EU-MiCare
Training the EU Health Workforce to Improve Migrant and Refugee Mental Health Care

KA2 Projekt 2022-1-DE02-KA220-VET-000087682

Work Package n°2 – Conceptual framework and Co-Created Training Scheme for covering mental health needs of migrants and refugees

RESULTS OF THE WP2

CO-CREATION ACTIVITIES

Countries: Cyprus, Germany, Greece, Italy, Spain

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Introduction

In the framework of WP2, two co-creation sessions were conducted in each partner country with a total of 60 experts. The participants of the sessions were members of the project target group and possible beneficiaries the EU-MiCare training (see participants´ overview in each partner country).

The aim of the co-creation sessions was to gain important insight into the needs and expectations of healthcare professionals and other professionals working with migrants/refugees in relation to migrant´s mental health. Through these activities, it will be possible to develop a training corresponding to their needs, practice-oriented and therefore more adequate and effective.

The focus groups allowed to get direct information and perspectives from the different future users of the training, to learn more about their everyday challenges, needs and wishes in order to develop the training content accordingly. Participants of the co-creation session contributed in deciding upon which areas and topic the training will focus on as well as its lenght and modality.

Although they come from different VET systems and backgrounds, all professionals participating in the focus groups confirmed that there is a need for the proposed content of the training curriculum. It was confirmed in the meetings that the existing vocational training for professionals from the psychosocial field in all project countries is not sufficient to prepare them adequately for the challenges of everyday work with refugees and migrants. In particular, the thematic interface migration-mental health, which is the focus of EU-MiCare, is not or not sufficiently represented in the current vocational training systems in all countries.

The sessions were recorded and significant passages were transcribed *verbatim*.

The co-creation activities were also an opportunity to start promoting the EU-MiCare project among the target groups and establish crucial first contacts to professionals and volunteers who will be included in further project activities, especially the validation sessions in WP3, when further feedback on the first draft of the training curriculum will be discussed.

Cyprus

1. Introduction

In this co-creation session, two focus groups were conducted. The first focus group, where participants were health academics, five people were involved. In the second focus group, where health professionals were involved, the participants were four people.

The interesting and most difficult part was the recruitment process. Firstly, a brief email was sent to the participants. Once they reacted to this, phone calls took place in order to give more information about the program and the purpose of these co-sessions. Then, a doodle poll was conducted in order to arrange the on-line meeting. This was a quite difficult, because all of our participants are working and have heavy schedule.

In the following part, tables of both focus groups which contain the demographic characteristics are shown.

Focus group 1 - Participants

Participants	Profession	Workplace
Participant 1	**Professor**	**University Department of Nursing**
Participant 2	**Lecturer**	**University School of Medicine**
Participant 3	**Lecturer**	**University Department of Nursing**
Participant 4	**Researcher**	**University**
Participant 5	**Adjust Faculty Instructor**	**Universities**

Focus group 2 - Participants

Participants	Profession	Workplace
Participant 1	**Physician**	**General Hospital**
Participant 2	**Phycologist**	**Health Centre**

Participant 3	**Nurse**	**General Hospital**
Participant 4	**Nurse**	**University**

2. Mental health issues of migrants/refugees in everyday professional practice

2a. Consideration of mental health in relation with the overall health and care provision

The most important elements in the considerations presented more detailed in chapters 2a and of the present report. These are:

Mental health is degraded in Cyprus, especially in migrants and refugees.

All the participants of both focus groups pointed out the degression of mental health in Cyprus generally but specifically in migrants and refugees.

“Our work and profession are quite underestimated in Cyprus.”

“Provision of mental health doesn’t exist. In addition, a recent action of CUT regarding the refugee, a report was made on the Hot spots about the bad conditions and especially in the mental health part (opinion of psychologists and professors).” (professor)

“There is no organized action” (giving an extra burden since clinical psychologist said it many times).

“Psychological support for these individuals is limited at all. It is a pressing need though.” (lecturer)

“Mental health is an integral part of health both at the personal level and at the health care system level. Unless someone is healthy from a mental perspective it will be hard if impossible to function at any other level of his/her life including the professional level.” (Adjust Faculty Instructor)

“Mental health is just as important as other aspects of good health. I therefore consider that mental health care should be provided equally (where necessary) with physical health.” (Nurse)

The provision of health in general for refugees/immigrants is degraded on Cyprus.

All participants agreed to a stressful conclusion. The provision of overall health and care is better than mental health.

“Of course, if we compare overall health and mental health, overall health is better for migrants and refugees.” (Researcher)

“If the comparison is between overall health and mental health, overall health is given more to migrants and refugees. But if the comparison is between migrants/refugees and locals, again migrant/refugees do not have a proper provision of overall health”. (professor)

"I believe that Mental health is an integral part of overall health and plays a vital role in the provision of care. It is interconnected with physical health, influences quality of life, and should be considered to ensure comprehensive and effective healthcare." (Nurse)

2b. Experience in mental health issues in your everyday professional practice.

All the participants pointed out the fact that there are also difficulties due to the fact that migrants and refugees have different culture, and underestimate the importance of mental health.

Migrants and refugee's dysfunctionality for asking help

"Unfortunately, migrants and refugees themselves do not easily ask for help for mental health issues (e.g. due to ignorance, culture, they practice medicine)." (Clinical Phycologist)

"Religious and social beliefs make them sideline mental health issues." (Researcher)

"In my current job, I do not face patients with mental health issues directly as it is not a primary focus of my role, however in a previous position I encounter some patients who were struggling with mental health conditions, such as anxiety or depression. While I found it challenging it's also rewarding experience." (Nurse)

"At this point of my life, I do not deal with any mental health issues. I try to keep a balanced life where work does not overcome my personal life, but I also take measures that help me deal with the daily stress such a breathing exercise, meditation, going for walk or exercising, things that migrants don't have the chance to do" (Adjust Faculty Instructor)

"In my daily practice I usually deal with problems mainly related to stress." (Nurse)

Differencing based on sex

"People who have attempted suicide come to the hospital and they are mainly women." (physician)

"Unfortunately, due to language issues there is difficult communication and sometimes the interpreter can make the situation more difficult (relative, untrusted person)." (Clinical phycologist)

"Language is a severe barrier in treatment especially for women." (physician)

2c. Mental health issues that have been observed while providing healthcare services to migrants/refugees.

All participants and specifically physicians, nurses and clinical psychologists, mention many mental issues that have been observed while providing healthcare services to migrants and refugees. The most important are: Suicide attempts, depression, anxiety disorders, panic attacks and post-traumatic stress syndrome.

- ***The most common mental disorder: Post Traumatic Mental Disorder (PTSD)***

"Post Traumatic Stress Disorder (Severe Disorder that requires a lot of work and organization to be able to work)" (lecturer)

"Post-traumatic stress syndrome is very common, especially when migrants and refugees originated from countries that have war." (Clinical phycologist)

“I do not provide any health care services to migrants/refugees, but I think PTSD is the most important” (Adjust Faculty Instructor)

- ***Depression, anxiety disorders and panic attacks***

“Suicide attempts, depression, anxiety disorders, panic attacks and post-traumatic stress syndrome.” (physician)

“The main issues I have observed are related to the emotional state of the migrants/refugees, like depression and anxiety.” (Nurse)

- ***Disorders that were created in Cyprus and specifically in Hot Spots.***

“The conditions in which they live is very serious problem!” (professor)

“We create the same problem. For example, rapes were observed inside the hot spots.” (researcher)

2d. If so, how often does this happen? How do you react in these cases? How do you feel?

All participants pointed out the fact that incidents are happening very often. The feelings are varied with the most common to be anger, affliction, shame and disappointment.

- ***Difficulties in the process of asking monitoring***

“For monitoring by a clinical psychologist, they have to make a request and the requests are constantly increasing. People with mental problems need support from the social context and unfortunately immigrants/refugees don't have it so I feel powerless to help.” (Clinical phycologist)

“Every week or every fortnight there are such incidents.” (physician)

“We have not learned from our history. I feel ashamed. They haven't changed much.” (lecturer)

“I feel anger. We are coming from parents that were refugees in their own country. We should be able to understand what kicked out of your house mean.” (professor)

“The feeling is disappointment about the situation of our state. There is a serious problem in an organized state. We tolerate many things without reaction. We learned not to react.” (researcher)

- ***Serious obstacle: language***

“Language is the most difficult barrier to communication.”

“It does not happen very often, but once they feel safe to talk to you people become more expressive and tend to show emotions that otherwise wouldn’t express. I try to be supportive in these cases and make the other person feel safe. I show compassion and try to understand them. Most of the times I feel sympathy and I feel that the position these people are found is unfair.” (Nurse)

“I think knowing the language of the migrant population helps a lot in gaining trust and entry into the migrant community.”

3. Knowledge and training on mental health issues for migrants/refugees

3a. If you have already encountered migrants with mental health issues in your professional practice, did you feel prepared and trained to address them?

Participants who have encountered migrants with mental health issues in their professional answered the same thing. They don't always feel prepared and trained to address them.

"Not always. Every situation differs." (Clinical Phycologist)

"I wouldn't say that I felt prepared since I was not trained to address them." (Nurse)

"During my work as a faculty member, I never worked with migrants unless we consider my former or current students as migrants. As a migrant myself, while a college student in the US and a faculty member at Kuwait, my friends and family were my social support that helped me deal with minor mental health issues such as being homesick, being stressed out so that they never escalated to a major mental health issue." (Adjust Faculty Instructor)

3b. Where did you acquire your competencies and knowledge in the field of mental health and migration? Was it part of your professional training?

- **First stage of education**

"My knowledge comes mainly from some classes we took during my bachelor's degree. Other than that, I did not have any special training." (Nurse)

"My first job in public health was to work as a health educator in the rural areas of South Carolina with migrants from Central America. That was many years ago, but I remember that my colleagues and I received a week's training before we worked with the migrants. The reason I wanted to work with this group of migrants was also due to my interest in the Spanish language and I did use Spanish when I communicated with the migrants." (Adjust Faculty Instructor)

- **Lack of knowledge in the professional training**

All the participants pointed out that in their training, there was lack of knowledge concerning mental health and migration. The interesting part is that our professionals studied in different countries such as Cyprus, Greece, United Kiddom and USA.

"No, in my medical studies there was no course about that I did in EU. It's all based on experience. There must be training and networking among health professionals." (physician)

"There was no course in my studies but the basics of managing mental health issues are always the same." (Clinical phycologist)

"Let's be honest. First line professionals such as mental health nurses, doctors, pathologists, social workers, interpreters need to be trained more and know where these people can stay." (researcher)

"There was nothing concrete about my degree in Psychology. Nothing mandatory. Only at the level of personal initiative concerning the training part. My Cyprus, England, Greece (Athens and Patras)" (professor)

3c. What was missing in your professional training, education etc. which could improve your knowledge on the field of migration and mental health?

Based on the answers of all the participants, for every and each point of view, one conclusion came out. There was no organized part on their education concerning their knowledge on the field of migration and mental health.

“I have no specialized knowledge. It's all empirical.” (physician)

“It would be beneficial if I was more aware of the culture and background of migrants / refugees, and how trauma impacts mental health in order to be able to apply the appropriate interventions.” (Nurse)

“The training I had was a long time ago, but I remember that it included some kind of bonding exercises among the professionals working with the migrants, and understanding the legal issues associated with the migrant population. I think it is important that the organizers put emphasis on the mental health issues of the workers and creating strong supportive relationships among them.” (Adjust Faculty Instructor)

3d. What knowledge, tools, materials could help you in your professional practice?

All participants pointed out the need for further knowledge. The tools and materials that could help in their professional practice are divided in two main arguments. Access to immigrant informational materials and familiarization with the cultural competency.

- ***Cultural Competency***

“I believe that one of the main problems in everyday practice is communication. It would be useful if we had some tools helping as with the language. Maybe, leaflets translated in other languages with some common, useful phrases, that could help us understand better the needs of each patient.” (Nurse)

“Availability of interpreters or translation tools.” (Clinical phycologist)

“A reference to the physical needs of refugees. No association of services with these groups (Community Services in Athens).”

“The cultural competency piece is needed -> Translators for programs with an immigrant background (refugee resume)”

- ***Information Materials***

“Information brochures e.g. in different languages to inform patients who will come for mental health issues and what steps they need to follow. (e.g. to go after a GP to a psychiatrist for follow-up)” (Clinical phycologist)

“Some information on the health-related habits of each culture would also be useful to be present at hospitals.” (Nurse)

“Moreover, opportunities for practical application and real-world case studies related to migration and mental health would have been valuable.” (Nurse)

“CUT Nursing Department in the 4th Year: Intercultural Nursing”

“Mental Health: Two Courses in the nursing department.”

4. Healthcare professionals' proposals regarding the content of the program's training

This part was one of the most interesting parts in our discussion. Every professional on its own field had many suggestions and proposal for the content of the program's training.

4a. What is the importance of migrants' mental health in relation to integration process

The importance of migrants' mental health in relation to integration process is imperative. The following quotes confirmed this statement.

- ***Importance based on profession***

"Yes, there is a need. Especially for pathologists, psychologists, psychiatrists, mental health nurses, social workers and even volunteers who work in immigrant structures as well as for other specialties such as police officers." (Clinical phycologist)

"Healthcare providers, social workers, counselors, and any other staff working with immigrants at First Reception Centre / Rescue Camp / Refugees camp." (Nurse)

"Migrants' mental health is important for the integration process because it impacts their ability to adapt, overcome challenges, and promote health equity. Addressing their mental health needs is crucial for their well-being and successful integration." (Nurse)

"Volunteerism is important. For example: Hope for Children is an organization in Cyprus. But also, more professions (police etc.)" (lecturer)

"This topic is necessary because if those directly involved If they understand its importance, they will be more ready to be trained in it and apply what they have been trained." (Nurse)

- ***Cultural Factors***

"Mainly the difficult part concerning this topic should be given importance. The main problem is cultural factors. For all health professionals (nurses and psychologists who are closer) the need is imperative." (professor)

"Professionals should be ready to integrate migrants and refugees. That acquires to know migrants' culture in order to be prepare to use the right tools. In that way, migrants will feel secure." (researcher)

"Migration and mental health context (e.g., phases of migration, protective and risk factors for mental health, etc.)" (Nurse)

4b. Improving healthcare professionals' skills on recognizing/ assessing migrants' mental health needs.

All participants admitted that the recognition of mental health needs in migrants and refugees is very important in order to begin the integration. Without recognition and assessment there is no point of trying improving the mental health need. Targeted actions should be done.

- ***Improvement on skills based on profession***

"Yes, there is a need. It is important to have such seminars so that medical staff learn to recognize when someone needs help." (physician)

"There is a need but how much time does a healthcare professional have? Those on the front lines need it. It could be short. E.g., do you sleep well with questions we can understand that something is happening." (Clinical phycologist)

"Healthcare professionals should be equipped with the skills to recognize and assess these needs to ensure appropriate interventions and support and also for providing effective and culturally sensitive care." (Nurse)

"Primary care physicians, psychologists, psychiatrists, nurses, social workers, counselors, and other professionals involved in providing healthcare and support services." (Nurse)

"Important issues are post-traumatic stress and suicidal tendencies." (Clinical phycologist)

"Grief of their own life is very important to understand it and try to feel it" (professor)

"To those directly involved who work in migrant structures or because of the nature of their work come into contact with refugees. Nurses, police officers, port guards, community workers, teachers, etc." (Nurse)

"It is necessary because the improvement of these skills is likely to prevent problems that arise (tensions, suicide attempts, etc.) due to more timely recognition of mental health needs." (Nurse)

- ***Cultural Factors***

"Education that should not be free from the theoretical framework. E.g., The psychological resilience parts." (researcher)

"In United Kiddom, there is something that is calling special training on unconscious bias. Very basic especially in a very sensitive population. This training attempts professional to influence as little as possible." (professor)

"Migrants and refugees experience loss, separation, and mourning which have a huge impact on their mental health. They also experience trauma and feel loneliness which in turns increase the risk of suicide. These topics are important to be covered so professionals can spot the signs and have the ability to intervene accordingly" (Nurse)

4c. Improving healthcare professionals' skills on managing migrants' mental health needs

Participants pointed out that improving healthcare professionals' skills on managing migrants' mental health is mandatory for themselves but also for our society, giving an extra burden to the fact that is equally important the provision after the incidence. Specifically:

"It is not so much the management in an acute case but the proper follow-up afterwards to avoid, for example, a second suicide attempt." (Clinical Phycologist)

"Migrants often have unique mental health needs. They come from a different cultural background, and experience language barriers, and acculturation challenges. Healthcare professionals need specific skills to address these diverse needs effectively." (Nurse)

“As with the previous topics, this theme would be useful for Primary care physicians, psychologists, psychiatrists, nurses, social workers, counselors, and other professionals involved in providing healthcare and support services.” (Nurse)

“I believe those who are on the first line on recognizing migrants’ mental health needs and dealing with them are the pharmacists, the nurses, the health care administrators, the physicians, the social workers and public health professionals and especially health educators. The reason being is that they are the ones who will do the first critical assessment of the needs of the migrants but also, they represent the ‘gate of the system” and if they migrants do not have a good experience while engaging with the health care system the first time, they may never come back and ask for help especially when dealing with mental health issues.” (Adjust Faculty Instructor)

“It is necessary because health professionals who work in structures that host immigrants come into contact with such problems that make it even more difficult for these people to live. So being with people properly trained in managing such problems will help refugees experience this period more smoothly as well as their integration period into Cypriot society.” (Nurse)

4d. Supporting healthcare and other professionals

Based on the answers of all participants, two arguments came up. Fragmentation and the need of health professional to feel support.

- ***Health professionals support***

“Mental distress happens to all of us. These people cannot talk to us so managing the situation is difficult. Immigrants/refugees do not offer extra stress. The issue is that I can't understand the background and the situation.” (Clinical Phycologist)

“Material to support professionals is necessary for everyone and not only for those dealing with immigrants / refugees.” (physician)

“Supporting healthcare and other professionals is necessary for several reasons. Professionals require assistance to navigate the unique challenges posed by diverse cultural backgrounds. Supporting professionals' well-being and preventing burnout is crucial due to the emotional demands of working with migrants, particularly those with mental health needs. Professionals may also need support to enhance their cultural competence and understanding of diverse cultural practices.” (Nurse)

“I am not sure who these might be, it could be the people who clean the health care premises, the receptionists etc. “(Adjust Faculty Instructor)

“The provision of health care or other services to people of different cultures who experience a stressful situation such as immigration, war, refugee certainly psychologically burdens the professional. It is important to support these professionals.” (Nurse)

- ***Elimination of Fragmentation***

“Health professionals also need awareness training.” (physician)

“Specialized intervention is one of the most important things” (researcher)

“The term Fragmentation! Difficulty in cooperation of professionals -> Inability of the system to have a strategy.” (professor)

“In the Public Health section, we have an issue there as well. There are various factors such as Language, trust and many more Barriers.” (researcher)

“Healthcare Professionals, community health workers (They provide support education, and guidance, and supporting them enhances their capacity to address migrants' mental health needs)

Interpreters (Supporting them in understanding mental health issues and effective communication strategies is essential for ensuring accurate interpretation and cultural sensitivity)” (Nurse)

“Need to include most public health issues that they face, use of surveillance system, if there is not one in place, to monitor related health indicators, emphasis on social determinants, incorporation of relevant NGOs and governmental organizations dealing with migrants and describing the legal framework in Cyprus and Europe regarding immigrants.” (Adjust Faculty Instructor)

Participants gave a large part in this section, mentioning the following considerations:

- **Is there a need for special training on the provision of psychological support with the presence of an interpreter?**

All the participants probe the fact that presence of an interpreter with special training in one of the most important steps in order to exist a correct provision of phycological support to migrants and refugees. There are times that a non-specialist interpreter works as an inhibitory factor-migrants and especially migrant women do not feel safe to express their feeling.

“The interpreter is not an independent person and the translator often does not translate everything or the patient does not tell everything to the translator.” (physician)

“If translators had formal training it would be easier.” (Clinical phycologist)

“I haven't had any experiences with interpreters because I speak English and French and the incidents I've had have been fine so far.” (Clinical phycologist)

- **Is there a need for special training on the special needs of different types of migrants in terms of recognizing and managing mental health issues? E.g., LGBTQI+ refugees, disabled migrant population, migrant population with chronic diseases, elderly migrants etc.**

“Of course! There is a special need for gender education. Many incidents are women. We have incidents of rapes inside the hot spots” (physician)

- **Is there a need for special training on preventing mental health issues of migrants?**

“Yes, prevention is important. Don’t forget that prevention is always better than therapy!” (physician)

5. Healthcare professionals' proposals regarding the methodology and other considerations for the Programme's training

All the participants gave very useful feedback regarding the methodology for the Program's training. All the considerations were discussed, helping us understand the value of this program and how can we make it better.

5a. Length of the Course

Through the discussion, most of the professionals agreed to one thing. Due to the fact that healthcare professionals acquire most of their time to occupied their profession, a training course with short duration will be more possible and helpful. Maybe two or three times a week for half an hour. On the other hand, academics were more flexible about the training course.

"An ideal training course should be short and simple, containing graphs pictures. The duration is important to be short" (physician)

"Every day we have to deal with so many things. A short duration is important." (Clinical Phycologist)

"Hm, about the duration. I think that depends on the context. I wouldn't go with a number." (professor)

"I believe that a few hours can provide a basic introduction, however in order to cover the topic more in depth more hours would be necessary. Probably a total of 3 days spread in 2-3 weeks." (Nurse)

"For me, ideally would be for about 1 year, once a week 2-3 hours." (Nurse)

5b. Methodology

- **The course should be more practical or more theoretical? Or equal?**

Most of the participants here explained that practice and theory is equally important! Of course, there was a difference between healthcare professionals and academics, with the second ones giving a little bit more value to theoretical part.

"Education should not be free from the theoretical framework. Practice and theory are always going hand by hand. A perfect example is psychological resilience -we need to understand what it is and how it works both theoretically and practically." (researcher)

"I think that combination of theoretical and practical material is the right one, giving extra burden to clinical problems and how you deal with them." (physician)

"I think should be equally practical and theoretical. You need to make sure that the participants when they leave, they have some skills they can use." (Adjust Faculty Instructor)

"Both practical and theoretical. Also, through experiential workshops." (Nurse)

- **By whom need to be carried out / type and occupation of the trainers? Or self-learning?**

All the participants pointed out the fact that both training from specialized trainers and self-learning is appropriate, giving an extra burden to specialized individuals.

“Self-learning process and specialized training are two different things. Both are needed and helpful.” (professor)

“When it is possible for specialized individuals to come, of course we preferred it.” (researcher)

“I think the first training should be in person and subsequent trainings (to brush up some skills) could be in as self-learning. I am not sure who should be doing the trainings, I suggest public health professionals with expertise in migrant health.” (Adjust Faculty Instructor)

“People who have experience and training with refugees / migrants and have knowledge on the other cultures. Could be psychologists, social workers or healthcare professionals that have work experience on the topic.” (Nurse)

“From psychologists mainly. It shouldn't be in a self-learning process in my opinion.” (Nurse)

- **Would it be important to have examples of best practices or study cases during the course?**

All participants agreed to something, even their occupation differs. Always an example of best practices or study cases during the course are quite important. Academics brought as an example their teaching to their students, where one of the most important things is to give examples and create an image.

“Targeting your knowledge through examples is always a success for us. Same applies here. Of course, is very important to have examples or case studies.” (professor)

“Case studies are very important. For example, we could have two training groups. Those who are already working and those who are preparing (i.e. in the part of the educational system) e.g. Sociology.” (lecturer)

“Yes, it would be really valuable to have those, especially study cases.” (Nurse)

“Definitely. I think within the European Public Health Association, there is a section on migrant health and you can contact the group leaders and find more information.” (Adjust Faculty Instructor)

- **Do you think it is important to have a training platform where collaboration and best practices among trainees and trainers can be shared during the course (chat, forum…)?**

“Platforms are very helpful when you try to share information and specialized knowledge, because is accessible to everyone who is interested.” (lecturer)

“I think it would be very useful.” (Nurse)

“Yes, I agree with that idea.” (Adjust Faculty Instructor)

- **What about language issues?**

Interesting approach from our participants. Besides the proposition of visual text, they also suggest a trained interpreter working on the platform. Migrants and refugees need to feel safe and accepted in the new societies that they enter and language is the biggest barrier to this.

“Language barrier is huge. So, the solution to this is trained and independent interpreter. It is very important for migrants and refugees not to have any sentimental attachment with the translator thus feeling safe.” (professor)

“I think English should be the language used if the workers come from different ethnic groups.” (Adjust Faculty Instructor)

5c. Training materials:

All the participants suggested a quite few trainings material. Course Handbook., Power Point Presentations, Complementary readings (pdf files, links to websites…), Videos or other media materials with examples of best practices, Website with access to different training materials.

“Ideally the course would be online. Short duration in order to stay focused” (Clinical Phycologist)

“A combination of Course Handbook., Power Point Presentations, Complementary readings (pdf files, links to websites…), Videos or other media materials with examples of best practices and website.” (Adjust Faculty Instructor)

“It would be very helpful to be recorded” (Physician)

“Combination of theorical and practical material. Something not very tiring. I don’t want just to read a power point in order to understand what it says” (Physician)

“It should have been simple and with short duration containing images and graphs” (professor)

“Videos would be very helpful. Ideally the existence of a website with access in order to find the videos whenever there is time.” (physician)

“Happy to ask. There are several training materials that could be applied to professionals. For example, skill-based workshops or role-playing. Don’t forget also the power of technology! Online workshops and a website would be perfect.” (researcher)

“I believe presentations are necessary but also some Interactive Activities with Hands-on exercises, group discussions, and role-playing activities.” (Nurse)

“I support more visual content.” (Adjust Faculty Instructor)

6. Conclusions

The role of these co-sessions is pretty important since valuable findings came up. Firstly, there is no organized part on professionals’ education concerning their knowledge on the field of migration and mental health. This brings the need of radical change on the system of education, but also in the training of professionals. If that is the case, specialized training must be provided to mental and health professionals based on their field. Secondly, professionals that have encountered migrants with mental health issues in their professional answered the same thing. They don’t always feel prepared and trained to address them. This brings the need of specific practical part of their training. Furthermore, fragmentation in one of the main problems concerning mental health of migrants and refugees. It is very important, health professionals to feel support and know that they can cooperate with different professionals, in order to achieve their goal; help migrants overcome serious mental issues such as suicidal thoughts, post-traumatic stress disorder etc. In addition, the tools and materials

that could help in their professional practice are divided in two main arguments. Access to immigrant informational materials and familiarization with the cultural competency. The cultural factors play a very unique part. In order to make migrants and refugees accept the help, all the professionals pointed out that cultural competency is what it takes as a first step. Last but not least, both online and face-to-face actions will help to deal with the need of evolution in this specific field.

Germany

1. Introduction

In Germany, two co-creation sessions were held in the second half of April 2023 (April 20th and April 25th) with a total number of 15 participants. The EU-MiCare German Team decided to organize two separate focus groups, the first one targeting participants specifically trained in mental health issues (psychologists, psychiatrists etc.) and another one with professional and volunteers dealing with mental health issues in their everyday activity who were not trained specifically on this issue. The aim was to observe if the focus group discussion was developing in a different way and touching upon different topics, and to find out which issues are perceived as fundamental across the different kinds of professionals.

The first session on April 20th was conducted face-to-face in the Ethno-Medical Center facilities in Berlin with 9 participants. The great majority of participants were active in the social sector and did not have a special training in mental health. The session lasted around 2,5 hours and was characterized by a vivid discussion among the participants. Many of them had a personal history of flight and/or migration and reported both personal and professional experiences.

The second session on April 25th was conducted online and all 6 participants had a formal training in mental health issues and worked either as psychologist, physiatrist or psychotherapist with refugees and migrants. This session lasted around 1,5 hours.

On both occasions, the focus groups started with a brief presentation of the EU-MiCare project and the aim of the session, as well as with a self-introduction by the participants. Both sessions were recorded in agreement with the participants.

The recruitment process did not take place in an open way, but only selected people were invited. For the first session, cultural mediators from MiMi-project who work with refugees and migrants were asked for participation, as well as further actors in the social sector who were already known to the EU-MiCare Team. The invitation found good resonance, as the topic is perceived as crucial by many people working with the project beneficiaries' group.

For the second focus group, some desktop research was carried out, in order to identify professionals from different organizations active in Berlin, Brandenburg and other federal states who could enrich the discussion. Also in this case, the invitation was met with interest and representatives of 5 different organization took part to the discussion.

Participants Focus Group 1

	Acronym	Age	Gender	Profession	Education level	Institution	Years of working with refugees
1	HT	57	Female	Counsellor	Bachelor, Master	NGO	20
2	CB	59	Female	Social worker	Bachelor, Master	NGO	18
3	NA	60+	Female	Social worker	Bachelor, Master	Asylum Seekers Reception Center	11

4	AG	56	Female	Counsellor, Cultural Mediator		Health Center	10
5	GT	35	Female	Psychologist	Bachelor, Master	Asylum Seekers Reception Center	16
6	AA	33	Female	Consultant/Expert	PhD	University	10
7	BK	31	Male	Pharmacist	Bachelor, Master	Pharmacy	/
8	NA	34	Female	Psychologist	Bachelor, Master	Hospital, Training institute	7years, 3months
9	MK	30	Female	Social worker	Bachelor, Master	Asylum Seekers Reception Center	/

Participants Focus Group 2

	Acronym	**Age**	**Gender**	**Profession**	**Education level**	**Institution**	**Years of working with refugees**
1	KB	35	Female	Psychotherapist	Bachelor, Master	NGO	4
2	FH	55	Female	Psychosocial Counselor	PhD	NGO	4
3	FM	34	Female	Psychologist	Bachelor, Master	NGO	8
4	IH	55	Male	Psychologist	PhD	NGO	22
5	FR	35	Female	Doctor	PhD	outpatient psychiatric care	4
6	IP	63	Female	psychologist	Bachelor, Master	NGO	>10

2. Mental health issues of migrants/refugees in everyday professional practice

In the following, some of the main issues addressed in both focus group sessions regarding mental health issues in general and participants´ experiences in their everyday professional practice are listed:

- **Need of applying a more differentiated view on refugees and migrants**

One participant of Focus Group 2 (psychologist) suggested to reflect on the beneficiaries of the project and to apply a more differentiated view on the group of "migrants/refugees" in the training. The situation of migrants and refugees shall be seen as heterogenous, as it is linked to different life situations and needs:

"You mention refugees and migrants in the same breath. Of course, this is understandable as an umbrella term, but the refugees who do not yet have a residence permit have quite different problems, in addition to the other problems they have, such as trauma or anything else, and exactly these problems they also have, starting with insecure residence, constant threats to deport them back, impossible accommodation conditions, difficulties for children at school, etc. -
create or aggravate the existing mental disorders." (IP, psychologist, FG 2)

- **Need for (mental) health professionals to take into account general life circumstances of refugees and migrants**

A further participant in Focus Group 2 reported that, although being a psychotherapist, her focuses on the social aspects of the life condition of her patients:

"With our patients, the complex situation of flight and migration is one aspect of many things, (...) there are soooo many areas, e.g.. whether I am living here as a single mother, perhaps still living in a shelter, but at the same time somehow still leading a marriage, in which I perhaps do not want to be, in which I may have experienced violence on my migration or escape route (...) or (issues like) "where does the money come from?" "I don't understand the educators, where I take my daughter every morning to daycare", so there are just so many things that are exhausting and overwhelming and so many expectations of life here and also so many disappointments (...) that I have the feeling, sometimes the focus is really not on the trauma confrontative - although most patients have Trauma Consequence Disorder, so depression, also in the area of severe somatoform disorders and of course PTSD -, but (...) with us the focus is to sort, to order, to have "a place" at all, because this survival mode leads to the fact that there is no place at all where I can even think about myself…" (FM, psychotherapist, FG 2)

A similar approach seems however not to be rule within the German health care system. One participant reported how elements connected to life circumstances of the refugees/asylum seekers are generally not take adequately into consideration by health care staff. This, in turn, causes refugees/asylum seeker to often not seek help from the "general" health care system but instead to rely to NGOs and similar services where they feel their needs and experiences are taken more seriously.

"And in my experience is unfortunately so, that the normal health system does not address it at all, they are quite diagnosis-oriented. Diagnosis is made quickly, pills are prescribed quickly, a good advice is also given quickly, but it is not (looked) at the circumstances of life, that interests only very very few dedicated doctors, psychologists, etc.
So that these people (the refugees), on the whole, do not feel understood in the system and that is why they do not seek help there either". (IP, psychologist, FG 2)

- **Some mental issues are not acute when arriving to Germany but arise in a later stage of migration**

Several participants of Focus Group 1, some of whom have fled or migrated themselves to Germany out of necessity, underlined that mental health issues often become acute or arise only after having lived in Germany for some time. This is consistent to what is known in the literature as different stages or phases of migration, to which often correspond different mental health statuses.

"That's mostly now, mental health will come out later. For example with me, I've been in Germany for 8 years, at the beginning everything was great, I did everything normally, I didn't react to mental health at all. And I think many

people who come from abroad, they don't react, they didn't learn that like (they do) here. We don't learn about our mental illnesses because there it's more important that you survive and so on. I mean a lot of people like me, a lot of migrants, it all comes (out) later." (BK, cultural mediator, fled from Syria in 2015).

Another participant, who has worked in first reception centers, confirmed that often mental health issues emerge after asylum seekers have "settled down": after they have been relocated in the accommodations, or even moved to other regions, the images of what they have lived in their homeland start to arise.

A further aspect mentioned by participant BK is the **knowledge and sensitivity toward mental health among refugees and migrants**. This is often culturally conditioned, and can be limited, tabooed, or just considered as secondary by the group. This implies that refugees and migrants should first be informed and sensitized toward the issue, in order for them to recognize the need of receiving professional health and reach out to different offers.

A further element tightly connected with mental health is the so-called "culture shock" or "acculturation shock", as highlighted by a participant of Focus Group 1:

"Not all, but many have acculturation and culture shock and these are the first steps that affect mental health, but this takes a back seat in discussions about refugees. Refugees come to Germany with certain expectations, including those of the family, and experience a very different story. That is the first issue and it leads to depression, and many other mental health consequences. And then they also get this pressure to integrate themselves, to master the language, etc. (...)" (CB, social worker, FG 1).

- **Additional symptoms aggravate mental health condition**

Mental health issues are often accompanied and exacerbated by symptoms such as chronic lack of sleep, nightmares, but also substance abuse, abuse of psychotropic drugs, which people often do not know how to take or do not understand what an impact they can have on health. Abuse or misuse of drugs was confirmed also by several professionals in both Focus Group Sessions.

- **Legal and administrative barriers complicate the provision of an adequate mental health care**

Administrative barriers, unclear allocation of responsibility (depending on the type of residence permit, the length of stay in Germany and the type of mental health issue) make it hard to find adequate care. The system moves slowly and this often leads to an aggravation of the mental health condition of the patients. The situation is especially complicated during the first 18 months of residence in Germany, when the access to health care provisions is regulated by the Law on Benefits for Asylum Seekers.

"The care and allocation of responsibility is really very difficult, people move in a vicious circle and try, try and don't get the important care (they need) and on top of that, in between everything becomes chronic or other disorders develop. (...) Everything piles up and afterwards the situation is so complicated that nobody dares to do anything". (NA, psychotherapist in training, Focus Group 1).

These barriers are experienced also by people with acute mental issues, e.g. suicidal risk

"I also see this problem with responsibility, so if it is acute, a station (at the hospital) is always responsible, the problem is afterwards. If the person has stabilized, I mean, is no longer acutely suicidal, the person has come

down a bit, (...) the care afterwards is problematic. Especially psychological support is difficult to find. (...)" (NA, psychotherapist in training, Focus Group 1)

3. Knowledge and training on mental health issues for migrants*/refugees*

- Formal education (e.g. university training) does not cover at all or not enough the topic of (mental) health and migration. Most professionals with a training in mental health of Focus Group 2 (psychologist, psychotherapist, psychiatrist) reported to have acquired most knowledge **directly on the field**.

- Several of the professionals from the social sector have participated in **specific short-term training on the topics of migration and health**. All in all, there is quite some offer on the topic, e.g. working with refugees, offers of supervision etc. Many of these offers have been established in 2015 in the aftermath of the arrival of Syrian refugees to Germany. While some trainings them were considered positively by the participants and useful in their professional setting, other were seen as superficial and insufficient.

" (in the trainings) It would be interesting to go more concrete and deeper into it and to work with examples, because we don't get to it, it remains superficial. Words are spat and strategy and methods are not taught (...) (CB, social worker, FG 1).

- Further aspects which appear as not being handled enough in available trainings are **self-reflection and confrontation with own prejudices**.

"I have attended many courses and trainings and what I would say now as a conclusion is: more self-reflection. We get a lot of input, but it always stays on a one-sided level, "one-side direction". There is a lack of space for self-reflection… (NA, psychotherapist in training, FG 1)

"very often there is a lack of confrontation with one's own prejudices. There is always a lot of knowledge to be acquired but that is missing (...) and once it happens, it is then also easier to deal with situations where you don't know how to act. (...) I think the core competence in transcultural work is to be able to accept and deal with situations where you don't know how to deal or what is going to happen". (AA, expert, FG 1)

- Training and self-reflection should be carried out also by **those working with refugees, who do not have a training in psychology.**

"If you want to be a therapist, you have to work on your own story, but all the other professionals don't have to do that at all. But they're in a very strong power position, they actually decide on future plans… (HT, ?, FG 1).

This leads to the fact that people working with refugees are possibly themselves perpetrators, have racist attitudes or own trauma which has not been elaborated etc.

4. Healthcare professionals' proposals regarding the content of the programme's training

At this point during the Focus Groups, the following thematic hubs were presented to the participants in order to facilitate a more focused discussion:

- Importance of migrants' mental health in relation to migration and integration processes
- Improving healthcare professionals' skills on recognizing/ assessing migrants' mental health needs
- Improving healthcare professionals' skills on managing psychologically vulnerable people
- Supporting healthcare and other professionals

The thematic hubs correspond to the training content suggested by the EU-MiCare Team. All the proposed topics were **considered as adequate and needed** by the focus groups participants. There were, however, several suggestions on additional topics to be included into the training programme:

- **Religion**

"The topic of religion is often subsumed under culture but is not only culture. And most people who come to us here, they are religious, they are deeply religious, and we do not include that in therapy. It's an area that takes place beyond therapy, these two areas are sort of separated and that doesn't do people any good. And we also don't understand them properly if we don't take in the meaning of their religion." (IP, psychologist, FG 2).

„I also find the role of religion very important. I always try to use it as a resource (when I work) with strongly religious people" (IH, psychologist, FG 2).

- **Interpreting and training of interpreters**

"This is very very important" A bad interpreter can blow up a whole session and turn an almost healthy person into a disabled one, just because things were misunderstood. Interpreters need to be taken care of, properly trained and also (we need to) understand their specific situation, because it is not easy. They are not machines, they are also people with their backgrounds that they bring in". (IP, psychologist, FG 2).

- **The specific situation of children**

"And the thing that's missing for me there, which is almost always missing, is the children's problems (…) Refugees, mom, dad, single travelers, but the children in the families, they are simply taken along automatically without looking at their specific problems. For example, how serious it can be, to be torn between two cultures and so on. If possible, you should definitely include this in the training modules." (IP, psychologist, FG 2).

- **Impact of racism, discrimination, delusion/ possible re-traumatization (sequential trauma)**

"Many people think: you fled, you are now safe here etc. (...) it is totally underestimated what people continue to experience here and this has to be taught". (KB, psychologist, FG 2)

- **Tailored modules for different profiles e.g. special support for volunteers**

Several participants highlighted the need of tailoring the training offer to the different target groups and for example differentiate between professionals with psychological training and experience and others without. A recurrent topic in Focus Group 1 was that of offering training content which can support **volunteers** working with refugees, who are often less prepared to address the complexity of the work with refugees, are often "left alone" and have no professional guidance and can hardly set the (emotional) boundaries of their engagement. On the other hand, the training should invite volunteers to reflect on their personal motivation and expectation in the volunteer work.

"there are many volunteers, they would need to be strengthened specifically, most of them start passionately but of course are overtaken by the overall situation, many also put their own financial resources, do not know how to protect themselves" (AG, cultural mediator, FG 1).

- **Right of residence, legal framework**

Morever, it was suggested to have some modules with **country-tailored content**, as the legal framework and context might be very different across the countries involved in the EU-MiCare project.

5. Healthcare professionals' proposals regarding the methodology and other considerations for the Programme's training

- Each thematic block should last at least 1,5/2 hours, possibly 3 or 4 hours
- The sessions could be held on the weekend with a "closed group"
- Sessions should be carried out as live-events and afterwards made accessible to participants as online resource (e.g. PowerPoint Presentation with audio, additional literature, case studies). This would allow participants to share materials within their teams and use them in their practice as well as to study them at their own pace.
- Sessions in English could not be accessible to a part of professionals working with refugees/migrants, therefore it would be better to hold them in German
- Collective dimension of training should be reinforced, possibility to have "study groups" between the session (to happen every 2, 3 weeks)
- Good balance between theory and practice, work with case studies
- It would be interesting to dialogue with international colleagues and to take advantage of their experience

6. Conclusions

The participants of both focus groups welcomed the invitation to participate in a positive way. All considered that there is a need for a training on mental health issues and several participants declared their interest in participating in the training when established. The idea of conducting two sessions with partly different participants was adequate, because the topics and needs reported were partly different. In Focus Group 1 the needs of volunteers and those with less specific training were highlighted. Generally, there was a consensus on the need of seeing mental health in the context of adverse life circumstances of refugees and migrants and to pay attention to what they experience in their everyday life such as racism.

Concerning the content and methodology of the training program, live-sessions were the preferred format and it was highlighted that group activities and interaction should be provided. The recorded material could be made available on the platform in a later moment.

Furthermore, several specific topics were suggested. Especially the possibility of including the topic of mental health of children should be taken into consideration by the EU-MiCare Team.

Greece

1. Introduction

Two co-creation sessions was carried out online, with an average duration of 90'. A total of 13 professionals participated in the sessions; 6 participants in the first session and 7 in the second one. Participants were physicians, psychologists, social workers, cultural mediators and an associate professor. Their average age was 38-years-old, while the majority were women. Most of the participants were working in NGOs, early reception centres, or hosting structures facilities.

All participants were recruited through the Prolepsis regional network. A clear explanation of the program, the study aims, objectives, and procedures were provided to all the participants during the recruitment and in the beginning of the co-creation sessions. Both sessions were moderated by a researcher with extensive experience in qualitative studies, with the support of an observer who took notes during both sessions. All participants were informed about the objective of the session and the characteristics of the research and completed an informed consent form.

DESCRIPTIVE CHARACTERISTICS OF THE PARTICIPANTS	**Greece (N=13)**
Age (years)*, M (SD)*	38±9
Gender (females)*, n*	8
Education*, n*	
Upper secondary education	1
Tertiary	3
Master	7
Doctoral	2
Profession*, n*	
Psychologist	2
Social worker	5
Cultural mediator	3
Professor	1
Physician	2
Institution*, n*	
NGO	8
University	1
Reception and identification centres	1

Early reception centres or hosting structures facilities	3
Years working with immigrants and refugees*, M (SD)*	9.1±6.1
Attended any training dealing with mental health issues of migrants and/or refugees (Yes)*, n*	8
If yes, was the training compulsory? *, n*	2

2. Mental health issues of migrants/refugees in everyday professional practice

The services provided by the national health system regarding the mental health of migrants are not "complete"; migrants rely mainly on related services provided by civil society (NGOs). More specifically, the health system operates in such a way that it actually accepts and treats cases with very serious and obvious mental health problems, e.g. psychiatric issues. Participants also reported that the first-reception services generate mental health disorders, i.e. bureaucracy, accommodation, legal status etc.

"In reality, only psychiatric cases are referred to the public health system that is, those that require a prescription and systematic monitoring by a psychiatrist." (Greece, General Director, NGO)

"When a refugee arrives in Greece they could be very well in terms of mental health, but all that he/ she experiences in the host country, during reception and until his/her legal status is decided may cause him/her mental illness. For example, his/her living conditions are almost dangerous, especially for women. Moreover, he/she he does not know where he will end up, will he/she move inland, how long will he/she stay on the island? All these could disturb his/her mental balance." (Greece, psychologist)

Moreover, participants reported that health professionals; training in relation to mental health of migrants is insufficient. Therefore, even if there is the suspicion of a mental health problem, they are not able to recognize it clearly and make appropriate referrals. Healthcare professionals also lack of cultural competence and sensitization. Participants reported that migrants' perceptions on mental health often leads to an underestimation of the importance of mental health and people not asking for help. Finally, participants referred to language difficulties of specific migrant populations.

"Look... as an immigrant from Africa, I had a very different perception of mental health. I didn't pay much attention to the symptoms, but now I have been in Greece for many years and that has changed. I remember an African woman who had come to our organization and as a cultural mediator I had many discussions with her in order for her to accept that she had a problem and it would be good for her to do some counseling sessions with a psychologist." (Greece, cultural mediator)

3. Knowledge and training on mental health issues for migrants/refugees

Participants mentioned that special training of health professionals in order to manage all the above-mentioned considerations does not exist. Apart from psychologists working with immigrants, other health professionals may have received some relevant training during their professional life but certainly not during their basic studies or their knowledge of mental health problems among migrants is purely experiential, based on everyday

experience. it was also clearly stated that relevant trainings are implemented exclusively by NGOs active in the field.

"Some NGOs offer training to workers of all specialties. Others still have no training. In public services there is no training." (Greece, University teaching staff)

4. Healthcare professionals' proposals regarding the content of the program's training

Concerning the content of the training, participants proposed the following modules:

- Importance of migrants' mental health in relation to migration and integration processes
- Improving healthcare professionals' skills on recognizing/ assessing migrants' mental health needs
- Improving healthcare professionals' skills on managing psychologically vulnerable people
- Supporting healthcare and other professionals

Moreover, they argued that the level of knowledge and sensitization of each specialty differs. For example, the knowledge of general practitioners regarding the management of various incidents related to mental health differs compared to the knowledge of social workers and psychologists. Therefore, the design of the modules should consider the different needs of the target group/ trainees.

"There is a different level of knowledge between a physician and a psychologist working with migrants. Both have related, yet, different needs. This is the first thing you should consider, when developing your training. Who will you reach out to and what level of knowledge will they have about migrant mental health." (Greece, Director of an NGO)

Proposals on the content of the 1st module: Importance of migrants' mental health in relation to migration and the integration processes

Participants argued that there is a need for informing and sensitizing trainees about the most influential determinants of migrants' mental health that are related to integration, such **as** discrimination, racism, accommodation, transitional phase, legal status, language barriers, navigation to the national health system etc. Trainees need to understand that staying in Europe might cause further traumatization due to demanding living conditions, legal procedures and insufficient information about the on-going processes.

"We have said it before, their staying in Greece cause mental issues to these populations. Because they struggle here." (Greece, social worker)

Proposals on the content of the 2nd module: Improving healthcare professionals' skills on recognizing/ assessing migrants' mental health needs

Participants mentioned the need for sensitizing trainees on the importance of synergies and cooperation between different professionals and organizations, in order to handle migrants' mental health signs/ issues.

"It must become a culture that only through collaboration between different specialties can we improve the services we provide. The doctor needs to work with the social worker." (Greece, psychologist)

The most common mental disorders that was mentioned by participants was Post Traumatic Stress Disorder (PTSD). Therefore, it should be included in the module.

“PTSD is the most common issue among migrants in Greece. You have to present information on its symptoms and therapy pathway.” (Greece, professor)

Proposals on the content of the 3nd module: Improving healthcare professionals’ skills on managing psychologically vulnerable migrants

Participants stressed the need for including knowledge and information on migrants, who belong to the following vulnerable populations: LGBTQI+, disabled migrants, migrants with chronic diseases, elderly migrants, women and children.

“Vulnerable migrant populations are LGBD, elderly, children and women. Especially women face many challenges.” (Greece, cultural mediator)

Proposals on the content of the 4th module: Supporting healthcare and other professionals

All participants discussed the issue of professional burnout for those working with migrants. Therefore, there is a need for the provision of self-care tools.

"The main issue is the burn-out of the employees. In addition to the supervision of psychologists and social workers, all workers, of different specialties, must learn to self-manage this burden." (Greece, cultural mediator)

Additional considerations concerning the training modules

Participants argued about the importance of working with migrant communities in order to enhance sensitization of the migrant population and prevention.

"Something that is very important if we want to talk about sensitization of migrants themselves and integration is to work with migrant communities on mental health issues. In their communities they feel more secure, they can express themselves, discuss and be informed by someone they trust." (Greece, director of NGO)

5. Healthcare professionals’ proposals regarding the methodology and other considerations for the Programme’s training

Participants preferred face-to-face training. However, they also mentioned the development of a digital platform which will include all the information of the training–modules, i.e. informative materials, methods etc.

“I can’t imagine this training taking place online. We all need to meet somewhere and share our experiences, do experiential work. However, there is a need for a digital tool that will include all the training materials and also provide the chance for professionals to exchange challenges and best practices.” (Greece, social worker)

Participants reported that the training should be mainly (but not exclusively) experiential, with participants working on case studies and best practices in groups.

“It would be nice if there could be an exchange of opinions on specific cases or a discussion on specific difficulties professions may experience regarding migrants’ mental health” (Greece, psychologist)

6. Conclusions

Mental health problems seem to be common issues during healthcare professionals’ daily practice with migrants. Moreover, they do not seem to receive systematic training. On the contrary, in many cases knowledge is purely empirical.

For the training development, the particular needs of different health professionals in managing the mental health of migrants should be considered. Moreover, emphasis on the collaboration among different professions needs to be given. The training needs to be practical, enhancing self-care for those working in the area of migrants' mental health.

Regarding the content of the training, participants reported the need to inform and sensitize trainees about the most influential determinants of migrants' mental health related to integration, since a lot of migrants face more mental health challenges following their arrival in the host or transit country. Participants also argued that the training should provide information both on specific tools, models, methodologies to assess mental health issues and on referrals to particular services that are related to migrants' mental health-care provision. They also stressed out that working close with migrant communities is rather crucial.

Italy

1. Introduction

Two co-creation sessions were held on 20 and 27 March respectively, with 6 participants each,plus a moderator and a note-taker. Both sessions were online and recorded with all participants' informed consent. The following tables show the demographic composition andthe individual codification of the participants:

1st Co-Creation Session: 03/20/23							
Code	**Country**	**Age**	**Gender**	**Education level**	**Profession**	**Relationship**	**Organisations**
1-NU	Italy	31	M	Tertiary (MA)	Nurse	Part-time	Public Hospital
1-PP	Italy	34	F	4-years Specialisation	Psychologist Psychotherapist	Part-time	Mental Health Centre (NGO)
1-TP	Italy	46	F	Post-graduate Specialisation	Clinical Transcultural Psychotherapist	Full-time	Ethno-Health Centre
1-MP	Italy	33	F	Tertiary (MA)	Minors Psychologist	Full-time	2nd Reception Centre (NGO)
1-MD	Italy	65	M	Tertiary (MA)	Medical Unit Director	Full-time	NGO
1-PC	Italy	49	F	Tertiary (MA)	Project Coordinator	Full-time	NGO
2nd Co-Creation Session: 03/27/23							
Code	**Country**	**Age**	**Gender**	**Education level**	**Profession**	**Relationship**	**Organisations**
2-NP	Italy	46	F	Post-graduate (PhD)	Child Neuropsychiatrist	Full-time	Public Hospital
2-SP	Italy	53	F	Tertiary (MA)	Systemic-relational Psychotherapist	Part-time	1st Reception Centre (NGO)
2-RP	Italy	27	F	Tertiary (MA)	Researcher in Psychology	Volunteering	Academy
2-SW	Argentina	32	F	Tertiary (MA)	Case Social Worker	Full-time	2nd Reception Centre (NGO)
2-PC	Italy	45	F	Post-graduate (PhD)	Training Projects Coordinator	Part-time	NGO
2-CM	Algeria	55	F	Alternative Specialisation	Cultural Mediator	Part-time	Public Hospital

The co-creation sessions had a significant female majority, 66.6% in the first case and 100% inthe second, which could be indicative of a specific, socio-culturally marked sensitivity, typicalof the Italian context. There was also a clear predominance of Italians in terms of nationality,with the only two exceptions being Argentina and Algeria. However, these were important to(partially) capture the views of people with a migration background who were integrated intothe reception system. The average age in both cases was 43, which results in the opportunityto collect inputs from several people who have known the Italian reception system for years and have experienced (at least in part) its transformation over time. At the same time, with 41,7% of the total participants under the age of 35, it was also possible to significantly highlight the perspective of young workers. Concerning the organisations in which the participants work, as a whole, the picture quite fairly reflects the Italian reality dealing specifically with migrants and refugees: a prevalence of people working in the third sector (66.6%), a reduced active contribution in public institutions (25% at hospitals) and a minority representation from the world of academia (8.3%). Furthermore, it may be relevant to note that the participants operate in different geographical areas (covering south, central, and north Italy), in all different organisations, and in the case of NGOs, they mostly come from some of the largest and most consolidated actors in the field of migration in Italy.

In the recruitment process, the biggest obstacle was finding time availability (even if only to give timely feedback) and convergence in schedules, as people active in this field tend to be overloaded with work commitments. On the other hand, there was a lot of engagement andgoodwill to do everything possible to offer a contribution. The main criteria used to recruit participants were: a) having had at least one work experience in the migration context of several months – most of the participants have been working in this field for several years andof all of them only 1-NU no longer works in that context at the present; b) representing a variety of professional profiles related to migrant's and refugees' mental health, both in a vertical sense (from direct contact in first reception and second reception/integration centres to coordination and management roles) and in a horizontal sense (cultural mediator, nurse, social worker, researcher, psychiatrist, psychologist, etc.) – a relatively higher proportion of people with training in psychology participated, however, in turn representing a variety of different approaches (transcultural, systemic-relational, etc.).

2. Mental health issues of migrants/refugees in everyday professional practice

Discontinuous or insufficient provision of mental health care in many first and second reception centres due to a lack of management effort and/or recognition of its relevance.

This opinion is expressed mainly by younger workers and/or those who work/have worked directly with migrants and refugees in reception and integration centres. Emphasis is placed above all on the paucity of efforts actually invested in mental health, in first and second reception centres, at the management level. At the same time, it is noted that there are a lackof continuity and a substantial inhomogeneity of the provision depending on the project or on the operator.

1-PC: [Talking about mental health care in first reception centres] “On paper, we have figuresassigned to this, then, in reality, this type of investment is not made. It is not realised, in the sense that the resource is dedicated to something else or, in any case, assistance to the personwith this purpose is not actually carried out. Therefore, in fact, psychological support and broader attention to mental health are not guaranteed. This is what we have been observingfor a decade now.”

1-NU: “It depends a lot on the various cooperatives that run the centres. I have noticed that there are some that are more sensitive to the needs of their guests, so they also invest more hours in the various necessary treatments, and other centres that basically leave them parkedthere and don't give a damn. This is what I have noticed: the “variable of the cooperative” thatruns the centres, in my opinion, is very important.”

1-PP: “I remember when I was in the centres, [...] not all centres are the same, not all cooperatives are the same, and therefore often different attention is given by the cooperativeto some services than to others. Often the hours, I found myself in centres with 200 or more beneficiaries doing only four hours [...] really something just not enough if we consider the demand in general.”

MP: “Within communities [i.e., at the level of second reception/integration] regarding mental health I notice a serious variability. [...] Actually, it is a mosaic because mental health is considered differently from operator to operator and from centre to centre.”

RP: “I know that there have been projects in the field of migration mental health, but –

although I am in it (certainly less than others, but quite in it) – I find it hard to identify anything that is permanent. […] There is perhaps a bit of a problem in providing services on an ongoingbasis, certainly also due to important logistical issues.”

General tendency to consider vulnerability and mental health only as “black or white”, i.e., either extreme cases or nothing.

This perception is shared by some experts with long-standing experience. They state that there is a tendency to take into account only either those population groups typically considered to be 'particularly vulnerable', or those cases that immediately manifest themselves as severe. There is a tendency not to do mental health prevention actions or not to provide services that take care of and follow up 'sub-threshold' cases – which, in reality, make up the majority of cases – as well as cases that are difficult to recognise with only a first-level intervention (as is often the case of PTSD).

TP: “Sometimes there is the idea that vulnerability is either everything or nothing. There is a somewhat extreme and perhaps polarised idea of the concept of vulnerability, which hopefully will change sooner or later, in the sense that either there is a psychiatric disorder orthere is nothing. But often communities and reception centres have to deal, instead, with thevast majority of people who are in a whole grey zone of existential suffering that is not necessarily a psychiatric disorder, but nonetheless important. [...] Or, for example, I believe that little is done on the question of maternal bending between mother and children in the context of women who give birth in Italy or shortly before arriving, and there is still perhaps little attention [...] on the very subject of prevention. For example, psychological distress in the age of development with respect to the children of immigrant women; which is still a newtheme, in my opinion, about which little is said. It is simply that once the

children have gone to school, they risk presenting behavioural problems, ADHD, some autistic spectrum syndrome, which is, however, little attributed by paediatrics to the stories of the mothers, who often bring stories of abuse, violence, and this obviously then falls back on the bending between mother and children."

NP: "Once they give warning signals, the [public] system takes them in, takes them in chargeand a path is activated. But often... [...] it would be advisable instead to be active in terms of mental health from the moment they arrive, not only when they give signals that then becomein some way, pass me the term, "harassing", but really to manage their mental health from the very beginning."

2- SP: "[We] work with a multidisciplinary team [...] We do the same now with the mobile clinics in the territory, always working with doctors, nurses and mediators. Yet, [...] what we see very often nowadays is the difficulty of intercepting those situations that are 'below the threshold', that are not so immediate [i.e. that do not immediately manifest themselves as acute distress. For example, regarding] PTSD, the symptomatology is not very clear [...] but we find situations that could be in that area of intervention, but being a first level interventionthere is little we can do beyond a little psycho-education."

Systemic failure to take charge of mental health due to the structural deficiencies of the national health service (i.e., public and free), which the third sector alone is unable to compensate.

This perception is expressed especially by those in project management and coordination roles and/or those who have been working in this field for the longest time. It was pointed out that the issue of migrants' and refugees' mental health has already been central at the level of health policies for several years. Nevertheless, there is a chronic gap between officialregulations and the real availability of qualified staff, structures, and services, especially in public service. Actually, it is the free initiative of the third sector that mostly deals with migrants' and refugees' mental health needs, but it is unable to compensate for the shortcomings of public service. This creates inequalities and, in fact, limits the concrete possibilities to follow and care for the mental health needs of migrants and refugees. The exceptions are just the most serious cases – which then possibly become a public order problem, as stated above.

2-PC: "Mental health and the issue of the vulnerability of refugees and asylum seekers have been particularly important for several years, and it is something that we [the third sector] are very often involved in. However, precisely [...] most often the NGO projects are called upon, and not [...] the public service, which is already overwhelmed/struggling for other reasons."

1-TP: "[Once mental health problems have been identified,] who do I send people to? Becauseclearly a public service should answer, [...] but the public service is not actually hiring. It's a huge problem that I think applies to all [potential beneficiaries], not just migrants. […] So evenwhen awareness increased, training is provided, and the operators [of the third sector] have finally done capacity building, which they continue to do thanks to this kind of projects [such as MiCare], there is a lack of clinical support, i.e., psychotherapy or competent support [it means in the public service]."

MD: "[Talking about public service] Here there is a situation of chronic understrength in all the services, [despite] the fact that we have a national project [targeted on mental health] that defines standards or regional objective projects that further define standards; […] It doesnot only concern immigrants and asylum seekers: it concerns everyone. And here is where inequalities arise, because those who can and have resources manage to reach them [i.e., private fee-paying mental health services], whereas others do not… except for situations of extreme gravity, in which case yes, there is a greater ease of... you can access [the public service]."

NP: "Indeed, we are a [public] hospital. So mainly extreme problematic cases come to our emergency rooms, our outpatient clinics."

The Italian reception system, because of its structural deficiencies and because of the way identification/management processes are conceived, is a major factor leading to cases of re-traumatisation, aggravation of mental disorders, and increased vulnerability.

This aspect is emphasised by more or less all categories of participants: young workers, seniorexperts, those working in the third sector and those working in the public service, those on the front line and those involved in management and planning. The main factors reported responsible for the aggravation of the mental health of migrants and refugees structurally concern material deficiencies, wrong approaches by operators, and the lack of training of keyfigures beyond health and social workers. The failure to meet basic needs, as well as the lackof care for people's psychological well-being at the various stages of the system not only exacerbates existing problems but can also lead to further disturbances, as well as to greatercomplications in treatment as beneficiaries become alienated, distrustful and hostile towardsthose who then should care for them.

1-PC: "In my opinion, a whole series of conditions are created, I would say almost deliberately,that put the young people in a condition of extreme psychological vulnerability when they arein the reception phase, even after disembarkation. I am talking about the lack of a whole seriesof arrangements and basic services that would really be the minimum for assistance during the reception. They are so badly managed that they lead the minor to express a more acute discomfort than that with which he/she arrived. In the sense that when you have a concomitance of contexts such as, for example, the absence of services in the structure, the lack of windows, the lack of doors, sleeping in the cold, the absence of hot meals... you understand, all these things together in relation to a child who has just arrived and who perhaps brought with him/her a baggage of fragility [...], these accentuate [his/her mental problems] and is, in my opinion, supplementary institutional violence with respect to what is the basis from which they start."

1-MP: "[Talking about the first level of reception and the CAS], at the moment they are dormitories: dormitories are not suitable places for minors, as far as mental health is concerned. This is an aspect that is, to say the least, neglected within the daily practice of thereception of minors here, because it is simply the basic needs that are the first to be lacking. It is the basic needs that are the first to be met in a way that is absolutely partial, and I wouldsay deliberately unfair and punitive towards minors. […]

Once they arrive on our territory, theneed for security, both as a primary psychological need and as a fundamental human right ofthese children as minors, is what emerges most as a problem."

TP: "Secondary victimisation [caused by reception conditions] was rightly mentioned, and itis fundamental, but there is also, together with these, secondary re-traumatisation operatedby operators who should instead be caring of. Unfortunately, I am also talking about colleagues who, either because they are part of certain specific projects, or because of stereotypes and prejudice [...], end up insisting on certain issues, such as Libya and torture. Sometimes, this becomes a huge clinical problem, because [...] asylum seekers and refugees in reception centres are in the process of a struggle, of an effort to be in the here and now, but they are prodded in clinical contexts, psychological support, sometimes even legal counters, on the need to bring up traumatic stories because they have to be included in that or that project. Obviously, all this then triggers secondary traumatisation phenomena."

NP: "Mostly, [people] with behavioural disorders come to us, e.g., explosive behaviour, escalation of anger, irritability, aggression, or even self-aggression, often associated with alcohol or substance abuse. Now I mention the emblematic case of Omar [fictitious name], a 17-year-old boy of Ethiopian origin, but who had spent two years in Libya [...] They describe him at first in the reception facilities as a very sunny boy and, therefore, with a good initial adaptation. Then he came to the emergency room for a behavioural problem about a year after his arrival in Italy. [...] He had attacked some people during an alcohol abuse, they had called the police and he was taken to the psychiatric emergency room. [...] Gathering then hisstory, it turns out that there had been a fundamental trigger event that had unleashed hell, namely the Commission for Requesting Political Asylum. During the exam of the Commission,Omar was asked to re-tell all the episodes that happened during the migration process. This, in a fragile situation, triggered an uncontrollable post-traumatic sphere. [...] So it had manifested as a behavioural disorder, but in reality, it was florid post-traumatic symptomatology. So, there is precisely this effect of re-traumatisation, of second traumatisation, due precisely to the reception [system. This] creates a great difficulty becausethe issue becomes complex: there are complex post-traumatic disorder traits that also become personality traits: reaction traits. So, the young patient in front of me is extremely distrustful: the circuit of trust is broken. [To his perception] I am not an 'helping figure', just an 'additional obstacle' to what could be his path."

PC: "In particular, I am referring to the reception system for the whole population of refugees and asylum seekers. Here it is the system itself that is pathogenic, i.e. we have created systems that produce suffering and re-acerbate it. [...] There are professions, with which migrants are confronted throughout the process, that really do not have the tools, theskills [...] I am thinking for example of territorial commissions. We did a very strong [training]work on the territorial commissions and we found ourselves with people who really did not have the tools to understand that what they were taught, what they were given as a mandate,the "truthfulness of the story", can actually be the problem, at that moment, for a traumatisedperson."

The issue of “irregularity”/bureaucratic problems and social determinants especially in the long-term perspective often exacerbate the problem of access to public service for mental health and, above all, mental health problems themselves as well.

These topics are particularly highlighted by participants with a migration background, as wellas by those who have gathered long-term work experience facing different situations from a global point of view. It is pointed out that these issues concern very diverse situations and living conditions, but a common point often is the "spectre of the failure of the migration project". Moreover, the issue of irregular status and social determinants often are linked together causing vicious circles. In many cases, these problems are underestimated/ignored, since they concern situations that are theoretically outside the “typical” emergency receptionand integration process (e.g., migrants who have been in Italy for more than 4-5 years, secondgenerations, family reunification, etc.) Cases are often reported of migrants and refugees whoat first have a quite positive psychological profile and then deteriorate dramatically over timedue to bureaucratic problems and living conditions in Italy – also relevant with reference to the previously discussed concept of the nuances of vulnerability. Again, mostly these cases are only intercepted once a critical situation has been reached. Finally, in some cases, it is also possible to observe a territorial differentiation in the prevalence of psychological problems, as these are strongly linked to social determinants, which in turn are linked to the type of ‘migration project’ situated in the different Italian socio-economic landscapes.

MD: “Here the main problems are problems of accessibility missed or denied, in both administrative and social terms. [...] I am faced with a very diverse population, [...] there are very strong health needs linked to the failure, threats of failure of the migration project, I amthinking of second generations, I am thinking of family reunification. And this is a whole chapter that is hardly ever addressed. We are talking about 5 million people, so important numbers, [...] and here all the social determinants, if you like, the political and immigration determinants weigh in. As far as social marginality is concerned, what we see on a daily basisis that serious social marginality produces mental health problems, just as mental health problems produce serious social marginality. […] we can talk around 500,000 people nationwide.”

CM: “The problem is still the question of documents. For example, for those who applied for political asylum, already there is a difference between those who managed to get then a health card and those who did not. [...] Then, maybe the foreigner waits a year to have his residence permit renewed. In that one year, he/she also loses the right to medical care, the health card... foreigners lose a lot of rights. [...] They have no support. They have no family tohelp them. I have seen people who were really well off before, and now they are queuing to get the food parcel. Everything is complicated, so they easily get anxious, they easily get depressed. After [the financial crisis and then] the covid, it became even worse. [...] Or I remember that in the past years, we took care of women in the first instance. But we saw thatby taking men out the door, over time these men came back in through the window with very serious psychological, psychiatric problems. [The meaning of this metaphor is that by taking care of a few particularly vulnerable categories, you leave aside other categories at first, whichthen deteriorate dramatically over time due to living conditions and social determinants].”

2-SW: “I, working on integration projects with people who have been in Italy for a long time, 4 or 5 years, I realised [...] that people are reported to us when there is a problem. In other words, we have

this project in which an Italian volunteer works alongside a foreign person, thinking of that moment when the person leaves the reception system and suddenly is alone.So we want to intervene there. And so many times [...] they end up reporting to us guys whohave very strong [psychological] needs, for which we are not equipped. [...] I think this is a basic problem because loneliness certainly hurts everyone. Eventually, you realise that a person needs a hand, a reference point or a psychological path, just once there are clear signs,when the person cannot find a job or a home and ends up living on the street among the binsfor more than a month."

SP: "We, working in different places in Italy, I can say that some situations, for example, arealso related to place and context. [...] For example, in Sicily [southern Italy], we are in the 'transformed belt' and we work with migrants who are employed in the seasonality, in short,in the harvesting of fruit and vegetables. And there our psychologist finds a great deal of the disorders of alcohol and drug addiction, within an all-male population group. Whereas, for example, in Marghera [north-eastern Italy] we have many [female] caregivers, who often havedifficulties that may be linked to depression because they have been here for so many years,perhaps they have seen many people die among the elderly they took care of... [...] Then we see many situations [...] also of mistreatment of women. In Milan [north-west] we see a lot ofit. [Maltreatment] linked to acute stress, also by virtue of a whole series of problems derivingfrom the administrative and housing situation. So, for example, the lack of a residence permitis a situation that certainly creates a condition of absolute discomfort and disorientation."

In many cases, cultural difference leads migrants and refugees not to ask for help regarding mental health issues or not to accept a "Western medical approach".

This theme was reported basically in the second co-creation session by both participants witha migration background and those working in public service. They claim that few people are willing to go through psychotherapy, much less take psychotropic medications. In general, cultural and migration context factors produce a reticence to express one's psychological problems or seek help.

2-SW: "Speaking a little bit as an outsider, we collaborated with some [mental health] projects, but limited in time: eight to ten sessions. Several people were sent to these projects.However, it was difficult to find out who was really willing to do such a course, and in the end,very few people completed the full course."

2-CM: "When psychiatric patients arrive, we also struggle to treat them, because they come from a culture where care is very different from Western care, very different. And they don't accept, for example, the [female] psychologist, they don't accept the medications, that is, they really put us in trouble. […] First of all as an immigrant, when one leaves one's country one brings the head. The only thing, the only organ perhaps that one brings is the head, and the rest one leaves in the country, one leaves the heart. We, for example, we Arabs love with our liver. The dear ones are loved with the liver. So I think losing your head in a land in which youhave put so many plans, in which you have put so many dreams, so much hope to change, tochange life is really difficult. Consequently, it is difficult for a foreigner, an immigrant, to ask you for help. Often when they present themselves they do not ask easily, they do not say theyare depressed or have anxiety."

2-NP: “Usually nobody asks for help from this point of view, [mental health] also because culturally they are not used to asking for help with treatment. On the contrary, they often can't wait to leave, they often swear at us and are not at all in favour of any kind of pharmacological therapy. Yet, the need would be high.”

3. Knowledge and training on mental health issues for migrants/refugees

Substantial lack of official structured educational paths on the well-being in general and specifically on the mental health of migrants and refugees, so that there is a general lack of basic, fundamental knowledge to operate on this target group.

This perception is mainly expressed by those already involved in training on such themes andthose who have worked in the migration field for many years, but is also confirmed by youngerworkers. On the one hand, examples are given of some of the fundamental elements that aremost lacking, such as transcultural psychology, but also the approach to trauma and clinical mediation in mental health. On the other hand, it is emphasised that the transcultural approach and the recognition of its importance are lacking at all, – even though people with a migrant background in Italy make up 10% of the population – and that this situation is also due to a contextual problem: the ideological polarisation of recent years on the subject of migration. Ultimately, it is reiterated that it is only the third sector that deals with this.

1-TP: “I am [among other things] a tutor in ‘Centro PENC’, in agreement with some universitiesin Italy to receive postgraduate trainees from the faculty of psychology, [...] I am talking aboutUnipa, Unicoré in Enna, from Bologna, from Florence, even from Milan. [In my experience, inthe institutional/official education,] the topics concerning the psychologist's approach to trauma [in the migration context], are not covered, or are treated very superficially. So, also the aspects of transcultural psychology, (to say nothing of the ethnopsychiatry at all). […] As is the subject of the methodology of clinical mediation in mental health. I am not referring tolinguistic and cultural mediation courses, but to those with a specific focus on clinical work, and therefore to mediation with gender violence, mediation with trauma: mediation right in the ‘Psy-field’. In conclusion, [the major gaps in basic education concern] at least these three aspects: trauma, transcultural psychology and methodology of clinical mediation in mental health.”

1-MD: “I don't have any specific training experience, I mean, from the 'Psy' point of view, butif I had to say: the training with respect to migrants' health issues is disastrous. There is nothing in the training curricula of medical students. Wherever there is a greater sensitivity, at best there are additional courses wanted by the students that last a few hours. [...] I think that since [people with some kind of migrant background] are 10% of the [Italian] population,these are issues that need to be included in basic medical education. I'm really talking about the transcultural approach, even beyond 'Psy'."

NU: "I confirm what has been said previously, namely that even in the basic education, butin fact also in the supplementary training of nurses, there is practically no mention oftransculturalism or an approach to migrants. […] At least in my experience at the universitiesof Perugia and Turin, I have not seen these issues addressed at all."

PC: "In my opinion, another very important thing [is] the context. These last few years haveled to a strong ideologisation of all this, of our professions and this commitment... I realise this by doing a lot of training at health companies. For a [standard] professional, it is not normal to conceive of having a transcultural competence, an ability to know how to welcomethe other. [...] And this is embodied in the fact that the entities that provide training on thesethemes are very rarely [public] institutions, they are for the most part associations, the third sector, specialised schools. So specialised niches have been created. [...] We never succeed intransforming this into a systemic perspective, in something that is part of the competencies that the health system must have. [The transcultural approach] remains the preserve of thosewho are committed, those who have that extra bit of willpower, either religious or political motivation, basically. Let's put it this way. Whereas it should be a matter of equity. It should be part of the right to health universally."

The need to train/to have available cultural mediators seems to be particularly relevant in order to clearly communicate health procedures and interventions. At the same time, diametrically, there is the need to culturally decentralise the approach of health workers.

According to some of those who have been working in this field for the longest time, the question of the availability of a properly trained cultural mediator is a particularly important element (also to prevent secondary traumatisation), but one that has never yet been resolved.

Diametrically, the only cultural mediator present among the participants highlights the fact that many operators do not know how to work with cultural mediators and should have targeted training to learn how to culturally decentralise.

1-TP: "The whole issue of a cultural-linguistic mediation that is competent in mental health is a huge challenge that has been talked about for perhaps 20 years and is still unresolved."

PC: "Another concrete [issue] is the whole discourse related to communication, to the relationship of the suffering migrant with the world of the hospital, [...] where doctors will bewaiting for you who do not speak your language and who certainly will not have a cultural mediation to act as a bridge to the type of intervention, assistance, and examinations [...] evenvery invasive ones… you understand that a colonoscopy cannot be done if you have not explained to this boy what he is going to... above all a boy, a male, a foreigner who comes from a [totally different cultural] dimension... all this [is] a very delicate area of possible re- traumatisation that could be absolutely avoidable if the hospital structure would have a certain type of service."

CM: "We cultural mediators go through almost all the services: I work with the social worker,I work with the psychologist, I work with a lot of people [...] often they make us do training courses, but [...] in my opinion everybody, everybody who works in this sector should do courses to acquire cultural decentralisation skills and to acquire specific techniques to managean interview together with us. [They should] learn how to work together with the cultural mediator. They [often] do not realise that they

have in front of them [a person, the patient,] who is very different from an Italian, because he/she comes from another culture, another religion. [...] There are operators who speak without realising that some people may need more time, or an extra explanation in order to understand the operator's speech. [It is not justa matter of grammatically translating a sentence or a word.] For example, it is now typical forpsychologists to use the term 'djinn' a lot, instead of saying psychosis or depression. They use our terms: "Have you been touched by a djinn?" they ask, for example. But I cannot simply translate the phrase. In the Arabic culture [...] when we use the term "djinn", we must make a prayer before and a prayer after, to protect the patient, then make a prayer to protect ourselves. Then the whole interview becomes more complex."

a) Basic targeted knowledge, b) varied field experience, c) continuous training through mentors/supervisors, and d) aptitude/ability to teamwork, seem to emerge as crucial pivots in training paths and, therefore, effective in work practice. Given the previous point about the absence of official structured education, all participants' training paths were very varied. However, in general, it emerges that curiosity and personal interest prompted participants to gain initial basic knowledge through occasional courses/opportunities and then to build their own individual path. In general, the most recurring and crucial elements seem to be 'experience in the field' (also in many different situations/contexts), 'continuous training through the support of mentors or reference figures', and 'teamwork'. Moreover, the multidisciplinary approach in multi-professional teams seems to be not only a source of training inputs, but also the key to dealing with the extreme complexity of this working field. It seems not to be possible to learn everything one would need to deal with every situation, so, beyond basic targeted knowledge, and additional training on targeted topics – which are also stimulated by experience in the field – teamwork makes it possible to meet occasional needs and to cope with the situations that emerge from time to time.

1-TP: "I started in Sicily, in Palermo, when transcultural psychology or ethnopsychiatry was nowhere to be seen. [...] I belong to an era that had to do with 'the mentors', there were thefamous mentors. I too accidentally came across a half subject at university, occasional, optional, where there were 10 of us taking it, which was called ethnopsychoanalysis and that'swhere I got hooked. And then of course there was the encounter with the territory, i.e., in a curious way I tried to understand what places were possible [...] Obviously, always having a methodology in my head, I actually started to meet people. [...] And then I also found myself a bit inside a phenomenon that I did not expect, torture, which I actually did not even want toapproach [...] and so I continued to look for masters and to ask people older than me to supervise me on the cases I saw. That was my path, because there were no structured paths,at university there still isn't, much less at specialisation schools."

1-MP: "An educational parable to approach the mental health of migrants, even minor migrants, is to approach the subject from different perspectives. So obviously study, obviouslymaster's degrees and specialisations. But [for example] it happened to me to volunteer, to work in reception, and to do internships. I would say that it is advisable, desirable, the possibility of working in different services, in different ways on the same subject, in the samesector."

PP: “Out of the blue, the first answer that comes to me is 'in the field'. Let's say that after the initial training, at least in my case, curiosity was born there. [...] I really owe a lot to the first people I met: having reference figures to turn to, to learn from, is fundamental. For me it was fundamental. For example, I did an apprenticeship precisely so I could have a direct confrontation with [some 'mentors']. And also the team itself: in the figure of the cultural mediator I really often found an enormous formation, with respect to experiences and also readings of what was seen as fundamentally important. So, I believe that curiosity and openness, then, also respect for the person involved, whom you take charge of, are fundamental."

SP: “Personally, but because that's who I am, I am constantly in training. I don't think thereis one possible training path that gives you the tools to be able to act in all cases. The contextof migration is a very very complex world. [...] At the time of the big landings [2015-2018] there were problems of a certain kind. The problem of the transients is a problem of anotherkind. And that of those who remain in Italy, or of the second and third generations are still other types of problems. And so on. The issue is really complex. So? Of course, one must havesome basic knowledge. [For example,] the basis of trauma. How to recognise it in these contexts. What stress is. How it affects you neurologically, etc. [But then it's a matter of] continuing to grow in experience and training, confronting yourself in the field with differentsituations.”

2-PC: “In my opinion, training needs [can be divided] into two major articulations. One is the disciplinary one, i.e., that of the in-depth study of certain topics (e.g. female genital mutilation,trauma, etc.), which must be done from the perspective of one's own profession. The other one [...], concerning the taking on of hardships, and therefore of people with a migratory background, is the multidisciplinary, multi-professional approach. [...] Nowhere you can learneverything you need to know [to deal with each situation, therefore] it is the team that can make the difference. This is certainly another important training component: […] continuous confrontation and exchange.”

1-TP: “[Fundamental is] teamwork, because I think that - I do clinical work, I am a therapist, but - even in a private studio, if you don't have a mind that is used to teamwork, you don't getvery far with this kind of people [migrants and refugees]. And this, for example, is another issue that is little addressed [in training].”

4. Healthcare professionals’ proposals regarding the content of the programme’s training

Beyond the general themes already presented in points 2. and 3. of this report, the participants of both co-creation sessions did not find themselves comfortable neither with the ‘list of suggested themes’ of point 4., or with the ‘list of aspects’ of point 5. It seems to be a too rigid type of schematisation in the face of the complexity of mental health in itself – whichalso cannot be summarised in the short space of the co-creation sessions – and, above all, because of the complexity of the interaction between all the variables of migratory phenomena and all the variable conditions of

the Italian reception system. Anyway, below arehighlighted some additional inputs that emerged in the discussion, regarding some specific topics.

About mental health needs related to the integration process:

1-MD: "A highly comprehensive system, everything from prevention, education, social interventions, hospitalisation, subsidies... because mental health has to be approached necessarily in global terms. […] One of the issues that I think should be brought into play is tofirst of all change the paradigm precisely in dealing with people in pathological conditions, andthat is to talk seriously about what are the [most influential] determinants: social, organisational, communicative determinants."

MP: "[Talking about the needs of minors in the integration process] the need to establish safe relationships, therefore with people who are at least coherent, [...] who know their role.Another very strong need is that of self-affirmation, also from a cultural point of view, and therefore of finding places where they can socialise and also express components of their ownhistory. That is, not only to fulfil one's mission, one's migratory project, which would be to work, to earn money, but also to find places of expression, socialisation on the basis of culturaldimensions, such as play, religion or other dimensions of a human type, of a more human character [...] cultural expressions such as dance, use of the body, personal culture, cooking...[finally, learning to] manage anger."

NP: "Perhaps what is often frightening, what is disorienting in already vulnerable situations,is the lack of clarity of what each subject's path is. [...] Not being clear what his or her path will be, whether he or she would stay there in the reception facility, whether there will be a transfer... [...] The lack of clarity confuses them and makes them even more distrustful, so I could be a doctor, but in reality, I could also be an undercover police or an inspector who thenhas to decide whether to give him or her political asylum. There is a lack of trust, but also perhaps a difficulty in making them understand what is being done, who is doing it and what the future project is."

About assessing migrants' mental health needs

1-PP: "The distinction between pre-migratory and migratory vulnerabilities […] represents a strong point in clinical practice, because it also makes it possible to prevent post-migratory re-traumatisation. Where the presence of a previous vulnerability is pointed out, it is also possible to give more attention to specifics, to some specific characteristics of the person, because each person is different [...] In my opinion, therefore, knowing and understanding the past vulnerability of the person is a way to prevent a re-traumatisation of the past."

1- TP: "I believe that there should be an understanding of the specificity of development, of what we call psychic development, but declined in a transcultural differential key. In the sensethat development, the stages of age, the so-called developmental age, are not all the same. […] The approach to the person cannot disregard the framing of the phase that person is in, but in order to understand what phase that person is in, I must know the arc of the life cycle in the different cultural contexts, which do not always coincide with our own. [...] There cannot be psi aspects and medicine aspects that do not walk together, because some

issues that pass through the body then have an impact on the psychic configuration. For example, [...] the whole subject of ritual circumcisions, which seem to be a subject sometimes related a little to the law, a little to medicine, instead is often very psy. The subject of circumcisions, because some circumcisions, if not done, block the educational development, block the approach, the afflatus towards a life project, for which a document can be as important as the circumcision. [...] scars and signs of violence can often be mistaken for ritualistic signs, and vice versa, so before talking about torture and violence, there should be an approach to the normal development of the psyche, which also passes through the making of scars, because that is the normal development in some worlds, whether we like it or not."

2- **SP**: "The big problem in training is the ability to recognise a whole range of symptoms that are not typical of our culture. So, the work with the cultural mediator becomes fundamental in the dialogue. Let's say that in this way we can [more easily] intercept the person's problembefore [it] becomes more serious."

About skills on managing migrants' mental health needs

1- **MP**: "Of technical skills we are rich, we are getting richer and richer; professionals are increasingly equipped with models, with tools, with methodologies. [But I think we should aim] to develop competencies, which are somewhat in between the two, between method and knowledge, i.e., knowing how to activate a solution based on a given problem. And the great thing about competence is that we cannot separate it from the way of being we are, from the operator. So, I would give priority to these [...] one learns how to be a professional in a given field, especially in ours, also sharing with others, with other professionals, with fellow travellers, colleagues, even fellow students, a certain way of being, of sharing and collaborating, I would say. So, absolutely I see as more important the development ofrelational competencies before the development of skills."

2- **SP**: "To really do some psycho-education for these people, [who, often] are not really usedto understanding, for example, that if they don't sleep at night, maybe there is an anxiety problem or a whole series of other things."

2-NP: "I am very much in agreement on these aspects, precisely of trauma knowledge, no doubt, and the psycho-educational aspects. Sometimes a good education is enough to defuse mines that could then explode. This is fundamental for adults and children alike."

2-PC: "Decentralisation, i.e., the ability of the practitioner to know how to decentralise himself/herself with respect to his/her own [socio-cultural] frame of reference, seems to me to be quite transversal [needed]. After that, we move on to issues more related to the profile of the practitioner, in the sense that professions that already include a habit, a study focused on interpersonal relations, are at an advantage."

About supporting healthcare and other professionals

1- **TP**: "The issue of self-care, i.e. the care of the operator, the well-being of the operator, whichhas to do with communication skills, empathic skills, etc. which are worn out by the aspects of vicarious trauma, burnout, compassion, fatigue. [...] I mean, in the idea of

opening a degreecourse I would put all this stuff."

2-PC: "In my past experience I had been in very painful situations, especially with women. [...]What I had seen make the difference in this situation, and in other situations of this kind, wascertainly the support of the group of those working with you at that time. […] Even with colleagues who were not particularly experienced, we told each other about those episodes, we got together a bit, it was a very significant support when there were such episodes. It wasthe support of colleagues that made the difference."

2-RP: "I believe that politics also plays a role, unfortunately, in the sense that at this historical moment we are not in a moment where much is being invested in reception policies, to put it succinctly and somewhat euphemistically. [...] I have a bit of an impression that this has an impact on how gratified we feel by the work, which is very complex. Almost sometimes one feels as if one is doing something wrong, or something not particularly legitimate. [...] I believe that unfortunately this also plays a role when you find yourself doing something that is already extremely complex and not perhaps feeling the support of a large part of public opinion and even the government."

5. Healthcare professionals' proposals regarding the methodology and other considerations for the Programme's training

Length of the Course

There was no really an answer to this question, because of the complexity of all issues. The few indications in this sense pointed out that it shouldn't be short. No spot-model. No just one or a few days. On the contrary, there seems to be a need for continuous and long-term training.

Methodology

Direct and practical experience, capacity building in the field, horizontal exchange between professionals – also multidisciplinary, right at the training level – and the presence of supervisors, seem to be the most important and recurring elements.

1-MD: "Today there is a methodology [...] that of the health equity audit, which is a methodology that, if it is applied, at whatever level it is applied, you actually go and identify what the needs are and what is the best strategy to address them, and with the lens of equity. That is, not to think of a service that is the same for everyone, [...] but a service that somehow takes into account the differences, which are there, which may be at various levels [...] And this could be a methodological tool - not a technical one - but a basic methodological tool that could also guide appropriate training."

1-MP: "You can also study many things, but embedding certain assumptions, certain theories is much more important than knowing them inside out. So, I would definitely include direct experience with the same beneficiaries, with the same populations, with the same sector,

from different points of view."

1- TP: "Structuring also co-vision, supervision, exchange groups between professionals, where of course you always find a senior person with respect to you who can give you indications on how to do or which kind of approach. Studying certain topics is certainly fundamental, I repeat, you need paths, but also then structuring supervision places, and this is another very fragile element of our country, Italy, which is not the case in Europe, because supervision is compulsory in European countries. Definitely, supervision and co-vision groups with other colleagues, even from a multidisciplinary perspective, who deal with the same issues. […] By the way, I am also thinking about the idea of creating a more structured training course. So, I've been thinking about it for a while now precisely because so much is actually being asked of me. Rather than going around doing little bits, modules, single modules and so on, I see a bit, I imagine precisely the structuring of a different, longer and more complex course. I thinkI have somewhat arrived at the idea that it must be an absolutely multi-modal course with variable settings. [...] And so, A) a little bit of classroom, which has to be done, because in anycase some indications have to be given that are classroom-like. It is also right that they pass on experiences from people who are the so-called mentors, people who have written, who have worked in the field, and so on. B) Then a different setting is that of supervision, that is, of working on specific cases; because I, who have been working for more than 15 years now, the Senegalese boy I met 15 years ago is very different from the Senegalese boy of today, because Dakar has changed so much, Casamance is no longer what it used to be, that is, placesof origin, anthropologies change... [...] C) And then precisely the third element of mobility arethe workshop dimensions, that is to say, to revive an eventual class just, as it were, to goad curiosity, to goad creativity. Because it is, in any case, a job that is also made up of creativity and curiosity, because mental health is an exploratory job in my opinion, of caring in a broad sense for people who come from worlds so different and so distant from our own. So to prodpeople to develop, through workshop deliveries, a whole dimension of curiosity and active research."

2- PC: "It is very, very difficult to structure a training fit for all. That is to say, to establish one tool that can meet all needs. Why? Because they are [...] complex needs, multiple actors, multiple professions, multiple disciplines, multiple contexts... Among other things, we have 21 different healthcare systems in each region of Italy, so different access to the health pathsin each place and, above all, what I think really makes a difference in each context is the network that has been created [over time] between public institutions and associations in the territories, which therefore configure all different situations. To this, we add [...] the fact that training for adult professionals must be adherent to their experiences and professional contexts. It seems to me that the training needs and consequently the training objectives in this case are not of a notional nature. That is to say, it is not so much a question of knowing more or less about a series of notions, but it is a question of changing approaches, readings, and the ability to interact with other actors in the field. And this is all something that is being done. So, in my opinion, one of the strong keys to training that responds to these needs is training in the field, that is, training that is adherent to the specific context. For example, the experiences of 'improvement groups' come to my mind. These are groups of professionals where training is horizontal, it is no longer vertical. And above all, that it is not a spot, that it is not a single day when you go to the classroom, they tell you ten things, and then it is over.

[…] To have a place where I confront myself with other people who face the same issues as me, what can be called a community of practice, is very important [...] Something that it is not separate and abstract. […] And on the other hand, in terms of training, a very stimulating experience is to ensure that the training itself is multi-professional, that right from the classroom it starts to bring the professions together."

2-NP: "I would have liked in my training, even as a specialist, to have confrontations with an Arab psychiatrist or an African psychiatrist. [...] Why not also think of including it in the specialisation courses? A comparison with targeted psychiatry, with mental illness in other cultures. It would be wonderful, I would sponsor it a lot."

2-CM: "[Also] another thing: in addition to the training package, also a supervisor, a good supervisor who follows us in our work, because it is not easy at all. Our work is very complex,it also leaves us very burdened. A supervisor who relieves us and also makes us think, also makes us reflect on what we have experienced and on the case itself."

Training material

MD: "I would say that training is by nature dynamic and progressive. Also bearing in mind another thing: the enormous dynamism and let's say transformability of the migration phenomenon. So in my opinion what needs to be given is the most transversal tools possible,which can then evolve according to what happens."

RP: "What I have found very useful is to ask a lot of questions with respect to the context, basically, with respect to the history of a country. [...] This could apply to all 190 or more countries in the world. Of course, you can't know everything, but let's say that I found it veryimportant to know as much as possible about the context, [people's context of origin,] and tobecome aware of the fact that without this part it became really difficult to design an adequate intervention. [...] To really take off the Eurocentric glasses, […] and try to really immerse ourselves in what the culture is, why things happen in another place. Don't start withthe idea that anyway, if we do things a certain way it is because it is right. That is absolutely detrimental when we strive to know, to do something for the other."

2-NP: "I would like to have a point of reference, like an online forum, where someone can giveme support even on that specific case. So, I could talk, tell a little bit about the elements of the story, and understand on a cross-cultural level what they mean. For me, now that I am working, that I have already trained, it could be this support. [The other discourse] instead would be to include [the transcultural approach] in the university education, for the young people, at least to set off alarm bells or even bells of curiosity."

6. Conclusions

There is a need to compensate for some basic deficiencies in university training, ranging from the transcultural approach, trauma in the migration context, relational and cultural decentralisation skills, practitioner self-care, etc. Moreover, it seems to be essential to take into account the complexity and dynamism of this field of work, as well as the huge variety of contextual elements. These include the many structural deficiencies of the Italian reception system, which seem to have a great impact on migrants' and refugees' mental health. However, it does not seem to be desirable to create a training package highly focused on notionalised or compartmentalised knowledge. On the contrary, there is a preference for long-term training solutions that focuses on direct, practical, and supervised experiences in field work within a multidisciplinary team. Furthermore, it is suggested to build permanent platforms/spaces for sharing and exchange between professionals, also from a not Eurocentric perspective.

Spain

1. Introduction

Two Focus Groups were carried out in a face-to-face manner with an average duration of 1:30. A total of 12 people participated in the sessions, with two separate sessions with 6 participants in each session. The participants were: nurses (1), doctor (1), psychologists (2), social workers (6), emergency technician (1), cultural mediator (1) with an average age of 33 years.

For the recruitment process, the heterogeneity of the participants was sought, in terms of job profiles, gender and age. However, the profile of social work professionals was more likely to participate and therefore made up an important part of the sample, it was difficult to count on the participation of medical and nursing staff due to their work schedules, but in the end we managed to get two people to attend. Finally, the sample contains a higher number of women than men, but this is undoubtedly influenced by the feminization of some professional sectors such as nursing, social work and psychology.

The sessions were led and moderated by a Polibienestar researcher (L.L) with extensive experience in qualitative studies, with the support of an observer (L.B) who took notes during both sessions. All participants were informed about the objective of the session and the characteristics of the research and completed an informed consent form.

Participant code	**Professional profile**	**Age**	**Gender**	**Education level**	**Time working with migrants**
P1	Doctor	50	Male	Doctoral	More than 15 years
P2	Nurse	37	Female	Tertiary	10 years
P3	Social worker	25	Female	Tertiary	1 year and 2 months
P4	Social worker	22	Female	Tertiary	2 months
P5	Social worker	22	Female	Tertiary	1 year and 2 months
P6	Social worker	36	Female	Tertiary	3 years and 6 months

P7	Social worker	21	Female	Tertiary	2 months
P8	Social worker	46	Male	Tertiary	4 months
P9	Cultural mediator	29	Female	Tertiary	8 months
P10	Emergency technician	33	Male	technical	1 year
P11	Psychologist	38	Female	Doctoral	3 years
P12	Psychologist	35	Female	Doctoral	7 years

2. Mental health issues of migrants/refugees in everyday professional practice

During the discussion it was consistently repeated that the mental health of migrants receives little attention from professionals, the reasons for this being varied. The following were highlighted:

- Difficulty in accessing mental health care services, appointments can take months or even more than a year.

"Getting an appointment with the psychologist at the health center is almost impossible...some wait more than 7 months and there is no follow-up" P5. (social worker)

- In the associations' services for migrants, there are few mental health professionals (psychologists/psychiatrists) and therefore the possibility of being attended to in a continuous and effective way is limited.

“Here (migrant care association) we have a psychologist who can see them for 15 minutes every few weeks and of course there is no time to deal with the problems they bring with them.” P9 (cultural mediator)

- Physical health is often given much more importance than psychosocial and mental health.

“Practitioners tend to focus more on the physical health of migrants, as they often come from conflict or areas where they are not in optimal physical health” P2 (nurse)

- The language barrier is also sometimes a problem for migrants to express their mental health problems.

“One of the barriers to accessing mental health is language, sometimes they don't express their emotions or problems clearly, i.e. you see that they are not well psychologically but they don't say so.” P6 (social worker)

In addition, it was pointed out that no follow-up of mental health problems detected due to lack of professionals and difficulty in adhering to treatment due to the mobility of migrants.

“I am constantly detecting post-traumatic stress syndromes and anxiety and depression disorders in migrants, but it is very difficult to follow up, these people move around the territory and there is often little adherence to treatment, and appointments with psychologists or psychiatrists have a long waiting list.” P1 (medical doctor)

The issues revolved around the shortage of professionals to attend to the mental health of migrants, a theme on which all participants converged. There was also consensus that physical health continues to be the main concern of professionals in general, taking precedence over mental health. There was no disagreement among participants on any of the themes highlighted. It was agreed that mental health in migrants is an issue that needs to be addressed urgently and improved considerably from all professional backgrounds of the people who participated in the FG.

3. Knowledge and training on mental health issues for migrants/refugees

It was generally highlighted that there is no specific training on the mental health problems of migrants and that in general physical health is the first thing to be attended to in this group. When mental health problems such as anxiety or depression are detected, the usual solution is to prescribe medication for crisis situations, but this is not treated in the long term.

"As a doctor or emergency nurse you can't just stand there and say, well, come on, what's wrong with you, because first of all there is no time, secondly that person may have a language barrier, and then when they are given diazepam it's all very well if they have an anxiety crisis, but then you often cure yourself or get better by talking and for that you need a psychologist or a therapist". P2 (nurse)

It was also pointed out that the professionals are not able to understand the situation because of the great cultural diversity, they are not able to connect with the cultural reality of the migrants, nor do they have training in different cultural realities.

"We do not know how to read them, i.e. understand them, because they come from cultural contexts that are very different from ours, and mental health is a delicate subject to deal with". P8 (social worker)

It was pointed out that mental health is still a taboo subject for many migrant groups and even for professionals who sometimes do not know how to deal with it.

"Even if one suffers from some kind of mental illness symptom, it is not discussed, as it would be judged by the circle of friends and family ... and you don't want to talk about it openly either, so that they don't close their minds." P12 (Psychologist)

All professionals highlighted a lack of training in mental health issues with the exception of psychology professionals. They also highlighted the need for a social change in which health problems are no longer a taboo subject and sufficient time is devoted to them both in primary care and in the emergency department. There was no disagreement on the topics discussed, although some professionals pointed out that it is more difficult to work on mental health issues with some migrant profiles, such as African or Latin American migrants.

4. Healthcare professionals' proposals regarding the content of the programme's training

With regard to the content of the training, it was suggested that the ideal would be to divide the programme according to the basic knowledge of the professional; doctors will not be interested in the same topics as social workers or psychologists.

"I think it is logical to think that in a training I will be interested in what can help me in my daily practice, for example, cultural issues of migrants, but I don't need to know the symptoms of a person suffering from bipolar disorder, I already know that". P1 (medical doctor)

It was stressed that information on how to deal with sensitive issues or issues that have to do with the cultural context or with people's own migration background is an issue on which more information would be useful.

"Many times you work and you don't understand that maybe a child comes and you are going to touch him/her to take a sample or an analytical test and it could be that this child insults you, hits you, because it has happened to me as a nurse and maybe this person has been abused and I think it is interesting to have tools to understand or deal with these situations better". P2 (nurse)

With regard to social sector professionals (social workers, mediators) it was highlighted that training can be very useful if it helps them to understand the main mental health problems that the migrant population may suffer from and it would also be very useful if the materials included resources available to refer migrants with mental health problems.

"I think the idea of training to empathize, to read, to know, to know... something basic, nothing extraordinary, but the basics to understand the subject." P3 (social worker)

There was general agreement among the professionals that the training programme should be divided into sections according to the professional profile of each person, it was pointed out that doctors, nurses, social workers and psychologists have different knowledge about mental health and will therefore be interested in different topics. The importance of including in the programme the legislation of the country where the profession is practised, in order to know to what extent certain

tasks can be carried out, to know the resources available to the immigrant population or their legal situation, is commented on.

5. Healthcare professionals' proposals regarding the methodology and other considerations for the Programme's training

Regarding the length of the course, there was consensus that it should not take too many hours, as working days are long and if the training is too dense this is a barrier to interest.

"I would do the course if it didn't involve too many hours, I mean, sometimes I have a few days off and if it's not too demanding in terms of hours I would do it." P1 (medical doctor)

There was also a consensus that if certification is issued by an official body, this will motivate professionals to take an interest in training.

"I think a certificate would help professionals to want to do the training, in the end something that motivates you a bit is important." P7 (social worker)

Regarding materials, some professionals preferred audiovisual materials, such as videos, but others preferred reading materials such as pdfs. However, all agreed that they should be easily accessible and that the training platform should be intuitive.

"Sometimes you sign up for a course and the materials are too long and unfriendly, so I prefer that they include videos or a podcast." P9 (cultural mediator)

There was a general consensus that ideally the course should contain a variety of materials and that it is possible to choose which ones are interesting and make use of them. The fact that the training platform is not very attractive or requires a lot of information in order to register and access the materials was highlighted as a barrier.

6. Conclusions

All professionals agreed that mental health is a secondary issue in the health system and that there is an alarming lack of resources for mental health care in general, and even more so for the migrant population, as other needs that are considered urgent often take precedence. With regard to the professionals' discourses on the training received in relation to the mental health of migrants, all of them stated that there are shortcomings, since, while psychology, medicine and nursing do study mental health problems to varying degrees, there is no specific training in mental health issues for the migrant population. The rest of the professionals expressed much more deficiencies in this area.

Training on issues of cultural differences was highlighted as one of the key topics for all professionals and materials on how to address mental health issues in conversations with migrants was also highlighted as a topic that the course should address, as in many cases it remains a taboo subject.

As a general conclusion, the different professional profiles that participated highlighted that each of them will be interested in different topics and this must be taken into account when developing the materials. In addition, a certain lack of confidence in the materials was expressed, i.e. it should be specified which professionals have developed the course materials and the knowledge that supports them.

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