Health in Sweden for asylum seekers and newly-arrived immigrants

NATIONWIDE IMPLEMENTATION OF INITIATIVES FROM THE FEASIBILITY STUDY ON POSITIVE HEALTH DEVELOPMENT FOR ASYLUM SEEKERS AND NEWLY-ARRIVED IMMIGRANTS
Foreword

As a part of a global world, Sweden is changing. We live in a country made up of new and established Swedes, with origins in different countries and cultures and with different knowledge.

In 2015, nearly 163,000 people applied for asylum in Sweden – compared with 29,000 in 2016. Municipalities and county councils have worked to provide accommodation, healthcare, education and employment opportunities for asylum seekers and newly-arrived immigrants.

Good health is fundamental for people coming to Sweden to achieve their full potential.

Many of the asylum seekers who come to Sweden have difficult experiences in their background. Trauma, torture and separation, insecurity and uncertainty, persecution and discrimination, as well as the length of the asylum process, can all have a negative impact on health. Anxiety, unease, difficulty sleeping and post-traumatic stress are more common than in the general population.

All newly-arrived immigrants are entitled to receive a medical examination, which places large demands on healthcare services both in terms of staff and logistics. Despite a strong increase in the number of medical examinations, not even half of the asylum seekers received a medical examination in 2014, and questions about mental health were often not addressed.

In autumn 2015, this prompted the Swedish Association of Local Authorities and Regions (SALAR) to seek funding from the Ministry of Health and Social Affairs for conducting a feasibility study to address illness among asylum seekers and newly-arrived immigrants. During the feasibility study efforts, the number of asylum seekers increased sharply and it became clear that there were large national needs for increasing knowledge and distributing it efficiently. We wanted to quickly increase capacity in the entire country and on all levels – from healthcare interventions for everyone to specialised psychiatric treatment.

This report describes what we have done regarding the nationwide implementation of training initiatives from the feasibility study in 2016, and we also present a successful training method for the training of trainers.

Stockholm, February 2017

Ing-Marie Wieselgren

Project Manager, Mission Mental Health
Table of Contents

Foreword ......................................................................................................................... 3
Summary ......................................................................................................................... 6
1. Introduction ............................................................................................................... 9
   1.1 Background ......................................................................................................... 9
   1.2 Purpose and goals of the “Health in Sweden” programme ............................. 10
   1.3 Framework of the report ................................................................................... 10
   1.4 Delimitations for this report .............................................................................. 10
2. Theoretical frame of reference ............................................................................... 11
   2.1 Migration stress before, during and after fleeing .......................................... 11
   2.2 Health promotion and illness prevention ......................................................... 12
   2.3 Support and treatment ..................................................................................... 12
3. Our method in brief .................................................................................................. 14
   3.1 Implementation model ..................................................................................... 14
   3.2 Preparation of course content ....................................................................... 14
   3.3 Training of trainers for rapid distribution ..................................................... 14
   3.4 Support for local coordinators ...................................................................... 15
   3.5 Dialogue and collaboration .......................................................................... 16
4. Actions ....................................................................................................................... 17
   4.1 Support for needs analysis and planning ....................................................... 17
   4.2 National training courses ............................................................................... 18
   4.3 Further development of the toolkit for the distribution of best practices .... 21
   4.4 Support for enhanced medical examinations .............................................. 22
   4.5 Support for implementation of the Asylum Healthcare Platform .............. 22
5. Results ....................................................................................................................... 24
   5.1 Increased understanding of working methods and materials ....................... 24
   5.2 Increased knowledge and awareness among staff ....................................... 24
   5.3 Online toolkit for best practices ................................................................... 26
   5.4 Improved medical examinations .................................................................. 27
   5.5 Implementation of the Asylum Healthcare Platform ..................................... 30
6. Outlook ....................................................................................................................... 33
   6.1 Continued pressure on systems .................................................................... 33
   6.2 More stringent refugee policies increase the risk of mental health problems .................................................. 33
   6.3 Various challenges associated with different phases of the asylum process .................................................. 33
   6.4 Flexibility and speed are key success factors ............................................... 34
   6.5 Identified areas for development .................................................................. 35
7. References ............................................................................................................... 38
Appendix A. Results of national needs analysis ......................................41
Appendix B. Description of the implementation of the programme .............51
B1. Programme management ........................................................................51
B2. Support for the county councils/regions .................................................54
B3. Development and implementation of national programmes ..................61
B.4 Development and connection to the Asylum Healthcare Platform ...........69
Appendix C. Number of registered participants per county council/region and national training module up to and including 3 February 2017 ..........73
Appendix D. Theoretical background and evidence ......................................74
Appendix E. ....................................................................................................79

Table of Figures
Figure 1. Training of trainers .........................................................................15
Figure 2. Representatives from operations who specified a need for reinforced measures for asylum seekers and/or newly-arrived immigrants (in Aug–Oct 2016) ..............................................................................................................................17
Figure 3. Promote, prevent, treat. Excerpts from the Training Catalogue 2017.19
Figure 4. Examples of training manual for trainers (Improved working methods for medical examinations) .................................................................................................20
Figure 5. Examples of how a tool is made available on the website (Culture- and language-specific health information) ..................................................20
Figure 6. Examples of distributable material ....................................................21
Figure 7. Registered participants per national training module up to and including 3 February 2017 (number). .................................................................24
Figure 8. Tools in the toolkit ............................................................................27
Figure 9. Number of asylum seekers and number of completed medical examinations, 2011–2016 ........................................................................28
Figure 10. Proportion of asylum seekers who have undergone medical examinations, 2010–2016 (two-year intervals) .................................................................29
Figure 11. Summary of the number of asylum seekers estimated to be waiting for a medical examination, per county council/region ................................30
Figure 12. Compilation connection status to the Asylum Healthcare platform in county councils and regions .................................................................32
Figure 13. Representatives from operations who specified a need for reinforced measures for asylum seekers and/or newly-arrived immigrants (in Aug–Oct 2016). .................................................................................................................................41
Figure 14. Programme Organisation for Health in Sweden ..............................51
Figure 15. Programme Plan for the Health of Sweden programme autumn 2016 .......................................................................................................................53
Figure 16. County councils and regions that conducted needs analyses ..........56
Figure 17. Illustration of the “train-the-trainer” dissemination methodology ....62
Figure 18. Most-viewed videos in Health in Sweden programme ........................63
Figure 19. Overview of courses in the Health in Sweden programme ..............66
Figure 20. Illustrative overview of how the platform can be used for production planning and monitoring .................................................................70
Figure 21. Technical description of the Asylum Healthcare Platform .............71
Figure 22. Views in the Asylum Healthcare Platform ........................................71

Health in Sweden for asylum seekers and newly-arrived immigrants
Summary

In June 2016, the government granted an application from the Swedish Association of Local Authorities and Regions (SALAR) to distribute results and methods nationally to achieve a positive health development among asylum seekers and new arrivals.

The objective of the effort has been to improve the quality of medical examinations, make it easier to identify needs and offer early intervention to prevent a negative development in health, especially regarding mental illness, and to improve the conditions for a rapid recovery and establishment in Sweden.

Health in Sweden – a national training initiative

To carry out this initiative, SALAR formulated the programme “Health in Sweden”. Focus for the programme has been to carry out a national training initiative to increase knowledge among healthcare staff to provide better interaction, support and care to asylum seekers and newly-arrived immigrants with a risk of or signs of mental illness.

The distribution methodology “train-the-trainer” was chosen to enable large-scale distribution in a short amount of time. Within the framework of the programme, the method was applied by county councils/regions appointing people who would attend national training arranged by SALAR. The participants had a commitment to distribute the content locally to other trainers and staff groups.

All county councils and regions participated in the training initiative

All county councils and regions participated in the training initiative. Of them, 17 county councils and regions conducted an initial needs analysis, with the aim of identifying needs for approaches, materials, training and supervision for customer service, support and care on various levels. The needs analysis indicated that most those questioned experienced needs at all levels.

Based on the needs analysis, the county council and regions formulated local distribution plans. The distribution plans stated a target for which units should participate in national training courses and how the knowledge should be spread further locally.

Between September 2016 and February 2017, 1,286 people participated in the national training courses, distributed over 14 different courses. The courses had such content as health information, health support, medical examinations, migration and mental illness for primary care, school health and specialist care, as well as efforts in the event of trauma. The participants’ average rating of the courses was 4.1 on a five-point scale.

The results are a national knowledge improvement – 6,243 people received training and a further 8,800 are planned to receive training in 2017

Based on estimates in the current status update from the county councils’ and regions’ distribution plans, at least 15,000 people will have received training in the scope of Health in Sweden in autumn 2016 and 2017.

- 6,243 people have already received training
  - 1,286 people received training in national courses
  - 4,957 people received training through local distribution of the courses
- At least 8,000 more people are planned to undergo training in 2017
235 people are registered for more national courses
8,600 people are planned to undergo training through local
distribution, 75 percent of them in spring 2017

Approaches, methods and support material that were identified during the
programme were compiled in an online toolkit. The tool bench targets staff who
meet asylum seekers and newly arrivals, managers and decision makers.

The number of medical examinations increased by 29 percent between 2015 and
2016. For the first time in several years, a break could be discerned in the trend in
the number of medical examinations in relation to the number of asylum seekers.
This combined with a lower number of asylum seekers means that most county
councils and regions perceived that they are in a phase of medical examinations at
year-end 2016. The quality of the medical examinations has also been improved
through stronger approaches, including templates and greater knowledge to identify
mental illness.

All county councils and regions were offered the possibility to join a national
platform for stronger management and follow-up of healthcare for asylum seekers,
the Asylum Healthcare Platform. Nine county councils and regions joined in
autumn 2016 and two more are planning to join in 2017.

A great deal of work has been done, but major challenges
remain

Continued challenges are expected in the next few years when the responsibility for
support and care efforts has shifted from the national government to municipalities
and county councils in connection with large groups shifting from being asylum
seekers to being recently arrivals.

Continued shifts in the rest of the world and in our own society mean that we must
continue to be prepared to review and adapt solutions based on the prevailing
situation. In conjunction with the Health in Sweden programme, we have shown
that it is possible to react quickly, prepare and act based on preliminary strategies
and adjust the course based on the obstacles and circumstances that come up along
the way.

With insight into the challenges that we are facing as a society, both from a
human and economic perspective, we believe that it is very important to
continue to invest in a good reception of asylum seekers and newly arrived
immigrants.

We also see a need to maintain what we have achieved to-date. Knowledge is a
fresh product and the training packages that have been developed need to be
continuously updated and distributed.

Our collective view based on having studied reports and knowledge
compilations over the situation of asylum seekers and newly arrived immigrants
in Sweden and experiences from county councils/regions, municipalities and
organisations in civil society shows that major needs for resource reinforcement
continue to exist, especially for competence improvement measures among
staff.

All county councils and regions participated in the training initiative

---

Health in Sweden for asylum seekers and newly arrived immigrants 7
All county councils and regions have participated in Health in Sweden

20 out of 21 county councils have analysed the need for improved working methods and interventions

- Completed needs analysis in cooperation with SKL
- Completed own needs analysis
- Planning to conduct needs analysis

~6000 people have been trained so far

~9000 additional people are scheduled to undergo training

=~15 000 people are trained!

9 county councils/regions are connected to the Asylum Healthcare Platform

11 tools
18 tools
80 tools

Health in Sweden for asylum seekers and newly-arrived immigrants
1. Introduction

1.1 Background

The rate of immigration to Sweden has increased for a long time, with a clear increase since the mid-2000s. In many county councils, regions and municipalities, there has therefore been a practice of adapting the operations to meet the needs of asylum seekers and newly-arrived immigrants. However, the level of preparedness was not developed to meet the substantial number of people who applied for asylum in Sweden in 2015 compared with earlier years (a doubling between 2014 and 2015, from 81,000 to 163,000 people). In many parts of the country, it resulted in a stressed situation in accommodation, school operations and healthcare.

In healthcare, a special challenge is handling the mental health of asylum seekers. Between 20 and 30 percent of asylum seekers who come to Sweden are estimated to suffer from mental illness. In some refugee groups, there is are indications that one out of three people suffers from severe depression or anxiety and/or displays symptoms that match post-traumatic stress disorder (PTSD). Another challenge in 2015 and 2016 was to be able to conduct a large enough number of medical examinations. The fact that number of asylum seekers decreased in 2016 means that the pressure to conduct medical examinations has decreased. At the same time, we are in a phase where the previous year’s asylum seekers have or are awaiting decisions on residence permits. This will probably entail a greater demand for healthcare efforts in the ordinary system as newly-arrived immigrants with residence permits have the same right to healthcare as citizens otherwise. The people whose asylum applications are turned down can also be expected to have extensive needs for care.

In October 2015, the government granted an application from the Swedish Association of Local Authorities and Regions (SALAR) to conduct a feasibility study with the aim of finding out if it possible to support a positive health development among asylum seekers and newly-arrived immigrants (S2015/06414/FS). The feasibility study was presented in March 2016 (Final Report, Positive health development among asylum seekers and newly-arrived immigrants). In June of the same year, the government granted SALAR’s application to nationally distribute results and methods from the feasibility study (S2016/04409/FS). The initiative was conducted with support from a central project office at SALAR (Mission Mental Health) under the working name Health in Sweden programme for asylum seekers and newly-arrived immigrants (hereafter Health in Sweden, HiS).

---

1 Statistics Sweden, 2017
3 Swedish Red Cross University College, 2016
4 In 2016, around 29,000 people applied for asylum in Sweden, which is the lowest number since 2009. In 2017, between 25,000 and 45,000 people are expected to seek asylum in Sweden. The decrease in 2016 can be partially explained by changes in Swedish legislation that have led to more difficult possibilities of family reunification and obtaining permanent residence permits. Other contributing causes are the refugee agreement between Turkey and the EU and reduced opportunities for asylum seekers to cross the borders in Europe. Swedish Migration Board, 2017b
5 SALAR, 2016d
6 SALAR was granted SEK 30,000,000 to carry out the initiative in 2016, of which 15,000,000 was to be distributed to county councils and regions. (S2016/04409/FS)
1.2 Purpose and goals of the “Health in Sweden” programme

The purpose of the programme has been (i) to improve the quality of the medical examinations that county councils are to offer all asylum seekers under the Health and Medical Service Act for Asylum Seekers, (ii) make it easier to identify needs and (iii) offer early intervention to prevent a negative development in health, especially regarding mental illness, and to (iv) improve the conditions for a rapid recovery and establishment in Sweden.

The objective of the programme has been to distribute results and methods that proved to be effective in the feasibility study (S2015/06414/FS), and to continue to gather good examples and make them available to the rest of the country.

Subgoals for the programme have been to:

1. Contribute to increasing the degree of implementation of medical examinations of asylum seekers and increasing the possibilities of identifying mental illness in conjunction with medical examinations
2. Ensure knowledge in all staff that meet asylum seekers and newly-arrived immigrants regarding migration stress, customer service, support and treatment for those affected by migration stress and related conditions.
3. Gather and make available good examples of tools, methods and approaches (for health promotion, illness prevention, early and specialised measures for mental health among asylum seekers and newly-arrived immigrants).
4. Implement the Asylum Healthcare Platform for planning and follow-up healthcare for asylum seekers care in all county councils and regions that have shown interest in joining.

Focus for the Health in Sweden programme has been to carry out a national training initiative to increase knowledge among county council and region staff to provide better customer service, support and care to asylum seekers and newly-arrived immigrants with a risk of or signs of mental illness.

1.3 Framework of the report

This report begins with the theoretical frame of reference that has formed the basis of the programme work (Chapter 2). This is followed by a brief description of method (Chapter 3), implemented activities to achieve the programme’s goals (Chapter 4) and the results of implemented activities (Chapter 5). The report is concluded with a prospective look at challenges and development areas in the future (Chapter 6).

Several appendices (A-F) belong to the main report. The appendices contain a detailed description of the programme work and delve deeper into some achieved results.

1.4 Delimitations for this report

A complete financial report is provided separately to the Legal, Financial and Administrative Services Agency according to the indicated form for final reports on 31 March 2017. A brief financial report is also available in the appendix.
2. Theoretical frame of reference

Research and tried experience regarding mental health of asylum seekers and newly-arrived immigrants have developed in recent decades. Consequently, the starting point for the work on the programme “Health in Sweden for asylum seekers and newly-arrived immigrants” has been that the reception and establishment shall be formulated with support in current research on conditions and needs of those who come to Sweden. Knowledge about mental health and what affects it needs to be held by everyone who works with the people who are asylum seekers and newly-arrived immigrants regardless of what role one has when meeting them.

The knowledge base used in the programme is mainly in four areas:

- Migration stress before, during and after fleeing
- Health-promoting and preventive efforts for children and young people
- Support and treatment
- Implementation close to day-to-day activities

A summary of key efforts in these four areas is provided below.

2.1 Migration stress before, during and after fleeing

Mental illness that arises in connection with flight can in basic terms be understood as a reaction to one or repeated traumatic events and/or exposure to long-term stress. This negative stress is usually associated with the situation that caused a flight, such as war and persecution, but research shows that circumstances during and after the flight are also important to triggering or reducing the risk of illness. Reducing stress factors after migration is therefore of major importance so that people in flight will not develop mental illness.

Stress factors before, during and after fleeing:

*Before* What gives rise to the migration, such as violence and unrest in one’s home country, war or persecution for ethnic or political groups.

*During* Material and personal losses. Traumatic experiences. In flight that lasts a long time, sexual abuse of women and children is common. It is not uncommon to have spent an extensive amount of time in a third country, in a refugee camp for instance. Insecurity and difficult circumstances during the asylum process also entail significant risks to mental health.

*After* Stress factors after the flight include the responsibility to live up to one’s own and one’s family’s expectations, the (im)possibility of seeing relatives again, living with their absence and loneliness, social alienation (i.e. being viewed as and feeling different and losing roles and status) and exposure to threats and violence. The wait for an asylum decision entails continued uncertainty and the clear majority live in a high-pressure situation, socially and economically. Decisions on permanent residence permits can also be linked to stress, going from a “state of emergency” to the reality of having to rebuild one’s life.

---

7 L. Kirmayer 2011
2.2 Health promotion and illness prevention

Symptoms such as anxiety, worry, depression, psychosomatic symptom, sleeping and concentration difficulties or acting out are common. But not everyone is traumatised or develops post-traumatic stress disorder (PTSD). The ability to master the situation can reduce the negative effects of risks. To be able to master the situation, it is of utmost importance to be able to maintain or re-establish a feeling of context and control.

Conditions for a health promoting reception can improve if:

- All actors around the asylum seekers and newly-arrived immigrants have a common frame of reference for understanding stress, risk and protection during the various phases of the migration process.
- Asylum seekers and newly-arrived immigrants are provided adequately formulated information (for example about how Swedish society works, the asylum process, the right to healthcare, children’s rights and fundamental social codes).
- The reception is structured to strengthen the perception of
  - Comprehensibility (what is happening and will happen? what reactions can I expect?). Providing knowledge about normal reactions to stress and health-promoting self-care (sleep, food, exercise and stress reduction). Showing kindness to the surroundings and listening.
  - Meaningfulness (what is happening to me is worth getting involved and is it possible to understand how it will help me?) A possibility of employment.
  - Manageability (I have access to resources to handle the situation I am in). A good, predictable accommodation situation. Receiving recognition for one’s strengths and abilities, encouragement and support for constructive problem resolution strategies.

2.3 Support and treatment

Adaptation of methods with knowledge and awareness concerning the exceptional circumstances of asylum seekers and newly-arrived immigrants

Elevated risk factors and fewer protective factors before, during and after migration increase the risk of mental illness. Within the group of asylum seekers and newly-arrived immigrants, there are also people with a vulnerability to psychiatric disorders that is elevated due to other reasons.

Research indicates that the same methods that are used to assess and treat mental illness of a corresponding nature among other groups are often valid among asylum seekers and newly-arrived immigrants. However, to provide the best effect, the methods must often be adapted with knowledge and awareness of the exceptional circumstances of asylum seekers and newly-arrived immigrants. This means that support and care should be provided in consideration of:

---

9 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases; 2015.
10 Lindencrona, 2008
11 EPA, 2014
12 Kirmayer et. al. 2011
13 Kirmayer et. al. 2011
- differences in approaches for seeking care and other expectations in the patient-care provider relationship
- differences in expressing mental health and the occurrence of stigma
- cultural and linguistic differences
- the practical situation regarding e.g. accommodation, finances, loneliness and limited social networks

**Adequate conditions should be able to be provided for support and care**

Research and well-tried experience point to seven prerequisites for being able to adequately provide support and care to asylum seekers and newly-arrived immigrants:

| Use of interpreters | The staff needs to develop good skills in working with interpreters. Specially trained medical interpreters should be used in talks with patients.  
14 |
|---------------------|---------------------------------------------------------------------------------------------------------------|
| Collaboration       | Collaboration between several different actors is a prerequisite for a good reception. The state, county councils/regions, municipalities, the private sector and civil society must collaborate for a successful reception.  
15 |
| Knowledge about diverse groups | Different conditions such as status (asylum seeker, newly-arrived immigrant), gender, level of education, previous living circumstances, etc. need to be taken into consideration in the planning of treatment  
16 |
| Psycho-pedagogical support and support materials | Healthcare services need access to descriptive materials on PTSD and depression, translated and validated questionnaires, etc.  
17 |
| Assessment (triaging) | Knowledge of indicators of chronic, serious or acute conditions that require immediate or rapid follow-up needs to be possessed by everyone who is assessing the health status of refugees. There also needs to be rapid and secured referral channels for this group to emergency psychiatric assessment and treatment.  
18 |
| A well-prepared and structured patient meeting | A lack of trust in figures of authority and cultural differences in the patient-care provider meeting are special challenges for creating a good climate for discussions on stress and psychological problems. Well-tried experience shows that some difficulties can be prevented by taking this into account. |
| Good and safe care | Relevant treatment efforts to an adequate extent for the current needs. |
| Implementation close to day-to-day activities | Efforts for asylum seekers and newly-arrived immigrants should to the fullest extent possible be carried out in the everyday settings. This may, for example, be in connection with preschool/school, at the accommodation facilities or in connection with language training and occupational placement.  
19 Building capacity in primary care (sometimes called the first line of care) is valuable since primary care is perceived as natural place for talking about all types of health issues and it is a familiar level of care for many people around the world.  
20 |

---

14 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases; 2015.
15 Government Offices of Sweden, 2016
16 UNHCR, 2015
17 Pottie, 2011; EPA 2014
18 Pottie, 2011; EPA, 2014; Kirmayer et al., 2011; U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Emerging and Zoonotic Infectious Diseases, 2015.
19 Pottie, 2011; EPA, 2014; Kirmayer et al., 2011; U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Emerging and Zoonotic Infectious Diseases, 2015.
3. Our method in brief

3.1 Implementation model

The method for implementing the knowledge improvement of the programme has been to (1) work based on regional and local needs for competence and support, (2) match the needs with identified sources of knowledge, methods and tools and (3) distribute the requested knowledge through training and support materials and the website for Mission Mental Health, www.uppdragpsykiskhalsa.se.

1. Needs analysis
To create training packages adapted to the specific needs of every county/region, all county councils/regions were offered support to conduct an analysis of competence strengthening needs in terms of asylum seekers and newly-arrived immigrants. The analysis comprised health promotion and illness prevention efforts, efforts in the event of mild mental illness and efforts in the event of moderate and severe mental illness. The needs analysis was done with the support of an online survey (see Appendix E. Form for needs analysis) that is completed by the county council’s/region’s appointed operations representative.

2. Planning
Using the needs analysis, every county council/region is offered support in formulating a local distribution plan. The plan indicated what parts of the programme the county council/region would receive and how the programme should be spread locally.

3. Training and distribution
According to the plan, appointed people received training in the courses and spread that knowledge locally to other trainers and staff groups.

3.2 Preparation of course content
The courses were developed based on successful approaches that were identified in county councils, regions and other principals and with support of experts from, among others, the Transcultural Centre, the Swedish Red Cross and Save the Children, researchers from Karolinska Institutet, Uppsala University, Linköping University, the National Board of Health and Welfare and the Public Health Agency of Sweden. Most of the course content was prepared in the scope of the feasibility study, but some new development was done to meet some of the needs of the county councils and regions.

3.3 Training of trainers for rapid distribution
The dissemination methodology of “train-the-trainer” was chosen to enable large-scale distribution in a short amount of time. In the scope of the programme, the method was applied by the county councils and regions appointing the people who would be trained in the national training with a commitment to spread the contents locally to other trainers and staff groups.

A key part of the structure of the courses was to give the participants the conditions to easily convey knowledge and tools at the local level. Besides the factual content, the training participants were, therefore, able to study manuals and speaker notes to themselves be able to pass on the factual content. Manuals
(including detailed cue sheets) and speaker notes were prepared in two versions, one for the training of trainers and the other for the training of staff groups. Many modules included filmed lecture sequences that can be presented during local training sessions. Trainers were also offered the possibility of participating in webinars broadcast live to get practice on and news about the materials, and tips on how it can be used for distribution.

All material prepared in Health in Sweden is available for free on the Mission Mental Health website, www.uppdagpsykiskhalsa.se.

Figure 1. Training of trainers
Excerpts from Course catalogue 2017. Courses offered in the programme Health in Sweden for asylum seekers and newly-arrived immigrants (SALAR, 2017)

Our model
We offer a number of courses with different content. The goal is to train trainers who can pass knowledge on to staff who meet asylum seekers and newly-arrived immigrants.

In addition to the national training sessions held in 2016, we are again holding our most popular courses in spring 2017. Independent teaching materials belong to all national courses that make it easy to pass on the knowledge locally.

We train you – You train others
Our courses and support materials give you knowledge and tools you can use yourself in your work, but above all, you are given tools to train others.

You do so by yourself holding courses in your organisation. To enable to the greatest possible spread, we have prepared support materials for training other trainers and support materials for those who will train staff groups directly.

We are also available as support along the way.

3.4 Support for local coordinators
County councils and regions that accepted the offer to participate in the programme received government funding to make it possible to free up time for a local coordination function. In this role, the coordinator has received operational support from the programme office in the form of guidance documents and continuous e-mail and phone support. For a more detailed description of the operational support for county councils and regions, please see Appendix B2. Support for county councils/regions.
The coordinator’s role has been to keep together the processes in the organisation and work to strengthen the collaboration between county councils/regions and other actors in the county that work together on the target group of asylum seekers and newly-arrived immigrants.

3.5 Dialogue and collaboration

For asylum seekers and newly-arrived immigrants to be given a coordinated and effective support, good collaborative formats are necessary, between authorities within the state, between the state, municipality and county council, and between the public, private and NGO sectors. Within the scope of the programme, Mission Mental Health and SALAR collaborated with authorities\(^\text{21}\), county administrative boards, volunteer and civil society organisations and other actors\(^\text{22}\) that work with the mental health of asylum seekers and newly-arrived immigrants. Internationally, the programme has participated with the UN refugee body IOM\(^\text{21}\).

For more information on collaboration within the scope of the programme, see Appendix B1. Programme management.

---

\(^\text{21}\) Among others, the National Board of Health and Welfare and the Public Health Agency of Sweden have on-going government assignments concerning the health of asylum seekers and newly-arrived immigrants, such as the National Board of Health and Welfare’s assignment “Assignment to conduct an analysis of healthcare and dental care for asylum seekers and newly-arrived immigrants”, “Assignment regarding the reception of asylum seekers and newly-arrived immigrants” and “Assignment due to the increased reception of unaccompanied minors, etc.”, their joint assignment “Support for the implementation of medical examinations” and the Public Health Agency’s assignment “Suicide prevention 2016”.

\(^\text{22}\) For example, the healthcare guide service 1177 Vårdgivarguiden, regarding a needs and target group analysis for translations on 1177.se

\(^\text{23}\) Conference calls with the Re-Health project, about the pilot project on Personal Health Record, the European health journal for migrants.
4. Actions

All county councils and regions have participated in the Hälsa i Sverige (Health in Sweden) programme. The following activities have been implemented under the programme in autumn and winter of 2016, and in some areas during spring 2017.

4.1 Support for needs analysis and planning

Needs analysis

In autumn 2016, all county councils and regions were offered support for conducting a local needs analysis to identify skills enhancement needs regarding asylum seekers and newly-arrived immigrants. Of these, 17 county councils and regions accepted the offer. Three county councils and regions had recently conducted their own needs analysis and used these as the basis for compiling a local needs assessment. One region chose to wait before conducting a needs analysis, in order to first assess the extent, and in what form, such an analysis would be relevant for the region.

The needs analysis conducted by the 17 county councils and regions under the programme used an online form as its basis, which was filled in by county personnel designated by the coordinator. A total of 310 people completed the online form, with broad representation across various areas of operation. The overall assessment presented clear needs at all levels, see Figure 2.

Figure 2. Representatives from operations who specified a need for reinforced measures for asylum seekers and/or newly-arrived immigrants (in Aug–Oct 2016)

<table>
<thead>
<tr>
<th>Severe mental illness</th>
<th>Average percentage of reported need</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Offer services</td>
<td>47%</td>
</tr>
<tr>
<td>2) Educate personnel</td>
<td>66%</td>
</tr>
<tr>
<td>3) Guidance to personnel (tutoring)</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mild to moderate mental illness</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Offer services</td>
<td></td>
</tr>
<tr>
<td>2) Educate personnel</td>
<td></td>
</tr>
<tr>
<td>3) Guidance to personnel (tutoring)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health promotion/prevention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Materials and methods to give health information</td>
<td>75%</td>
</tr>
<tr>
<td>2) Materials and methods to conduct health exams</td>
<td>31%</td>
</tr>
<tr>
<td>3) Offer promotive and preventive care</td>
<td>63%</td>
</tr>
<tr>
<td>4) Educate personnel on migration and effects on mental health</td>
<td>75%</td>
</tr>
</tbody>
</table>

---

24 For example, primary care, specialist psychiatry, the Swedish Public Dental Health Service and integration units. Many of the respondents were operations managers, unit managers and department heads.


26 Average (mean of the average of the 17 county councils and regions that participated in the programme’s needs survey).
The needs analysis shows that the majority of the people surveyed experienced a need for promotion and prevention activities as well as for response measures for mild, moderate, and severe mental illness. Most respondents indicated a need for further promotion and prevention efforts, specifically: “training for staff on migration and mental health” (78 percent) and “materials and working methods for providing health information” (75 percent). The areas with the lowest proportion of respondents reported that they had a need for: “reinforcement for conducting medical examinations” (31 percent) and “interventions for severe mental illness” (47 percent). Over 60 percent named requirements concerning “staff training in mild, moderate, and severe mental illness among asylum seekers/newly-arrived immigrants”. For a more detailed summary of the needs analysis see Appendix A. Results of national needs analysis.

Distribution Plans

The needs analyses also served as a basis for planning and establishment of the training initiatives locally. Based on a needs analysis, county councils and regions designed local knowledge distribution plans specific to local conditions. In the distribution plans, an objective was presented for the operations that would take part in which training initiatives as well as the approximate number of people per operation targeted for participation in each course. The distribution plan also included suggestions for trainers – those who would participate in national training programmes and be responsible for implementing the local distribution of the courses. The distribution plans have been dynamic documents, as conditions in the county councils and regions have shifted over time.

Various models for distribution were selected. Some county councils and regions chose to send a larger number of people to attend the national training courses who undertook smaller distribution assignments while others sent a small number who undertook major distribution assignments.

4.2 National training courses

There were 14 different types of courses developed (see Figure 3) to meet some of the requirements identified during the needs analysis. The courses were held with two different tracks:

- Ten courses were held during August and October 2016 in a “fast track” for the county councils and regions who opted to start training and distribution parallel with needs analysis and planning.
- The main period of the national training courses was from November to December in 2016. There were 16 national training courses held then, of a total of 28 courses so far.  

---

27 As of 17 February 2017
Courses offered within the Health in Sweden programme for asylum seekers and newly-arrived immigrants (SKL, 2017)

The courses we offer can be categorised based on the types of interventions for mental health offered – health promotion and prevention, interventions for mild conditions and interventions for moderate to severe mental illness.

To some extent, the division reflects the way healthcare interventions are organised in Sweden. Formally, health promoting initiatives are offered in the context of public health, interventions for mild problems by primary care and interventions for severe mental illness by specialist psychiatry or similar operations. In practice, however, there is often overlap between the duties of the various levels of healthcare. Interventions provided by primary care or specialists can, for example, have promotion and prevention components, such as by providing orientation information on how Swedish healthcare works.

- **Introductory training on trauma among asylum seekers and newly-arrived immigrants** (Code HiS7)
- **Lifespan Integration – method for PTSD and traumatic memories** (Code HiS8)
- **Migration and mental health – FOR SPECIALIST PSYCHIATRY** (Code HiS11)
- **Health Support – method for maintaining health support groups for asylum seekers and newly-arrived immigrants** (Code HiS2B)
- **Introductory training on trauma among asylum seekers and newly-arrived immigrants** (Code HiS7)
- **Lifespan Integration – method for PTSD and traumatic memories** (Code HiS8) *
- **Migration and mental health – FOR PRIMARY CARE** (Code HiS9)
- **What the entire organisation should know! Tools for improved reception of asylum seekers and newly-arrived immigrants** (Code HiS1)
- **Culture- and language-specific health information** (Code HiS2A)
- **Finding your way – supporting unaccompanied youth** (HiS3)
- **Newly-arrived immigrants as a resource** (Code HiS4) *
- **Improved working methods for medical examinations** (Code HiS5)
- **Migration and mental health – FOUNDATION COURSE** (Code HiS6)
- **Introductory training on trauma among asylum seekers and newly-arrived immigrants** (Code HiS7)
- **Migration and mental health – FOR STUDENT HEALTH** (Code HiS10)
- **New methods for leading group activities and change efforts** (Code HiS12)

* Only direct training, i.e. not the training of trainers
Figure 4. Examples of training manual for trainers (Improved working methods for medical examinations)

Figure 5. Examples of how a tool is made available on the website (Culture- and language-specific health information)
Methodological support to maintain health information matches (Tigrinja)

Film about the nurse’s role (Somali) in course “Culture- and language-specific health information (HiS2A)”

Film about the state of knowledge about the mental health of refugees by Anna-Clara Hollander, MD., licenced psychologist, postdoctoral fellow in the Department of Public Health Sciences, Karolinska Institutet, under the programme “Migration and mental health – for primary care (HiS9)”.

All materials can be found on the programme’s website and are available for download.

4.3 Further development of the toolkit for the distribution of best practices

During the programme period, the feasibility study’s toolkit function was improved and further developed to be more useful, including an improved search and filtering function based on need and target audience. See toolkit,
4.4 Support for enhanced medical examinations

In 2016, SKL worked at the national level, as part of the feasibility study and programme work, to help improve conditions for county councils and regions to meet the need for medical examinations. The programme has compiled, developed and distributed existing good examples of working methods and materials for increasing the proportion of individuals who undergo medical examinations, as well as ensuring that implementation and monitoring of the examinations is conducted in a high-quality, timely and resource-efficient manner.

For example, the programme has distributed previously compiled material on medical examinations from the Adlon Group and the Public Health Agency of Sweden, translated the information into languages that are common among asylum seekers and compiled successful strategies and methods that have been applied by county councils. A particular focus area has been to provide enhanced models and knowledge to improve the identification of mental illness in medical examination. Examples of successful strategies and methods also include improved health information for medical examination, working methods for enhancing the patient admission process as well as innovative approaches to increase the capacity and efficiency of mobile teams and weekend clinics.

Materials and working methods are distributed mainly through the free course HiS5. Reinforced approach to medical examinations, which aims to train people who can engage in systematic development efforts linked to medical examinations locally.

The programme also took the initiative to develop more efficient methods for identifying mental health problems in asylum seekers and newly-arrived immigrants in conjunction with medical examinations or regular health visits to primary care. The aim is to strengthen the identification of mental health problems through the development and evaluation of tools and methods and implement them in collaboration with the County Council of Uppsala in spring and summer of 2017.

4.5 Support for implementation of the Asylum Healthcare Platform

All county councils and regions have received support to facilitate connection to the Asylum Healthcare Platform. This support has included the project leadership in the form of guidance documents and email, telephone and Skype meetings as well as technical assistance concerning communication and validation of data entry and technical issues.

To best take advantage of the connection, all connected counties and regions also offered local course sessions. During these sessions, trainers from SKL, together with the respective county/region, go through how the Asylum Healthcare Platform can be used in the operational work to contribute to better planning and monitoring of healthcare for asylum seekers. From this training, a plan is developed for the information contained in the Asylum Healthcare Platform to be used and distributed within the organisation. Four counties have

---

28 SKL, 2016d
so far²⁹ undergone training with about 10–12 participants each. Three county councils and regions are scheduled for spring 2017 and two more are currently planning the course sessions.

²⁹ As of 25 February 2017
5. Results

5.1 Increased understanding of working methods and materials

In a follow-up survey in February 2017, 76 percent of healthcare managers in the 17 participating counties/regions said the needs analysis under the programme “Health in Sweden for asylum seekers and newly-arrived immigrants” increased understanding of the county council’s/region’s needs for working methods and materials for improving care and services for asylum seekers and newly-arrived immigrants with a focus on mental health.

5.2 Increased knowledge and awareness among staff

The programme has led to increased focus on the issue of interventions to prevent mental illness among newly-arrived immigrants. Staff who work with the issue said they have experienced a boost in how the work efforts are being conducted as well as an increase in knowledge within the area, although major needs remain.

Participant statistics

Between September 2016 and February 2017, 1,286 people (of which, 961 in 2016) participated in the national training sessions held in Stockholm (distributed across 14 different courses, “modules”, altogether held as 28 sessions). All county councils and regions have participated in the national training programme.

Figure 7. Registered participants per national training module up to and including 3 February 2017 (number).

<table>
<thead>
<tr>
<th>Course code</th>
<th>Training module</th>
<th>Registered participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>HiS1</td>
<td>What the entire organisation should know!</td>
<td>55</td>
</tr>
<tr>
<td>HiS2</td>
<td>Health information and support for asylum seekers and newly-arrived immigrants</td>
<td>118</td>
</tr>
<tr>
<td>HiS3</td>
<td>Finding your way – supporting unaccompanied youth (HiS3)</td>
<td>296</td>
</tr>
<tr>
<td>HiS4</td>
<td>Newly-arrived immigrants as a resource</td>
<td>35</td>
</tr>
<tr>
<td>HiS5</td>
<td>Improved working methods for health surveys</td>
<td>56</td>
</tr>
<tr>
<td>HiS6</td>
<td>Migration and mental health – FOUNDATION COURSE</td>
<td>236</td>
</tr>
<tr>
<td>HiS7</td>
<td>Trauma interventions for asylum seekers and newly-arrived immigrants</td>
<td>39</td>
</tr>
<tr>
<td>HiS8</td>
<td>Lifespan Integration – method for PTSD and traumatic memories</td>
<td>20</td>
</tr>
<tr>
<td>HiS9</td>
<td>Migration and mental health – FOR PRIMARY CARE</td>
<td>93</td>
</tr>
<tr>
<td>HiS10</td>
<td>Migration and mental health – FOR STUDENT HEALTH</td>
<td>152</td>
</tr>
<tr>
<td>HiS11</td>
<td>Migration and mental health – FOR SPECIALIST PSYCHIATRY</td>
<td>58</td>
</tr>
<tr>
<td>HiS12</td>
<td>Leading group activities and change efforts in conjunction with new working methods</td>
<td>42</td>
</tr>
<tr>
<td>HiS13</td>
<td>Forum on mental health for managers and decision-makers: The right action at the right time, at the right level</td>
<td>51</td>
</tr>
<tr>
<td>HiS14</td>
<td>Health School</td>
<td>35</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td></td>
<td><strong>1286</strong></td>
</tr>
</tbody>
</table>

30 The number is based on the number of registered participants in the period 6 September 2016 – 3 February 2017. See the representation of the different counties in Appendix C. Number of registered participants per county/region, and course
All training materials are openly available on the Mission Mental Health’s website on the page “About our programmes”. During the programme period (1 July 2016–31 January 2017) this page had 4,684 page views (of which, 3,291 unique visitors).

88 percent of participants have been active in the counties/regions, 12 percent involved in municipal activities (primarily residential staff and student health) authorities and civil society.

On average, 55 percent of respondents stated that they have been commissioned to further distribute the courses.

**Review of the training courses**

The participants’ evaluations of the course sessions have been positive. The participants’ average rating for the training was 4.1 on a scale of 5.

In a survey of the county council healthcare directors (in the 17 counties that participated in the programme in its entirety, including completed needs analyses) two-thirds said the county council/region experienced significant or very significant benefit from the programme. Comments from the healthcare directors included that the initiative was appreciated and in-demand, the programme has contributed with a good review of the work with the target group, led to discussions about the organisation and coordination efforts, and helped the county councils and regions with “focus and perseverance”.

In a survey of the county council healthcare directors (in the 17 counties that participated in the programme in its entirety, including completed needs analyses) two-thirds said the county council/region experienced significant or very significant benefit from the programme. The coordinators highlight advantages such as receiving a knowledge bank of experiences, working methods and materials, and that staff have been given the opportunity to exchange different experiences when meeting at the training sessions.

**Local distribution of educational content**

Local distribution efforts were initiated by a number of county council and regions in parallel with, or directly after, participation in the national programmes in autumn, 2016. During the first quarter of 2017, distribution at the local level has intensified. The leaders of the distribution efforts who participated in the national training programmes in Stockholm organise the local courses, both for trainers and staff groups. Implementation of the local courses is based on the county council’s/region’s overall distribution plan that was prepared based on the results of the initial needs analysis.

The programme office will continue to support the local distribution efforts during the first quarter of 2017, through supporting coordinators in county councils and regions by monitoring and compiling the comprehensive results of the distribution efforts. In addition, further course sessions will be held with certain in-demand national courses. These participants will then also implement local distribution efforts.

Based on the status of the distribution plans of the county councils and regions, at the time of this reporting the training initiatives will have resulted in the following:

---

31 Of the remaining respondents, 20 percent said they did not know how beneficial the programme had been; one said that it was too early to assess the benefits and that he/she had no view, having just recently been assigned to the position.

32 Of the respondents, 6 percent said they did not know. Of the coordinators, 18 percent commented that they had been conservative in their assessment of the benefits because the local distribution is still at an early stage.
At least 15,000 people in total will have been trained under the initiative in autumn of 2016 and 2017 if the local distribution efforts go as planned. 33

- At least 6,243 people have already been trained
  - 1,286 people have participated in national training courses
  - 4,957 people have participated via local distribution of the courses
- At least an additional 8,800 people are scheduled to participate in courses in 2017
  - 235 people are registered for further national training courses34
  - 8,600 people are scheduled to undergo training through local distribution, 75% of these during spring 201735

The number of people who have completed training and are scheduled to undergo training locally is likely even higher in practice; it has been assessed that not all the distribution is included in the reporting.

About half of the people trained locally take part in a training programme that combines several of Health in Sweden’s training initiatives, while the other half take part in a training programme in accordance with a nationally-developed format. Of those taking part in courses in accordance with a nationally developed format, around one-fifth participate in “What the organisation should know!” (HiS1), around one-fifth in “Migration and mental health – for primary care” (HiS9) and around one-sixth in “Migration and mental health – Foundation Course” (HiS6).

In addition, several county councils and regions also distribute educational material, especially from the course “What the organisation should know!” (HiS1) by posting on their websites, through mass mailings and printed brochures, etc.

Further continued distribution is also expected through self-education via the website. This self-education provides both new participants and those already trained with an update and/or continued advancement of their knowledge.

### 5.3 Online toolkit for best practices

In addition to training courses, the techniques, methods and support materials identified during the programme are compiled in a web-based toolkit. The toolkit is aimed at staff who meet asylum seekers and newly-arrived immigrants, managers and decision-makers.

33 Registration statistics for national training courses on 14 February 2017, and local distribution plans for all county councils and regions in Sweden at the time of reporting 10 February 2017. In Stockholm, local distribution consists of participation in the Trans-Cultural Centre’s courses that correspond with the training initiatives of Health in Sweden. Of those who have completed training and are scheduled to undergo training locally, about 15 percent are asylum seekers and newly-arrived immigrants. These will predominantly participate in courses that focus on self-help such as Hälsovård (Health Support) and Hälsoinstitutet (Health School).

34 As of 14 February 2017 (before the registration was opened for training on suicide prevention in March 2017)

35 The distribution in 2017 is scheduled as follows: 75 percent in spring, 2 percent in autumn, 11 percent distributed over the entire year. For 13 percent, distribution has not been scheduled for a specific time of year.
The toolkit has 95 tools\textsuperscript{36}, of which 80 are categorised as Promotion or prevention, 18 as Interventions in mild to moderate mental illness and 11 as Interventions in moderate to severe mental illness. The tools can be applied to more than one needs level.

The toolkit comprises both those developed under the feasibility study/programme in collaboration with county councils and regions and/or experts, and tools from other development efforts and/or those that other organisations have chosen to share. For each tool, contact information is provided for the organisation/company responsible for the material.

The toolkit is an integral part of all training programmes but also an autonomous function. The toolkit had nearly 3,000 page views between July 2016 and February 2017.\textsuperscript{37} The feedback from training participants and coordinators has expressed that the toolkit is a readily available source of knowledge with a large amount of good material, activities and approaches.

5.4 Improved medical examinations

One of the objectives of the programme has been to help increase the rate of implementation of medical examinations for asylum seekers and to increase the chances of identifying mental health problems related to medical examinations.\textsuperscript{38}

Between 2011 and 2015, the number of medical examinations increased threefold, from 15,910 to 64,051.\textsuperscript{39} As the number of asylum seekers increased fourfold over the same period, the ratio between the number of asylum seekers in a year and the number of medical examinations in the same year dropped from 54 percent in 2011, to 39 percent by 2015.\textsuperscript{40}

Increased implementation 2016

In total, about 82,863 medical examinations were conducted in 2016 according to reported data from county councils and regions. This represents an increase

\textsuperscript{36} As of 17 February 2017

\textsuperscript{37} During the period 1 July 2016–31 January 2017, there were 2,853 page views by 1,860 unique visitors.

\textsuperscript{38} The County Council will, unless it is clearly unnecessary, offer asylum seekers a medical examination (Law 2013: 407). Newly-arrived immigrants can also be offered a medical examination if they have not received one as an asylum seeker. The survey aims to identify health risks, infection-related risks and healthcare needs. The Public Health Agency of Sweden and the National Board of Health and Welfare reported in May 2016 that the planning, implementation and monitoring of medical examinations needs to be improved (Public Health Agency, National Board of Health and Welfare, 2016).

\textsuperscript{39} SKL. 2016b; SKL 2016c. Number of medical examinations conducted, based on the medical examinations for which county councils and regions have received state compensation.

\textsuperscript{40} Note that statistics at the national level take into account whether asylum seekers arrived in the same year as they underwent a medical examination. This entails that the calculation of the proportion of asylum seekers who have undergone a medical examination in a single year is of limited relevance, especially during the years when the number of asylum seekers increases considerably.
of 29 percent in medical examinations over the previous year. There are more people who received a medical examination than who applied for asylum in 2016, because the largest number of asylum seekers came to Sweden in late autumn 2015, and medical examinations for this group were, therefore, conducted extensively during 2016.

Figure 9. Number of asylum seekers and number of completed medical examinations, 2011–2016

One way to show how the number of completed medical examinations in relation to the number of asylum seekers has evolved over time, is to look at trends over a two-year period. This way better addresses changes in the number of asylum seekers occurring near the turn of the year. As shown in the figure below, the percentage of asylum seekers who have received a medical examination almost doubled between the period 2014–2015 to 2015–2016, from 41 percent to 77 percent.
Increased ability to identify mental illness

The programme has helped increase the chances of identifying mental illness in medical examinations by distributing enhanced models and knowledge about mental illness to 319 people. Additional local distribution is planned in the near future for another 180 people. Therefore, in spring 2017, there will be at least 500 people working with improving working methods for mental illness in medical examinations in 14 county councils and regions.\(^{41}\)

County councils/regions perceive that they are now in phase with the need for medical examinations

At the turn of the year 2016/2017 the county councils and regions determined that they are in phase with the need for medical examinations. An estimated total of about 8,000 people are waiting for a medical examination.\(^{42}\) The highest number reported is in Skåne Regional Council (about 3,500), while in ten county councils and regions, fewer than 100 are waiting. Some uncertainty exists in the data on the number of people waiting. In talking to county councils and regions, the most significant sources of uncertainty are: absence of adequate search and filtering features in the current technical systems, variation in recording practices among healthcare providers and a limited ability to track medical examinations conducted in other counties or regions.

\(^{41}\) Registration statistics for national training courses on 14 February 2017, and local distribution plans for all county councils and regions in Sweden at the time of reporting 10 February 2017.

\(^{42}\) This excludes Västerbotten and Vastra Götaland where data is missing. For the county councils and regions that have provided numbers in 2017, asylum seekers are included in the statistics for 2017 for the amount waiting.
### Figure 11. Summary of the number of asylum seekers estimated to be waiting for a medical examination, per county council/region

<table>
<thead>
<tr>
<th>County council/region</th>
<th>Estimated number that waiting for a medical examination</th>
<th>Reporting date for numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blekinge</td>
<td>400</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td>Dalarna</td>
<td>0</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td>Gotland</td>
<td>0</td>
<td>23 Feb 2017</td>
</tr>
<tr>
<td>Gävleborg</td>
<td>42</td>
<td>31 Jan 2017</td>
</tr>
<tr>
<td>Halland</td>
<td>84</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td>Jämtland/Härjedalen</td>
<td>15</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td>Jönköping</td>
<td>531</td>
<td>31 Jan 2017</td>
</tr>
<tr>
<td>Kalmar</td>
<td>0</td>
<td>13 Feb 17</td>
</tr>
<tr>
<td>Kronoberg</td>
<td>636</td>
<td>31 Jan 2017</td>
</tr>
<tr>
<td>Norrbotten</td>
<td>0</td>
<td>31 Jan 2017</td>
</tr>
<tr>
<td>Skåne</td>
<td>3,572</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td>Stockholm</td>
<td>700</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td>Province of Södermanland (south of Stockholm)</td>
<td>825</td>
<td>31 Jan 2017</td>
</tr>
<tr>
<td>Uppsala</td>
<td>117</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td>Värmland</td>
<td>52</td>
<td>31 Jan 2017</td>
</tr>
<tr>
<td>Västerbotten*</td>
<td>Data not available</td>
<td>-</td>
</tr>
<tr>
<td>Västernorrland **</td>
<td>1027</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td>Västmanland</td>
<td>11</td>
<td>31 Jan 2017</td>
</tr>
<tr>
<td>Västra Götaland***</td>
<td>Data not available</td>
<td>-</td>
</tr>
<tr>
<td>Örebrot</td>
<td>30</td>
<td>31 Jan 2017</td>
</tr>
<tr>
<td>Östergötland</td>
<td>134</td>
<td>31 Dec 2016</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>8,176</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Västerbotten reported difficulty producing accurate data, due to variation in registration on completion of a medical examination and insufficient filtering functions.

** Calculated on the basis of SKL’s information that 80 percent of the 5,137 asylum seekers who arrived in 2015 and 2016 and who remain in the county were given a medical examination.

*** Västra Götaland reported that they have no reliable statistics for this information.

### 5.5 Implementation of the Asylum Healthcare Platform

Part of the initiative has been to contribute to improving the management and monitoring of healthcare for asylum seekers and to provide them with the right intervention at the right time. Healthcare for asylum seekers has a particularly significant need for effective and proactive productivity planning, because the need for such care can vary dramatically over time, based on the number of asylum seekers.

As part of the initiative, all county councils and regions were offered free connection to a newly developed platform – the Asylum Healthcare Platform. The Asylum Healthcare Platform compiles data from the Swedish Migration Agency on asylum statistics and healthcare data for asylum seekers as well as from county councils/regions. It is built on the same platform as the SKL database Väntetider i vården (Wait times in healthcare), which enables all county councils and regions to connect.

---

Compilation of data from the county councils and regions under the programme.
Through the platform, county councils and regions can gain an overview of their productivity regarding medical examinations, interventions for mental health and other care. They can also monitor how monthly productivity corresponds to current and forthcoming needs for healthcare for asylum seekers. The platform also provides detailed information on current productivity in healthcare for asylum seekers, such as of municipality, care unit and age distribution among the asylum seekers receiving care.

**Participation of county councils and regions**

The initiative resulted in 17 of 21 county councils and regions registering their interest. Of these, nine county councils and regions have registered to participate so far. Two more county councils and regions will join in 2017. A summary of the participation of county councils and regions is illustrated in Figure 12 below.

**Implementation through local training courses**

In February and March 2017 courses in the platform were offered to connected county councils and regions. The training is intended for people who will benefit from the Asylum Healthcare Platform. This includes those responsible for planning and monitoring as well as operations managers within healthcare for asylum seekers and refugees, primary care, psychiatry, infectious diseases, emergency care and coordinators for healthcare for asylum seekers.

The programme aims to ensure that the platform will be a valuable tool for improving management and monitoring of healthcare for asylum seekers. Four counties have so far undergone training with about 10–12 participants each. Three county councils and regions are booked and two plan to schedule training sessions.

A detailed description of the Asylum Healthcare Platform and connection procedure is described in Appendix B4, *Development and connection to the Asylum Healthcare Platform*.

---

44 As of 20 February 2017, the following are participating: Blekinge, Gävleborg, Kalmar, Kronoberg, Stockholm, Södermanland, Värmland, Västmanland och Östergötland.

45 As of 25 February 2017
Figure 12. Compilation connection status to the Asylum Healthcare platform in county councils and regions

- Connected county councils/regions
- Connected during 2017
- Registered county councils/regions
- Have declined connection
6. Outlook

6.1 Continued pressure on systems
Although many county councils/regions and municipalities have adapted their operations over time to increased immigration, preparedness has not been sufficient for the substantial number of people who applied for asylum in Sweden in 2015. In many parts of the country, this has strained accommodation situations, school activities and in healthcare. Further challenges are expected in the coming years when the responsibility for support and healthcare efforts will shift from the state to local governments, as a result of much of the group shifting status from asylum seekers to newly-arrived immigrants.

6.2 More stringent refugee policies increase the risk of mental health problems
Since 2016, Sweden’s more stringent refugee policies, characterised by closed borders, temporary residence permits and tougher requirements for reuniting with family members, have, to some extent, had stabilising effects on the county councils and regions and municipalities. At the same time, the legislation and regulations have had a counter-productive effect on much of the efforts made by the principal actors working to reduce mental illness among asylum seekers and newly-arrived immigrants. The refugee policies contribute to precarious living conditions that risk hampering integration in Sweden.

Unaccompanied children and adolescents are examples of a group for which we are receiving signals of negative developments, from several directions. Previously we have seen that this group fared well in Sweden; they became educated, found jobs and become an asset to our country. Now there are signs of a disturbing trend in which uncertainty about whether they will stay, temporary residence permits, little prospect of reuniting with families and friends who are deported, or have hurt themselves, are causing these young people, who were previously highlighted as motivated and high-performing, to no longer have the energy required to succeed. Not being able to hope or aim for something results in succumbing to the effects of one’s difficult experiences, which, in many cases, leads to mental illness and increased risk of substance abuse. The experience of hopelessness and lack of trust in our institutions among young people also presents a risk of carrying over to the staff who meet and work with them, resulting in a negative impact on the psychosocial work environment.

6.3 Various challenges associated with different phases of the asylum process
The “Health in Sweden” programme has enabled us to follow the development of the county councils and regions, including through regular contact with the county councils’ and regions’ designated coordinators for Health in Sweden and through national training sessions that have gathered together various functions and professions. On closer inspection, we have seen that the development and support needs of county councils and regions (and municipalities) for meeting with asylum seekers and newly-arrived immigrants have gradually changed from when the programme began. The programme’s initial objectives, to increase the number of completed medical examinations and to create
awareness among people about the mental health of asylum seekers and newly-arrived immigrants, is now about to be achieved. We believe that the future will entail finding strategies and methods to meet five different groups with partly unique needs:

**Asylum seekers**  
A continuing challenge regarding asylum seekers is to manage people’s uncertainty about whether they will be allowed to stay. It also entails finding ways to meet people who have been rejected in the best way possible, both for the applicant and for the staff. Furthermore, there is a continuing challenge in developing the content of medical examinations to better detect mental illness and its risk factors.

**People with residence permits**  
In terms of the second group, there are many who receive temporary residence permits, which impedes the healing process and establishment in society. Unlike in the asylum phase, the social impact is ultimately on counties, regions and municipalities primarily, as opposed to the state. In this regard, we believe that it is worthwhile to find ways to take advantage of the accrued expertise among nurses who provide healthcare for asylum seekers in order to provide increased support for newly-arrived immigrants.

**Unaccompanied children (18 years)**  
A particular group consists of many unaccompanied children who are put into a radically altered situation as they reach the age of 18 or through age revaluation. At that moment, they go from being a child to an adult, which involves, for example, cessation of the right to a legal trustee or change in the form of residence and placement options, resulting in relocation and loss of whatever social network they might have built up.

**Quota refugees**  
An increased number of quota refugees will entail more people with different diseases and risk factors. The medical examination is a good primary screening when they arrive, but in addition to the enhanced quality previously mentioned, the opportunity for follow-up medical examinations also needs to be ensured.

**Undocumented**  
There are already signs that we will have a growing group who will go underground after receiving a rejection decision. Most likely, the group of undocumented residents will be concentrated to the major cities and places where there are many asylum seekers and newly-arrived immigrants with residence permits. This means that some areas that already have a large burden will see that burden increase.

### 6.4 Flexibility and speed are key success factors

Continuing shifts in the world and in our own society entail continued preparedness for having to reconsider and adapt solutions to the situation at

---

46 Mission Mental Health, 2017
hand. With Health in Sweden, we have shown that it is possible to respond quickly, develop and act on preliminary strategies and adjust the course based on the obstacles and opportunities that emerge along the way.

Recognising the challenges that society faces, both from a humane and economic perspective, we consider it crucial to continue to invest in receiving asylum seekers and newly-arrived immigrants well.

We also see a need to maintain what we have achieved to date. Knowledge is a perishable commodity and the training package that has been developed needs to be continually updated and distributed. The developments taking place and the new needs that arise as more people receive a residence permit and seek care in all stages of life mean that the need for cross-cultural knowledge will present itself in all areas of healthcare. Needs will also appear in the coordination of efforts between governmental agencies such the Swedish Public Employment Service, which is responsible for supporting the establishment, and the Swedish National Boards of Institutional Care (SIS), which has a substantial proportion of young people with a background as asylum seekers.

### 6.5 Identified areas for development

Our overall assessment based on the reports and summaries\(^47\) of asylum seekers’ and newly-arrived immigrants’ situation in Sweden and the experience of county councils and regions, municipalities and civil society organisations shows that there is still a great need for additional resources, particularly for skills enhancement among staff.

#### Skills development needs among municipal and government employees

The Health in Sweden initiative in 2016 has focused on improving skills among employees in county councils and regions, whose principle actors were required to use funding to participate in the initiative. Since promotion and prevention form an essential basis for ensuring the mental health of asylum seekers and newly-arrived immigrants, the programme office developed adaptations of the training modules for staff within operations such as accommodation (HVB), student health and employment.

For the coming year, we consider the following to be of particular importance:

- Provide staff in local authorities and government agencies with the financial capability to take part in the training.
- Further develop educational content designed for staff within local authorities and government agencies.

During the programme period, the programme office will, in exceptional circumstances, offer to hold local courses\(^48\) for municipal employees. In the event of continued and increased investment, this form of distribution in the counties remains an option. Conferences in the counties can also promote collaboration.

#### Strategies and approaches in increased risk of mental illness and/or suicide

There are indications that the group with severe mental illness and/or suicide risk is growing among asylum seekers and newly-arrived immigrants. People with temporary residence permits, individuals who have been rejected for a...
residence permit, young people approaching the 18-year age limit or having received an age revaluation and people in hiding are specific risk groups.

For the coming year, we consider the following to be of particular importance:

- The development and distribution of working methods for working preventively with people who have been, or will likely be, rejected in their asylum application.
- The development and distribution of working methods to identify and provide assistance to people at risk for developing substance addictions.
- The development and distribution of working methods including outreach, how healthcare can provide support and treatment of mental illness despite the patient living under precarious and unsafe conditions. An important aspect is the need to develop effective forms of collaboration with Swedish National Boards of Institutional Care (SiS), accommodation to provide support, and treatment for SiS-placed individuals with mental illness.
- Training and support to other actors such as civil society, businesses that provide assistance with, for example, language-cafés, foster family homes, legal trustees, etc. whose wards are experiencing psychological difficulties and exhibiting signs of despair.

Needs arising from the establishment process

Meaningful employment promotes mental health. Conversely, mental illness hampers establishment, for example, by reducing the energy and motivation for learning, training and job seeking. In many parts of the country, the interaction between employment, healthcare and social insurance presents a major challenge for the establishment of newly-arrived immigrants. In particular, we see a need for support for young people who, on their 18th birthday lose some of their previous support. For this group, 18–25 years old, we see signs of increasing psychological distress and increased risk of substance abuse and crime.

For the coming year, we consider the following to be of particular importance:

- The development and distribution of working methods for better cooperation and support to newly-arrived immigrants in the establishment process.
- The development of specific working methods for student health units in support students. We also need training in youth clinics to meet students from other traditions regarding sex and relationships as well as students with a more stigmatised view of mental health problems, who, therefore, do not seek medical care for when psychological difficulties arise.

Continuing need for support material and training in healthcare

The following are examples of matters where staff and representatives of the county councils and regions have expressed a need for additional knowledge and support materials.

- Initiatives for children, unaccompanied and family (i.e., in conjunction with the preschool/school, student health)
- Effective treatments for mental health of asylum seekers and newly-arrived immigrants in primary care, such as group therapy

The programme office is looking into the possibility of further developing the Health School/Health Support concept, under the working title “Health Support Plus”.

---

49 The programme office is looking into the possibility of further developing the Health School/Health Support concept, under the working title “Health Support Plus”.

---

Health in Sweden for asylum seekers and newly-arrived immigrants
• Practical treatment of people presenting signs of suicidal thoughts\textsuperscript{50}
• Outreach to groups at risk of substance abuse, prostitution, etc.
• Information and support for people with serious physical illnesses
• Parental support programmes
• Difficult ethical issues\textsuperscript{51}
• Use of interpreters
• Honour culture and honour violence
• Culture-specific treatment
• Working methods for HBTQ individuals

\textsuperscript{50} The programme office is planning for a day on suicide prevention in March 2017.
\textsuperscript{51} The programme office is planning for an ethics workshop in autumn 2017.
7. References


Regeringskansliet, 2016, *Stora utmaningar som kräver samverkan*
http://www.regeringen.se/artiklar/2016/03/stora-utmaningar-som-krav-samverkan/


EPA 2014, *Guidance on Mental Healthcare of Migrants*

Folkhälsomyndigheten, 2016, *Suicidprevention 2016 EN* LÄGESRAPPORT OM DET NATIONELLA ARBETET MED ATT FÖREBYGGA SJÄLMORD
https://www.folkhalsomyndigheten.se/pagefiles/30893/suicidprevention-2016-16150.pdf

Folkhälsomyndigheten, Socialstyrelsen, 2016, *Delrapportering av regeringssuppdrag Stöd till genomförande av hälsoundersökningar*


Göteborgsregionens kommunförbund, *Ensamkommande barn och ungdomar – psykisk ohälsa och Traumasymptom,*

Hetrick et al 2010 Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD)

Jongedijk R, 2014 – *Narrative exposure therapy: An evidence-based treatment for multiple and complex trauma*

Kate E Murray et al 2010 – *Review of Refugee Mental Health Interventions Following Resettlement: Best Practices and Recommendations*
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3727171/#!po=0.549451

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3168672/

Lindencrona, F. 2008 *Strategies for a Health promoting introduction.*
https://openarchive.ki.se/xmlui/bitstream/handle/10616/38703/thesis.pdf?sequence=1
https://www.migrationsverket.se/download/18.4100dc0b159d67dc614b0d/1486539367565/Migrationsverkets+prognos+2017_febr+P2-17.pdf


Patel et al 2014 – *Psychological, social and welfare interventions for psychological health and well-being of torture survivors*  

https://www.ncbi.nlm.nih.gov/m/pubmed/16077055/

Pottie, K., 2011 - Evidence-based clinical guidelines for immigrants and refugees  
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3168666/pdf/183e824.pdf

SKL, 2016a - *Behovsanalyser i 17 landsting/regioner genomförda via webbformulär under aug-okt 2016.*


https://skl.se/download/18.1e6b67f157049021df84f20/1474291239461/PM-H%C3%A4lso-o-sjukv%C3%A5rd-asyls%C3%B6kande-2015-med-tabellbilaga.pdf (2017-02-17, 14:31).

SKL, 2016d. *Positiv hälsoutveckling för asylsökande och nyanlända* 
RAPPORT TILL SOCIALDEPARTEMENTET EFTER REGERINGSBSLUT 32O15/06414/FS,  
http://www.uppdragpsykiskhalsa.se/wp-content/uploads/2016/05/Positiv-h%C3%A4lso-utveckling_nyanl%C4%A4nda_kortversio.pdf

Socialstyrelsen, 2015 – *Psykisk ohälsa hos asylsökande och Nyanlända migranter – ett kunskapsunderlag för primärvården*  

http://www.socialstyrelsen.se/publikationer2016/2016-10-13

Socialstyrelsen, 2017a, “*Uppdrag om mottagande av asylsökande och nyanlända*,” http://www.socialstyrelsen.se/omsocialstyrelsen

Socialstyrelsen, 2017b, “*Uppdrag med anledning av det ökade mottagandet av ensamkommande barn m m*,”  
http://www.socialstyrelsen.se/omsocialstyrelsen

Socialstyrelsen och Folkhälsomyndigheten, 2016, Stöd till genomförande av hälsoundersökningar, 


US Department of Health and Human Services Centers for Disease Control and Prevention National Center for Emerging and Zoonotic Infectious Diseases, 2015. Guidelines for Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees 

Uppdrag Psykisk Hälsa, 2017, Sökresultat “Hälsostöd’’ i Verktygsbanken 

Appendix A. Results of national needs analysis

In autumn 2016, all county councils and regions were offered support for conducting a local needs analysis to identify skills enhancement needs regarding asylum seekers and newly-arrived immigrants. The purpose of the needs analysis was to provide the basis of a local plan for the training initiative. The analysis included health promotion and prevention measures, as well as response measures for milder cases of mental illness as well as to moderate to severe mental illness.

17 county councils and regions accepted the offer: Blekinge, Dalarna, Gotland, Gävleborg Halland, Jämtland/Härjedalen, Jönköping, Kalmar, Kronoberg, Norrbotten, Sörmland, Uppsala Värmland Västerbotten Västernorrland Västmanland and Örebro.

The needs analysis conducted by the 17 county councils and regions was developed based on an online form (see Appendix E. Form for needs analysis), which was completed by select people in the county designated by the coordinator. The online form was completed by a total of 310 individuals with broad representation of different areas of operation, such as medical centres, healthcare for asylum seekers, children’s and young people’s healthcare, emergency rooms, specialised psychiatric clinics, ambulance personnel, clinics for the disabled, rehabilitation clinics, the Swedish Public Dental Service, the Swedish Migration Agency, Infectious Disease Control, social services, substance abuse treatment centres, accommodation for asylum seekers and integration units. Many of the respondents were operations managers, unit managers and department heads.

Results

Figure 13. The combined results of the needs analysis are reported, with the average results for the 17 participating counties and regions.\(^{52}\)

\(^{52}\) SKL, 2016, Behovsanalyser i 17 landsting/regioner genomförda via webbformulär under aug–okt 2016.

Average (mean of the average of the 17 county councils/regions conducted via online form during Aug–Oct 2016)

---

\(^{53}\) Average (mean of the average of the 17 county councils and regions that participated in the programme’s needs survey).
The needs analysis shows that the majority of the people surveyed experienced a need for promotion and prevention activities as well for response measures for mild, moderate and severe mental illness. Most respondents indicated a need for further promotion and prevention efforts, specifically: “training for staff on migration and mental health” (78 percent) and “materials and working methods for providing health information” (75 percent) The areas with the lowest proportion of respondents reported that they had a need for: “reinforcement for conducting medical examinations” (31 percent) and “interventions for severe mental illness” (47 percent). Over 60 percent named requirements concerning “staff training in mild, moderate and severe mental illness among asylum seekers/newly-arrived immigrants”.

The following pages provide a more detailed compilation of the results per survey area:
Promotion and prevention

Need for improved materials and working methods to provide health information

Is there a need?

![Graph showing percentage of respondents]

Proportion of asylum seekers with estimated needs

- [75-100%]

Proportion of asylum seekers with estimated needs

- [50-75%]

Examples of needs:

- Material on self-care, how to find different types of care, how to find care on relocation, pharmacy’s function
- Material in different languages with images, adapted to different degrees of reading and writing ability writing skills – preferably locally-adapted

---

54 Average response distribution of respondents in the 17 participating county councils and regions

55 The respondents’ assessment of the proportion of asylum seekers and newly-arrived immigrants to the need of providing/expanding health promotion and prevention measures. Average response range of the respondents in the 17 participating county councils and regions (selectable ranges: 0-25%, 25-50%, 50-75% or 75-100%).

56 The respondents’ assessment of the proportion of asylum seekers and newly-arrived immigrants to the need of providing/expanding health promotion and prevention measures. Average response range of the respondents in the 17 participating county councils and regions (selectable ranges: 0-25%, 25-50%, 50-75% or 75-100%).
Need for improved materials and working methods for medical examinations

Is there a need?
Average distribution of responses, %

Examples of needs:

- Material in different languages, with pictures
- Need for information to send out with appointment notice, appointment notices in more languages
- Improved and standardized working methods in terms of cultural differences, effective work with interpreters, routines for early detection of signs of mental illness
Need to provide health promotion and prevention initiatives

Is there a need?
Average distribution of responses, %

Proportion of asylum seekers with estimated needs
Average response range, %

Examples of needs:
- Counselling and support interventions within diet, exercise, hygiene, sexual health, oral health, smoking, addiction, vaccination, common diseases
- Psychosocial efforts in the group to strengthen mental health, for example support for insomnia
Need to provide/expand training
Staff on migration and mental health

Is there a need?
Average distribution of responses, %

Examples of needs:

The need for training on transcultural competence, reception, understanding of how mental illness can manifest itself, suicide, worry, anxiety, migration stress, basic knowledge on trauma

Needs of all staff groups that encounter asylum seekers and newly-arrived immigrants, especially integration caseworkers, accommodation staff and midwives
Mild to moderate mental illness

Need to offer/expand efforts for Mild to moderate mental illness

Is there a need?
Average distribution of responses, %

- Yes: 62%
- No: 25%
- Do not know: 25%

Proportion of asylum seekers with estimated needs
Average response range, %

- 50-75%

- 25-50%

Examples of needs:

- Need for talk therapy such as for anxiety and suicide, trauma support, crisis management. Would like group treatment
- The need for more professions to perform different types of interventions, such as call support
- Extended information on improving mental health yourself
- Increased interventions for sleep problems, psychosocial interventions in primary care and language and cultural interventions
Severe mental illness

Need to offer/expand efforts for Severe mental illness

Is there a need?
Average distribution of responses, %

Proportion of asylum seekers with estimated needs
Average response range, %

Examples of needs:

Interventions in psychiatric specialist care including trauma treatment and interventions for suicide attempts, depression and anxiety, and better access to these

Insights on psychiatric specialist care for children

Improved collaboration between healthcare agencies, e.g. BUP, psychiatric services, dental care and primary care
Mild to severe mental illness

Need to provide/expand training for staff on mild to severe mental illness

Is there a need?
Average distribution of responses, %

Examples of needs:

- Transcultural competence, treatment, safely looking after
- Treatment methodology for crisis, PTSD, migration stress, self-harm, suicidal thoughts and torture experiences
- Needs of primary care and accommodation staff
Need to provide/expand training for
for staff on mild to severe mental illness

Is there a need?
Average distribution of responses, %

Examples of needs:

- Support in difficult conversations, debriefing, feelings of guilt
- Regarding cultural meetings, reception and treatment, communication with interpreters
- Proposed group supervision
Appendix B. Description of the implementation of the programme

B1. Programme management

Programme Organisation

For the implementation of the programme, a programme organisation was formed consisting of two projects – A. National rollout and B. New development. National rollout is the primary focus of the programme work, with the aim of distributing the results of the feasibility study. New development aims to develop new working methods and materials based on needs identified in the process of national rollout. The programme is led by Programme Director Ing-Marie Wieselgren and supported by a programme office. Project managers and team members are appointed for all projects and sub-projects.

The local development efforts of the county councils and regions, in collaboration with the municipalities, form the foundation for implementation of the national rollout.

A. National rollout comprises three sub-projects with the objective of providing county councils and regions operational support in the implementation of training initiatives, making available tools in the form of a platform for the management and monitoring of healthcare for asylum seekers, developing and organising national training programmes.

B. New development comprises the development of new materials, working methods and entire courses both within the programme and with support from expert organisations and municipalities, county councils and regions as well as external suppliers.

Figure 14. Programme Organisation for Health in Sweden

SKL, 2016d
An example of new development work with support from external providers is the programme’s collaboration with Linköping University for the development of an interventions consisting of cognitive behavioural therapy (CBT) online for asylum seekers and newly-arrived immigrants with mild mental health problems.

Another example is the collaboration with the Swedish-Somali medical association, which develops conceptualised information about mental health/illness for the Swedish-Somali population.

The programme has worked together in collaboration with a wide range of experts, projects and actors described in more detail in the next section. The programme has also had the support of a regular steering committee and strategy for Mission Mental Health’s efforts.

Working together collaboratively

The recent refugee situation has accentuated the need for effective collaboration among state agencies, state and local government and the public and private/non-profit sectors. Mission Mental Health is working closely with government agencies, county administrative boards, NGOs and civil society organisations and other actors working with mental healthcare for asylum seekers and newly-arrived immigrants.

In order to provide asylum seekers and newly-arrived immigrants coordinated and effective support, good forms of cooperation are required within the counties, including the county councils, municipalities, county administrative boards and civil society.

The programme has regularly collaborated with The National Board of Health and Welfare and The Public Health Agency of Sweden, which have ongoing government assignments dealing with healthcare for asylum seekers and newly-arrived immigrants. As part of the National Board of Health and Welfare’s report on healthcare and dental care for asylum seekers and newly-arrived immigrants, the programme held workshops with maternity care, obstetric care, and children and young people’s healthcare professionals.

The programme has participated in reference group meetings held by the Swedish Agency for Participation (MFD) on asylum and establishment issues for people with disabilities. We have contributed information to, and commentary on, the Agency’s report on people with disabilities in the Swedish asylum and establishment process.

The programme has also held meetings with representatives of the Swedish Public Employment Service, the Swedish Social Insurance Agency and the Swedish Migration Agency and several of the country’s county administrative boards to discuss the challenges of asylum seekers and newly-arrived immigrants with mental illness.

At the international level, the programme has been in telephone meetings with UN’s International Organisation for Migration’s (IOM) Project Re-Health, regarding the pilot project for European medical records for migrants, Personal Health Record. A couple of employees have participated in the pilot test of an EU-funded e-learning initiative in English for health professionals and managers about migration and health. The project has, on several occasions, contributed information to the monthly reports the EU Agency for Fundamental Rights (FRA) compiles on the refugee situation in the member countries.

The programme has participated in a research and practitioners meeting at Ombudsman for Children in Sweden in relation to BO’s in-depth study of
newly-arrived immigrant children’s right to healthcare, as well as participated in several of RFSU’s networking meetings on sex education and SRHR (Sexual and reproductive health and rights) for newly-arrived immigrants.

**Other organisations** the programme collaborates with include: The Swedish Red Cross, Save the Children International, the Swedish Association of the Visually Impaired and Doctors Without Borders.

**Programme management**

The programme is led by the programme office, and its main duties have included ongoing programme management, comprehensive specification of requirements for projects and sub-projects, quality assurance, support and communication.

As a basis for programme management, a comprehensive programme plan was developed.

**Figure 15. Programme Plan for the Health of Sweden programme autumn 2016**

For ongoing programme management, programme documents have been established for each sub-project: Project description (Word), project planning (Excel), status report (PowerPoint).

A meeting structure was also established as follows:

- Every week project managers, sub-project managers and team members (when necessary) convene for a **Project Status Meeting**. The aim of the project status meetings is to coordinate the work of the project and to work on issues that affect all sub-projects and/or monitor the dependencies between sub-projects.
- Every week, programme directors, programme managers, project managers, communications representatives and external contacts, as well as the Project Administrators, convene for a **Programme Status**
Meeting. For this meeting, each project prepares an updated status report of planned and completed activities, identified risks and the need for a decision from the programme office.

Communication
Communication within the programme has mainly taken place directly with the staff and management of local governments through dialogue within the operational support and in conjunction with course sessions. The county councils and regions have also received concrete support in their internal communication through strategy proposals for their communications work.

The programme’s extensive cooperation and collaboration work has been a key channel for external communication on the programme.

In addition to external communication through interaction and participation at meetings, conferences and other forums, a newsletter is sent out every two or three weeks to the people who have subscribed via the Mission Mental SANCO website.

B2. Support for the county councils/regions

The work of the county councils and regions forms the basis for implementing the training initiative, and the programme was, therefore, formed to create the conditions for efficient and scalable national and local training and distribution of knowledge. The implementation was carried out in three phases: needs analysis, planning and training, and distribution – and to support the implementation, financial and operational support was provided. The programme was implemented in autumn 2016 with continued local distribution in the first quarter of 2017.

Financial and operational support

County councils and regions that accepted the offer to participate in the programme received state funding to enable the implementation of a needs analysis and free up time for a local coordinating function. Operational support was provided to the coordinators from the programme office at SKL.

Financial support

At the start of the programme, county councils and regions were offered an amount of SEK 300,000 per unit to facilitate the needs analysis work based on the results of the needs analysis, the county councils and regions resolved to participate in the training and distribution parts of the programme. Participation afforded the county councils and regions an opportunity for additional financial support provided they adopt local distribution initiatives and report the results to SKL. The basis for issuing additional funding was determined by the results of the needs analysis, an overall plan for the local distribution of knowledge in the county councils and regions (to which operations and number of people), and a commitment to reporting. All county councils and regions decided to participate in the programme, and additional financial resources were allocated based on population. In total, the financial support amounted to between SEK 400,000 and SEK 1.1 million per county council/region.
Operational support

At the start of the programme, each county/region was requested to appoint a coordinator for Health in Sweden. The coordinator’s role is to coordinate and organise programme work during the three phases of the programme.

As support for the coordinators’ efforts, SKL’s programme office provided guidance documents for each phase of the programme with a timetable and detailed suggestions for activities, including, for example, templates for decision-making documents, mailings and reporting documents. Further support was offered in the form of a person providing process management support through ongoing email and telephone contact. All county councils and regions have taken part of the support take was made readily available and adapted to local conditions.

Implementation in three phases

1. Needs analysis

The needs analysis aimed to identify the need for coordination and development efforts regarding healthcare for asylum seekers and newly-arrived immigrants. Of the county counties and regions, 17 carried out a needs analysis under the programme. In the other three county councils and regions, needs analyses had been recently carried out, which were used as the basis for compilation of local skills enhancement needs.

In the 17 county councils and regions that chose to conduct a needs analysis under the programme, an online form (see Appendix E.) was sent to selected operations representatives who provided input on the needs. Proposals for the online form were developed and administered by SKL. Some county councils and regions made minor adjustments in the online form to adapt it to local conditions.

The county councils and regions were then supported in analysing the results and determining which of the programme’s courses and tools matched the identified needs. Support was also provided in the form of a proposal for a decision-making model the county councils and regions could apply to determine how they should participate and distribute the knowledge, which they then could finalise according to local decision-making procedures. The last step in the needs analysis was the decision-making model being presented by the coordinator in a decision-making forum appropriate to the specific county council/region choosing to proceed with the training and distribution phase.
2. Planning

Based on subsequent decisions on continued programme participation, the coordinators clarified proposals for a distributed plan for disseminating knowledge from the national training programmes within the county/region, with support from SKL. The coordinator then developed a distribution plan and, together with operations representatives and employees, identified the distribution leader/trainer. The distribution leaders’ assignment is to participate in the national distribution programmes and be responsible for implementing the local distribution of courses.

The coordinator then steps in to ensure that the identified distribution leaders have registered to attend the national course sessions. (in Stockholm). To support the coordinators in these efforts, SKL sent weekly emails providing an overview of which people from the county councils and regions were registered for the course sessions. This approach has been highlighted for being effective as it enabled the coordinator to see the people who registered, those who needed to be reminded to register and those who signed up voluntarily and would, therefore, be included in the distribution efforts.

To ensure that the distribution leaders were notified well in advance of the national course sessions, coordinators were encouraged to identify and notify distribution leaders in parallel with awaiting a decision on participation from the county council/region.

Great emphasis was placed on local adaptation and each county and region chose the model of distribution suited to their local circumstances. Some county councils and regions chose to send a larger number of people to attend the national training courses who undertook smaller distribution assignments while others sent a small number who undertook major distribution assignments.

However, as a focus for designing the distribution model, a general recommendation was given to ensure that most participants in national training programmes had been assigned to train the trainers locally. These local trainers were then estimated to be able to train approximately 30–50 employees during the first quarter of 2017, the main period for local distribution, from the programme’s perspective. SKL also recommended the county councils and regions register at least two distribution leaders to make the training less person-centric.
During the planning phase, coordinators, in cooperation with the communications department of the county council/region, developed a communication plan for how the programme would be communicated in the county council/region. SKL assisted with a template for communication, while also encouraging the county councils and regions to cooperate with their local communications department to determine the appropriate scheduling, channels, messages and relevant parties for internal and external communications.

3. Training and distribution

During the ongoing training and distribution phase, the coordinator’s role is to support and monitor implementation of the distribution plan. Distribution based on the distribution plan includes three main activities:

- National training
- Local training
- Follow-up

National training

First, the distribution spread leaders participate in the national training courses organised by SKL in Stockholm. At the national training courses, participants receive materials and support on how to train other trainers and staff groups locally. Most of the national training programmes were conducted in autumn 2016, but many popular courses were also offered in spring 2017. At the time of compiling this report, five national course sessions have yet to take place.

In conjunction with the national course sessions, those who will train others complete a personal distribution plan. This document was developed by SKL to support the planning of local distribution with the aim to help the distribution leaders:

- Clarify their distribution objectives
- Formulate their plan to achieve the objective
- Report status to the coordinator in their county/region

Prior to the distribution leaders attending the national training courses, the coordinators inform them of the proposal for personal distribution objectives, based on the overall dissemination plan of the council/region. The personal distribution plans are also a tool for the coordinators to follow the distribution status in the county council/region, and form the coordinators’ basis for compiling the status for distribution to the county council/regional management and SKL.

Local training

During local training, the trainers use materials and support from the national training courses to train other trainers and staff locally. Planning of the local courses is based on in the overall distribution plan of the county council/region and/or self-defined objectives. Coordinators are there to support trainers but have a limited role in this function.

Follow-up

During the distribution phase, the coordinators follow up on distribution activities carried out in relation to the overall distribution plan and report the results. This is done by collating the distribution leaders’ personal distribution

---

58 As of 25 February 2017

Health in Sweden for asylum seekers and newly-arrived immigrants
plans with the latest status and compiling this information into a comprehensive distribution log. The reporting is done partly to the county council/regional management and partly to SKL, which reports to the government. The comprehensive distribution log was first compiled in February 2017 (in preparation for this report). To monitor the distribution, a second follow-up, and compilation, will take place in late March 2017.

During the training and distribution phase, two networking events were organised for coordinators to meet and exchange experiences and success factors. A networking meeting is also planned to be held in late March to secure continued distribution efforts at the local level.

The programme also plans to hold an earnings conference with politicians, programme coordinators, employees and managers from county councils and regions, expert organisations, etc. in spring 2017. The results conference aims to report the results of the distribution and lessons learned on the method of dissemination as well as to focus on the remaining challenges and suggestions on how to improve conditions for integration and mental health.
**Success factors**

The coordinators described many success factors in their efforts to implement the programme.

| To drive the efforts forward: | • Have a clear decision point, with a decision from management  
• Show the problem/need  
• Maintain close contact with management  
• Argue that taking the time to participate in the programme now will save time and lead to increased quality later |
|---|---|
| To identify those who will participate in the courses: | • Determination  
• Send personal emails  
• Make a name for yourself as a coordinator  
• Show the problem/need |
| To secure the distribution: | • Find key people who can take the knowledge further  
• Set the ambition at the right level for the trainers; considering the various ways to distribute the message, it is important not to make excessive demands of people who could be intimidated and, therefore, be inhibited from distributing the message altogether.  
• Organise a planning day/distribution seminar following the course sessions in Stockholm  
• Participate in the first course session at home in order to be able to provide feedback  
• Send people that will become trainers to coaching training to build up their confidence in presenting to a group audience  
• Have a communicator closely linked to the work, to get help with the following:  
  • Revise the website, including making available information from the course “What the organisation should know! (HiS1)” on the county council/region’s website  
  • Designing invitations to courses and news on the county council/region’s website  
  • Generally, keep communications short and concise  
• Think broadly when invited to course sessions – ask yourself these questions:  
  • Who else would benefit from receiving the training content?  
  • What other professions could the patient in question meet representatives from?  
  • What do we need to have a comprehensive understanding of? |
| In order to ensure collaboration on these issues: | • Find and work closely with collaborative groups – such as the Associations of Local Authorities  
• Collaborate with politicians |
Feedback from the coordinators

The coordinators have given feedback to SKL both regularly during programme implementation as well as online. The results of the online survey show that SKL’s support was appreciated.

Of the 17 county councils and regions that conducted needs analyses under the programme 76 percent of the coordinators rated that the support received by the county council/region from SKL in conjunction with the needs analysis as “good” or “very good”.

In these county councils and regions 94 percent of the coordinators also rated of the support linked to the planning and implementation of distribution as “good” or “very good”. The coordinators emphasised that the preparatory work in the form of guidance documents and templates etc. facilitated their efforts.

The coordinators also expressed that the programme has focused on implementation and driven the operational work well. The coordinators expressed appreciation for the programme’s responsiveness, flexibility during implementation and its compliance with the various conditions specific to the needs of the county councils and regions. The coordinators described the support as fast, accessible, clear, structured, educational and helpful. The personal touch was particularly appreciated.

In addition, the network meetings where coordinators could share experiences were also valued.

The coordinators gave positive feedback on the information and support material, in particular on the importance of its availability as a source of knowledge even after conclusion of the programme, thereby forming the basis for ongoing work and increased preparedness in the event of another sharp increase in the number of asylum seekers coming to Sweden.
B3. Development and implementation of national programmes

A significant part of the programme efforts has been directed at developing, planning, and implementing training programmes for trainers, and to support them in their work. The following describes how the programs were developed and implemented.

At the end of this part of this report, there is an overview with a brief description of the content and the intended audience per course.

Development

*Training courses were developed to meet the needs of all levels*

The training that was developed within the programme was developed in the most viable way to respond to the needs identified by the needs analyses conducted by county councils and regions.

Training courses were developed to meet the needs of all three levels: the analysis included health promotion and prevention measures, as well as response measures for milder cases of mental illness and moderate to severe mental illness.

To some extent, the division of courses into three levels of need reflects the way healthcare interventions are organised in Sweden. Formally, health promoting initiatives are offered in the context of public health, interventions for mild problems by primary care and interventions for severe mental illness by specialist psychiatry or similar operations. In practice, however, there is often overlap between the duties of the various levels of healthcare. Interventions provided by primary care or specialists can, for example, have promotion and prevention components, such as by providing orientation information on how Swedish healthcare works.

To reflect this, an important condition of the training initiative was to allow county councils and regions to themselves identify who should participate in each course. This has been done through training catalogues on the website with more available clear descriptions of examples of professions that are appropriate for participation in each course (see Figure 19).

*The development was based on the “train-the-trainer” method*

To be able to train large groups of staff in a short time, knowledge, materials and working methods were developed that support the dissemination methodology “train-the-trainer”. Under the programme, this methodology involves training national trainers/distribution leaders who, through the training courses, receive the knowledge and tools necessary to distribute the training regionally and locally.

Initially, the programme was in collaboration with a training company that contributed with relevant experience in developing training programmes and material supporting the “train-the-trainer” methodology.

To enable the best possible distribution, we have consistently developed support materials to train other trainers, and support materials for training staff groups directly.
**Success factors to enable the best distribution:**

- Development of manuals with advice and suggestions on how to plan and conduct courses on one’s own for different target groups, including rosters
- Consistent use of speaker notes in PowerPoint, so that participants can easily download documents and adapt them to local conditions
- Development of films that support training locally
- Support from SKL provided to all distribution leaders in adapting the material to their own local conditions
- Live webinars (also available on-demand online) for distribution leaders with review of training materials, any news about the material, and advice on how it can be used for distribution (20-30 minutes long)
- Use of digital channels and tools for making material available (see in more detail below)

Training materials that clearly show how knowledge can be distributed, and how to adapt the material to local conditions, have consistently been appreciated by the participants.

In addition to courses specifically developed to meet the broad distribution needs of the county councils and regions, complementary courses with lower demands on distribution were identified. This refers to the theme day on School Health, and the theme days “Newly-arrived immigrants as a resource” (HiS4) and “Forum on Mental Health for managers and decision-makers: The right action at the right time” (HiS13). Within the programme, we also offered a two-day course “Lifespan Integration – method of traumatic memories” (HiS8) that provides knowledge and skills in the therapeutic treatment technology Lifespan Integration of traumatic memories and PTSD.

**Digital channels helped make the courses easy to distribute**

Digital channels support the programme’s distribution model by being scalable, continuously updated and available to anyone with access to a computer.
The first versions of the courses were mainly based on existing digital material produced by SKL, government agencies or other organisations. During the programme, we have been producing customised materials that provide good conditions for local distribution.

**Digital channels: Quickchannel**

- The programme’s course sessions are recorded with professional video equipment, which, in addition to video and audio, captures speaker notes, films, and everything that is presented on-screen during the physical course session (speaker notes in PowerPoint or equivalent). All recorded course sessions are available to stream on Mission Mental Health’s website. The recordings are divided into separate chapters, enabling the user to choose to select individual presentations instead of being required to view the entire course session.

**Digital channels: Vimeo**

- A large number of videos (over 40 in all) have been recorded under the programme, and published on the Mission Mental Health Vimeo channel [https://vimeo.com/psykiskhalsa](https://vimeo.com/psykiskhalsa)
- All videos are free to stream and download. During the course sessions, we encourage all distribution leaders to download the videos and play them from their computer’s hard drive for the best possible quality and to avoid being dependent on Internet access during the course session. The number of actual screenings is therefore greater than the number of views online.

The five most-viewed videos in the project during the period 1 July – December 31 are listed below:

**Figure 18. Most-viewed videos in Health in Sweden programme**

<table>
<thead>
<tr>
<th>Video</th>
<th>Number of views</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ing-Marie Wieselgren on the programme efforts during autumn</td>
<td>588</td>
</tr>
<tr>
<td>2. Health in Sweden: a training initiative on the subject of asylum seekers and newly-arrived immigrants</td>
<td>371</td>
</tr>
<tr>
<td>3. Health Support group meeting 4: Diet and exercise – language Swedish</td>
<td>168</td>
</tr>
<tr>
<td>4. Health Support group meeting 2: Migration and health – language Swedish</td>
<td>161</td>
</tr>
<tr>
<td>5. Health Support Group meeting 3: Trauma and stress – language Swedish</td>
<td>149</td>
</tr>
</tbody>
</table>

The first two videos are general information films on the programme, which are also included in certain parts of the courses. Videos 3–5 are part of the initiative Health Support, which is one of the most acclaimed courses in the programme.
The development of content along with expert organisations and employees in the regions and counties

The courses have been developed based on successful working methods identified in the county councils, regions and other authorities and organisations and with the support of experts from organisations such as Transcultural Centre and the Swedish Red Cross, researchers from Karolinska Institutet, Uppsala University, Linköping University, the National Board of Health and Welfare and the Public Health Agency of Sweden. Most of the training content was developed based on the feasibility study, but some new developments were made to respond to some of the needs of the county council and regions. The development efforts focused primarily on making the training content as easy to distribute as possible.

Implementation

Training courses were held at the national level where the participants met physically, promoting engagement and dialogue

During the initial course sessions, we received positive feedback on having set aside ample time for discussions, exchange of experiences and opportunities to make new contacts. This was continually updated during the training programme. In several cases, table seating was arranged, in some cases with difference seating placements during the morning and afternoon to enable the best possible conditions for networking. This was appreciated by the participants.

A large number of participants due to a simple registration process, combined with clear communication

It has been easy to sign up for the courses, which have remained free-of-charge for participants. All information about the programs has continuously been published online, which simplified distribution via the coordinators and other channels. Participants could register online, and only in rare exceptions have we had prerequisite requirements requiring a dialogue with coordinators in each county council/region.

Distribution effects have arisen during the programme as a result of previous participants, both on their own initiative and on our request, informing colleagues and members of their network about the courses and recommending them.

In many cases, we also proactively promoted training courses for various identified target groups, primarily local government, agencies and organisations, to complement the communication efforts of the county council and regional coordinators.

The training was provided in several rounds of courses

The feasibility study identified several significant training needs. With these needs as the starting point, a number of course sessions were offered before the participating county councils and regions had the opportunity to conduct a needs analysis (round one). These training sessions were, despite short notice, well-attended and appreciated, and above all provided an opportunity for participants to test different approaches to training early in the process, the valuable experience of which led to an increased capability to adapt and develop training courses to the various target groups’ needs during the programme. The
most popular courses were repeated on several occasions from October until mid-November (round 2).

Before course round three (18 November – 16 December) a course catalogue was developed, with the Internet as the main channel for continuously updated information on the different courses. In round three, broad educational programmes were offered for the dissemination leader, the most popular on more than one occasion.

Participants were motivated to distribute further
The majority of respondents stated their assignment as distribution leaders within their organisation, but there was also a large proportion of participants without a pronounced assignment. Throughout, the message to participants – before, during and after the course sessions – has been to encourage sharing the motto “no one can do everything but everyone can do something” as a starting point.

Distribution has been a common theme in all courses, and many exercises have focused on how to self-organise and spread knowledge further. The personal distribution plan has been provided as support for planning, coordination and follow-up.

A mixture of SALAR’s own speakers and external speakers were used
The evaluations show that external lecturers have been appreciated feature, both experts and strong personal stories of people who themselves have experience of migration and mental health. The programme took in several external speakers to complement SALAR’s own experts, and this mixture is seen as a success factor.

Feedback on training sessions was collected
In connection with each course session, participants were given the opportunity to provide feedback on the training day via a form, anonymously if desired. Participants rated each individual course component as well as their overall experience of the day, and provided comments and suggestions on how the programme could be improved for the next time. A good response rate there has provided us with comprehensive feedback on the results and development needs. Feedback and requests were also collected in direct dialogue with the participants, during and after the training.

Overview of training
Figure 19 A brief description of the training courses offered under the programme, including the purpose, content and suggestions for which staff groups are best-suited to further train other trainers or staff groups.
<table>
<thead>
<tr>
<th>Courses offered by Health in Sweden to meet needs</th>
<th>Brief description of content</th>
<th>Staff groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>HiS1. Information for asylum seekers and newly-arrived immigrants</td>
<td>The course provides an overview of the sources and services that provide information about social services and rights under the asylum and establishment process as well as tools to convey information tailored to different target groups.</td>
<td>People who, in the workplace, encounter asylum seekers and newly-arrived immigrants and require basic knowledge of social services and rights under the asylum and establishment process and need to be able to offer guidance and respond to questions on the workings of society and healthcare pertaining to asylum seekers and newly-arrived immigrants.</td>
</tr>
<tr>
<td>HiS2. Health information and support for asylum seekers and newly-arrived immigrants</td>
<td>The course provides knowledge and tools for providing health information about the Swedish healthcare system and self-care, as well as methods of health support in cases of mild mental illness, in groups or individually.</td>
<td>Trained medical professionals who, in their work, need to provide information on Swedish healthcare system and basic self-care for asylum seekers and newly-arrived immigrants. * People who work with information and communication. * For example, healthcare communicators, nurses.</td>
</tr>
<tr>
<td>HiS3. Finding your way – supporting unaccompanied youth (HiS3)</td>
<td>The course provides knowledge and tools to support unaccompanied youth.</td>
<td>Managers, Executive Director, trainers and staff encountered unaccompanied youths. *</td>
</tr>
<tr>
<td>HiS4. Newly-arrived immigrants as a resource</td>
<td>The day will cover how knowledge and experience among newly-arrive immigrants can be used to support others who are new to Sweden as part of the full support of society.</td>
<td>Managers and decision-makers Actors/functions that come into direct contact with newly-arrived immigrants. * * For example, coordinators within county councils and municipalities for issues pertaining to newly-arrived immigrants, communications and information officers within county councils and municipalities, religious communities and country associations, the voluntary sector.</td>
</tr>
<tr>
<td>HiS5. Improved working methods for health surveys</td>
<td>Courses provide knowledge and tools to increase the implementation rate and quality of the medical examinations offered to asylum seekers.</td>
<td>Staff in primary care and healthcare for asylum seekers who work with and conducting medical examinations.</td>
</tr>
</tbody>
</table>
## Courses offered by Health in Sweden to meet needs

<table>
<thead>
<tr>
<th>Courses offered by Health in Sweden for asylum seekers and newly arrived immigrants</th>
<th>Brief description of content</th>
<th>Staff groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HiS6. Migration and mental health – FOUNDATION COURSE</strong></td>
<td>The course provides a basic understanding of how migration affects mental health, how mental illness can manifest itself in different cultures and simple tools for responding to people with stress symptoms related to the migration experience.</td>
<td>Coordinators for issues pertaining to newly-arrived immigrants within county councils and municipalities, Communications and information officers within county councils and municipalities.</td>
</tr>
<tr>
<td><strong>HiS7. Trauma interventions for asylum seekers and newly-arrived immigrants</strong></td>
<td>The course provides the knowledge and tools to provide support and care for trauma victims.</td>
<td>People without medical training who, in their workplace, encounter asylum seekers and newly-arrived immigrants. * For example, staff of accommodation facilities (accommodation for asylum seekers, elderly accommodation), preschools, schools, social services, home help services, leisure, civil society, religious communities, the Swedish Social Insurance Agency, the Swedish Public Employment Service, the Swedish Migration Agency.</td>
</tr>
<tr>
<td><strong>HiS8. Lifespan Integration – method for PTSD and traumatic memories</strong></td>
<td>The course provides knowledge and skills within a new treatment method for post-traumatic stress disorder (PTSD).</td>
<td>Trained therapists (step 1), psychologists in primary care and specialist psychiatry. Please note! Participants are required to know at least two languages: Swedish + a common language among asylum seekers/newly-arrived immigrants.</td>
</tr>
<tr>
<td><strong>HiS9. Migration and mental health – FOR PRIMARY CARE</strong></td>
<td>The course provides knowledge of how migration affects mental health, how mental illness can manifest itself in different cultures and how primary care * can meet the need among asylum seekers and newly-arrived immigrants for psychosocial interventions.</td>
<td>* Team and managers in primary care and specialist psychiatry. Can also be considered for: Children’s healthcare, maternal care, somatic care. * For example, doctors, nurses, social workers, nutritionists, psychotherapists, district nurses, home healthcare staff.</td>
</tr>
<tr>
<td><strong>HiS10. Migration and mental health – FOR STUDENT HEALTH</strong></td>
<td>The course provides knowledge of how migration affects mental health, how mental illness can manifest itself in different cultures and how student health * can meet newly-arrived immigrant students.</td>
<td>Team * in student health, school principals and student health managers. Can also be considered for: Youth clinics. * School doctors, nurses, school psychologists, school counsellors.</td>
</tr>
<tr>
<td>Courses offered by Health in Sweden to meet needs</td>
<td>Brief description of content</td>
<td>Staff groups</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------</td>
</tr>
</tbody>
</table>
| HiS11. Migration and mental health – FOR SPECIALIST PSYCHIATRY | The course provides knowledge of how migration affects mental health, how mental illness can manifest itself in different cultures and how specialist psychiatry *can meet the need among asylum seekers and newly-arrived immigrants for psychiatric interventions. | * Team and managers in specialist psychiatry  
Can also be considered for: Those who work with the disabled  
* For example, doctors, nurses, orderlies, psychologists, social workers, nutritionists, physiotherapists, occupational therapists |
| HiS12. Leading groups in change and implementation | The course provides the knowledge and tools to lead groups in development efforts. The knowledge can for example be applied in group operations aimed at asylum seekers and newly-arrived immigrants, or in the implementation of new working methods for the staff within an organisation. | People who lead various types of groups, such as groups of asylum seekers and newly-arrived immigrants, or staff, to implement development of operations*  
* For example, coordinators for issues pertaining to asylum seekers and newly-arrived immigrants, who will lead health support groups or Health School, trainers/distribution leaders with local responsibility for the distribution of Health in Sweden in the county councils and regions and municipalities. |
| HiS13. Day for managers and decision-makers | The day includes a group discussion on care and support for asylum seekers and newly-arrived immigrants in the short- and long term, based on the needs analysis conducted. | Politicians, senior officials and managers in county councils, municipalities and county administrative boards, those responsible for monitoring (e.g. controllers, business developers) and other relevant actors *  
* For example. the Swedish Social Insurance Agency, the Swedish Public Employment Service, the Swedish Migration Agency |
| HiS14. Health School | This day will present the experiences and results of Health School concept for newly-arrived immigrants in Sweden. Those responsible for the development and implementation of Health School will give advice and guidance on how to establish and conduct the initiative. | Staff who have been assigned to investigate and/or implement the Health School: managers, operations managers, doctors, nurses, psychologists, social workers, nutritionists, physiotherapists, district nurses, and several staff groups within primary care. |
| Suicide Prevention (continuing education in March 2017) | Practical experience and practical advice about suicide prevention, specifically on unaccompanied children and young people and for the target group of asylum seekers and newly-arrived immigrants in general. | Healthcare (healthcare for asylum seekers and integration health, primary care, first-line psychiatry, children’s and young people’s psychiatry, specialist psychiatry); Accommodation facilities; Student health; Social services; Governments and civil society |
B.4 Development and connection to the Asylum Healthcare Platform

Background

The Asylum Healthcare platform was developed from an identified need for a tool to support the county councils and regions plans for meeting the healthcare needs of asylum seekers.

The need was identified during the feasibility study carried out in autumn 2015–winter 2016 by Mission Mental health within SKL together with the Värmland County Council\(^{59}\).

The preliminary study revealed a need for a steering- and planning tool because productivity needs healthcare needs for asylum seekers can vary significantly over time. The Asylum Healthcare Platform was developed for adapting the productivity of healthcare for asylum seekers to both periods of larger and smaller numbers of asylum seekers.

Implementation

In 2016, county councils and regions offered connection to the Asylum Healthcare Platform free-of-charge. Nine counties and regions have so far acceded to the platform, and two more counties and regions will join in 2017\(^{60}\).

To support the county councils and regions in the connection process, several guidance documents were designed describing the connection. A product description and information film on the Asylum Healthcare Platform were developed to distribute information about the platform’s purpose and content\(^{61}\).

All county councils and regions have received support to facilitate connection to the Asylum Healthcare Platform. This support has included the project leadership in the form of guidance documents and email, telephone and Skype meetings as well as technical assistance concerning communication and validation of data entry and technical issues.

To best take advantage of the connection, all connected counties and regions also offered local course sessions. During these sessions, trainers from SKL, together with the respective county/region, go through how the Asylum Healthcare Platform can be used in the operational work to contribute to better planning and monitoring of healthcare for asylum seekers. From this training, a plan is developed for the information contained in the Asylum Healthcare Platform to be used and distributed within the organisation. Four counties have so far\(^{62}\) undergone training with about 10–12 participants each. Three county councils and regions are booked and two plan to schedule training sessions.

The Asylum Healthcare Platform utility and function

The Asylum Healthcare Platform allows connected county councils and regions to receive assistance with planning and follow up for healthcare for asylum seekers. The analyses in the platform contains data on the county council,

---

\(^{59}\) SKL, 2016d

\(^{60}\) As of 20 February 2017, the following are participating: Blekinge, Gävleborg, Kalmar, Kronoberg, Stockholm, Sörmland, Värmland, Västmanland och Östergötland.


\(^{62}\) As of 25 February 2017
municipality and reception level, making it possible to see the current productivity of interventions conducted for asylum seekers and estimated future needs. County councils and regions can use the platform to see which municipalities or care units have an increased or decreased need for healthcare for asylum seekers.

The Asylum Healthcare Platform:

- Enables enhanced production planning and monitoring of healthcare for asylum seekers
- Is a straightforward way to distribute information at the county council level and, for related parties at various levels, to assimilate knowledge of the current situation of healthcare for asylum seekers.
- Enables the exchange of experience between county councils and regions about healthcare for asylum seekers and how the healthcare system will meet the needs

The information can be used to prioritise which areas need resources to meet the needs. The platform is updated monthly, allowing users to continuously monitor the results of the activities designed and implemented to improve healthcare for asylum seekers.

Figure 20. Illustrative overview of how the platform can be used for production planning and monitoring

1. Analysis
   - Assess future needs
   - Assess results of implemented actions

2. Planning
   - Plan which areas need priority
     - Identify the need for specific resources or activities to meet existing needs

3. Design
   - Design activities to be implemented
     - Basis for planning
     - Basis for objectives and objectives

4. Implementation
   - Continuously follow up the results and implement the activities planned
     - Follow up that the implementation plan is monitored and results are given

Content and structure
The platform is a technology platform that collects data from the Swedish Migration Board on asylum flows and from the county councils regarding various healthcare interventions. Based on their data sets, calculations of care needs and production are made and presented in clear visual graphs in the online platform.
The platform consists of three main views. The first view gives an overview of the needs and productivity of medical examinations, the second view an overview of other activities for mental health, and the third of selected operations within other care. Each view comprises a plan and more in-depth information on the analyses, which are described Figure 22 below.

For the analyses in the platform to correspond with the county councils’ and regions’ local estimation of the need for interventions, the analyses can be supplemented with several variables such as estimated proportion of asylum seekers in need of medical screening and interventions for mental health. The analyses in the platform are then adapted to the individual situations in the county councils and regions.

Lessons on healthcare data for asylum seekers in county councils and regions

During the connection process, a number of limitations in the healthcare data for asylum seekers data for connected county councils and regions emerged. These included: records errors, limited availability of data from private care units, lack of uniform registration procedures for healthcare records for asylum seekers in the county councils and regions or registration procedures that complicated the compilation of data. This resulted in a substantial need for

---

63 Interventions for Mental Health consists of visits to a psychologist, psychotherapist, psychiatrist, counsellor and/or asylum seekers have been given a psychiatric diagnosis and/or appointment at a psychiatric clinic/reception.
regular procedures in collaboration with the county counties and regions for quality-control and validation of the data sent in.

Work during the connection process was perceived to contribute to heightened awareness of data quality and data coverage of data pertaining to healthcare for asylum seekers, in 8 out of 12 people who were involved in the connection process.

To account for differences in healthcare records for asylum seekers between different counties and regions, the Asylum Healthcare Platform adjusted its definitions during the connection process. An example of this is some counties and regions using a variety of diagnostic and procedure codes to register medical examinations. To cope with the variation in the diagnosis and procedures, the classification terms for medical examinations were adapted to match the routines in each county council and region.

The time when a medical examination is recorded may also vary between healthcare parties, where some units report an intervention after the first visit, after the second visit, or when compensation is sought. Likewise, it varies when county councils and regions have adequate data and, therefore, they have had to determine themselves when the monthly transfer of medical data for asylum seekers should be transferred to the platform.

In connection with the procedures to reconcile data, it was also revealed that county councils and regions have limited availability in obtaining data on the number of asylum seekers who are waiting for medical examinations. A number of county councils and regions report difficulties in retrieving data as their current system only allows snapshots. These systems often lack an adequate filtering function when the lists at the time contain newborns who will not be offered medical examinations and asylum seekers who have repeatedly refused or failed to arrive for their medical examination. In some cases, it was reported that the lists include asylum seekers who are still waiting for a medical examination even though they moved to the county 10 years earlier.

Based on the above differences regarding procedures for the registration of healthcare for asylum seekers, carefully charting such variations becomes a requirement when developing a platform such as the Asylum Healthcare Platform. Regular collaborative procedures with each county and region to assure data quality, have, therefore, been essential to adapting the platform and maintaining the quality of the data it contains.

---

64 Online survey questionnaire to people involved in the connection process during February 2017.
## Appendix C. Number of registered participants per county council/region and national training module up to and including 3 February 2017

<table>
<thead>
<tr>
<th>Module</th>
<th>Blekinge</th>
<th>Dalarna</th>
<th>Gotland</th>
<th>Gävleborg</th>
<th>Halland</th>
<th>Jämtland/Härjedalen</th>
<th>Jönköping</th>
<th>Kalmar</th>
<th>Kronoberg</th>
<th>Norrbotten</th>
<th>Skåne</th>
<th>Stockholm</th>
<th>Province of Södermanland (south of Stockholm)</th>
<th>Uppsala</th>
<th>Varmland</th>
<th>Västerbotten</th>
<th>Västernorrland</th>
<th>Västmanland</th>
<th>Västra Götaland</th>
<th>Örebro</th>
<th>Östergötland</th>
<th>Other</th>
<th>TOTAL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HiS1. What the entire organisation should know!</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,286</td>
</tr>
<tr>
<td>HiS2. Health information and support for asylum seekers and newly arrived immigrants</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>58</td>
</tr>
<tr>
<td>HiS3. Finding your way – supporting unaccompanied youth</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>HiS4. Newly arrived immigrants as a resource</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>HiS5. Improved working methods for health surveys</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>HiS6. Migration and mental health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>31</td>
</tr>
<tr>
<td>HiS7. Trauma interventions for asylum seekers and newly arrived immigrants</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>HiS8. Lifespan Integration – method for PTSD and traumatic memories* (Code HiS8)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td>HiS9. Migration and mental health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>HiS10. Migration and mental health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>HiS11. Migration and mental health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>HiS12. Leading group activities and change efforts in conjunction with new working methods</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>HiS13. Forum on mental health for managers and decision-makers: right time at the right level</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>HiS14. Health School</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>267</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>34</strong></td>
<td><strong>58</strong></td>
<td><strong>26</strong></td>
<td><strong>40</strong></td>
<td><strong>1</strong></td>
<td><strong>31</strong></td>
<td><strong>61</strong></td>
<td><strong>59</strong></td>
<td><strong>27</strong></td>
<td><strong>28</strong></td>
<td><strong>46</strong></td>
<td><strong>267</strong></td>
<td><strong>88</strong></td>
<td><strong>41</strong></td>
<td><strong>41</strong></td>
<td><strong>17</strong></td>
<td><strong>44</strong></td>
<td><strong>103</strong></td>
<td><strong>53</strong></td>
<td><strong>59</strong></td>
<td><strong>22</strong></td>
<td><strong>140</strong></td>
<td><strong>1,286</strong></td>
</tr>
</tbody>
</table>
Appendix D. Theoretical background and evidence

This appendix provides a basis for support and treatment of asylum seekers and newly-arrived immigrants based on evidence, proven experience (best practice) and policy documents.

On using interpreters

- If it is difficult to arrange an interpreter physically in place, telephone interpretation is often an excellent alternative
- It is preferred to work continuously with the interpreter if the patient and interpreter work well together
- Before the meeting, it is useful to prepare the interpreter on the meeting’s focus and clarify any potential challenges the interpreter and the patient might have in their interaction (e.g. gender, age, cultural background). Clarify that the interpreter needs to ask the therapist to reformulate statements if it becomes difficult for the patient to understand or express themselves.
- During the meeting, it is useful to clarify the roles and issues of confidentiality for the interpreter
- Maintain focus on the patient and not the interpreter
- After the meeting, it is useful to have a dialogue with the interpreter, for debriefing and planning together for future meetings

Creating conditions for a good patient encounter

- Use assessment tools to normalise the problems associated with taboos/stigmas
- Managing patient expectations that the therapist should be an expert in the power position
- Explain in an educational way that symptoms of mental illness are common among asylum seekers and newly-arrived immigrants and can manifest in diverse ways, such as physical symptoms, and that there is good help available.
- As a therapist, address in brief cooperation between therapist and patient
- Begin with open-ended questions to the patient. Be curious and watch for signs of trauma, but wait until the right time to raise issues and do not pressure with questions. There is a risk of arousing strong reactions based on the emotionally-charged nature of these experiences. Examples of formulation for normalising trauma without pressuring the patient: “Many refugees are perhaps not aware that stressful life situations and events they experienced may have lasting effects on their health. The clear majority of refugees experience short-term psychological and social challenges because of the establishment process. It is normal and completely expected. If you experience that these symptoms are ever-present and negatively affect your life and/or if you have thoughts of harming yourself or others, you are always welcome to ask for help “(freely translated from US HSS Guidelines)

On working methods for mental illness related to migration stress and post-traumatic stress disorder (PTSD)

Research into the effects of psychotherapeutic treatment for asylum seekers and newly-arrived immigrants are limited. Various types of psychiatric disorders may be more common among asylum seekers and newly-arrived immigrants.
due to the difficult circumstances that many have experienced during the period before, during and after the migration.

- Use existing methodology for the assessment, treatment and follow-up for other people with the same condition who are not asylum seekers or refugees. Adapt support and treatment based on a person-centred approach, with particular regard to the specific bio-psychosocial conditions that exist in each patient.
- Pay attention to the signs and symptoms of post-traumatic stress and PTSD (such as unexplained somatic (physical) symptoms, sleep disorders or psychiatric illnesses such as depression or panic disorder).
- Do not conduct routine screening for trauma exposure, because the pressure to talk about the traumatic events among highly-functioning patients can introduce problems from the emotionally-charged nature of discussing the events.
- In milder problems: offer psycho-educational support on trauma and its effects.
- Interventions that work actively with physical symptoms and sensations experienced by the patient associated with the traumatic event are recommended.
- The direct trauma processing often toned down in favour of emotional responses, which often are more in focus than the cognitive.
- Research supports the use of cognitive-behavioural therapy (CBT), narrative therapy and group therapy in treating post-traumatic stress disorder (PTSD).
- The overall assessment of the limited research available on psychological treatment methods shows that there is support for the following interventions, especially CBT, to be effective for at least up to a month following treatment:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual trauma focused CBT (TF-CBT)</td>
<td>It seems that the most successful cognitive behavioural therapy involves an effective cultural adaptation, CA-CBT (Culturally Adapted CBT). A variant of CBT which includes a number of techniques that help a person overcome their trauma by actively focusing on thoughts and behaviours related to traumatic experiences.</td>
</tr>
<tr>
<td>Prolonged Exposure (PE)</td>
<td>A variant of trauma-focused CBT based on the premise that anxiety disorders, such as PTSD, stem from pathological psychological fear structures where different parts connect in a way that do not correspond to reality. This is carried out by two different types of exposure, in vivo (in reality) and fantasy. Through guided support from the psychotherapist, the patient can gradually change their perception of the world around them.</td>
</tr>
<tr>
<td>Narrative-Exposure Therapy (NET)</td>
<td>A psychological treatment method that can be used successfully in complex trauma presentations. NET assumes that trauma management always takes place in close relation to the traumatic event and in relation to a person’s overall life experiences. The method starts with putting up a life-line with clear symbols; flowers for positive events and stones for traumatic experiences, candles for sadness and sticks for aggressive events, in a chronological life-line. In the therapy, the life-line is processed in the chronological order in which both positive and negative experiences.</td>
</tr>
</tbody>
</table>
are presented and processed. The story ends with a written testimony. NET (Narrative Exposure Therapy) has been shown to be effective in studies of asylum seekers and newly-arrived refugees in Europe, as well as refugees in refugee camps in Africa.

**Eye movement desensitisation and reprocessing (EMDR)**

A psychological treatment that helps a person to reprocess memories of a traumatic event. The therapy includes recalling distressing trauma-related memories, perceptions and bodily experiences while the therapist guides the movement of the eyes from side to side. It has been shown to provide more positive memories of the traumatic experience.

**Brief Trauma Treatment (BAT)**

BTT was developed in a format that can be given in 20–30 minute sessions, which is suitable for the primary care structure. The method is based on three main areas:

1) Psycho-education on trauma its effects

2) Behavioural activation for both activities that are experienced as positive and activities that are avoided because they arouse discomfort and traumatic memories

3) Motivational support to engage in activities that are perceived as positive (i.e. being able to participate in activities that feel positive and function well in various roles in the home and the community, etc.)

All three components were chosen for pragmatic reasons (e.g. easy to teach, disseminate and implement), and for their strong support of the research (Nathan & Gorman, 2007).

- In milder depressive symptoms, provide training in self-care and monitoring to assess development
- For moderate to severe symptoms, use a “stepped-care” model, beginning with psycho-education and antidepressant medication, close monitoring and counselling adapted to the cultural context
- If there is access to information on accepted treatments for depression (see, for example, The National Board of Health and Welfare’s guidelines), the initial assessment can be recommended with a systematic clinical interview and assessment/self-assessment instruments such as PHQ-9 or equivalent instruments (translated and validated for the target group)
- People with depression may often report somatic symptoms such as fatigue, pain, etc. themselves. When depression is suspected, ensure that the patient receives a guaranteed contact to starting treatment.
- A systematic assessment of losses, stressors and symptoms is important for creating a good overall clinical assessment

**On pharmacological treatment interventions for adults**

The National Board of Health and Welfare’s knowledge overview describes how there are many studies providing evidence for the efficacy of
antidepressant medications, primarily SSRI (e.g. Fluoxetine [42-44], and sertraline [45, 46]) and SNRIs (e.g. Venlafaxine [47]) in treating depression, anxiety disorders and PTSD. In PTSD, successful medications primarily influence the re-experiencing of a traumatic event and other core symptoms of PTSD syndrome.

The European Psychiatric Association (EPA) guidelines for pharmaceutical treatment describe significant research-supported evidence for cultural traits affecting biological factors, which, in turn, can affect how pharmaceuticals work in the body.

**Special considerations**

- The time it takes for pharmaceuticals to have a clear initial effect on PTSD can often be up to 7–8 weeks, almost twice as long as for an initial effect in the treatment of depression or anxiety
- The National Board of Health and Welfare stresses that this and the side effects patients can experience, often lead to the patient to discontinuing treatment
- There is a particular risk of discontinuing treatment if motivation is low and the information has been limited
- There is an increased risk of interruption of treatment, which requires systematic management, when there are different languages among therapists and the patient, and different beliefs about illness and treatment.
- Taking this into consideration, close monitoring and motivational efforts are recommended to ensure correct dose and duration of treatment are achieved.

**References to Appendix D. Theoretical background and evidence**


Kate E Murray et al 2010 – Review of Refugee Mental Health Interventions Following Resettlement: Best Practices and Recommendations https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3727171/#!po=0.549451


Socialstyrelsen, 2015 – Psykisk ohälsa hos asylsökande och Nyanlända migranter – ett kunskapsunderlag för primärvården

US Department of Health and Human Services Centers for Disease Control and Prevention National Center for Emerging and Zoonotic Infectious Diseases, 2015. Guidelines for Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees
**Appendix E.**

Below is the online form for the needs analysis that was developed by SKL. Some county councils and regions made minor adjustments in the online form to adapt it to local conditions.

---

**Formulär för behovsanalys – inom programmet "Hälsa i Sverige för nyanlända och asylsökande"**

Regeringen har beviljat SKL och SKL:s medlemmar stöd för att sprida och implementera effektiva arbetssätt för att främja nyanlända och asylsökandes hälsa. Arbetet koordineras av SKL i programmet "Hälsa i Sverige - för nyanlända och asylsökande." Första fasen i arbetet är att landsdelsregioner och kommuner själva identifierar vilka behov av utveckling och samordning som behövs, innan de delar som programmet "Hälsa i Sverige" omfattar.

Detta formulär, som vi kallar "Formulär för behovsanalys," är ett verktyg för att skapa förståelse av vilka behov ett landsdel/region samt kommuner har.

Om formuläret:
I det första steget ombads du att fylla i dina kontaktuppgifter, detta för att samordnare i landsdel/regionen ska kunna kontakta dig inom ramen för det fortsatta arbetet. Därefter följer 10 frågor med underfrågor, två avsnitt om behov av material och arbetssätt för att främja en positiv hälsoutveckling hos asylsökande och nyanlända. Formuläret uppskattas ta cirka 10-15 minuter att fylla i.

Svara utifrån din bild av behoven hos asylsökande och nyanlända samt med fokus på just din verksamhets perspektiv.

---

Definition av centrala begrepp i detta formulär:

Asylsökande – en utländsk medborgare som tagit sig till Sverige och begärt skydd, men som ännu inte fått sin asylsökning avslutad, ovan jön fylls i av migrationsverket och eller migrationsdomstol.

Nyanlända – en person som under de senaste åren ankommit till Sverige och bevistats uppfallandebeständigt. Försiktigen fokus är nyanlända med flyktingaspirerande, så vid frågor om nyanlända svara utifrån din bild av behoven i den månggruppen.

*Obligatorisk

---

**Kontaktuppgifter till dig som fyller i formuläret**

1. **Landsting/Region/Kommun** *

2. **Namn (för- och efternamn)** *

3. **Organisatorisk enhet (ex. avdelning/enhet)** *

4. **Rolle* *

5. **Mejladdr** *

6. **Upprepa mejladdr** *

7. **Mobilnummer (07XXXXXX) ** *
Behov hos alla asylsökande och nyanlända

Nedan ställs ett antal frågor om behov hos alla asylsökande och nyanlända, med fokus på de områden som ingår i programmet ”Hälso i Sverige”. I nästa avsnitt ställs frågor om behov kopplat till asylsökande och nyanlända med psykisk ohälsa samt övriga behov.

8. 1) Har ni behov av förstärkta material och arbetsätt för att ge hälsoinformation till asylsökande och nyanlända? *

Beskrivning: Med ovan avses material (på olika språk samt anpassat till olika kulturer och grad av läskunnighet) och arbetsätt för att stärka kunskaper om hälsa, svensk hälso- och sjukvård och hålls xhrörsökning hos alla asylsökande och nyanlända.

Markera endast en oval.

- Ja
- Nej
- Vet ej

9. Om ja på fråga 1), beskriv behoven:

10. Om ja på fråga 1), uppskatta hur stor andel asylsökande respektive nyanlända som har behov av hälsoinformation? *

Markera endast en oval per rad:

<table>
<thead>
<tr>
<th>0-25%</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
<th>Vet ej</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylsökande</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nyanlända</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. 2) Har ni behov av förstärkta material och arbetsätt för att genomföra hålls xhrörsökningar av asylsökande? *

Beskrivning: Med ovan menas arbetsätt och material för att öka genomförande graden och kvaliteten i de hålls xhrörsökningar som genomförs.

Markera endast en oval.

- Ja
- Nej
- Vet ej

12. Om ja på fråga 2), beskriv behoven:

13. 3) Har ni behov av att erbjuda/utöka utbildning för personal om migration och psykisk ohälsa? *


Markera endast en oval.

- Ja
- Nej
- Vet ej

14. Om ja på fråga 3), beskriv vilken typ av utbildning som behövs och vilken/vilka personalgrupper som har behovet.
15. Om ja på fråga 3), uppskatta hur stor andel inom denna/dessa personalgrupper som har behov av utbildningen: 
   Markera endast en oval per rad.
   0-25%  26-50%  51-75%  76-100%  Vet ej
   Personel med behov av utbildning

16. 4) Har ni behov av att erbjuda/utöka hälsofrämjande och förebyggande insatser för asylsökande och nyanlända?
   Markera endast en oval.
   Ja
   Nej
   Vet ej

17. Om ja på fråga 4), beskriv behoven:

18. Om ja på fråga 4), uppskatta hur stor andel asylsökande respektive nyanlända som har behov av hälsofrämjande och förebyggande insatser:
   Markera endast en oval per rad.
   0-25%  26-50%  51-76%  76-100%
   Asylsökande
   Nyanlända

**Behov hos asylsökande och nyanlända med psykisk ohälsa**

19. 5) Har ni behov av att erbjuda/utöka insatser för asylsökande/nyanlända med lätt till medelsvår psykisk ohälsa?
   Beskrivning: Med ovan menas insatser för att hantiera lätt till medelsvår psykisk ohälsa motsvarande Lex, råd- och sällsamma insatser, behandling för lätt till medelsvår psykisk ohälsa i primärvården samt trauma behandling i primärvården.
   Markera endast en oval.
   Ja
   Nej
   Vet ej

20. Om ja på fråga 5), beskriv behoven:

21. Om ja på fråga 5), uppskatta hur stor andel av asylsökande respektive nyanlända som har behov av insatser vid lätt till medelsvår psykisk ohälsa: 
   Markera endast en oval per rad.
   0-25%  29-50%  51-75%  76-100%  Vet ej
   Asylsökande
   Nyanlända
22. 6) Har ni behov av att erbjuda/utöka insatser för asylsökande/nyanlända med svår psykisk ohälsa? *  
□ Ja  
□ Nej  
□ Vet ej  

23. Om ja på fråga 6, beskriv behoven:  

_________________________________________________________________________  

_________________________________________________________________________  

_________________________________________________________________________  

24. Om ja på fråga 6), uppskattar hur stor andel av asylsökande respektive nyanlända som har behov av insatser vid svår psykisk ohälsa: 
Markera endast en rätt per rad.

<table>
<thead>
<tr>
<th>Asylsökande</th>
<th>0-25%</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
<th>Vet ej</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nyanlända</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25. 7) Har ni behov av att erbjuda/utöka handledning för personal om vård av asylsökande och nyanlända med psykisk ohälsa? *  
□ Ja  
□ Nej  
□ Vet ej  

26. Om ja på fråga 7), beskriv vilken typ av handledning som behövs och vilken/vilka personalgrupper som har behovet:  

_________________________________________________________________________  

_________________________________________________________________________  

_________________________________________________________________________  

27. 8) Har ni behov av att erbjuda/utöka utbildning för personal om vård av asylsökande och nyanlända med psykisk ohälsa? *  
Beskrivning: Med ovan avses utbildning för att öka den grundläggande kunskapen om möjliga utmaningar i patientmötet, kulturella aspekter av symtom och beskrivningar av besvär m.m. Markera endast en rätt.
□ Ja  
□ Nej  
□ Vet ej  

28. Om ja på fråga 8), beskriv vilken typ av utbildning som behövs och vilken/vilka personalgrupper som har behovet:  

_________________________________________________________________________  

_________________________________________________________________________  

_________________________________________________________________________  

---

Health in Sweden for asylum seekers and newly-arrived immigrants

82
29. Om ja på fråga 8), uppskatta hur stor andel inom den/dessa personalgrupper som har behov av utbildning: 

Markera endast en oval per rad.

<table>
<thead>
<tr>
<th>O-25%</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
<th>Vet ej</th>
</tr>
</thead>
</table>

Personal med behov av utbildning ( ) ( ) ( ) ( ) ( )

30. 9) Vilka ytterligare behov har ni av insatser, material och arbetsätt för att förbättra hälsan hos asylsökande och nyanlända? Beskriv:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

31. 10) Vilka behov har ni kopplat till samordning och koordinering av arbetet med asylsökande och nyanlända? Beskriv:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

32. Övriga behov/kommentarer:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Health in Sweden for asylum seekers and newly-arrived immigrants
### Appendix F. Financial statement

#### Health in Sweden for asylum seekers and newly-arrived immigrants

<table>
<thead>
<tr>
<th>Funding received 2016</th>
<th>in SEK thousands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds to distribute to county councils</td>
<td>-15,000</td>
</tr>
<tr>
<td>Asylum Healthcare Platform (operational and support)</td>
<td>-847</td>
</tr>
<tr>
<td>Staff office</td>
<td>-3,306</td>
</tr>
<tr>
<td>Training</td>
<td>-9,746</td>
</tr>
<tr>
<td>Materials/ new development (collaboration with external operators etc.)</td>
<td>-3,856</td>
</tr>
<tr>
<td>Distribution (course sessions, packaging of courses, etc.)</td>
<td>-5,890</td>
</tr>
<tr>
<td>Other</td>
<td>-1,089</td>
</tr>
<tr>
<td><strong>AMOUNT to refund</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

#### Distribution by county council/region

<table>
<thead>
<tr>
<th>Distribution by county council/region</th>
<th>Distribution*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blekinge</td>
<td>500,000</td>
</tr>
<tr>
<td>Dalarna</td>
<td>600,000</td>
</tr>
<tr>
<td>Gotland</td>
<td>400,000</td>
</tr>
<tr>
<td>Gävleborg</td>
<td>600,000</td>
</tr>
<tr>
<td>Halland</td>
<td>700,000</td>
</tr>
<tr>
<td>Jämtland/Härjedalen</td>
<td>500,000</td>
</tr>
<tr>
<td>Jönköping</td>
<td>700,000</td>
</tr>
<tr>
<td>Kalmar</td>
<td>600,000</td>
</tr>
<tr>
<td>Kronoberg</td>
<td>500,000</td>
</tr>
<tr>
<td>Norrbotten</td>
<td>600,000</td>
</tr>
<tr>
<td>Skåne</td>
<td>1,100,000</td>
</tr>
<tr>
<td>Stockholm</td>
<td>1,100,000</td>
</tr>
<tr>
<td>Province of Södermanland (south of Stockholm)</td>
<td>600,000</td>
</tr>
<tr>
<td>Uppsala</td>
<td>700,000</td>
</tr>
<tr>
<td>Värmland</td>
<td>600,000</td>
</tr>
<tr>
<td>Västerbotten</td>
<td>600,000</td>
</tr>
<tr>
<td>Västernorrland</td>
<td>600,000</td>
</tr>
<tr>
<td>Västmanland</td>
<td>600,000</td>
</tr>
<tr>
<td>Västra Götaland</td>
<td>1,100,000</td>
</tr>
<tr>
<td>Örebro</td>
<td>600,000</td>
</tr>
<tr>
<td>Östergötland</td>
<td>700,000</td>
</tr>
<tr>
<td>Asylum Healthcare Platform (start-up and IT development)</td>
<td>500,000</td>
</tr>
<tr>
<td>Inera (1177 online)</td>
<td>500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15,000,000</strong></td>
</tr>
</tbody>
</table>

* All county councils and regions were initially assigned SEK 300,000 and then an additional supplement (SEK 100,000–800,000) calculated as five size classes based on the number of inhabitants.
Health in Sweden for asylum seekers and newly-arrived immigrants

Final report for the national distribution of interventions from the feasibility study of positive health development for asylum seekers and newly-arrived immigrants

For further information on the content
Ing-Marie Wieselgren ing-marie.wieselgren@skl.se

© Sveriges Kommuner och Landsting, 2017

Order or download at webbutik.skl.se. ISBN / Order Number No