-s) and core symptoms of post-traumatic stress (CPTS). Translation and validation of the new questionnaire included forward and back-translation and two pilot tests with refugees in the Introduction (Brislin 1973). Discussions were held at each stage with the pilot test participants. They were also requested to rate the questionnaire on three items with endpoints 1 for negative and 4 for positive. Participants’ overall perception was that the questionnaire was clearly relevant to them (3.0), not intimidating (3.7) and not hard to answer (3.2).

The study used symptoms of common mental disorder from the 12-item version of the General Health Questionnaire as one of two dependent variables. The GHQ-12 has been translated into Arabic, Sorani and Bosnian and it has consistently shown good reliability and validity in community samples in different cultural contexts (Furukawa and Goldberg 1999; Goldberg and Williams 1988). Different methods of scoring can be used, but the method chosen (the GHQ method) have shown favourable validity across different contexts (e.g. Goldberg, Gater, Sartorius, Ustun, Piccinelli, Gureje and Rutter 1997). In this sample the GHQ showed high internal consistency (Cronbach’s $\alpha = .90$).

Several explanatory variables were used. Socio-demographic data were self-reported in the questionnaire. Pre-resettlement traumas were not distinguished between whether they happened in the country of origin for the refugees or on the often taxing journey to reach Sweden. Three trauma experiences were asked for: a) war at close quarters, b) being imprisoned or in detention due to political and/or religious reasons, and c) being tortured or exposed to systematic physical and/or psychological assault. Each experience was scored 1 if it had happened and 0 if not. The person’s capacity to handle stress included three psychometrically tested questions about sense of coherence (Antonovsky 1987; Eriksson and Lindstrom 2005) and one question about the person’s perceived control over their own life (Bailis, Segall, Mahon, Chipperfield and Dunn 2001; Eriksson and Hallsten 2000). The two constructs have been found valid in different cultural groups (e.g. Grob, Wearing, Little and Wanner 1996; Roth and
Ekblad 2006; Sundquist, Bayard-Burfield, Johansson and Johansson 2000). Each question about sense of coherence covered one of the three main components in the concept: meaningfulness, comprehensibility and manageability, and were scored on scales with end points 0-2 (high scores representing a high level of the construct). The perceived control question used 0-4 as end points, with 4 representing having a lot of control. A single item was used to identify the subjective experience of strain caused by the duration of the wait for an asylum decision. The subjective experience was used because time is subjectively experienced and dependent upon prior trauma (Beiser and Wickrama 2004). The resettlement stressor scales were constructed from the theoretical framework of core adaptive systems of importance for mental health among refugees (Silove 1999). Specific items in each of these five systems were gathered from earlier instruments and research findings from Sweden and elsewhere (Broström 2002; Lindencrona and Ekblad 2006; Silove, Steel, McGorry and Mohan 1998). Of the original 18 questions, two were excluded on account of an unacceptable internal missing rate (> 10%). A Principal Components Analysis with oblique rotation was first done on 16 items; one item was then excluded because of low communality. For the remaining 15 questions, communalities ranged between .44 and .73 and when the Principal Components Analysis was re-run with the 15 items, a factor solution was obtained with four components, accounting for 30%, 14%, 11% and 8% (62% in total) of the variance. In the next step, scales were constructed for each component with each item allocated to the scales where it had its highest loading. Four scales were created: social and economic strain, discrimination and status loss, violence and threats in Sweden, and alienation. The pattern of factor loadings was clear except for one item, lost roles at home, which loaded >.40 on two factors. When internal consistency was tested for each scale, inclusion of this item in the scale social and economic strain gave an improvement for both scales. This psychometric improvement was also justified by the fact that the item was more theoretically coherent with the scale in which it finally ended up.

In addition to these factor analytic procedures, the statistical analysis in Paper II included a) a test of the bivariate correlation between the derived resettlement stressor instrument, in total and for each scale separately for the two mental health outcomes, with Pearson product-moment correlation, and b) path analysis of the different mental health outcomes with sociodemographic variables, pre-resettlement trauma, capacity to handle stress, exposure to asylum-seeking and resettlement stressors (the theoretical model is presented in figure 5, next page). Pair-wise deletion was used to treat internal missing data, based on recommendations by Roth & Switzer (1995). Path analysis is a statistical method that is useful for decomposing direct, indirect and shared effects of variables upon each other and on some final outcome (Cohen, Cohen, West and Aiken 2003). In order to keep the risk for mass-significance at a minimum, it is recommended that only sets contributing to $R^2$ at a significant level ($\alpha \leq .05$) are included for further analysis. Power estimates were based on a similar Australian study that was able to explain 40% of the variance in post-traumatic stress symptoms (Steel, Silove, Bird, McGorry and Mohan 1999). Without any similar reference, the explained variance for symptoms of common mental disorder had to be estimated. With reference to the explanatory variables included in the model, it was believed that a somewhat higher proportion of GHQ-s could be accounted for (50%). With these estimates, power for each set was above the proposed value of .80 in both models. Central assumptions of
linearity, homo-scedasticity, normality and multicollinearity were tested without detection of any violations (Osborne and Waters 2002).

Figure 5. A schematic description of the postulated pathways to symptoms of general mental distress (GHQ-s) and symptoms of post-traumatic stress (CPTS). Lines on top of the boxes ending with an arrow-head pointing to the outcome illustrate direct effects, while dotted lines beneath the boxes illustrate indirect effects.

6.3 METHODOLOGY IN PAPER III & IV

Papers III and IV use material from the same study. The material was collected by postal questionnaires sent to all local authorities that had received a total of more than 25 persons during the period 1998-2000. This level was chosen in order to involve most local authorities but exclude those that could not be expected to have any organized structure, process or praxis to carry out this work. The questionnaire was sent to the head of the Introduction unit when such a position existed and to the person responsible for the Introduction services when it did not exist. In all, 143 local authorities met the inclusion criteria, but only 134 were included in the sample because nine that had assisted in the pilot test were excluded. After two reminders, the second including a new questionnaire and an invitation to a feedback workshop with participation from other local authorities, the national government and some national agencies in this field, questionnaires were returned by 83 local authorities. A satisfactory response rate, 62%, was achieved, with no systematic bias in terms of refugee reception between respondents and non-respondents. In order to provide valid answers, respondents were requested to consult with managers in other agencies providing Introduction services and with their staff, an option chosen by the majority of the respondents.

The questionnaire was developed through five strategies: 1) review of relevant literature; 2) workshops with representatives from Introduction units, Swedish for Immigrants schools, national and local levels of the Employment Service, primary health care services and psychiatric health services; 3) consultations with the Swedish Integration Board; 4) qualitative interviews with managers and staff in different organizations involved at the local level; and 5) a preliminary questionnaire piloted by completion and follow-up interviews with the head of the Introduction unit in nine local authorities, each representing one of the types of local authorities in the classification
used by the Swedish Association of Local Authorities. The pilot study resulted in some questions being removed, others simplified and additional information provided to clarify some questions. The final questionnaire was assessed by all the respondents as relevant, in accordance with the needs of the organization, but somewhat difficult to answer, especially for those respondents that had to search individual files to obtain appropriate data on client outcomes. The questionnaire covered several different areas that concerned the structure, process and practice of the Introduction, with a particular focus on inter-organizational collaboration. Of the eleven objectives of the Introduction (table 1, page 37), Papers III and IV treat the four main objectives for adults in detail: a) planning of services delivered, b) provision of adequate language tuition, c) provision of early contact with the Swedish labour market and work life, and d) services to support individuals without the equivalent of the Swedish compulsory 9-years of school to start supplementary education (Swedish Integration Board 2004). Three objectives that refer to access for elderly persons, persons with health problems and with functional disability to the Introduction services were also covered as a specific performance variable. Objectives referring to children and adolescents are not included in these two papers.

Network performance measures are used as dependent variables in both Paper III and Paper IV. In this context, coordination of services and network learning were considered two critical performance dimensions. Alter & Hage propose a three-dimensional model that operationalizes coordination as a performance measure of a whole network (1993). The three aspects: comprehensiveness, compatibility and accessibility, were operationalized and measured by whether each of 20 services was available to the service recipients, as indicated by the respondent. The measure of comprehensiveness concerned all services; seven services represented compatibility; accessibility was measured by five services. The second dimension, network learning, was measured by the number of positive answers to eight statements concerning the perceived ability within the network to learn from the on-going interactions and activities. Two sample items were: “collaboration in our local network provides access to new knowledge and new methods” and “collaboration in our local network provides better opportunities to meet the multifaceted needs of the clients by our ability to combine different knowledge”.

Papers III and IV also use the same measures of group modes of interaction. Two group modes of interaction were identified. Multi-organizational team concerned the respondents’ choice between three alternative coordination methods for direct service delivery (sequential, parallel and collective; Alter & Hage, 1993) in relation to each of the four main objectives in the national policy covered. Respondents who indicated that the collective method (defined as “clients are served by several organizations simultaneously and a common plan, worked out by staff from different organizations and the participant, has been developed which is continuously reviewed and changed”) was most often used in “planning” and one or more of the other fields of activity, were identified as using the multi-organizational team. Network steering group was identified by asking whether there existed any superordinate steering group for the programme with representation from several different organizations active within the local resettlement programme during 2000. In both Paper III and Paper IV, the combination of these two variables makes up the variable mode of interaction, with
four different alternatives: no group mode of interaction, only multi-organizational team, only network steering group, and multiplex coordination (both group modes of interaction). This variable is treated as a categorical variable in Paper III and because of the clear pattern of findings in that study, it is considered as a continuous variable in Paper IV, where the different solutions represent the degree of structuring in the whole network.

Several variables are specific to either Paper III or Paper IV. In Paper III, the client outcomes in two areas, becoming economically self-sufficient and passing the Swedish test, were collected. Without a national register containing this information and no general routines for systematic collection at the local level, the only option was to request respondents’ self-reports on the proportion of persons among those that started their Introduction in 1998 who had reached these goals after 24 months participation in the Introduction. In the pilot study it became clear that this information often had to be hand-searched in individual files. It was corroborated by the fact that only a limited number of respondents reported that they used any kind of yearly evaluation of the services. In order to maximize the response rate on these questions, given these circumstances, it was decided that self-reports should be given in broad ranges. Thus the response categories were set at 0-24%, 25-49%, 50-74% and 75-100%. Even so, not all respondents (55/83 for economic self-sufficiency and 51/83 for passing the Swedish test) provided information on these outcomes. All observations could be used in the analyses of the network performance measures. However, only Introductions that had not undertaken structural changes during the study period that could impact upon the modes of interaction could be used when the effect of group modes of interaction was examined. The methodological challenges make all analyses of client outcomes susceptible to error. Because of this problem and the interest in elucidating more fully the complex pathways to the different network performance measures, these client outcomes are not included in Paper IV.

In Paper IV the variables are categorized into three sets: core agency capacity, network characteristics, and modes of interaction. Core agency capacity concerns four different measures. The first is top level management support, measured by whether a local policy for the Introduction services and related areas has been developed in the local authority and whether the top level of the local authority is perceived by the respondent to give active support for the services. The second measure is whether a more proactive (prospector) or reactive (defender) strategic stance has been taken (Boyne and Walker 2004) toward the Introduction services in the local authority. Changing the organizational placement of the Introduction services away from the social administration and providing alternative types of economic benefits other than ordinary social benefits were two progressive ideas at the time of the study. Early adopters of these ideas were considered to show more of a prospector strategic stance. The third measure is the number of years during the study period that systematic evaluation of the services was conducted. Finally, the fourth measure of core agency capacity is stability in organizational placement of the Introduction unit.

Five network characteristics are included. Three of these can be considered structural characteristics: 1) the existence or lack of existence of an appointed network leader, 2) the number of organizations that are reported to be actively involved in the whole
network and its operations, and 3) multiplexity, the mean number of objectives out of the four main objectives that the organizations in the whole network are actively involved in. For the last measure, a low number means that most of the organizations are specialized, i.e. only active in the work around one or a few of the objectives. Two measures represent climate characteristics of the network. One item represents the organization’s perceived lack of knowledge about each other and two items cover lack of trust (experience of collaboration in the whole network as frustrating and experience that the result of the collaboration process is often limited).

Finally, paper IV tests four control variables that may confound the relationships between dependent and independent variables: 1) the number of years during 1996-2000 when more than 10 persons resettled in the local authority, 2) a change index (a measure of variation in reception between each pair of years during 1996-2000 in relation to the total number received in the local authority during the same period), 3) number of citizens in the local authority, and 4) percentage of persons in the population for the local authority that have a non-Swedish citizenship. All explanatory variables except the control variables were gathered in the questionnaire.

Some variables are included in both Paper III and Paper IV but their theoretical role differs. In Paper III, the variable shared decision-making was considered a network performance measure likely related to the modes of interaction used in the whole network. However, the pattern of associations for this variable in Paper III suggested that its role could be another. In Paper IV this variable was considered as a mode of interaction that could itself promote coordination of services and network learning. The variable number of organizations was included as a covariate in Paper III. In Paper IV, when the design allowed for a larger set of independent variables, it could be included as a theoretical variable in its own right.

The statistical analysis differs between Paper III and Paper IV. In Paper III, the main analyses were separate ANOVAs and in a later step ANCOVAs for each network performance measure, a bivariate analysis between network performance measures and client outcomes and median comparisons of client outcomes between networks with different modes of interaction. Before ANCOVAs were conducted, critical assumptions were tested (Howell 2007). Some adjustments to the analyses were needed: 1) the covariate volume of reception was not normally distributed and was therefore log transformed (base 10), 2) the two covariates’ variation in reception and volume did not meet the criteria of correlation with the dependent variable network learning (.20) and was therefore excluded, 3) in network learning the interaction term, steering group times number of organizations, was significant and therefore number of organizations was median split and used as an independent variable instead of a covariate. Bonferroni-adjusted post-hoc analyses are presented together with unadjusted measures. The bivariate analysis between performance measures and client outcomes was done with non-parametric methods. Because few observations could be used in the median comparisons of client outcomes, the analysis proceeded in two steps. First the median value for each mode of interaction was calculated and second the pattern of median values was used to collapse the four types of networks into two larger groups. In the third step, group comparisons were tested with Mann-Whitney’s U tests.
In Paper IV, the risk for mass-significance problems was restricted in a first step in which multiple regression models were used to identify only statistically significant variables ($p \leq .10$) to be included in the second step, path analyses. These analyses were conducted in line with what has already been presented concerning Paper II. Again, the central assumptions of linearity, homoscedascity, normality and multicollinearity were tested and no violations were detected (Osborne and Waters 2002). In addition, a systematic test of the common method variance found no support for such a bias (Lindell and Whitney 2001).
7 RESULTS

In this section, main results from each of the four papers will be presented to provide a summary of the findings. To avoid unnecessary repetition, the results of Papers III and IV will be presented together. A description of and a few preliminary findings from the two strategies that were designed and implemented in four Swedish local authorities to strengthen the health promoting potential of the Introduction and its environment are given at the end of this chapter.

7.1 MAIN RESULTS IN PAPER I

The analyses show that the staff’s constructions of health are quite complex and multilayered. In the general material, health issues are mainly considered as referring to illness and the need for special attention to it and the special needs arising from it. This construction of health addresses the administrative demarcation between the responsibilities of different sectors, where health is not considered the responsibility of the Introduction. Rather the responsibility falls upon the healthcare sector to provide appropriate curative treatments to alleviate the problem. However, in the episodes about health in the everyday context within the Introduction and its environment, alternative constructions of health are most often used. Here, the constructions fall into four categories: positive dimensions of health at the personal level, threats to health at the personal level, dimensions of the setting and its surroundings that promote health, and dimensions of the setting or its surroundings that are threats to health. The absolute majority of the episodes have a construction of health which actually stands for mental health or more general health dimensions. In these episodes, health is understood as part of normal functioning, including three critical personal abilities or capacities that represent being in balance with others, oneself and one’s life situation. Experiences such as exposures along the migration process can act as threats to these balances. The model also includes significant promotive factors and threats at the level of the setting and its environment. The full model is referred to as staff’s model of refugees’ mental health.

The staff’s model of refugees’ mental health is organized around three health spheres at the personal level, each representing a main area of health. Specific categories constitute each health sphere and distinct threats can be identified for each sphere. These relationships are portrayed in the graphic illustration in figure 6 (next page). At the level of the setting and its surroundings, six defining dimensions of a health-promoting context are identified. These dimensions and significant threats to health at the contextual level are portrayed in figure 7 (next page).

In order to clarify the perspectives in the staff’s model of refugees’ mental health, it is compared to three other conceptualizations of mental health and mental health promotion (Broström 2002; Herrman 2001; Silove 1999). These comparisons show that a) all models have one dimension that concern the ability to relate to others, b) much as in Herrman’s model of mental health within mental health promotion, the staff’s model upholds a division between cognitive and behavioural aspects of agency capacity and the emotional positive self-image and emotional balance, c) also similar to mental health promotion, the model is general and does not consider either belonging to
Figure 6. Health spheres (black) and threats to health at the personal level (red). (Graphical layout: Ulrika Lindencrona).

Figure 7. Defining dimensions of the health promoting context (in the inner circle) and threats to these dimensions (outer circle). (Graphical layout: Ulrika Lindencrona).
cultural, religious or other belief systems, or gender or social class position for the meaning of mental health, and d) the model only refers to secure material conditions as threats to health at the level of the setting and its surroundings, not as security as a personal level phenomenon, which it is in Silove’s model (1999) and in the view of refugees in the Introduction (Broström 2002). In general, the model can be said to represent a functionalistic perspective on mental health (Braidwood 2000).

In general, the staff and the refugees are in agreement about the understanding of health and health-promotive factors. Both groups conceive of the Introduction in line with Moos’ model (2002, see figure 3, Chapter 3), with the Introduction functioning as a transitory condition and the surroundings as the environmental system. Through this setting, two pathways to mental health can be identified. The programme environment pathway refers to the possible impact of the programme environment and the environmental system upon the participants at the time the programme is provided. The instrumental outcome pathway refers to the capacity of the Introduction to provide the refugees with the appropriate tools to cope with the environmental system after the programme is over. Both staff and refugees provide detailed accounts of critical dimensions at the level of the setting and its surroundings which are missing in the other models. However, there are also disagreements. Most importantly, the refugees report many promotive factors in the environmental system and are generally more concerned with the instrumental outcome pathway. Men report work, financial situation, housing and relational issues, and women refer to possibilities and responsibilities in relation to family and other people as important promotive dimensions in the environmental system. In contrast, no gender distinction is reported by staff; in fact, while staff report both promotive dimensions and threats in the Introduction, they only identify threats in the environmental system.

It is not clear why staff often refer to health as an administrative illness concept as their ordinary practice, but hold a more comprehensive understanding when everyday episodes are in focus. A tentative explanation may concern processes of organizational and professional socialization. Objectives for the Introduction frame health in a curative perspective, in line with a deficiency discourse on refugees. This organizational socialization may pressure for such a model of health to be superimposed upon the professional socialization and training in subjects who use more functional, contextual and positive models of health and mental health. However, to build the potential for health promotion in this setting as an everyday context for most newly resettled refugees, the programme environment pathway and the instrumental outcome pathway should both be used to guide comprehensive structural strategies for settings development (Whitelaw, Baxendale, Bryce, MacHardy, Young and Witney 2001). Improved inter-sectoral collaboration and refugee participation in decision-making are two essential elements to make these strategies work. However, the ratings of the Introduction and its environment in terms of the identified dimensions are a matter for empirical assessment.
7.2 **MAIN RESULTS IN PAPER II**

The second paper starts with the psychometric evaluation of the new resettlement stressor scales. This evaluation resulted in a series of scale characteristics (table 3, page 70) and the bivariate correlation between the full scale and each of the four separate scales with symptoms of common mental disorder (GHQ-s) and symptoms of post-traumatic stress (CPTS). The full scale and two of the four separate scales have several items, a good distribution in response scores and good internal consistency. The full scale and all four scales are correlated with GHQ-s, and all except alienation are correlated with CPTS (table 3, page 70).

The second part of the paper reports the outcomes of separate path analyses for GHQ-s and CPTS. The results show that the path model accounts for a larger portion of the variance for symptoms of common mental disorder (adj. $R^2=.55$; figure 8, page 71) than for symptoms of post-traumatic stress (adj. $R^2=.40$; figure 9, page 71). The most influential set in the path model of GHQ-s is the capacity to handle stress, contributing 26% of the variance. Resettlement stressors contribute almost as much, 24%. Torture, a pre-resettlement exposure, is only the third most influential set, with 6%. The total direct effects (the sum of the unique and shared direct effects) are largest for alienation ($\beta=.57$), control ($\beta=-.41$) and social and economic strain ($\beta=.40$). Perception of the situation as meaningful has a protective effect upon GHQ-s that seems to work together with other personal capacities to handle stress and indirectly through buffering the effects of the resettlement stressors. A part of the effect of the resettlement stressors cannot be allocated to each separate scale but refers to this whole set of independent variables.

Pre-resettlement traumas, especially torture, make up the most influential set in the path model of CPTS with 22%. Capacity to handle stress is involved in the path model of CPTS as well but is only the second largest contributor, with 10%. The third most influential set in the model of CPTS is being a woman, which contributes 8% of the total variance. The total direct effects (the sum of the unique and shared direct effects) are largest for torture ($\beta=.40$), meaning ($\beta=-.35$) and manageability ($\beta=-.29$). Part of the protective effect of being a woman works through women being less exposed to the three chosen pre-resettlement traumas. However, the lower personal capacity to handle stress among women weakens this protective effect.

In conclusion, the major influences on GHQ-s are current exposure to resettlement stress and the personal capacity to handle this stress, a capacity that may be negatively affected by earlier exposure to traumatic events. CPTS is affected mainly by pre-resettlement trauma, especially exposure to torture, which affects CPTS through weakening the personal capacity to handle stress after this exposure. Stressors in the early phases of resettlement do not seem to aggravate CPTS but such an effect may well occur over time, mainly as a consequence of lower capacity to handle stress. Overall, no impact of the subjective strain caused by waiting time to obtain asylum is found in this study. Perhaps this may suggest that if the mean time to obtain this decision is comparatively short and the decision is positive, the strain during this period may not carry over to the next phase of resettlement.
Table 3. Psychometric characteristics of the resettlement stressor scales.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>mean/sd</th>
<th>A. Social and economic strain (Items 1-4+10)</th>
<th>B. Discrimination and status loss (Items 5-7)</th>
<th>C. Violence and threats in Sweden (Items 8-10)</th>
<th>D. Alienation (Items 11-15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of money</td>
<td>2.3/1.4</td>
<td>.81</td>
<td>.03</td>
<td>.02</td>
<td>-.11</td>
</tr>
<tr>
<td>2. Isolation</td>
<td>2.3/1.6</td>
<td>.74</td>
<td>.10</td>
<td>.13</td>
<td>.04</td>
</tr>
<tr>
<td>3. Lost roles in society</td>
<td>2.3/1.6</td>
<td>.63</td>
<td>.03</td>
<td>-.10</td>
<td>.10</td>
</tr>
<tr>
<td>4. Worried about family abroad</td>
<td>3.2/1.3</td>
<td>.62</td>
<td>-.28</td>
<td>.29</td>
<td>.08</td>
</tr>
<tr>
<td>5. Discrimination in school</td>
<td>.18/.60</td>
<td>-.08</td>
<td>.82</td>
<td>.03</td>
<td>.03</td>
</tr>
<tr>
<td>6. Discrimination in contact with authorities</td>
<td>.26/.80</td>
<td>-.14</td>
<td>.70</td>
<td>.34</td>
<td>.10</td>
</tr>
<tr>
<td>7. Lost respect and status</td>
<td>.54/.95</td>
<td>.35</td>
<td>.67</td>
<td>.06</td>
<td>-.05</td>
</tr>
<tr>
<td>8. Experiences of threats and violence in Sweden</td>
<td>.27/.79</td>
<td>-.06</td>
<td>.32</td>
<td>.74</td>
<td>.03</td>
</tr>
<tr>
<td>9. Experiences of conflict in your family</td>
<td>.55/1.2</td>
<td>.07</td>
<td>.19</td>
<td>.70</td>
<td>.03</td>
</tr>
<tr>
<td>10. Lost roles at home</td>
<td>1.4/1.6</td>
<td>.41</td>
<td>-.21</td>
<td>.59</td>
<td>.08</td>
</tr>
<tr>
<td>11. Other people’s understanding of your view of life</td>
<td>1.3/1.2</td>
<td>-.10</td>
<td>-.02</td>
<td>.22</td>
<td>.84</td>
</tr>
<tr>
<td>12. Different views on important aspects of life</td>
<td>1.8/1.4</td>
<td>-.10</td>
<td>-.15</td>
<td>.07</td>
<td>.84</td>
</tr>
<tr>
<td>13. Harder to fend for oneself in Sweden</td>
<td>2.0/1.6</td>
<td>.37</td>
<td>.16</td>
<td>-.22</td>
<td>.51</td>
</tr>
<tr>
<td>14. Time is not used satisfactorily</td>
<td>1.5/1.5</td>
<td>.41</td>
<td>.14</td>
<td>-.18</td>
<td>.49</td>
</tr>
<tr>
<td>15. Hard to live the life one wishes to live</td>
<td>0.84/1.2</td>
<td>.14</td>
<td>.22</td>
<td>-.18</td>
<td>.58</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scale characteristics</th>
<th>Full scale</th>
<th>Scale A</th>
<th>Scale B</th>
<th>Scale C</th>
<th>Scale D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cronbach’s α</td>
<td>.83</td>
<td>.75</td>
<td>.67</td>
<td>.63</td>
<td>.79</td>
</tr>
<tr>
<td>Mean/standard deviation of scale</td>
<td>20.8/10.4</td>
<td>11.4/5.3</td>
<td>.98/1.9</td>
<td>1.7/.82</td>
<td>7.6/5.1</td>
</tr>
<tr>
<td>Min-Max Value</td>
<td>0-57</td>
<td>0-20</td>
<td>0-11</td>
<td>0-8</td>
<td>0-20</td>
</tr>
<tr>
<td>Inter-item correlations (Max-min)</td>
<td>.55-(-.05)</td>
<td>.54-.26</td>
<td>.55-.38</td>
<td>.50-.50</td>
<td>.52-.32</td>
</tr>
</tbody>
</table>
Figure 8. Reduced model of the path analysis for symptoms of general mental distress (GHQ-s).

Figure 9. Reduced path model for core symptoms of post-traumatic stress (CPTS).
7.3 MAIN RESULTS IN PAPER III & IV

The descriptive data presented in Papers III and IV show that among the 83 whole networks that provide the Introduction there are wide differences in performance measures and client outcomes. Although some variation in local implementation of a national policy can always be expected, the level of variation is considerable, particularly given that the whole networks are provided with per-capita funding and have to adhere to the same policy objectives. In Papers III and IV, various factors that can explain this variation are examined.

In Paper III, the typology of networks based on mode of interaction is used: multiplex network, only network steering group, only multi-organizational team and no group mode of interaction. Most networks (53/83, 65%) use some group mode of interaction and the most common of these is multiplex coordination (22/53 with group mode, 42%; 27% of total). Simple ANOVAs show that for comprehensiveness and compatibility there is a significant difference between types of network. No difference is identified for accessible services and therefore no further analysis is conducted for this outcome. For network learning, the difference between the four types is not statistically significant, but the difference is significant when multiplex networks and only network steering groups are compared with the other two. The difference therefore seems to be related to the existence of a network steering group, independently of whether a multi-organizational team has also been organized. ANCOVAs were used to test the comparisons when controlling for covariates: volume of reception, number of organizations in the network and, in some cases, variation in reception. For comprehensiveness and compatibility, the differences remained in the second analysis. Post-hoc analyses showed that the multiplex network type performed significantly better than no group mode of interaction for comprehensiveness and better than both no group mode of interaction and multi-organizational team for compatibility. The ANCOVA for network learning confirmed that the effect of steering group is dependent upon network size, such that steering groups help small networks achieve network learning at the higher level occurring in larger networks.

The analyses showed that multiplex networks were more likely to have developed methods for clients’ involvement in decision-making, but the results were far from statistically significant. Due to the limited number of observations that could be included in the analyses of the relationship between mode of interaction and client outcomes, these analyses had to proceed in two steps. In the first step, median values of each client outcome were calculated. For the proportion passing the Swedish test, the pattern showed that the two types that use a multi-organizational team (multiplex network and multi-organizational team) have worse outcomes. When proportion in economic self-sufficiency was concerned, the median comparison showed a positive pattern for networks with steering groups. Testing both patterns with Mann-Whitney U tests confirmed that the differences were statistically significant in the first case and borderline statistically significant in the second case. The last analyses in paper III examine the relationships between the performance measures and client outcomes. The only statistically significant result is the positive association between methods for clients’ involvement in decision-making and client outcomes in terms of economic self-sufficiency.
In Paper IV the same performance measures are used, except that clients’ involvement in decision-making is considered as a strategy to coordinate services instead of a performance measure. In this paper the analysis proceeds in two steps. The variables are arranged in three main sets: core agency capacity, network characteristics, and mode of interaction (figure 10). Direct effects of each upon performance measures can be hypothesized. In addition, the capacity of the core agency can influence the network characteristics. Core agency capacity and network characteristics can have an impact upon mode of interaction. The indirect effects can clarify some of the pathways to network performance. In a first step, multiple regressions were performed on each set of variables in order to reduce the number of variables in the path models. In a second step, further reductions were done so that only sets which contributed significantly to the total variance would be kept. Both variables in the mode of interaction set were statistically significant in the multiple regressions for comprehensive services and network learning but this set did not contribute enough in addition to the other sets to be included in the path models.

Figure 10. Hypothesized relationships between main sets in Paper IV.

Four path models were produced: comprehensive services, compatible services, accessible services, and network learning. The path model for comprehensiveness explained 27% of the total variance in this variable. Of the two included sets, core agency capacity explained more than network characteristics (17% vs. 10%). Indirect effects were small. Top level management and number of organizations in the network had the largest unique effects upon comprehensiveness. The path model for compatible services is the only one that includes all sets and they account together for 30% of the total variance. In this model, network characteristics have the largest influence (20%), with the other having more modest impacts (5% for each). Here, number of organizations, their broader activity across objectives (multiplexity) and the more the network is organized towards multiplex coordination are the variables with the largest unique effects. Accessible services is the path model where the included sets and variables are able to account for the smallest part of the variance (13%). Core agency capacity (10%) is more important than network characteristics (3%). Again, top level management and lack of network leadership are the specific variables with the largest unique effects. Only one set, network characteristics, accounts for 25% of the variance in network learning.
In conclusion, Papers III and IV show that several different factors are involved in explaining the variation in performance measures. The combination of and weight given to a limited set of building blocks can explain a significant portion of the variation in the four performance measures. The first building block is appropriate management activity in top management and the political constituencies at the highest level in the local authority. Much can be achieved through committed managers who are willing to work actively together with managers in neighbouring organizations. This work can be facilitated in the first instance by a competent network leader and later by the formation of a steering group that involves organizations across the whole network. Even when this structure is in place, a network leader has a key role to play that may facilitate the work of the steering group (Weiss, Anderson and Lasker 2002). The second building block is evaluation. Whole networks that have core agencies which engage in systematic and recurrent evaluation perform better. The third building block, which is related to the first, concerns the need for basic structural characteristics to be in place. The lack of an indirect effect of core agency capacity on network performance through network characteristics indicates that core agency capacity does not have any measurable influence on the involvement of other organizations in the network. What applies to the management of core agency capacity is therefore likely to be relevant for involvement in the network by each organization in the network. In order to perform well, whole networks need to be aware that both the number of organizations that are involved in the network and the breadth of their activity across objectives are critical. Too often these are off-set against each other. The fourth building block is the need for appropriate modes of interaction. Arranging multiplex coordination generally seems most efficient. Appropriate methods to achieve clients’ involvement in decision-making must be developed. Their role as a mechanism to achieve coordination and to get good outcomes seems important. The fifth building block should perhaps more appropriately be called critical contingencies for performance. Networks with little variation in reception numbers over years and those in larger cities tend to have better network performance. However, while receiving new participants each year may improve the capacity of the core agency and the network, these positive effects serve only to moderate the otherwise negative effect of continuous reception. While these five building blocks seem important and should be taken into account in strategies to achieve whole network development, the level of explained variance in the different models suggests that research should continue to identify other variables that may add to the understanding.

7.4 TWO INTERVENTIONS: DESIGN, IMPLEMENTATION AND SOME REFLECTIONS

The whole project “Strategies for a health promoting Introduction for newly-arrived refugees and other immigrants” was designed to provide an opportunity to test some appropriate interventions based on the results of the first stages, problem definition and solution generation, portrayed in figure 4, page 55. In line with the settings approach taken throughout the project, these strategies addressed characteristics of the setting in order to make sustainable changes to strengthen the health promoting potential of the Introduction and its environment. The two interventions were delivered to four whole networks of organizations that currently delivered and could be engaged to start to deliver services to refugees and other immigrants along the resettlement process in four
different types of local authorities: a relatively wealthy suburb of Stockholm (the capital of Sweden), a university city in the south of Sweden, a traditional medium-sized industrial city in the west of Sweden and a relatively large city in the middle of Sweden. The different cities were chosen because they represented some important different environments for refugee resettlement in general and the Introduction services in particular. All four cities volunteered to participate in the project, which required quite extensive commitment of resources, particularly staff time, over a period of at least two years.

The first intervention, called goal-forum, focused on the planning process throughout the Introduction period for the participants. Based on preliminary results of the studies presented above, the hypothesis was that if clients’ involvement in decision-making over their own process could be supported, it could strengthen the agency capacity of the participants by providing more autonomy and develop future-orientation and better opportunities for them to plan for their situation in the new environment. Being actively engaged in decisions about the proper services in relation to one’s goals could perhaps provide the participants with a higher degree of perceived control over their situation and an experience of their situation and the services they were engaged in as more meaningful. Making the Introduction more responsive to the participants’ experiences before coming to Sweden and what they wished for after the programme was over could provide better information that could be used to adapt the services to each person’s particular needs. The interest in clients’ involvement in decision-making was also spurred by the findings that where methods to assure this were in place, the proportion of participants who were economically self-sufficient after two years was higher.

The principles of goal-forum, as well as the name of the intervention, was inspired by prior methods to support clients’ involvement in goal-setting concerning their own treatment in long-term care relationships for persons with rheumatoid problems in physical therapy (Arnetz, Almin, Bergström, Franzén and Nilsson 2004). In a randomized controlled trial, this model has resulted in better subjective ratings of care quality as well as larger improvements in observed symptom levels (ibid). Adapting the ideas in the original version of goal-forum to a different setting demonstrated the need to reinvent the model to fit these new conditions. First, because of the need for coordination across different services that are delivered to a participant, goal-forum within the Introduction is based on multi-organizational teamwork with a permeable boundary to the participant. Second, based on prior findings, the main perspective in goal-forum within the Introduction is which personal and external psychological, physical and social resources that are available to the participant and can be built on in the process. Third, the communication in goal-forum should aim at bringing in the views and the ideas of the participant so that the group can create a coherent idea of where the participant is aiming before detailed planning into specific activities are discussed between the staff and the participant. A fundamental principle is that there are several experts in the room where everyone, including the participant, can contribute their expertise. The primary expertise of the participant is about his/her needs, wishes, expectations, resources, knowledge, aims and goals in relation to past, present and future states of his/her life. In order to clarify the Introduction process and its different parts and not to overwhelm the participant, he/she needs to have
established a working relationship with each representative of the different services that are offered before the first joint goal-forum is conducted.

The goal-forum process starts with a two-month surveying phase that ends in the first joint goal-forum. The early meeting/meetings with the responsible staff member within the Introduction unit are the first step on the way. In these meetings, economy, children’s kindergarten, schools, housing and other basic issues are solved. In addition, the staff member provides information about the goal-forum process and the participant is given a survey with questions about a) family relations, housing and economy, b) work, c) language and other educational achievements and aspirations, d) leisure activities and hobbies, e) physical health, and f) mental health. Each section includes questions about the participants’ past, their expectations for the Introduction period and life after it. The participants are not requested to hand this survey in, just to use it as a tool for them to reflect upon their situation and to aid in communicating with staff in the different services they will encounter throughout the Introduction. The next meeting takes place with teachers in Swedish for Immigrants’ classes. Here the participant is invited to discuss prior education experiences and educational ambitions in Sweden. The process in Swedish for Immigrants’ education is described and other available educational options are presented. The last meeting before the joint goal-forum is held with a labour market specialist from the local authority or the employment agency. This meeting is intended to give the same kind of opportunities for orientation as with the educational specialist, but in relation to the Swedish labour market, prior work experiences and about possible ways forward. Practical issues, such as the start of the process of validation of work or educational certificates, start at this early stage.

After the three meetings it is time for the first goal-forum. In this meeting the participant, the three staff members and additional staff from other organizations, if needed for planning the service package for the specific participant, are present and aided by an interpreter. In order to strengthen the participants’ voice in the process of goal formulation, he/she is given a form about different areas of his/her life, corresponding to the survey provided in the initial meeting with the Introduction unit. The participants are asked to rate their present and expected situation in two years time on the form. They are also asked to think about the two ratings and how they are connected, besides indicating the three most important areas for improvement according to them. This form is the starting point for the goal-forum. The participant is requested to tell the staff about their ratings, how they think about them and possible ideas about how to reach their expected level in the two years available for Introduction services. Staff encourage the participant to articulate his/her wishes and engage in discussing how prior experiences can be made useful in Sweden and offer suggestions for how the goals held by the participants can be realized. Once a shared understanding of the whole envisioned situation in two years time is reached, the goal-forum proceeds with the next step: process planning in relevant areas. The specific goal for each area is documented in a specific form in Swedish and the participants’ mother tongue. More detailed steps to reach this goal are specified and what everyone, including the participant, commits to doing to reach the goals at a specified time is written on the form, which everyone now has a copy of. In the ordinary situation, the participants in the goal-forum agree on a time for a new meeting about six months later as well as a further time, after another six to eight months. Sometimes more than one meeting is
needed to reach a shared understanding or make the detailed plan, or the goal-forum needs to meet more frequently. The general rule is that a new goal-forum is arranged whenever there is need for a revision in planning that affects more than one organization.

In order to support implementation of the goal-forum process, three requirements were needed: 1) a steering group of managers for the organizations in which also some staff members are involved, 2) training in the method and clarification of roles, and 3) continuous supervision in areas such as multi-organizational/multi-professional teamwork and how to work in a consultative relationship that builds on participants’ resources. To this intervention a research component was added. Participants in the Introduction were asked to fill in questionnaires at the very beginning of the process and after the first and every subsequent goal-forum. Questions covered areas such as prior trauma, resettlement stress, personal capacity to handle stress, perceived quality of the interaction with staff, perceived quality in the collaboration between staff and participant, perceived quality of the planning process, perceived quality of the goal and the goal-setting process and perceived quality of service provision. In order to compare the answers from the participants in the intervention, participants in three other local authorities were asked to fill in the forms at corresponding times along their Introduction process. The three comparison sites most often used the traditional single expert model of planning and goal-setting. In this model, the participant is requested to provide information to the staff in the Introduction unit and this person decides an appropriate service process, sometimes in back-office consultation with staff from other organizations. However, one of the comparison sites is generally considered to be very successful in providing systematic opportunities for participants to be part of decision-making. In all, 30 persons have done at least one goal-forum and 21 persons have done at least two; 31 persons in the comparison have provided surveys on two occasions.

Early preliminary evaluations of goal-forum suggest that there are important differences between participants in the intervention and the comparison sites, respectively. Although the groups are relatively small, the differences seem to be statistically significant for most measures after the first goal-forum. The differences become more pronounced over time. The quality of the different services, such as learning Swedish, getting relevant contact with the labour market and feeling well-informed and positively valued, is perceived as better in the intervention group after goal-forum and here, too, the differences increase over time. Since no systematic differences have been detected in who has participated under the different conditions and the intervention seems to have produced similar results across four different settings, it is likely that the detected effects are actually meaningful and related to the intervention. However, these early claims need to be corroborated by thorough analyses of the collected material. Another interesting effect was that the model can be sustained without external support once intense implementation support has been given initially. When the intervention sites were re-visited in fall 2006, two years after the support ended, the goal-forum model was still applied despite changes in the staff, management and organizational structure of the Introduction services.

The second intervention addressed a complementary set of dimensions of the health-promoting potential of the Introduction. In the problem definition stage and the first
experiences of implementing the goal-forum process it became clear that the Introduction often did not have a broad variety of services that could easily be combined to match the specific needs of each participant throughout the programme. This meant that the programme could not create an individualized fit with meaningful services but tended to work instead as a single programme to which everyone had to adapt. The study of inter-organizational dimensions showed some important building blocks that seemed able to achieve a comprehensive set of services that would be compatible which each other, and a sustained possibility to improve network processes through learning. Setting up a whole network steering group with active management involvement from a broad set of organizations seemed to be a central starting point. To achieve particular effects, such as making services accessible for people with health problems, the results suggested that healthcare organizations needed to be more actively involved in the network. A critical analysis of the client outcomes, based on the instrumental outcome pathway, suggested that a better level of goal-fulfilment, particularly in access to employment and education after the programme ended, required the active involvement of organizations like local business and other employers, unions, local voluntary associations and sports and cultural associations, as well as of universities and other educational institutions that could affect these outcomes directly. Developing new collaborative relationships with these organizations could also challenge staff’s rather negative view of the ability and interest of critical actors in the environmental system to promote health. Persons with current or prior experience of the Introduction were also included in the whole network steering groups and the workshops.

The first part of the intervention involved supporting the whole network steering group to plan and prepare for a 2-day workshop with all stakeholders to the resettlement process for refugees in the city. In order to reach this goal, the first task was to discuss local needs in light of the preliminary findings and appropriate organizations and persons that could be critical to involve in order to improve this process. The second task was to directly contact and motivate all critical stakeholders to participate in the workshop. Recruitment was successful in all four sites and workshops were held. In two local authorities, a slight variation of the originally proposed workshop method was considered necessary. Instead of a 2-day workshop, in one case the workshop was conducted during one day and some months later one day was used for follow-up. In another site, a one-day workshop was used. The Future Search method is structurally suitable for a 2-day workshop (Weisbord and Janoff 1995). A more flexible workshop model called “Open Space Technology” was used for the two sites were a 2-day workshop was not chosen (Owen 1997). The thesis author is an experienced process facilitator and these skills were used to support both the steering group development process and the workshop. The main supervisor and head of the project “Health Promoting Introduction” was engaged throughout the process and participated in meetings of critical importance. No in-depth systematic evaluation has yet been conducted on the material collected in and about the workshop. Discussions with participants during and after the workshops have pointed to the potential of the workshop to mobilise a wide range of local actors and create a shared vision for all involved, to share thoughts and ideas and get acquainted with other stakeholders and their services and to build momentum for a development of the local capacity to help refugees to resettle well in the city. All workshops resulted in new inter-sectoral
thematic work groups that took on different questions. In one city, a new network of businesses and other employers and Introduction services was established. A core group of about ten persons, each representing a company in a particular industry, meets regularly with the Introduction services to discuss how the services can be more adapted to the needs of the employers and what can be done to help more newly resettled refugees to reach the jobs they are looking for. The network has been successful in providing each newly resettled refugee with contact for traineeships and work at an employer which matches his/her prior experience and future wishes.

As a result of their position and expertise, representatives in the steering group were often key actors in the workgroups. The cohesiveness of the whole network steering group was therefore considered critical for maintaining the momentum and coordinating the workgroups in the broader network of organizations after the workshop. The intervention therefore continued to focus on the development and active work of the whole network steering group. The thesis author facilitated a process focusing on strategic planning with a logic model approach, where shared visioning, clarification of goals and existing and needed activities where critical elements to further develop the Introduction and its environment towards functioning as a health-promoting setting. Having identified the issues and solutions discussed in each workshop and the early phases of the strategic planning process, it became clear to the researchers that the different steering groups would gain from exchanging their ongoing work with each other. Travelling together in the steering group and processing their own and others possibilities and challenges would also support the development of cohesiveness in the group. A systematic series of five one-day workshops was held, the first at a “neutral” location and then one at each site. Participation from each steering group was high over the whole process, new contacts were made and ideas for new solutions were discussed. In several cases, sites were able to adopt existing practices and methods from other sites.

The whole second intervention has been conceived methodologically as an intervention research process where defined elements can be identified. The first element concerns the activities over two years in the whole network steering group, including the planning phase before the workshop and strategic planning and coordination after the workshop, all with experienced process facilitation. The second element is the workshop, its contents and evaluations. The third is the process of reciprocal knowledge diffusion between the steering groups. Different types of material, including three focus groups with each steering group that cover all three elements – written surveys from participants in the workshop, network data on existing and new relationships, and documentation from the workshop and the meetings – provide good opportunities to raise many interesting research questions about strategies for settings development (Poland, Green and Rootman 2000). A first glimpse of the value of this intervention was provided when the researchers visited the sites about two years after it ended. The whole network steering group was still active and worked with identifying ways to build the health promoting potential of the setting, seemingly a valuable counterweight to the pressure of budget cuts, re-organization and drastic up- and downward shifts in the number of refugees resettled in each city.
Understanding and acting upon absolute and relative levels of adversity for countries in
the world and for groups within these countries is a moral responsibility for anyone
engaged in the development of our common world. From a human rights perspective,
refugees and other forced migrants may be a group of particular importance. War,
persecution and other outlets of human destruction expose those affected around the
world to severe suffering from unbearable conditions. In each such situation there are
people who are able to save their lives and the lives of those dear to them and escape
the atrocities. Of those, the majority find a respite in another part of their country or in
neighbouring countries. Only a small proportion are able to get further away, to another
continent, where they hope to be free of the horrible situation and use their human right
to protection. For many of them the journey to this uncertain new home is full of
challenges, for some it includes further exposure to severe strain, for most it is a longer
or shorter period of harsh circumstances. The entry into countries in Europe or other
regions of the industrialized world presents many problems, including the period of
asylum-seeking. To deter asylum-seekers, countries have actively decided to impose
restrictions on the everyday existence of this group. These policies and measures can be
considered unjust because they penalise a group that proactively uses the human right
to protection in the name of regulated immigration, protection from terrorist threat or
whatever other reason is used to convince voters in the host countries. The loss of
opportunities during this period is accentuated by the oft-reported experience of being
distrusted as lacking an acceptable reason for being in the host country. Being granted
residency provides security and protection from threats which the refugee has been able
to leave behind, but this does not mean that the struggle is over.

For the few who are granted residency, an often strenuous process to establish a normal
life in the new country starts. It is hard to imagine a resettlement process for anyone in
any context that is completely without distress but the degree of stress experienced by
many refugees and other forced migrants and their limited opportunity of regaining an
economic and social position on a par with their pre-flight situation are matters of great
concern. A country’s ability to offer an effective and prompt way through the maze of
resettlement is of enormous humanistic value for the refugees and also of great benefit
to the host country in terms of social stability, ethical concern and economic
development. The limited ability to provide such a fast track is and should be a real
dilemma for many countries in the industrialized world. The situation has dramatic
consequences for everyone in the countries of resettlement, both in terms of suffering
and in terms of lost potential. A basic assumption in this thesis is that the structural
perspective in modern health and mental health promotion can contribute some fresh
ideas to the resolution of this dilemma. In particular, this perspective can play an
important role in the development of societal support for refugees in the early stages of
resettlement. To further this vision, this thesis has the more modest aim of identifying
the preconditions and strategies for strengthening the health promoting potential of the
Introduction for newly-arrived refugees and other immigrants and their environment.
8.1 THE PROBLEM

When a structural health promotion perspective is applied to refugee resettlement support in general and the Introduction for refugees in Sweden in particular, the first question that presents itself is very basic: what is the goal of refugee resettlement? Unless we know where to go, any road will do; in order to make a difference, we need to define what constitutes progress. However, defining the goal of refugee resettlement may be less straightforward than one might believe. As identified earlier in this thesis, a look at the policy level alone shows that several attempts have been made to formulate a precise goal and each of them has been criticized for being ineffective or open to conflicting interpretations. Opinions on this issue tend to differ, both at the policy level and among the general and the migrant populations. From the structural health promotion perspective, the arguments would start from a human rights perspective and the formulations in Swedish Integration policy that issues of inequity and inequality shall have precedence and that everyone in this society, regardless of their background, shall have the same rights, responsibilities and possibilities for participation and co-responsibility. In line with this, the goal of refugee resettlement is to reach a situation in which refugees have the same rights, responsibilities and possibilities as anyone else in society and where refugees participate and are co-responsible for the society in which they live. However, all available measures show that this is not the case in Sweden today. On the contrary, measurements in just about any area show significant differences between people born in other countries, especially if they are from outside Europe and from countries from which many people come as refugees. The fact that this difference often persists for ten years or more must be considered a failure of refugee resettlement. Moreover, this failure has considerable consequences for health and other issues for the migrants and should be considered a lost potential for society.

From a structural health promotion perspective, the main factor behind the health status of migrants is the economic and social living conditions in Swedish society. Therefore, finding appropriate strategies to address these conditions becomes the most important path towards improving population health among refugees and people with refugee-like grounds in Sweden. This insight leads to the need to recognize the interdependence of health and mental health on the one hand and integration and refugee resettlement conditions on the other. Simply put, improving resettlement conditions can be expected to lead to improvements in health. This insight is an important premise of a structural health promotion perspective on refugee resettlement. The next question is therefore: how can resettlement conditions be improved? which are the most important factors? It seems that two forms of resource loss may play a critical role. First, the whole migration process may entail different kinds of loss of social, material and other resources. Second, loss may come about through other people’s perception of refugees’ resources. For instance, 15 years as a professor of psychology in Baghdad is often worth less in Swedish academia than it would be in Baghdad, especially if command of the Swedish language is not perfect or the person lacks a Swedish reference.

In public policy, these two forms of loss have been assigned to different areas of activity. Simplifying somewhat, Swedish resettlement support has been set up to handle the first dimension of loss, while the second is primarily targeted through discrimination laws that often work reactively, ex post facto. Systems for validation of
educational or occupational competence and qualifications are an important exception to this division. The focus in resettlement support and its main initiative, the Introduction for newly-arrived refugees and other immigrants, is upon services that target refugees to compensate for real or perceived losses that may be inflicted through entry into Sweden. The interventionist welfare states’ high ambitions in compensating for inequality caused by limited access to provision from social networks or the market motivate a high level of service provision. This must truly be considered an act of solidarity. Think about the alternative: doing nothing to help newly-arrived refugees in need. However, the compensatory logic of welfare production entails the recognition of clear needs. The problem is that an institution geared to identifying needs and compensating for losses is liable to perceive its beneficiaries, in this case the refugees, as deficient. There is a considerable risk of this leading to a situation where refugees are seen as clients for whom services should be provided. This is contrary to a structural health promotion perspective because of the risk of victim-blaming and sole reliance on the development of personal skills. The Introduction can only become a health promoting setting if the organization, practice, outcomes and steering principles for the whole service-implementation network are developed on the basis of the four alternative structural means presented in the Ottawa Charter: build healthy public policy, create supportive environments for health, engage the community, and reorient health services, in different combinations. The remaining part of this discussion will be devoted to presenting the basics of such a model.

8.2 THE HEALTH PROMOTING INTRODUCTION MODEL

The results from the four studies in this thesis and previously presented research on structural health promotion have been integrated in the Health Promoting Introduction Model (figure 11, next page). A basic starting point for the model is that the Introduction is seen as a setting for health promotion in line with the more comprehensive and structural models of setting-based work (Moos 2002; Whitelaw, Baxendale, Bryce, MacHardy, Young and Witney 2001). The Introduction is considered to be an open system, highly interrelated and in need of exchange with the environment in which it is embedded. A fundamental precondition for the model is that the focus on refugees’ deficiencies is replaced by a more sophisticated resource-focus where refugees are considered resourceful and possessing many capacities that can be built upon, added to or adjusted in order to be of maximum value in Sweden. First and foremost, they have at least a basic level of agency capacity, i.e. they are able to strive for purposeful self-determination, have autonomy, manage to cope proactively and foresee the future and make sense of, initiate and influence events in line with personal values, goals and aspirations for the future as well as past experience (Fryer 1998a; Lindencrona and Ekblad 2006; Lindencrona, Ekblad and Hauff 2008). The model represents a falsifiable theory of the health promoting Introduction where a few network building blocks make particular setting qualities possible; the setting qualities in turn may cause a spiral of interrelated personal capacities, environmental facilitators and programme outcomes to spin in a positive direction, the long-term end result being individual, group and population levels of health and mental health and social and economic outcomes. The model is not disease specific; instead it takes a social consequences (i.e. with unspecific effects) perspective on mental health (Aneshensel 2005).
The model will be presented in detail here, followed by an evaluation of it based on 7 criteria for assessing research in health promotion (Lahtinen, Koskinen-Ollonqvist, Rouvinen-Wilenius, Tuominen and Mittelmark 2005).

Figure 11. The Health Promoting Introduction Model. (Graphical layout: Ulrika Lindencrona).

8.2.1 Network building blocks

The first area of the model contains five main building blocks. The factors in these building blocks are mainly structural at present but it is likely that other kinds of factors will be added. The network building blocks increase the probability of important setting qualities and may directly affect the variables in the outcome spiral. The exact relationships between different building blocks and specific setting qualities have been studied in detail in Paper IV. The general conclusion is that while the importance of a particular building block may differ between different settings qualities, all the network building blocks are needed to develop the necessary setting qualities.

- **Active management on all levels**: The first building block concerns the need for active management support on all levels in all organizations in the network. The heads of administrations and heads of department may be the managers that need to most be active in continuous interaction in the network. However, they are dependent on the active support and clear directives of the top management and political leadership of each participating organization. The highest level needs to ensure adequate support and resources for the services and provide a mandate for negotiation at their subordinate managerial level. Driving constructive processes in the network requires active network leadership by an appointed network leader.

- **Basic network characteristics**: For the network to be able to deliver a broad variety of services that can be combined flexibly, it is important that all needed organizations at the local level are engaged in service provision. However, this needs to be done without services trying to reduce their relative contribution. If borders are drawn prematurely and limited interaction occurs, there is a large risk of sub-optimization. Networks that allow the responsibilities to be dynamic and where synergy between different actors is developed through joint problem-solving and resource-exchange, can deliver more flexible service combinations that are adapted to each participant.

- **The need for certain competencies**: The complexity of refugee resettlement requires that many local organizations’ competence is accessible to the refugees and to the other service providers in the Introduction. One such important actor is the healthcare sector, which should be engaged in its traditional role of providing treatment to those in need. The role of healthcare also needs to be expanded into providing competence development to managers and staff about mental health and
its risk and buffer factors. They should also work together with the Introduction to build up adequate language learning and work-life rehabilitation opportunities for refugees with health problems, for example severe post-traumatic stress disorder. Another completely indispensable sector is employers in the local authority. Without close collaboration with this group, it is hard to see how the critical outcome of employment can be effectively addressed. When this group becomes an important and trusted partner, it can be involved in deciding which services should be delivered and the proper ways to deliver them. Perhaps at a company as part of employment rather than in school. Early and extensive collaboration with employers can facilitate the recognition of participants’ knowledge and experience, provide an adequate opportunity for Swedish work-life experience and be a source of personal references, all possibly critical factors to increase the chance of employment at the particular organization or in other organizations in Sweden. Activating such partners at the local level is highly related to the former building block but it deserves to be treated as a separate building block on account of the limited role it has been accorded hitherto in the Introduction. Building close collaborative relationships with partners in the environmental system outside the traditional boundaries of the Introduction will be necessary to change the one-sidedly negative perception of the environmental system among staff.

- **Mode of interaction:** The network needs to have systematic and intense interaction between all those involved. Group modes of interaction are the most effective ways to exchange information, solve problems and support constructive development and learning among many partners. Systematic interaction has to be established as a way of supporting participants’ shared decision-making at the participants’ level. This can favourably be combined with multi-organizational/multi-professional teams of staff that assess, plan, decide, implement and follow-up the coherent service package delivered to each client. Active steering groups for the network are critical for making the whole-service implementation network coherent. The active steering groups will benefit from including employers, healthcare and other actors from the local level in the group.

- **Systematic evaluation:** Adequate indicators for systematic evaluation and processes for discussing the outcomes are necessary to establish a continuous improvement and learning loop within the network. Annual indicators and feedback from clients and others can effectively be used as a guide for the network steering group, as well as for a yearly workshop between all actors at the local level in order to identify new areas of activity or new strategies to address the outcomes. Indicators are also necessary to find out which strategies or services lead to important outcomes.

- **Environmental conditions:** The preconditions for different kinds of outcome may vary between local authorities. Policy decisions at the national and local level can often address these differences, either by providing different levels of funding or by using appropriate strategies to engage with the environment. However, in some local authorities the conditions may be so detrimental so that the capacity to provide the right conditions for refugee resettlement are not present, for instance failing labour markets in peripheral regions. These local authorities should not be used for service provision.
8.2.2 Setting qualities

In any comprehensive settings model, the interdependence of ordinary practice in the setting and health outcomes needs to be understood. The setting qualities that are included in this model are those that can both promote health and be expected to be important for attaining the main aim of the Introduction. Reaching the main aim of the Introduction is in itself necessary for promoting health among the participants. The following setting qualities are considered:

- **Agency motivation:** The culture and practice of the Introduction need to motivate participants to have agency over their own process through the programme as a way to reaching important outcomes in Sweden. Participants are resourceful, but may need different kinds of complementary services to reach their aspirations in Sweden. Many participants are clear about where they are heading; the role for the services is then to help with what they can to facilitate this process. For others, traumatic experiences, uprooting, migration and resettlement are so distressing that it is harder for them to find their new direction. In this case, the first job for the services is to help in finding the next step on the way. Nevertheless, the services have to be arranged so that everyone is able and motivated to take maximal agency over finding their direction in life and moving toward this goal. When agency motivation is established as a guiding principle, it can counter tendencies to exclude participants from decision-making. Instead, joint problem-solving occurs between an actively contributing participant and a professional using his or her competence to aid this process.

- **Easily comprehensible and transparent structure:** A necessary prerequisite for the setting to be agency-motivating is that the setting, the activities and the responsibility and opportunities that exist for participants are easy to understand, clear and transparent for all. This is also important for staff in the network in order to know about other available services and how they can be combined to match the needs of the participants in a comprehensive manner.

- **Meaningful and individualized services:** Given the quality of agency-motivation, the tendency in the Introduction to provide a single programme to which everyone has to adapt is detrimental to both meaningfulness and outcomes. Assessment and discussions to identify the aspirations and prior experiences of each participant are necessary to arrive at the exact combination of support that will build upon the participant’s existing capacities and resources. Matching the needs of the diversity of participants calls for a comprehensive set of services that may be flexibly combined.

- **Caring for the participant:** Just as participants differ, so does their need for support. The practice is sometimes that people with health problems that may affect functioning such as post-traumatic stress disorder or depression, either have to participate fully, on the same level as anyone else, or are totally excluded from participation. Given the interdependence of health and other outcomes, excluding participants from service provision amounts to not caring for the participant. On the contrary, care is expressed when adjusted services are provided that cater for the specific needs of participants with health problems.
Therefore, opportunities to learn Swedish or find an appropriate place in employment and society at large must be developed that are suitable for each participant’s capacity.

- **Learning and synergy**: Variation and flexibility require good processes to achieve continuous learning between all actors in the setting. Learning requires that systems are in place to collect and process experiences and feedback from participants, staff, managers and actors in the environment. Providing for intense discussions and learning about each other makes the opportunities for synergy more likely. To be able to act on this synergistic understanding, several of the network building blocks have to be in place.

### 8.2.3 The health promoting spiral

Factors in three areas interact to promote health and other important personal and societal outcomes of the health promoting Introduction. To affect such long-term outcomes, the model adopts a population strategy rather than a high-risk strategy. The inter-relationship of the areas in the health creation spiral may make the prevention paradox a limited problem because improvements that strengthen personal capacities contribute to better chances for access to the labour market and other dimensions that are valuable in themselves. Such outcomes also feed back to the healthy development of persons resettling in Sweden. Given the diversity of participants’ aspirations and the prior and current experiences, establishing a single goal for the services would be simplistic. The processes for reaching the goals are seldom straightforward. Even for those with strong personal capacities, the environment may be so deprived of facilitators that reaching outcomes is very hard. In other situations there may be easy access to employment but the job provides only limited training in Swedish or is below the individual’s qualifications, with a detrimental effect on prior levels of personal capacities. Still others need time to strengthen personal capacities after a turbulent period; once this has happened, reaching outcomes such as adequate employment and learning Swedish proceeds quickly. Evaluations of the health promoting Introduction should therefore use performance measures for each of the three areas.

- **Personal capacities**: Many inter-related and interdependent personal capacities have been identified. First, being able to form new relationships to staff in the programme, people in the new environment or existing family or other social networks is important to get needed instrumental and emotional support and other kinds of benefits. It is important to recognize that the atrocities to which people have been exposed can sometimes be hard to communicate and this has to be arranged in appropriate circumstances. Things may be hard to understand in the early stages of the resettlement process and many people can become reliant on the advice of others. The social network is an important source of support and people need to be updated with the most adequate information. Agency capacity is an important personal capacity, a resource available right from the start for most refugees. Finding meaning in the services and in life in general is a critical capacity. Manageability requires the feeling that one’s competence is valuable and this may or may not require external validation. Control over life is related to an ability to be proactive, have a future-orientation and capacity to plan. The ability to act proactively and plan requires an understanding of the situation. A person who perceives the situation as meaningful is more likely to feel motivated and an active agent. The last dimension of personal capacity is positive self-image and emotional balance.
Genuine self-confidence and a feeling of self-worth can counteract the constant challenges experienced by everyone during resettlement. The process is facilitated if people can remain in mental and emotional balance. This is definitely not easy, especially since the external environment is often unsupportive, discouraging and does not appreciate the refugee’s competence. For some, previous exposure to trauma may make them more vulnerable to new exposures.

- **Programme outcomes:** At least four important main outcomes of the Introduction for adults can be identified in the policy. The most general concerns participation in society. Four more specific outcomes are defined: access to employment or further study, gaining mastery of the Swedish language, getting complimentary education based on the individual’s preconditions, and knowledge about Swedish society and working life as well as about citizens’ rights and responsibilities in Sweden. There is evidence for each of these being important health determinants.

- **Facilitators and barriers in the environmental system:** The availability of facilitators in the local authority environment may affect personal capacities and programme outcomes. High availability of employment opportunities and intra- and interethnic networks are two important factors. Exposure to a social environment in the community and in different services that is not familiar and perhaps even intolerant can lead to an experience of alienation for newly-arrived refugees. The general social and economic conditions put a lot of strain on refugees that may act as environmental barriers to personal capacities in this group.

### 8.2.4 Long-term outcomes

A positive health promoting spiral will have relatively immediate effects on the situation for the participating refugees and other immigrants in terms of relationship dimensions and personal growth dimensions of coping, as well as outcomes in central areas of life such as employment, social networks and participation in society. The relatively short-term gains will most likely carry over to long-term gains at individual, group and societal levels in a local authority. In a longer-term perspective, such health outcomes may be closely connected to social and economic gains. Evidence for several of these long-term effects has not yet been provided for refugees during resettlement but may exist for other groups.

- **Personal level:** The effects for persons participating in the Introduction can be important, in terms of living conditions, life opportunities and more intrapsychological dimensions with a constructive health promotion spiral. The effects on psychiatric symptoms have already been identified in this thesis, but there are likely several other mental and somatic outcomes that will be affected through different pathways. In broader terms, a constructive resettlement process is likely to have consequences for the subjective feeling of integration among the new members of society.

- **Group level:** More favourable outcomes for refugees participating in the Introduction will possibly strengthen the capacity of the different networks of refugee and other migrant groups in Sweden. Persons who are positive
examples can be expected to have positive effects on new arrivals because they can aspire to reach the same level and find out what enables them to do so.

- **Society**: People must be able to reach their aspirations reasonably soon if they are to consider their resettlement process successful. If dramatic differences and inequality prevail, integration is not possible. This is a social and democratic failure that negatively affects society at different levels and in different areas. In contrast, the economic benefits of a successful resettlement process are great for society and specific employers. For society, there is a tremendous democratic and economic potential in helping people to start work and pay taxes instead of needing economic benefits. For many companies and other employers, finding the right competence and new kinds of knowledge or networks can be critical for economic success.

### 8.3 THE VALUE OF THIS PROJECT AS A HEALTH PROMOTION RESEARCH PROJECT

The discussion about the role of different methods for producing evidence of health promotion has been intense and heated (e.g. McQueen and Anderson 2001; Rychetnik, Frommer, Hawe and Shiell 2002). This is hardly surprising, given the broad disciplinary base of the health promotion field. However, if health promotion aspires to be considered a distinct field of research, an important mission is defining the characteristics of the examples of best practice in the field. Clearly, the general and specific aims of this thesis position this research project within the health promotion field; it is therefore of interest to scrutinize the project in relation to proposed quality criteria for health promotion (Lahtinen, Koskinen-Ollonqvist, Rouvinen-Wilenius, Tuominen and Mittelmark 2005). Applying these criteria to the research project can help in identifying specific methodological considerations for the research project and proposing issues for further research on the concluding implications.

#### 8.3.1 Health promotion relevance

**Definition of criteria**

The rationale for the research addresses priorities for health promotion research as set forth by relevant policy instruments or other sources.

**Assessment**

The need to support vulnerable groups such as migrants has been stressed in the WHO and European Union declaration on mental health from 2005 and in reports on mental health in Europe (European Union 2004; World Health Organization 2005). Structural means, such as mental health impact assessments on all policies (with particular attention to vulnerable groups), establishing partnerships, developing coordination and leadership across regions, countries, sectors and agencies that have an influence on mental health and social inclusion, have been proposed to achieve an improvement in mental health in this group. The research presented in this thesis meets most of these requirements.
8.3.2 Health promotion values

Definition of criteria
The research methodology explicitly addresses how health promotion values, such as citizen participation, partnership, authorized participation, open communication, sustainability and empowerment, are incorporated in the research.

Assessment
On the positive side, the first study uses a qualitative methodology that allows the study participants to present their understanding of a health promoting Introduction. Their descriptions have an important impact on later stages of the research project. However, the understanding among staff has been more in focus than the understanding among programme participants. Moreover, the research designs of studies two and three are participatory to just a limited extent. First, in each study, items and questions include previous findings from interviews and other sources with refugees (study two) and staff and policymakers (study three). Second, pilot interviews in several rounds were conducted on the material and methods used in each of these studies. These processes resulted in ideas and suggestions that were incorporated into the final versions of the questionnaires. Third, feedback on the perceived quality of the questionnaires was obtained on the final versions from all study participants. Fourth, the material has been presented and discussed in many different contexts within the Introduction, although mostly with staff and policymakers at the local, regional and national levels. The greatest limitation in terms of health promotion values is the lack of a systematic process for discussing the results with study participants, particularly programme participants, and using these discussions as an alternative source of information when drawing conclusions in the studies. To achieve this, it is important to consider issues of timing when planning research on ongoing programmes. Programme participants are often hard to reach because they have already completed the programme by the time results are available for discussion.

8.3.3 Health promotion innovation

Definition of criteria
The research is innovative and distinctive, explicitly addressing its intentions to clarify and/or strengthen an important aspect of health promotion practice.

Assessment
The research project aims to identify and devise strategies to develop the potential of the Introduction as a health promoting setting. Settings and inter-sectoral action have been given a key role in health promotion practice. Recent health promotion research has become increasingly interested in understanding settings from a more structural and comprehensive perspective. The study of settings as whole service-implementation networks provides an innovative perspective for integrating healthy public policy implementation with settings development and inter-sectoral action.

8.3.4 Health promotion discourse

Definition of criteria
The study questions are framed in a manner consistent with, and flowing from, clearly stated theory with a high degree of relevance to health promotion discourse.
Assessment
The general aim of the study concerns the health promoting potential of a particular setting. The specific objectives include the identification of risk and protective factors at different levels of the setting and its environment and the examination of structures and processes (i.e. organization, process and practice) in the setting that can be addressed in order to achieve change. Theory of settings and their potential impact on health is a fundamental part of the modern discourse in structurally oriented health promotion. The particular dimensions of the setting that are in focus have been chosen because of their relevance for health promotion, specifically issues such as control, shared decision-making, flexible adjustment of services and determinants of health and mental health. The major role attributed to network development as a strategy for improving setting qualities addresses the need for sustainable change that can influence the interdependent relationship between health and other outcomes.

8.3.5 Health promotion practice
Definition of criteria
The research has practical relevance for health promotion activities, and makes explicit reference to the arenas of practice to which it applies.

Assessment
The whole research project addresses a particular setting, the Introduction for newly-arrived refugees and other immigrants and the environment in which it is embedded. The aim of the project, to develop strategies to strengthen the health promoting potential, points directly to several activities that are of practical relevance for achieving change. The project has already resulted in two new strategies that have been tested in an intervention project in the Introduction in different local authorities in Sweden.

8.3.6 Health promotion action
Definition of criteria
The research explicitly addresses action for health promotion, including action for change and action to create opportunities for choice at any level or combination of levels.

Assessment
Because of the limited knowledge of how health and mental health promotion can be applied to refugee resettlement in general and to the policies and programmes in particular, it was important that the first task would be to suggest points of leverage that could be addressed to achieve change and create opportunities for choice. The results of the different studies and the Health Promoting Introduction Model provide a useful tool to identify needed areas to address health promotion ends. The processes and outcomes of action are part of the research project’s second step, presented in some detail in Chapter 7.

8.3.7 Health promotion context
Definition of criteria
The research demonstrates appreciation of the manner and degree to which it is embedded in a larger health promotion context, by reference to critical aspects of the
problem that are not objects of study, e.g. systems, ecologies and/or processes of which the object of study is a part.

**Assessment**

The research project has taken a theoretical stance in favour of structural dimensions as the primary methods of change. There is less focus on more individualistic measures that can help high-risk individuals or that are solely concerned with providing information and improving skills to promote health. The end result, the Health Promoting Introduction Model, does include possible long-term effects for the individual, group and society but these matters have not yet been studied and are still just a matter for speculation.

### 8.4 METHODOLOGICAL CONSIDERATIONS

In this section, the research in this thesis will be discussed in relation to more general qualities of good research. The four papers in this thesis are based upon three different studies. The first study aimed at illuminating staff’s constructions of health in the everyday environment in the Introduction and its environment. The choice of qualitative methods was justified by the limited level of knowledge available at the time of the study and because qualitative research methods are well suited to studying questions concerning context, meaning and relations between levels of analysis (Stewart 2000). Group interviews with existing collegial groups, suggested by Kitzinger (2000), were required to study interaction, to identify shared and diverse understandings and to provide the opportunity for colleagues to reflect upon their common practice. This provided a rich description of the issues of interest. Fortunately, a smaller study of the perspectives among refugees in the programme could complement the interviews with staff. The validity of the findings has been acknowledged in many presentations of the study among policymakers, staff and refugees.

The second study introduced a new questionnaire to measure resettlement stress at an early stage after permanent residency. Unfortunately, there was no similar instrument with which the association could be assessed. However, the instrument showed acceptable psychometric characteristics, including internal consistency and expected associations with health outcomes. The choice of mental health outcomes should be considered. First, the use of core post-traumatic stress symptoms, rather than a full account of such symptoms, was based on the interest in clarifying the specific pathways to each of the two outcomes. Evidence shows that the symptomatology of post-traumatic stress has one component that is particularly associated with more general distress than other components (Simms, Watson and Doebbeling 2002). Second, for both these outcomes, their scaled measures rather than categorical cut-offs were used for two different reasons. One was that dimensional scales have been found to be more appropriate when considering social factors (Goldberg 2000). The other reason was a lack of appropriate cut-off levels for each instrument in our three language groups of refugees in resettlement. Third, path analysis allowed the creation of a tentative process where factors in each step could be introduced and tested for their moderation and mediation of the effects of prior factors. However, it should be recognized that as the process is artificial and constructed, it does not overcome the problems in cross-sectional designs. Another challenge with path models is that they are highly sensitive
to model specification. The protected t-test and the process of path analysis give priority to earlier sets in the sequence because it is only what the new set adds that is taken into consideration when statistical significance is examined. Fourth, the study of resettlement stressors focused on variation in individual-level factors. More comparative studies using preferably multi-level modelling are required to understand the impact of the shared environment in local authorities upon health and other outcomes.

The third study concerns the factors that can explain network performance. In order to maximize the number of observations in this study, a key respondent strategy, with only one respondent, the manager of the network’s core agency, was applied. This respondent was encouraged to consult with managers in other organizations and with his or her staff or other persons who could provide the needed information. However, the choice of a key respondent strategy restricted the type of factors that could reliably be reported from each network. Since subjective climate and attitude ratings from a key respondent could not be expected to represent the full network, the variables were limited to structural variables for which consensus could be expected. The problem of lacking non-systematic reports of client outcomes has already been addressed and is critical for service research in the Introduction. Finally, the challenges in path analysis, addressed in the second study above, may have presented a risk of bias in paper IV. The limited knowledge of relationships between core agency capacity, network characteristics and mode of interaction can lead to a risk of incorrect model specification. In order to handle this problem, both multiple regression analysis and path analysis were conducted and presented in the paper. The strong demands in the protected t-test are needed to balance the risks of type I and type II errors, but it can lead to some insensitivity to modest statistical effects. The position of mode of interaction as the final set in the path model may explain why the variables in this set are statistically significant in the multiple regressions, whereas the set enters only one final path model in Paper IV.

8.4.1 Ethical considerations

Research in general and research with potentially vulnerable groups in particular must always consider the ethical conduct and implications of the research. Ethics may be perceived in many different ways and should be debated continuously. Here, some more general reflections will be provided on the ethics of the whole thesis project because ethical considerations in the design and methods of the specific studies are reported in each paper. The first reflection concerns the role of critical thinking in government-funded research. The project of which this thesis formed a part, was mainly funded by the Swedish Integration Board. While this situation provides many opportunities in terms of possible influence on policy and its implementation, the attention and involvement of government agencies in the project’s reference group placed a specific demand on the researchers to keep ethics up front. That the research group was free to develop a research programme without steering from the government agencies, together with the shared understanding that the Introduction was not functioning well and that much needed to be done, made it possible to be critical and free in formulating hypotheses and other research considerations.
The second reflection has to do with the need for a serious approach to research that studies areas where policy is critical for peoples’ lives. When this project started, Swedish research on refugee resettlement and its institutions was very limited in general and virtually non-existent as regards health and health promotion. Although the research project has aimed to find practical solutions and ideas for change, an important aim throughout the studies has been to base recommendations on research of as good quality as possible. Some examples that should guide future research are the need for qualified translation and back-translation of questionnaires, choice of appropriate methods for each study, and several rounds of detailed pre-testing of new instruments. However, with the luxury of hindsight, there is one dimension which the project design ought to have emphasized more strongly: better documentation and systematization of the many discussions about research findings with different stakeholders, such as professionals and programme participants.

The third reflection is that the choice of perspective on health and mental health in groups such as refugees is an issue of ethical concern. This thesis challenges the traditional disease perspective on refugees. Being able to understand the variety of experiences and to stress the available resources rather than the weaknesses is an ethical principle in health promotion. This is an important alternative to the dominant perspective because the main characteristic of refugees is clearly not illness or disease but rather their strength and ability to cope under extreme conditions. Since this perspective is readily misinterpreted more or less intentionally, it must be stressed that it is not an argument to the effect that refugees do not need resettlement support services or, even worse, that they do not suffer and therefore do not need protection. There are, of course, refugees in Sweden who do need curative treatment for health and mental health problems, just as there are in any population group. But we would not regard the whole population as ill even if at some point in time there is a large proportion with some detected health problem. Basing the study of refugee adaptation and resettlement on refugees as resourceful rather than only suffering may be an important ethical principle for the future of refugee mental health. A focus on refugees’ resources can challenge negative public opinion and place more emphasis on the structural conditions that may affect refugees negatively.

### 8.5 CONCLUSIONS

The often precarious situation for refugees throughout the stages of migration may subject them to extensive strains. Despite this, many refugees display impressive strengths and must be considered exemplars of the human capacity for adaptation. Most refugees do not migrate beyond their native region; just a small proportion end up far away in Western countries such as Sweden. Regardless of where they end up, the environment is seldom the most appropriate for recovery; instead, the process of resettlement places heavy demands on refugees. The exposure to stress and strain, including loss of different kinds of resources, may vary between resettlement environments. It is important to realize the tremendous diversity that can be found among refugees under resettlement in Sweden and other countries. Research in the past decade has paid more attention to the protective and risk factors in the resettlement environment. This thesis starts from the fundamental assumption that structurally oriented health and mental health promotion could bring a new perspective to
understanding how certain dimensions of the environment can be improved in order to promote health and other outcomes among newly-arrived refugees and other immigrants during resettlement. The structurally oriented perspective of health promotion considers health as being closely related to the characteristics of the nested levels of the everyday environment. The appropriate way to address these issues is through different means, such as influencing public policy and developing important settings for health. New perspectives on settings see these as holding certain health protective and health damaging factors in their organization, practice, main activities etc. In the case of refugee resettlement in Sweden, the most critical public-policy directed setting is the Introduction for newly-arrived refugees and other immigrants. This thesis aims to identify the preconditions and the strategies for strengthening the health promoting potential of the Introduction for newly-arrived refugees and other immigrants and its environment. The four papers included in this thesis have different specific objectives and use different methods to contribute different pieces to the puzzle. Together, these results and other relevant research are used to propose the Health Promoting Introduction Model.

The Health Promoting Introduction Model starts from the need to reformulate the fundamental view of the relationship between refugees and the host society. Traditionally, the resettlement support services have often been arranged and justified in terms of a deficiency perspective i.e. that a different level from the host population can be explained by deficiencies and limitations in the resettling population. A change of focus from refugees’ deficiencies to their resources during resettlement raises two questions: are there any additional support measures that can further the refugee’s agency capacity in the new context, and how can refugees’ resources be better appreciated in the host country? The resource focus is an important starting point for the model, which aims to clarify how building blocks in the whole service-implementation network can provide important setting qualities. These setting qualities can affect health through the way the services are delivered and through the outcomes they produce, leading to an integrated health promoting spiral, including a) outcomes such as employment, language and participation in society, b) personal capacities, and c) environmental facilitators and barriers. A constructive spiral will presumably lead to different outcomes at the individual, group and societal levels.

The health promoting spiral illustrates the interdependence of health and other effects and the importance for successful resettlement of different levels of environmental and personal capacities. Due to the many important facilitators and barriers in the environmental system, inter-sectoral collaboration with employers and other actors at the local level is critical for improving access to important resources, such as employment or education. Given the diversity among refugees and other programme participants, a broad variety of services is needed to address skill development, adjustment or recognition of qualifications among newly-arrived refugees, and help to adapt workplaces and recruitment policies to make them more accessible for refugees.

The model is developed within a health and health promotion framework and meets the major requirements of research in this area. Facilitating refugees’ resettlement is an important strategy for realizing the maximal potential of individual refugees, different groups in Sweden and the whole of Swedish society.
8.5.1 Implications for research

The Health Promoting Introduction Model is the first attempt to apply a comprehensive and structural settings approach to refugee resettlement support. The model is intended to initiate a more precise agenda for research on health promoting settings in general and settings targeting refugees during resettlement in particular. The major areas in the model are supported by research either included in this thesis, in on-going research based on the findings in this thesis or in other research. Nevertheless, certain areas in the model require attention in future research. Starting with the network building blocks, the structural variables need to be expanded, with more subjective data on climate and culture as well as better financial and economic measures. Also, the relationships between the parts of the health promotion spiral, such as between social networks in the community, access to employment and personal capacities, must be understood in more detail.

Several hypothesized relationships in the model need further study. First, the qualitative findings of the relationship between setting qualities and the different parts of the health promotion spiral need close attention. The goal-forum intervention, presented in Chapter 7, will provide some evidence on this relationship. Second, much of the hypothesized long-term effects has still to be validated. This applies in particular to group and society effects. Third, while a relationship between network building blocks and client outcomes has been identified, it is likely more often to be indirect, acting via certain setting qualities. However, the evidence for client outcomes from specific setting qualities or service elements is still very limited or non-existent. Therefore, as suggested in other network and service systems research (e.g. Isett and Morrissey 2006), perhaps the most important research area in this field at present concerns evaluation of specific service elements. After a period of model specification and revision, the next research task should be initiated: field testing of the complete model in several intervention sites with appropriate controls. Instruments covering the different areas have been worked out in the studies in this thesis, but revisions may be needed in the light of the current situation. Model testing should be done longitudinally, with appropriate technical support from researchers acting as intervention facilitators.

The lack of comparative studies of delivery systems for refugee resettlement support in different countries makes it hard to assess the extent to which the full model or specific areas are applicable outside Sweden. There is reason to believe that the model is most easily transferable to countries where the structure of welfare is similar to Sweden’s. A first step would be to examine the perspectives and systems of service delivery of refugee resettlement support in order to adapt the model to these circumstances. Another dimension of generalization concerns the usefulness of the model in other policy areas. The model could be expected to be useful for areas where certain conditions apply. First, the model is relevant for policy areas where the dominant mode of service delivery is whole service-implementation networks. Second, the model will be most appropriate for programmes where health and other outcomes can be considered interdependent. Third, the model starts from an assumption of diversity, where the capacity to deliver the right combination of services for each person is an important quality dimension. Fourth, the model could be appropriate when the primary task of the services is not health provision but the way services are delivered and the
outcomes they have are both important for health. The settings that are most likely to meet these requirements are perhaps elderly care, work rehabilitation and other social services. However, the model can possibly be useful in healthcare settings if it is used to develop ideas about how health can be promoted through coordination of complex care processes.

8.5.2 Implications for policy

The structural perspective of health and mental health promotion addresses policy directly and indirectly as a fundamental part of both the problem and the solutions. Most of the findings in each paper and in the review of previous research in this thesis have implications for policy. However, in this conclusion, five central implications for policy are focused.

First, the thesis and the Health Promotion Introduction Model have pointed to the problems involved in basing policy on a deficiency perspective on refugees and other immigrants. To avoid misinterpretation, it should be emphasized that this does not deny the need for refugee resettlement support. Rather, it means that the perception of refugees as having few resources is an obstacle because it addresses the wrong problem and risks blaming the victim. Refugees do have resources, though as in any group there is variation within the group as well as individually over time. A much better perspective is the one introduced by Fryer in his ideas about agency restriction, where people are seen having agency (Fryer 1998a; Fryer 1998b) but their current position imposes restrictions on how this can be expressed. Overall, the policy needs to be based on the diversity of needs, resources and aspirations among resettling refugees and other immigrants. Clearly, the appropriateness and value of different resources may vary in the new context both as a matter of real restrictions and because of the new environment’s limited appreciation of the competencies. Therefore, refugee resettlement support is critical provided it builds on the existing agency capacity and other resources and is delivered in close collaboration with the participants. It is in the constructive interaction of refugees and services that the requirements for developing and adapting existing resources can be identified. It is as important that the actors in the Introduction and in the environmental system understand and find ways of using existing competence and resources among the newly-arrived. This leads to the second implication for policy.

Second, because of the key strategic role that refugees and other immigrants are able to play for the development of Swedish society, socially and economically, the effective provision of refugee resettlement support should be given high priority among politicians in the highest assemblies at the national, regional and local levels. The preconditions for effectiveness in this process is determined by political action in policy fields from economic growth, infrastructure and city planning to details in the delivery of healthcare services and everything in between. A critical starting point for this process is to realize the interdependence of many different areas, such as health and mental health and individual and societal social and economic success. Learning about the impact that decisions in different areas may have for this process is another key strategy. This could possibly be done by starting to conduct integration impact assessments along the lines of the health impact assessment that is proposed as a critical
strategy in the Ottawa Charter and later work (This strategy is more elaborated in Lindencrona, Ekblad and Johansson Blight 2006). Different processes involving the interaction between refugees, the general public, professionals, policymakers and politicians need to be an integrated element in this development.

Third, to enable systematic learning and improvement, adequate measures are required to follow the outcomes of the Introduction. Monitoring systems are critical for ascertaining that all citizens have the same levels of important resources, such as employment, education, housing and health (Phillimore and Goodson 2008). The lack of a national system for follow-up of outcomes makes it impossible to compare different programmes’ critical outcomes. This has severe negative consequences for accountability, effectiveness, resource-use and systematic learning and improvement. While data are often available on many important determinants of mental health in Sweden’s local authorities, it is often not possible to compare refugees during their first years with other groups in the local authority. However, given the diversity of programme participants and resettlement environments, deciding appropriate measures is by no means a simple matter. Some ideas concerning this area have been presented in the Health Promotion Introduction Model but many questions remain: How can variety in needs and expected outcomes be handled within the indicators of success in the Introduction? What drawbacks can be seen in limiting the outcomes to a single focus on employment? Can measurement systems be developed that tap into “giving the right services to each person”, where the results show, for example, time to get an adequate job for those that have this goal, access to appropriate rehabilitation for those with such a need? Another critical consideration is the possible existence of environmental facilitators and barriers that may influence refugee resettlement. These need to be taken into consideration to present a valid picture of the extent to which the Introduction and other policies contribute to the success of refugee resettlement in a certain local authority.

The fourth implication is the need to fund research and systematic evaluation to find effective strategies to achieve results. Currently, there is a great lack of knowledge about effective refugee resettlement support. An appropriate national follow-up system would make it possible to address many interesting questions about the relationship between organizational and network factors, setting qualities, environmental facilitators and outcomes. Billions of Swedish and European public tax money are channelled annually into service provision and into projects that test different methods, but few systematic processes are available to learn from these examples and few strategic measures are taken to coordinate the funding between different actors, to conduct well-designed research upon the interventions and to support the implementation of successful strategies in new sites. A new project evaluation and funding process has been proposed, including active involvement of researchers and policymakers and the requirement of a process to ascertain the implementability of good examples in the specific project site and support education for implementation in other sites (Lindencrona, Ekblad and Johansson Blight 2006).

Fifth, while a specific role can be devised for politicians and policymakers in facilitating the process of refugee resettlement support, it should be emphasized that integration must always involve the whole population. A better understanding of the
factors and actors that can lead to each prioritized outcome can be derived from the Health Promoting Introduction Model. However, effective processes to build commitment for providing good opportunities to support refugee resettlement among local business, the general population and other actors need to be tested and studied in detail. An important part of this work involves realizing the interrelatedness of local authorities in a larger region, where each can support or impede the others in providing the right resettlement opportunities. Interlocal collaboration in larger regions is a strategy that can help overcome several of the problems of limited capability for variation in service provision in local authorities with a small refugee reception.

8.5.3 Implications for practice

While the political arena and other actors at the local, regional and national levels have an important role to play in providing the opportunities for high-quality refugee resettlement support, the everyday environment for refugees and other immigrants of the Introduction is a key to a successful process. The practical implications of the research in this thesis are many, varied and often interrelated with those portrayed in the last section.

First, the need for a resource focus and active processes to motivate agency can be specified in policy, but to be of much use this needs to be imbued in daily practice. The requisite change is a movement from an expert-client relationship, where one party (the professional) knows and the other asks for advice and solutions, to a consultant relationship where two people with different responsibilities and competences try to find and define what already exists and can be built on, what additional steps are necessary and what goals should be addressed. Professionals need to be able to navigate the health promotion spiral and find the appropriate position of each participant at every step until programme termination. The capacity among professionals to tune into and help each specific person to find out exactly what they need is a critical competency for dealing successfully with the diversity among programme participants. To reach this goal, an educational process may be needed in which professionals are encouraged to alter their perspectives and practice over some extended time.

Second, helping professionals to see and build the positive facilitators in the environmental system is critical. If outcomes, negotiated with the participants, are central for the service process, it will be easier to see which service combinations can be offered from different partners throughout the process. Third, this change needs to be supported by a real expansion of available service alternatives. Engaging the local network of actors and making all service options available and known to each professional and participant is an important first step in this process. Fourth, the local network should have a systematic process and structure in place for supporting network development, to work with the outcomes that can be derived from the national follow-up system.

Fifth, the Health Promoting Introduction Model is developed in order to be useful for systematic appraisals of local implementation and services processes in the local authority. The two interventions, goal forum and network development, described in detail in Chapter 7, illustrate how the model can help find sustainable interventions that
address critical areas in the services. The first intervention was motivated by the realization that the personal capacities of agency capacity, control and ability to relate could be critical for health and perhaps client outcomes. To reach these two outcomes, it was found that the primary setting quality that needed to be developed was agency motivation and this in turn seemed to be closely connected to multi-professional teams and methods for shared decision-making. Goal forum could provide a method for integrating methods for shared decision-making with multi-professional teamworking. This illustrates how both the intervention and the relevant measures for evaluation could be derived from the model. The same was true for network development, where the focus was on outcomes in employment and providing or getting access to a more varied set of services. The analysis showed that systematic collaboration between actors, such as employers for employment and healthcare for healthcare competencies, could be important for achieving critical outcomes. Future evaluations are needed to show whether this is correct.
9 ACKNOWLEDGEMENTS

Writing a thesis is like a roller-coaster ride with many ups and downs, bumps and sharp turns. At times the slope seems so steep that you are not certain you will ever reach the top. When the track turns downward, the reward is so great that you almost forget the earlier struggle. The ride has many turns and twists, some quite smooth, others that make you feel you are about to fall off. A safe arrival calls for seatbelts, brakes and other precautions. I want to thank all those who have accompanied me on this ride for the fun, excitement and safety you have provided. Thanks for encouraging me to continue by always assuring that after a tough climb, the track will eventually turn downhill and that the reward is worth the effort, which is something I have learned for sure.

First, I want to express my warmest thanks to my main supervisor, Associate Professor Solvig Ekblad, and my co-supervisor, Professor Edvard Hauff. Thanks Solvig for showing me the roller-coaster on our first project together at the Fittja Psychiatric Outpatient Clinic and my first academic presentation in that gigantic ballroom in New Orleans. Giving your inexperienced research assistant the opportunity to present your joint research project at a large international research conference only months after you have started to work together was just the first in a very long series of examples of your generosity and trust in the capacity of your students. Solvig have always provided both the basic necessities and the support, in terms of knowledge and inspiration, for me to test and develop my ideas. For practical reasons, my co-supervisor, Professor Edvard Hauff has been less involved in my project on a day-to-day basis, but I could not have completed the project without his support, his clear and precise ideas and the challenging questions he has raised. Each time I have discussed my project with Edvard, over the phone, via e-mail, in person in Stockholm or through his hospitality during my visits to Oslo, he has helped me to understand what I needed to do to solve the problems which arose during my sometimes rather complex research project. Dear Solvig and Edvard, thanks for your companionship, it has been a great ride!

After my half-time control, at which Professor Runo Axelsson was a member of the examination committee, I have been able to draw on Runo’s knowledge and experience. In Runo I have found an experienced Professor of Management who is willing to help me to condense my ideas about organizations, collaboration and other related issues into just what is necessary, not a single word more. I look forward to learning more from Runo’s gift of clarity and conciseness. Through Solvig I have also had the privilege to meet two great pioneers in the field of refugee mental health, Professor Richard Mollica from Harvard University and Professor Derrick Silove, University of New South Wales. They have both participated in our research group as foreign adjunct professors at Karolinska Institutet. During my visit to Harvard and Professor Mollica’s visits to Sweden, I have always enjoyed our long and exciting discussions about almost anything. Thanks Richard, it has been truly brilliant and I look forward to working with you in the future. Thanks Derrick for your encouragement and inspiration and the methodological ideas you have suggested for my research project. As you probably already know, your ideas have been a great inspiration for my thesis. I also want to thank Professor Bengt Arnetz and Judy Arnetz, PhD for suggesting the
QWC-questionnaire and the goal-forum idea as tools for the intervention studies. Thanks as well to Zachary Steel, University of New South Wales, for suggesting that I use path analysis, an important contribution to this field of research, and for showing me how to run them properly. In the early phases of the project, Jan-Olov Persson helped me as a consulting statistician; his close supervision really helped me in thinking about and applying statistics. Thank you, Jan-Olov. I also would like to thank the translators and language specialists that have helped me during the project. Mr Steve Wicks and Mr Patrick Hort have corrected my English, while Nael Toquan has translated the questionnaires into Arabic. Tuqan Tuqan has assisted with all the technical challenges involved in making a questionnaire into Arabic and Sorani. Tina Frankfeldt used her graphic design skills to make the cover picture. Thanks Tina!

Throughout the long period during which I have been engaged on this project I have been a member of the research group, Migration and Health, headed by Solvig Ekblad. This group is impressive in many ways. The variety of competencies, the many and varied fields in which people do excellent research, and the participation of people from at least three continents are just some of them. In my project’s lifetime the composition of the group has changed, often as a result of people becoming PhDs. Those with whom I have had the privilege of working include Catherine Abbo, Sofie Bäärnhielm, Masoumeh Dejman, Anna-Clara Hollander, Karin Hultman, Elly Okello, Pernilla Pergert, Paula Schmidt, Shervin Shahnaz, Maria Stålgren, Malin Svensson, Hans-Peter Søndergaard and Göran Roth. Separate mention is called for of Karin Johansson Blight as my fellow researcher on the project throughout these years. Karin, I still hold our intense discussion and questioning of each other’s work in high regard and as of critical importance for many insights and ideas in my research. Thank you! The research group has had excellent help throughout the years from two coordinators: Gunilla Andersson and Annika Byström. I wish to thank you both for your time with us and Gunilla in particular for graphic support and coordination of rather boring tasks in research administration. Throughout the project I have been employed by the Section of Psychiatry at Karolinska University Hospital/Huddinge, a section within the Department of Clinical Neuroscience at Karolinska Institutet. I thank Professor Jerker Hetta and other colleagues at the section and Gullan Rydén at the Department for help in many practical matters. Thank you! During the last year of my thesis, I have been part of the research group, Social and Forensic Psychiatry headed by Tom Palmstierna. Hope we can do some work in the future Tom! I also wish to thank all colleagues at the former Institute for Psychosocial Medicine, now the Stress Research Institute, Stockholm University, where my workplace has been throughout this project.

A large item in the research project, Strategies for a health promoting Introduction, but a smaller part of this thesis, is the work done in and together with seven local authorities in Sweden. This work took the greater share of my time for a couple of years; it was stressful at times but worth every second. When I think of the people I have had the privilege to meet and work with during the time I spent in the local authorities, I understand why things function in spite of limited budgets and many other challenges. I am very impressed by what you all do for refugees in the Introduction. Thank you for generously sharing your knowledge and expertise with me. I hope I will soon be able to show that the work we did together actually led to improvements for the
refugees. Thanks also to Else Berglund, Björn Colliander and the other policymakers in the project’s steering group.

Most of all I want to thank my wonderful wife Ulrika. Your humour and support, as well as your brilliant and sharp analyses and your beautiful designs have helped me to straighten out some of my sometimes very fuzzy ideas, and your commitment to us and our shared life projects is a source of great happiness. My clan also includes my parents, Hanne and Tomas, my bonus-parents, Gerti and Sture, my brother Peder, his wife Åsa and my fantastic nephews Jacob and David, and my three sisters, Lene, Josefin and Johanna, her husband Manni and their children Linus and Matilda. I also want to thank the Wachtmeister family for being so welcoming to me. To all my family and friends I just want to say thank you for being my greatest support in life.
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