

Programa De Formação Em Saúde Mental E Bem-Estar Para Profissionais E Voluntários, Que Não Os De Saúde, Trabalharem Com Requerentes De Asilo (APT4U2)

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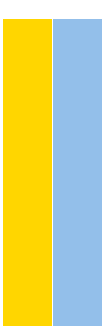
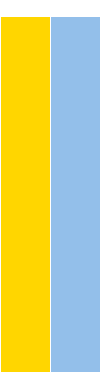
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Programa De Formação Em Saúde Mental E Bem-Estar Para Profissionais E Voluntários, Que Não Os De Saúde, Trabalharem Com Requerentes De Asilo (APT4U2)

Luísa Micaela Teixeira Santos



LUÍSA MICAELA TEIXEIRA SANTOS

**PROGRAMA DE FORMAÇÃO EM SAÚDE MENTAL E BEM-ESTAR
PARA PROFISSIONAIS E VOLUNTÁRIOS, QUE NÃO OS DE
SAÚDE, TRABALHAREM COM REQUERENTES DE ASILO
(APT4U2)**

**MENTAL HEALTH AND WELL-BEING TRAINING PROGRAM FOR
NON-HEALTH PROFESSIONALS AND VOLUNTEERS WORKING
WITH ASYLUM SEEKERS (APT4U2)**

Tese de Candidatura ao grau de Doutor em Ciências
de Enfermagem submetida ao Instituto de Ciências
Biomédicas Abel Salazar da Universidade do Porto.

Orientador: Professor Doutor Wilson Abreu

Categoria: Professor Coordenador Principal

Afiliação: Escola Superior de Enfermagem do
Porto, Porto, Portugal.

O trabalho conducente a esta tese foi financiado pela Fundação para a Ciência e tecnologia através da concessão de uma bolsa de doutoramento (2020.06712.BD.), atribuída ao projeto de Investigação “*Mental health and well-being training program for non-health professionals and volunteers working with asylum seekers (APT4U2)*”, na sua tradução, “Programa de formação em saúde mental e bem-estar para profissionais e voluntários, que não os de saúde, trabalharem com requerentes de asilo (APT4U2)”.



Pensamento

“Fica-me a certeza de que, ao enfermeiro que jurou cuidar da vida humana, a complexidade e a distância nunca serão impedimentos para as suas ações, porque para ele todas as vidas são iguais e merecedoras dos melhores cuidados”

(Teixeira-Santos, 2018)

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RESUMO

Introdução: Anualmente, milhares de pessoas são forçadas a atravessar as fronteiras por questões de sobrevivência. A maioria destas pessoas são jovens requerentes de asilo que procuram proteção internacional em países de baixo e médio rendimento, sobrecarregando os recursos dos países de acolhimento. A Europa, considerada um continente de oportunidades, enfrenta há vários anos a entrada ininterrupta de requerentes de asilo, aos quais só é possível dar resposta através da sinergia de colaboração entre as organizações governamentais e não-governamentais. Contudo, as organizações não-governamentais são, frequentemente, formadas por voluntários sem formação específica para trabalhar com estas populações vulneráveis o que pode prejudicar a sua própria saúde mental e a dos requerentes de asilo. Com o intuito de contribuir para a formação dos voluntários que trabalham com requerentes de asilo, propõe-se o desenvolvimento de um programa de formação em saúde mental e bem-estar chamado APT4U2. Este programa de formação, liderado por enfermeiros especialistas em enfermagem de saúde mental e psiquiátrica, pretende ser um contributo para melhorar a resposta às necessidades dos jovens requerentes de asilo e fortalecer as competências dos voluntários.

Objetivo: Desenvolver um programa de formação em saúde mental e bem-estar para trabalhar com requerentes de asilo (APT4U2).

Métodos: A investigação desenvolveu-se segundo as etapas da Fase de Desenvolvimento otimizada do Modelo de Intervenções complexas do *Medical Research Council (MRC)*. Foram realizados 5 estudos: protocolo de revisão *scoping*; uma revisão *scoping*; um estudo transversal e outro transversal e correlacional, envolvendo voluntários e profissionais, que não de saúde, para compreender as necessidades formativas para trabalhar com requerentes de asilo (N=91); e, por último, um estudo descritivo com apresentação do programa APT4U2 com validação por grupo de peritos (n=8).

Resultados: O desenvolvimento dos diferentes estudos permitiu desenvolver o Programa APT4U2, um programa de formação em saúde mental e bem-estar para trabalhar com jovens requerentes de asilo. A realização dos estudos permitiu, primeiramente, fazer um levantamento da evidência científica sobre as competências para trabalhar com requerentes de asilo; e, de seguida, compreender quais as componentes dessas competências são necessidades formativas na perceção de 91 voluntários e profissionais, sem formação em saúde, na qual se inclui saúde mental, para trabalhar com requerentes

de asilo. A síntese e integração dos resultados dos estudos serviram de base ao desenvolvimento do Programa APT4U2. Através de um grupo focal de peritos foi realizado o processo de validação teórica do programa APT4U2, que lhe permite estar pronto a ser operacionalizado na fase seguinte do Modelo de Intervenções Complexas do MRC.

Conclusões: O desenvolvimento do Programa APT4U2 representa um avanço significativo na formação de voluntários que trabalham com requerentes de asilo, abordando uma lacuna crucial na capacitação para reconhecimento e suporte em questões de saúde mental. Baseado em uma revisão científica rigorosa e otimizado de acordo com o Modelo de Intervenções Complexas do MRC, o programa é estruturado em três módulos que fornecem competências específicas e culturalmente adequadas. Validado por peritos, o APT4U2 capacita voluntários para oferecer apoio psicossocial eficaz, promovendo a saúde mental e o bem-estar tanto dos próprios voluntários quanto dos requerentes de asilo. Esta tese destaca ainda o papel essencial dos enfermeiros especialistas em saúde mental na liderança e implementação de soluções inovadoras para problemas complexos de saúde global, como é a prestação de cuidados aos jovens requerentes de asilo que vivem em condições de acolhimento indignas durante o seu processo de requerimento de proteção internacional.

Palavras-Chave: Requerentes de Asilo; Saúde Mental; Programa de Formação; Educação; Enfermagem.

ABSTRACT

Introduction: Every year, thousands of people are forced to cross borders for survival reasons. Most of these people are young asylum seekers seeking international protection in low- and middle-income countries, putting a strain on the resources of the host countries. Europe, considered a continent of opportunity, has been facing an uninterrupted influx of asylum seekers for several years, which can only be dealt with through the synergy of collaboration between governmental and non-governmental organisations. However, nongovernmental organisations are often staffed by volunteers with no specific training to work with these vulnerable populations, which can be detrimental to their own mental health and that of the asylum seekers. To contribute to the training of volunteers working with asylum seekers, it is proposed to develop a training programme in mental health and well-being called APT4U2. This training programme, led by nurses specialising in mental health and psychiatric nursing, aims to help improve the response to the needs of young asylum seekers and strengthen the skills of volunteers. Translated with DeepL.com (free version)

Aim: To develop a mental health and wellbeing training programme for working with asylum seekers (APT4U2).

Methods: The research followed the steps of the optimised development phase of the Medical Research Council's (MRC) Complex Interventions Model. Five studies were carried out: a scoping review protocol; a scoping review; a cross-sectional study and another cross-sectional and correlational study involving volunteers and non-health professionals to understand the training needs for working with asylum seekers (N=91); and finally, a descriptive study presenting the APT4U2 programme with validation by a group of experts (n=8),

Results: The development of the different studies made it possible to develop the APT4U2 Program, a training program in mental health and well-being for working with young asylum seekers. The studies made it possible, firstly, to survey the scientific evidence on competences for working with asylum seekers; and, secondly, to understand which components of these competences are training needs in the perception of 91 volunteers and professionals, with no training in health, including mental health, for working with asylum seekers. The synthesis and integration of the studies' results served as the basis for the APT4U2 Program development. A focus group of experts carried out the theoretical validation process of the APT4U2 program, enabling it to be ready to be operationalized in the next phase of the MRC's Complex Interventions Model.

Conclusions: The development of the APT4U2 Program represents a significant advance in the training of volunteers working with asylum seekers, addressing a crucial gap in capacity building for recognizing and supporting mental health issues. Based on a rigorous scientific review and optimized according to the MRC's Complex Interventions Model, the program is structured in three modules that provide specific and culturally appropriate skills. Validated by experts, APT4U2 trains volunteers to offer effective psychosocial support, promoting the mental health and well-being of both the volunteers themselves and asylum seekers. This thesis also highlights the essential role of specialist mental health nurses in leading and implementing innovative solutions to complex global health problems, such as the provision of care to young asylum seekers living in undignified reception conditions during their application process for international protection.

Keywords: Asylum Seekers; Mental Health; Training Program; Education; Nursing.

LISTA DE ABREVIATURAS, ACRÓNIMOS E SIGLAS

ACNUR	Alto Comissariado das Nações Unidas para os Refugiados
DGS	Direção-Geral da Saúde
EEESMP	Enfermeiros Especialistas em Enfermagem de Saúde Mental e Psiquiátrica
ICN	<i>International Council of Nurses</i>
MRC	<i>Medical Research Council</i>
ONGs	Organizações não-governamentais
OMS	Organização Mundial de Saúde
ONU	Organização das Nações Unidas
SPSS	<i>Statistical Package for the Social Sciences</i>

LISTA DE FIGURAS

Figura 1 - Modelo das Intervenções Complexas do *Medical Research Council* 51

Figura 2 - Fase de Desenvolvimento otimizada do Modelo de Intervenções Complexas do *Medical Research Council* 52

Figura 3– Enquadramento metodológico e resultados do desenvolvimento do Programa APT4U2 54

Figura 4– Enquadramento metodológico e resultados do desenvolvimento do Programa APT4U2 151

PREÂMBULO

O “Programa de formação em saúde mental e bem-estar para profissionais e voluntários, que não os da saúde, trabalharemos com requerentes de asilo (APT4U2)”, e na sua tradução “*Mental health and well-being training program for non-health professionals and volunteers working with asylum seekers (APT4U2)*” é um programa de intervenção desenvolvido no âmbito do Programa Doutoral em Ciências de Enfermagem do Instituto de Ciências Biomédicas Abel Salazar, da Universidade do Porto, em Portugal. É um projeto financiado pelo concurso nacional da Fundação para a Ciência e a Tecnologia, avaliado no domínio científico das Ciências Médicas e da Saúde, com a atribuição de bolsa número 2020.06712.BD.

O estudo foi conduzido de acordo com as diretrizes da Declaração de Helsínquia e foi aprovado pela Comissão de Ética da Unidade de Investigação em Ciências da Saúde: Enfermagem com o Parecer nº 0 P742 12/2020) (Anexo 1).

A tese de doutoramento é apresentada na forma de capítulos que integram os artigos de investigação publicados, outros submetidos, em revistas científicas com revisão por pares e acesso aberto. A candidata foi responsável pela conceção do projeto de tese, estudos a ela associados, colheita de dados, análise dos dados, interpretação e análise dos resultados e preparação de cada manuscrito científico, sob supervisão do Orientador deste projeto, Professor Doutor Wilson Abreu. A evidência da tese produzida é clarificada pela apresentação em quatro capítulos principais, antecedido por uma nota introdutória, e precedido por uma nota conclusiva.

O Capítulo 1, “Enquadramento Teórico”, apresenta o enquadramento do projeto, nos seus referenciais teóricos e com o objetivo geral da tese. O Capítulo 2, “Enquadramento Metodológico”, apresenta um enquadramento dos referenciais metodológicos que guião cada fase do projeto que se apresenta nesta tese. O Capítulo 3 “Estudos Empíricos”, incorpora os resultados dos estudos sob a forma de artigos científicos, integrando, nomeadamente, o protocolo de revisão *scoping* (Artigo 1) e a revisão *scoping* que serve de base ao desenvolvimento do projeto (Artigo 2), um estudo observacional transversal (Artigo 3) e outro transversal correlacional (Artigo 4) que explanam as necessidades formativas da população-alvo. Por fim, apresenta-se o Programa APT4U2 (Artigo 5) sob a forma de artigo descritivo que expõe a conceção do programa com a incorporação da validação teórica dos peritos quanto programa de formação e seus manuais. O Capítulo 4, “Discussão Geral e Perspetivas Futuras”, analisa e discute os principais resultados e aspetos mais importantes dos estudos realizados, considerando as perspetivas futuras de investigação num projeto que se espera de continuidade.

Cada artigo foi publicado com a sua própria lista de abreviaturas e referências bibliográficas. Para simplificar a leitura, a lista de figuras, tabelas e anexos apresenta apenas as relevantes para o corpo principal da tese e não as de cada artigo individualmente.

DIVULGAÇÃO CIENTÍFICA REALIZADA NO ÂMBITO DA TESE

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Reconhecimentos

- Finalista do *One Health PhD Forum* ICBAS com o trabalho APT4U2 – A mental health and well-being training program for lay people working with asylum seekers. Porto, Portugal. Junho de 2024.
- 1º Prémio de Melhor Poster intitulado “APT4U2 Project (Phase 1)” na *European Academy of Nursing Sciences Summer School*, Oslo, Noruega. Julho de 2023.
- Finalista no *Three Minutes Thesis - U.Porto 3MT® Competition* com o trabalho “Mental health and well-being training program for non-health professionals and volunteers working with asylum seekers (Apt4U2)”. Porto, Portugal. Maio de 2023.
- 1º Prémio de Melhor Comunicação Oral “A saúde mental das crianças que vivem nos campos de refugiados às portas da Europa” no XII Congresso Internacional d’A Sociedade Portuguesa de Enfermagem de Saúde Mental, Felgueiras. Outubro de 2021.
 - *Prémio Pião Dourado 2020* na vertente Bolseiro jovem Investigador, atribuído pela Unidade de Investigação em Ciências da Saúde: Enfermagem, Coimbra, Portugal. Junho de 2020.

SUMÁRIO

AGRADECIMENTOS	VIII
RESUMO	IX
ABSTRACT	XI
LISTA DE ABREVIATURAS, ASCRÓNIMOS, SIGLAS	XIV
LISTA DE FIGURAS	XVI
PREÂMBULO	XVIII
DIVULGAÇÃO CIENTÍFICA NO ÂMBITO DA TESE	XX
NOTA INTRODUTÓRIA	25
CAPÍTULO I - ENQUADRAMENTO TEÓRICO	33
1.1. SER JOVEM REQUERENTE DE ASILO: UMA NOVA CONFIGURAÇÃO NAS TRANSIÇÕES DE VIDA	40
1.2 CUIDAR DE JOVENS REQUERENTES DE ASILO	46
CAPÍTULO II - ENQUADRAMENTO METODOLÓGICO	49
CAPÍTULO III - ESTUDOS EMPÍRICOS	55
ARTIGO 1	57
Mental Health Training Programs for Non-Health Professionals and Volunteers Working with Asylum Seekers and Refugees: a Scoping Review Protocol.	

ARTIGO 2	69
Mental health training programs for non-health professionals and volunteers working with asylum-seekers and refugees: Scoping Review	
ARTIGO 3	83
Empowering volunteers to work with asylum seekers and refugees: conceptual and psychometric considerations of new inventory assessing training needs.	
ARTIGO 4	105
How can we help? A training needs assessment for non-health professionals and volunteers working with asylum seekers and refugees.	
ARTIGO 5	117
Mental Health Nurses leading the way in the training of lay people working with young asylum seekers: The APT4U2 Program	
CAPÍTULO IV - DISCUSSÃO GERAL E PERSPETIVAS FUTURAS.....	143
NOTA CONCLUSIVA	155
REFERÊNCIAS BIBLIOGRÁFICAS	161
ANEXOS	177
ANEXO I - Parecer da Comissão de Ética	179

NOTA INTRODUTÓRIA

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Um dos fenómenos mais importantes do século XX e XXI é o aumento da migração. Nas últimas cinco décadas, verificou-se um crescimento ininterrupto, e sem precedentes, da migração internacional. O crescimento dos fluxos migratórios é um dos fenómenos sociopolíticos e económicos que mais tem preocupado a comunidade internacional, pese embora que seja um elemento crucial da globalização, relacionando-se a sua pertinência com o crescimento económico e o acesso a produtos e serviços potenciadores de uma interconexão global¹.

A eclosão de fluxos migratórios sem precedentes ganha especial atenção pelos seus fatores desencadeadores, nos quais se incluem, para além da globalização, as condições socioeconómicas, as alterações climáticas e as mudanças geopolíticas^{2,3,4}. As condições socioeconómicas são, talvez, as mais antigas e conhecidas razões para a movimentação dos fluxos migratórios. Na história da humanidade não é incomum o movimento das massas migratórias na procura de oportunidades de emprego e da melhoria do seu nível de vida, assistindo-se à migração de pessoas das zonas com um nível de vida mais baixo para outras com melhores perspetivas económicas^{1,3}. No entanto, nas últimas décadas, as razões dos movimentos migratórios ganham outros contornos devido às mudanças climáticas e geopolíticas. Os fenómenos climáticos, sejam eles inesperados ou graduais, têm levados milhares de pessoas a deslocarem-se como forma de adaptação aos fatores de stress ambiental e a permitir a segurança e subsistência das populações. Representam, portanto, um dos maiores desafios para os governos e organizações internacionais pela exigência de respostas coordenadas e sustentáveis na resposta às necessidades humanitárias^{4,5,6}. Não menos importante, e muitas vezes em coexistência, os movimentos migratórios exacerbam-se em locais nos quais a sobrevivência das populações é posta em causa pela instabilidade geopolítica. Esta, a par dos conflitos armados, violência, violação dos direitos humanos e distúrbios da ordem pública, tornaram-se uma realidade diária nos nossos *media* trazendo à tona as verdadeiras razões que levam milhões de pessoas a fugir dos seus países de origem na esperança de asilo internacional e liberdade democrática^{3,4,7}.

Mundialmente, contabilizavam-se a meio do ano de 2023, mais de 110 milhões de pessoas forçadas a deslocar-se devido à instabilidade geopolítica e social, promotora de conflitos armados e violação dos direitos humanos. Estes conflitos já causaram mais de 62.5 milhões de deslocados internos, 36.4 milhões de refugiados, 6.1 milhões requerentes de asilo e 5.3 milhões de pessoas que precisam de proteção internacional temporária. A maioria destas pessoas, 52%, é proveniente dos três maiores conflitos humanitários tão sobejamente

conhecidos, e com tantas repercussões, na Europa; nomeadamente, da República Árabe da Síria, do Afeganistão e da Ucrânia⁸. Destas pessoas, 75% são recebidas em países de baixo e médio rendimento, sobrecarregando as comunidades e os recursos nos países de acolhimento^{8,9}. Dos países de acolhimento destacam-se a República Islâmica do Irão (3.4 milhões), Turquia (3.4 milhões), Alemanha (2.5 milhões), Colômbia (2.5 milhões) e Paquistão (2.1 milhões)⁸.

A Europa é vista, pelos que procuram asilo internacional, como um continente de sonhos¹⁰, não só pela proximidade geográfica aos conflitos com maiores repercussões nos fluxos migratórios, como também por ser símbolo e defensora dos ideais de proteção, solidariedade e justiça. Estes ideais são declarados nas mais diversas diretivas e regulamentos emanados pelo Sistema Europeu Comum de Asilo, os quais atestam a responsabilidade, compartilhada entre países europeus, quanto à receção e acolhimento de requerentes de asilo de forma digna e justa¹¹.

A partir de 2014, e com particular incidência em 2015, os fluxos migratórios em direção ao continente europeu assumiram proporções alarmantes com o inesperado influxo de mais de 1 322 850 pedidos de asilo na Europa¹². Apelidada como “a crise migratória” pelos *media* e atores políticos internacionais, retratava-se, visualmente, pelas enchentes de gentes a entrar numa Europa que não conseguia dar resposta às necessidades, culminando em milhares de mortes nas mais diversas rotas das travessias ilegais. De 2015 a 2023, 2 545 002 migrantes ilegais chegaram à União Europeia, principalmente através da Rota do Mediterrâneo Oriental, Rota do Mediterrâneo Central, Rota dos Balcãs Ocidentais, Rotas do Mediterrâneo Ocidental e da África Ocidental. No final de 2023, registava-se o maior número de migrantes ilegais nestas travessias rumo à Europa desde 2016, sendo as Rotas do Mediterrâneo Central, Oriental e dos Balcãs as mais utilizadas como porta de entrada na União Europeia¹³.

O influxo de migrantes na última década despoletou a criação de locais de acolhimento, outrora temporários, que persistem na sua existência pela tamanha afluência de requerentes de asilo que chegam às portas da Europa diariamente, tornando-se numa fonte geradora de instabilidade política e social¹⁴. Estes locais de acolhimento, designados também como centros de acolhimento, abrigos ou campos de refugiados, são uma nova provação à jornada de sobrevivência dos requerentes de asilo. Ainda que sob o controlo dos governos europeus, que pautam as suas medidas político-sociais pela defesa dos direitos e da dignidade humana, carecem das condições mais básicas de sobrevivência: Tornou-se comum, quicá banal, principalmente na última década, o relato e a denuncia, por requerentes de asilo e por organizações não-governamentais (ONGs), as condições

precárias em que os requerentes de asilo ficam a viver sendo privados do usufruto dos direitos humanos fundamentais¹⁵⁻²¹. Além de todas as perdas, relacionadas com os referenciais identitários, familiares e bens, veem-se privados de um lugar no mundo, da pertença a uma comunidade, e da liberdade de ações e decisões, sobre si e sobre os seus, outrora dadas como adquiridas²².

O processo migratório e de acolhimento em situações precárias têm um elevado impacto na saúde física e mental dos requerentes de asilo²³⁻²⁶. Especialmente para os jovens, a vivência das múltiplas, simultâneas e abruptas transições de vida, em concomitância com a perda dos referenciais identitários, podem conduzir ao sofrimento, experiências de confusão e mudanças comportamentais que condicionam o desenvolvimento da sua identidade^{27,28}, aumentando a sua vulnerabilidade às perturbações da saúde mental²⁹. A par destas vivências disruptivas, vivem anos de incerteza sobre o seu futuro e a integração numa nova sociedade. Embora chegados à Europa, estes jovens vivem o processo de requerimento de asilo exilados da possibilidade de aquisição de uma identidade positiva para si na sociedade de acolhimento, devido ao facto de serem obrigados a viver nos centros de acolhimento. É nestes contextos de precariedade permanente que ficam ao cuidado de dezenas de voluntários e profissionais integrados em ONGs³⁰ que, na maioria das vezes, não têm formação para o trabalho que desempenham³¹.

As ONGs fazem-se representar na maior percentagem das mais de 900 entidades parceiras do Alto Comissariado das Nações Unidas para os Refugiados (ACNUR) que trabalham com o intuito de garantir a segurança, a proteção e o acesso às necessidades básicas fundamentais dos requerentes de asilo, nos quais se incluem o acesso aos cuidados de saúde, alojamento e educação³². As ONGs não profissionais são compostas, principalmente, por uma comunidade de voluntários da sociedade civil³³ que, ao contrário das que contratam pessoal qualificado, possuem formação limitada ainda que o seu trabalho tenha um enorme impacto social^{34,35}. A escassa preparação para trabalhar com requerentes de asilo, especialmente pela falta de formação e pela inexperiência de trabalho, quer com a requerentes de asilo, quer em contextos precários, deixa os voluntários mais vulneráveis às perturbações da saúde mental. Na literatura são descritas consequências adversas como estados de ansiedade, depressivos e de *burnout*, o envolvimento excessivo com requerentes de asilo, manifestações de apatia e comportamentos autodestrutivos, assim como conflitos interpessoais e stress pós-traumático secundário³⁶⁻³⁸. Estes sintomas de sofrimento psicológico variam de acordo com a formação prévia³⁹⁻⁴¹, sendo menos evidentes quando os voluntários têm formação no âmbito da saúde mental⁴².

Pese embora a evidência supramencionada, os poucos programas/ações de formação disponíveis, com foco particular na formação em saúde mental para leigos em saúde e ou saúde mental para trabalharem com requerentes de asilo, foco deste trabalho, estão dispersos e, na sua maioria, acessíveis apenas em sites de ONGs, as quais optam por gerir a própria formação⁴³ socorrendo-se do *know how* dos voluntários mais antigos e com mais experiência prática. Contudo, os poucos programas disponíveis são desadequados, seja por se focarem especificamente em diagnósticos psiquiátricos médicos, por representarem uma realidade demasiado específica que impede a transferibilidade para outros contextos, ou por serem de autoadministração não permitindo a monitorização das aprendizagens⁴⁴. Estes factos evidenciam uma clara necessidade de desenvolvimento de programas de formação em saúde mental para leigos mais inclusivos, capazes de serem utilizados e adaptados a diferentes contextos, e principalmente ministrados por pessoas com competências nesta área.

É assim que surge a oportunidade dos enfermeiros poderem estar na vanguarda da formação de milhares de pessoas que, diariamente, se voluntariam para trabalhar e cuidar de jovens requerentes de asilo. Para além do seu conhecimento sobre os processos de transição de vida que, em boa verdade, são o foco dos cuidados de enfermagem⁴⁶; os enfermeiros têm uma compreensão profunda do impacto das situações disruptivas na estabilidade emocional das pessoas, em particular, dos mais jovens. Neste sentido, e no entendimento de que os enfermeiros não podem simplesmente deslocar-se para as linhas da frente dos mais diversos pontos críticos do mundo, para trabalhar diretamente com jovens querentes de requerentes, estão numa posição privilegiada de dotar de conhecimentos todos os que, sem formação em saúde e saúde mental, tantas vezes vão ao encontro de ajudar estes jovens nas mais variadas partes do mundo. Os enfermeiros são, por excelência, exímios educadores em saúde e, neste âmbito, são a chave para cuidar dos requerentes de asilo e refugiados do mundo⁴⁷, ainda que, de forma indireta, através da dotação de conhecimento, capacidades, atitudes e valores dos que, todos os dias, lidam e trabalham com estas populações vulneráveis⁴⁸.

Para dar resposta à falta de preparação dos voluntários para trabalharem com esta população vulnerável, o objetivo geral da tese é desenvolver um programa de formação em saúde mental e bem-estar para voluntários e profissionais, que não os de saúde, trabalharem com jovens requerentes de asilo. Este programa, na sua abreviatura designado por APT4U2 (apto para ti também), desenvolveu-se de acordo com os pressupostos da primeira fase do modelo de intervenções complexas do *Medical Research Council* (MRC). Este programa de intervenção é um contributo para a formação não profissional dos milhares de voluntários que, diariamente, são cuidadores de jovens

requerentes e que carecem de uma formação digna e adequada, ministrada por profissionais qualificados.

Com o intuito de concretizar o objetivo geral vários estudos foram realizados dando resposta a objetivos mais específicos, nomeadamente: i) mapear a evidência científica relativamente aos programas de formação no âmbito das competências em saúde mental para profissionais e voluntários, sem formação em saúde (na qual se inclui saúde mental), trabalharem com requerentes de asilo em qualquer contexto; ii) identificar as necessidades formativas de voluntários e profissionais, que não os da saúde, para trabalharem com jovens requerentes de asilo; e iii) apresentar o programa APT4U2 com a validação teórica, perspectivas e sugestões, de um grupo de peritos sobre o programa e seus materiais de apoio.

Estão incluídos cinco estudos, que partem da análise inicial das transições de vida dos jovens requerentes e da descrição da problemática relaciona com a formação dos voluntários que diariamente cuidam destas populações vulneráveis. Dois com foco na revisão de literatura (protocolo *de scoping review* e a *scoping review*), dois estudos que envolvem voluntários e profissionais com particular interesse no trabalho com requerentes de asilo (um estudo observacional transversal e outro transversal e correlacional que avaliam as necessidades formativas dos voluntários e profissionais que trabalham com requerentes de asilo) e, por último, um estudo de abordagem qualitativa que descreve o Programa APT4U2 que incorpora as perceções do grupo de peritos sobre um programa de formação desenvolvido (estudo descritivo).

A tese encontra-se organizada por capítulos, iniciando-se com a nota introdutória, na qual se realiza uma abordagem abrangem dos temas em estudo culminando na descrição . Segue-se um enquadramento teórico com engloba uma descrição pormenorizada quando aos conceitos relacionados com os fluxos migratórios. Incorpora uma descrição pormenorizada do que é ser um jovem requerente de asilo, com a apresentação de uma nova configuração categórica quanto às transições de vida. Por fim, este enquadramento aborda as características do cuidar dos jovens requerentes de asilo. De seguida, apresentam-se os objetivos de estudo, a apresentação enquadramento metodológico, com uma breve abordagem a cada um dos estudos desenvolvidos descrevendo-se a sequência lógica entre eles. Posteriormente, são reproduzidos, na secção de resultados, os artigos publicados e os que estão submetidos para publicação. Por fim, apresenta-se a discussão geral e as perspectivas futuras de investigação para dar continuidade aos trabalhos desta tese. A nota conclusiva apresenta uma súmula dos resultados mais relevantes.

Notas sobre a terminologia e idiomas utilizados na tese:

1. Doravante, os voluntários e profissionais, sem formação em saúde e/ou saúde mental, possíveis participantes do programa de formação designar-se-ão apenas por voluntários;
2. Apesar da tese ter como população alvo os voluntários que lidam com jovens requerentes de asilo, nos artigos são utilizados os termos “criança(s)” ou “menor(es)”. Estes termos apenas são mantidos com o intuito de não deturpar o significado dos aspetos aos quais nos referimos e que dizem respeito aos menores de idade (18 anos) no qual se incluem os jovens;
3. Os artigos incluídos na tese estão escritos em inglês, de acordo com as regras de publicação das revistas às quais foram submetidos. Assim, apresentam-se com as devidas adaptações e particularidades linguísticas consoante o país e critérios das revistas onde foram submetidos e/ou publicados.

CAPÍTULO I

ENQUADRAMENTO TEÓRICO

CAPÍTULO I - ENQUADRAMENTO TEÓRICO

A Organização das Nações Unidas (ONU) destaca no seu Relatório Mundial sobre Migração 2022, o último publicado, que existem mais de 281 milhões de migrantes internacionais, o que equivale a 3,6% da população mundial⁴⁹.

As «**migrações**» são definidas, pela Organização Internacional para as Migrações (OIM), como o movimento de indivíduos para longe do seu local de residência, seja esta deslocação dentro de um Estado ou pela travessia de fronteiras internacionais⁵⁰. Um fenómeno tão antigo quanto a humanidade, as migrações são parte constituinte da história mundial e europeia. A migração, enquanto elemento essencial para o desenvolvimento económico e obtenção de melhores condições de vida, representa, enquanto fenómeno global, uma forma de sobrevivência⁵¹. Compreende-se, então, como «**migrante**» qualquer pessoa que se afaste do seu local de residência habitual, seja internamente, seja através de uma fronteira, independentemente de ser um movimento 'forçado' ou voluntário^{51,52}. Este conceito tem vindo a ser utilizado de forma abrangente já que não se encontra definido pelo direito internacional e que reflete um entendimento leigo que posteriormente se divide em categorias jurídicas⁵⁰.

As categorizações da migração resultam de políticas estatais que visam objetivos políticos e económicos para dar resposta a reações públicas. Assim, os Estados tendem a adotar categorias para diferenciar as migrações internacionais e, por consequência, as pessoas que delas usufruem. As novas definições de migração prendem-se essencialmente com enquadramentos jurídicos que colocam o migrante como 'legal ou ilegal', em 'situação regular ou irregular', com estatuto de refugiado, de requerente de asilo ou deslocado interno, etc^{53,54}.

Na última década, foi principalmente a retórica política e dos *media* que fez aumentar o mal-entendido público sobre os termos relacionados com a migração⁵⁴. Uma das principais distinções que deve ser feita centra-se na voluntariedade da migração já que, não poucas vezes, tanto na esfera política quanto nos *media*, a migração é retratada de forma homogénea, sem a distinção entre aqueles que migram por escolha própria e os que são forçados a fazê-lo. Esta falta de distinção contribui para a perpetuação de estereótipos negativos e para a desumanização dos migrantes, dificultando a concretização de políticas públicas eficazes para lidar com as complexas questões migratórias⁵⁵. A «**migração forçada**» embora não seja um conceito jurídico internacional, tem sido utilizado para descrever os movimentos de refugiados, pessoas deslocadas (incluindo aqueles deslocados por desastres ou projetos de desenvolvimento) e, em alguns casos, vítimas de

tráfico. Entende-se, portanto, que representa um movimento migratório envolto em força, compulsão e coerção⁵⁶ sendo despoletado, maioritariamente, por violação de direitos humanos. Um dos seus maiores exemplos atuais são os movimentos migratórios forçados devido aos conflitos armados que dispararam o número de refugiados, requerentes de asilo e deslocados internos mundialmente.

A atenção prestada pelos meios de comunicação social aumentou de forma significativa a consciencialização da população em geral sobre os refugiados, requerentes de asilo e deslocados internos, não apenas na UE como no mundo. Infelizmente, muitas das informações são enganosas e inflamatórias. Os termos “migrante”, “refugiado” e “requerente de asilo” tornaram-se cada vez mais politizados e alvo de desconfiança por parte da sociedade civil⁵⁵. Não obstante, requerer asilo ou proteção internacional é um direito humano fundamental, já que todas as pessoas têm o direito de procurar proteção internacional devido a um receio fundado de perseguição ou ofensa grave vivida no seu país de origem⁵⁷, consagrado no artigo 14º da Declaração Universal dos Direitos Humanos⁵⁸. Contudo os modelos de acolhimento de requerentes de asilo e refugiados, assim como a definição do seu estatuto legal, tem sido alvo de análise e especialmente quando não parece haver consenso face à sua integração em diversos países europeus. As questões relacionadas com as migrações, que podem enquadrar, ao nível político e social, as pessoas como deslocadas internas, migrantes, refugiadas e requerentes de asilo, são um dos temas mais complexos e debatidos na comunidade internacional, e alvo de intensos debates nas nações Unidas, que procuram encontrar os meios mais eficazes para proteger e prestar assistências a estes grupos particularmente vulneráveis⁵⁹.

Os principais instrumentos internacionais utilizados em matéria de asilo internacional são a Convenção das Nações Unidas relativa ao Estatuto dos Refugiados, assinada em Genebra a 28 de julho de 1951⁶⁰, e o seu respetivo Protocolo Adicional, assinado em Nova Iorque a 31 de janeiro de 1967⁶¹. É nesta Convenção de 1951⁶⁰ que se define, pela primeira vez, o termo «**refugiado**» como toda e qualquer pessoa que:

“ ... receando com razão ser perseguida em virtude da sua raça, religião, nacionalidade, filiação em certo grupo social ou das suas opiniões políticas, se encontre fora do país de que tem a nacionalidade e não possa ou, em virtude daquele receio, não queira pedir a proteção daquele país; ou que, se não tiver nacionalidade e estiver fora do país no qual tinha a sua residência habitual após aqueles acontecimentos, não possa ou, em virtude do dito receio, a ele não queira voltar” (pag.61).

Um dos princípios basilares consagrados nesta Convenção, nos termos do n.º 1 do artigo

33.º, é o de *non-refoulement*⁶⁰, ou seja, os Estados que ratificam os documentos comprometem-se a não expulsar ou repelir pessoas com estatuto de refugiadas dos seus territórios. Esta Convenção veio dar conteúdo ao direito já consagrado no artigo 14.º da Declaração Universal dos Direitos Humanos⁵⁸.

A obtenção do estatuto de 'refugiado', ou seja, a atribuição da proteção internacional que concede direitos de cidadania a qualquer pessoa que comprovadamente dele necessite, está, naturalmente, pendente da prova que a pessoa deve fazer para que lhe seja atribuído tal estatuto. A pessoa a quem ainda não lhe foi atribuído estatuto de 'refugiado', mas cuja reivindicação está a ser analisada após ter solicitado proteção internacional designa-se, legalmente, como «**requerente de asilo**»⁶². Nem toda a pessoa requerente de asilo será reconhecida como refugiada, mas qualquer pessoa com estatuto de refugiado reconhecido foi, inicialmente, um requerente de asilo. Em virtude de um entendimento claro quanto aos conceitos, destaca-se que, por sua vez, a pessoa que se viu forçada a deslocar por razões de sobrevivência, mas não trespassou as fronteiras do seu país, caracteriza-se como «**deslocado interno**»⁶³.

Até meio de 2023, mais de 110 milhões de pessoas no mundo foram forçadas a deslocarem-se por razões de sobrevivência relacionadas com a fuga a conflitos armados, perseguições, violência, violação de direitos humanos e de eventos que perturbam seriamente a ordem pública. Destas 110 milhões de pessoas, 62.5 milhões são pessoas deslocadas internamente nos seus países, 36.4 milhões de pessoas obtiveram já o estatuto de refugiadas, 6.1 milhões são requerentes de asilo e 5.3 milhões de pessoas pediram uma proteção internacional temporária sem requerer o estatuto de refúgio⁸. Note-se que a maioria das pessoas que procuram asilo são provenientes de conflitos próximos da Europa (República Árabe da Síria, Afeganistão, Ucrânia) potenciando neste continente a entrada massiva de migrantes em busca de asilo internacional. Sabendo que cerca de 83% dos refugiados acabam por ser acolhidos em países de baixo e médio rendimento, é natural a sobrecarga sentida e percebida nas comunidades de acolhimento e nos seus recursos⁹.

Na União Europeia (UE) permanecem constantes as falhas no sistema de asilo, reveladas em 2015 aquando da entrada de mais de um milhão de migrantes à procura de proteção internacional⁵³, colocando a UE numa posição de fragilidade e sobrecarga, especialmente pela exigência à capacidade de dar resposta a abrigo e aos cuidados básicos temporários, assim como à capacidade de avaliar os pedidos de requerimento de asilo dos milhares de pessoas que procuram asilo. A sobrecarga é sentida, com maior incidência, junto dos países pelos quais entram as pessoas que procuram a proteção internacional, em particular os do sul da UE. Torna-se ainda mais insustentável quando está definido, pelo

Regulamento de Dublin⁶⁴, que apenas um país da UE pode analisar o pedido de proteção internacional, sendo geralmente o primeiro país de entrada, salvo exceções descritas nas sucessivas ratificações desse documento. É nestes países de entrada que os requerentes de asilo devem permanecer até obter autorização de livre-trânsito e, com isso, ingressar no país que lhes concede asilo, por outras palavras, só quando lhes é atribuído o estatuto de refugiado poderão ingressar num país de acolhimento europeu^{53,65}. Estas medidas têm contribuído para a sobrelotação dos locais de acolhimento temporário disponíveis nas fronteiras da UE. A par disso, medidas político-sociais que defendem o fechamento de fronteiras^{66,67}, que impedem a entrada de requerentes de asilo criando acordos-bilaterais para recolocar estas pessoas fora da UE⁶⁸, ou que fomentam a criação de acordos que possibilitam a colocação de requerentes de asilo em África, independentemente da sua origem⁶⁹, têm contribuído para que fossem postos em causa e contestados os princípios construtivos da UE.

Independentemente das políticas de migração, mais ou menos eficazes, mais ou menos inclusivas, o número de pessoas que passam as fronteiras ilegalmente rumo à UE para requerer asilo não tende a recuar. É neste sentido que, desde a sua criação, o ACNUR tem procurado, em conjunto com organizações governamentais e ONGs, nas mais diversas partes do mundo, dar resposta às necessidades básicas de requerentes de asilo e refugiados³², factos que na UE não são diferentes. Nas primeiras 72 horas após uma emergência, o ACNUR mobiliza equipas de resposta para avaliar a situação e coordenar o alojamento temporário com as autoridades locais com o intuito de garantir a segurança. Estes alojamentos temporários têm uma tendência crescente para se tornarem permanentes, carecendo do apoio estatal dos países que recebem e acolhem, numa primeira instância, os requerentes de asilo⁷⁰. O alojamento temporário pode ser realizado em centros de acolhimento, abrigos ou campos de refugiados, sendo que a distribuição de requerentes de asilo depende das vagas e das condições em que os requerentes chegam à UE, assim como do tipo de alojamentos de que dispõe o país de entrada. Na UE existem vários alojamentos deste género, estando declarados como ativos durante 2023, 2 centros de acolhimento na Croácia⁷¹; 3 na Hungria⁷²; 4 no Chipre⁷³; 6 na Roménia⁷⁴; 8 em Malta⁷⁵; 8 na Bulgária⁷⁶; 4 casas de asilo na Eslovénia⁷⁷; 6 centros de acolhimento legais em Espanha⁷⁸ (2 centros de estadia temporária para migrantes, 4 centros de acolhimento nas ilhas); 5 intitulados *'hotspots'* para requerentes de asilo na Itália⁷⁹; 5 Centros de Receção de Processos na Holanda⁸⁰; 12 centros de acolhimento legais e 2 campos de refugiados em França⁸¹; 5 centros de asilo e 14 centros de acolhimento na Sérvia⁸²; 18 'centros de chegada' e 8 centros de Receção, Tomada de decisão e Repatriação na Alemanha⁸³; e 32 campos de refugiados na Grécia⁸⁴.

Os campos de refugiados, são uma das estratégias de alojamento mais rápidas que o ACNUR dispõe de conseguir abrigar e providenciar cuidados imediatos aos requerentes de asilo³². Contudo, podem tornar-se semipermanentes ou permanentes, o que acaba por ser uma fonte de instabilidade política e social, agravando a resolução das necessidades destas pessoas a curto e longo prazo¹⁴. Para além disso, as condições nestes alojamentos, em particular na UE, têm sido descritas por ONGs, requerentes de asilo e refugiados como desumanas. Os campos de refugiados tornam-se espaços fechados, muitas vezes com recurso a medidas de segurança mecânicas e físicas (muros, redes eletrificadas, agentes de autoridade armadas, etc) criando uma forte sensação de insegurança nos requerentes de asilo. Segundo denúncias efetuadas pelas ONGs *Save the Children*, *Refugee International*, *Amnesty International*, *Doctors Without Borders*, entre outras, assim como pelos próprios requerentes de asilo, os campos de refugiados são contextos precários, sobrelotados e inseguros^{15-21,29}. Na grande maioria não existem fontes de água potável, a alimentação é insuficiente e de baixo valor nutricional^{85,86}, causando desnutrição severa, especialmente nas crianças⁸⁷⁻⁹⁰; as instalações sanitárias são insuficientes e desadequadas^{87,91}; o acesso à eletricidade, quando existe, é limitado; e não há aquecimento nem isolamento térmico adequado⁹². Mesmo depois da chegada são expostos a constantes situações de violência, discriminação e humilhação. É nestas condições e contextos que os requerentes de asilo se encontram privados de cuidados e direitos básicos, privados de ações e decisões, perdendo o direito a um lugar no mundo e ao sentimento de pertença²².

Atendendo ao descritivo até ao momento, não é difícil entender que ser um requerente de asilo significa muito mais do que perder a sua casa, os seus locais de lazer e de culto, os seus pares, a maior parte dos seus pertences e, por vezes, até a sua família. Este novo estatuto legal significa não ter para onde ir, nem para onde regressar e, portanto, viver confinado em centros de acolhimento na UE. É uma das experiências mais abruptas e disruptivas na vida de um ser humano^{29, 94}. Vai muito além da perda de bens materiais. Implica perder as referências identitárias: aquelas referências que moldam a identidade da pessoa e sem as quais a pessoa perde a noção de quem ela é; no fundo, os elementos que dão sentido à vida de cada pessoa^{95,96}. Este cenário é mais desafiador quando falamos dos jovens requerentes de asilo que se encontram em pleno desenvolvimento físico, emocional e social, e se confrontam com a rutura da vida que conheciam e, por questões de sobrevivência, abraçam uma vida de procura por asilo, sujeitos às mais variadas adversidades²⁹.

1.1. SER JOVEM REQUERENTE DE ASILO: UMA NOVA CONFIGURAÇÃO NAS TRANSIÇÕES DE VIDA

Não existe uma definição concreta relativa ao grupo etário dos jovens. A OMS caracteriza o período de adolescência, que marca a etapa da vida entre a infância e a fase adulta, entre os 10 e os 19 anos, mas declara que a juventude se estende dos 15 aos 24 anos⁹⁷. Já a ONU, sem prejuízo de quaisquer outras definições feitas pelos Estados-membros, caracteriza a “juventude” como o grupo etário composto por pessoas entre os 15 e os 24 anos^{98,99} e as crianças como as pessoas com idade igual ou inferior a 14 anos¹⁰⁰. Não obstante, para os efeitos de defesa dos direitos das crianças, o artigo 1º da Convenção sobre os Direitos da Criança, reitera que deve ser considerada criança todo o ser humano com idade inferior a 18 anos, salvo se, nos termos da lei que lhe for aplicável, atingir a maioridade mais cedo¹⁰¹. Esta definição de ser criança foi assumida e ratificada por 193 países, que se comprometeram a respeitar os direitos das crianças, reconhecidos pela Convenção, protegendo-as assim da fome, pobreza, violência, negligência, entre outras formas de injustiça e dificuldade, permitindo o seu adequado desenvolvimento. Não indiferente aos movimentos migratórios forçados, no seu artigo 22º, a mesma Convenção prevê a necessidade de proteção especial à criança refugiada ou que procure estatuto de refugiada” devendo-lhe ser facultada “proteção e assistência humanitária (...) assegurando direitos da Convenção e outros instrumentos internacionais relativos aos direitos do homem ou de carácter humanitário”(pag.15) ¹⁰¹. Neste entendimento, a maioria dos países do mundo declara, para efeitos legais, os 18 anos são como a fasquia para a passagem à idade adulta. Esta caracterização cronológica do ser humano, faz a diferença na análise da problemática dos requerentes de asilo, já que a mesma faz a diferença no processo de requerimento de asilo e obtenção de proteção internacional. Segundo a Diretiva de Acolhimento dos Requerentes de Asilo do Parlamento Europeu, ser criança ou adulto vai determinar o tipo e a duração das condições de acolhimento. Dada a particular vulnerabilidade dos menores de idade, entenda-se menores de 18 anos, e atendendo a que muitos chegam desacompanhados, sem conhecimento do idioma e das políticas do sistema de asilo, impera a necessidade de representação para que lhe sejam imputados os devidos e particulares direitos, especialmente se o requerente de asilo for menor de idade e precisar comprovar a sua idade¹⁰².

Estes instrumentos internacionais de avaliação de processos de asilo tomam particular importância quando os dados atuais revelam que, embora as crianças, entenda-se menores de 18 anos, sejam menos de um terço da população global, representavam, em 2022, mais

de 41% dos refugiados do mundo⁴. São mais de 43,3 milhões, as crianças que se viram obrigadas a deslocar como consequência de conflitos e violência. Entre os migrantes internacionais (ou população nascida no exterior), em 2020, quase 1 em cada 3 crianças eram refugiadas¹⁰³.

As repercussões físicas, mentais e sociais do deslocamento forçado são incalculáveis, e vividas de forma sistemática e longitudinal no período peri-migração. Vários estudos relatam altas taxas de sofrimento, perturbações de saúde mental¹⁰⁴⁻¹⁰⁸; saúde física e problemas de desenvolvimento em crianças desde a infância até a adolescência que persistem e se perpetuam na vivência nos países de acolhimento^{109,110}, em particular quando vivem anos de espera como requerentes de asilo em condições indignas que atentam contra os Direitos Humanos fundamentais²⁹.

A vivência da espera, aquela sem um tempo cronológico determinado que se perpetua desde a chegada até à obtenção de estatuto de refugiados que permitem a integração nos países de acolhimento, e com isto se entende o usufruto de direitos de cidadania e todos a ela associados, é um limbo entre a esperança e a desesperança de poder sobreviver. Viver neste limbo é tão mais desafiador quando falamos de jovens que se encontram em pelo desenvolvimento físico, emocional e social acarretando enormes consequências na formação da sua identidade pela rutura abrupta e extrema nas suas transições de vida²⁹.

Os jovens requerentes de asilo vivem múltiplas e simultâneas mudanças nas suas vidas, desencadeando múltiplos processos de transição na esperança de obterem a liberdade. A transição de vida é um dos conceitos mais interessantes e estudos na investigação em enfermagem devido ao seu impacto no bem-estar físico e emocional¹¹¹⁻¹¹³. Todas as transições são experiências humanas que se traduzem num conjunto de respostas moldadas pelas condições pessoais e ambientais, pelas experiências e expectativas da pessoa, pelos significados atribuídos à experiência, pelos conhecimentos e competências adquiridos no processo de mudança, e pelo impacto desta mudança na sua vida e bemestar¹¹¹. Procurar refúgio internacional, tornando-se um requerente de asilo, envolve mudanças que, claramente, se percebem não serem feitas com o envolvimento consciente e voluntário de que qualquer mudança carece para que proporcione uma transição saudável. Este entendimento é refletido à luz da necessidade que os jovens requerentes de asilo sentem sobre as tomadas de decisão num curto espaço de tempo e que impactam profundamente o curso da sua vida, para as quais não existe uma preparação ponderada e deliberada do processo de decisão. Esta jornada de sobrevivência está rodeada de acontecimentos críticos com condições pessoais, ambientais e globais desfavoráveis, que podem antecipar dificuldades nos ajustes de vida e nas transições saudáveis¹¹⁴.

Os jovens requerentes de asilo que residem em locais de acolhimento, tenham eles a designação que cada Estado-membro assim o definir, vivem uma **transição situacional** associada a acontecimentos que exigem uma redefinição de tarefas e papéis pré-existentes¹¹⁴. Essa transição ocorre com o acréscimo ou perda de membros familiares por nascimentos ou falecimento que ocorrem durante o processo¹¹². Diversos são os relatos de perdas de familiares, seja em condições pré-existentes ao processo migratório, seja nas diversas travessias entre países, em particular nas travessias ilegais realizadas por barco^{19,29,115-117}. Esta redefinição de papéis e tarefas implica muitas vezes o assumir responsabilidades, quer por si, quer, por exemplo, por irmãos mais novos ou amigos que consigo façam essa jornada de sobrevivência²⁹, em ambientes estranhos e considerados indignos e inseguros^{15-21,29}.

A vivência neste novo contexto de espera, enquanto requerente de asilo que aguarda a possibilidade de integrar os países de acolhimento, implica também mudanças no ambiente social, político e económico, as quais podem ser enquadradas numa **transição organizacional**. As transições organizacionais representam não apenas mudanças no ambiente social, político e económico, mas também mudanças intraorganizacionais na estrutura ou na dinâmica¹¹¹. Neste caso, as alterações ambientais potenciadas, principalmente, pelas guerras e pelas mudanças sociais e políticas nos países de origem, fazem com que estes jovens se sintam obrigados a procurar asilo internacional em países vizinhos. É neste novo contexto que vão ser expostos a uma nova sociedade e governo, e a novas regras sociais, políticas e morais que implicam uma transição organizacional¹¹⁴.

Todas as mudanças, quer em termos situacionais ou organizacionais, são impactadas pelo desenvolvimento socio-emocional, cognitivo e físico dos jovens requerentes de asilo. Estes jovens encontram-se em pela **transição desenvolvimental** face ao estadió do seu ciclo vital, já que, pela sua definição cronológica estão na passagem da infância para a fase adulta, fase à qual se associa à construção da sua identidade, a qual, por si só, requer adaptação^{112,113}. Os jovens requerentes de asilo registaram uma interrupção abrupta no seu desenvolvimento infantil. Continuam a crescer na idade biológica. Contudo, muitos deles tiveram regressões na infância em resposta a eventos traumáticos e a grande maioria não supera satisfatoriamente os estádios de desenvolvimento. A infância e adolescência são fases socialmente decisivas, já que uma boa resolução das fases de desenvolvimento permite a obtenção de confiança, autonomia e motivação para se sentir capaz a enfrentar os desafios da vida. No entanto, a jornada de sobrevivência de se tornar um requerente de asilo coloca o seu desenvolvimento dos jovens em *standby*¹¹⁴.

Não obstante, as vulnerabilidades a que estão expostos dão lugar ao aparecimento de doenças físicas e mentais devido aos diferentes gatilhos que enfrentam quer na jornada de sobrevivência quer durante a permanência em campos de refugiados. Esta vulnerabilidade expressa coloca-os constantemente numa situação de transição saúde/doença¹¹¹⁻¹¹³.

Na jornada de sobrevivência são mais prevalentes escoriações, queimaduras, situações de desidratação, hipotermia e problemas musculoesqueléticos¹¹⁸. As condições precárias do processo de migração (locais de acolhimento sobrelotados, condições higiénicas inadequadas, consumo de água e alimentos contaminados e acesso limitado a cuidados médicos, incluindo falta de vacinação) também aumentam as doenças transmissíveis, como a salmonelose, hepatite A, cólera, infeções respiratórias, sarampo, varicela, leishmaniose, sarna, febre recorrente e riquetsioses¹¹⁹⁻¹²⁴, sendo infeções respiratórias agudas e diarreia as principais causas de morbidade em campos de refugiados¹²⁵⁻¹²⁷. Além das doenças físicas, as doenças mentais dos jovens requerentes de asilo têm sido cada vez mais relatadas. As experiências traumáticas começam pelas razões que os fizeram fugir dos seus países, mas continuam com as travessias entre países, à medida que testemunham abusos e são contrabandeados através das fronteiras. As suas experiências traumáticas antes, durante e depois da migração afetam o seu estado emocional e muitos já apresentam sinais e sintomas de sofrimento mental, com particular incidência para a ansiedade, depressão, stress pós-traumático e comportamentos autolesivos nos jovens¹⁰⁴¹⁰⁸. Ao chegar à UE, alguns jovens podem demonstrar euforia e emoções positivas momentâneas, enquanto outros se veem vivenciando o processo de luto como consequência da perda sucessiva de pessoas, lugares e vidas anteriores²⁹. A maior parte dos jovens, principalmente os desacompanhados, vivenciam medos e preocupações extremos manifestados por comportamentos verbais e não-verbais negativos, como expressões de raiva e tristeza, ansiedade e embotamento afetivo¹²⁸⁻¹³⁰. Sinais de sofrimentos psicológico e social são extremamente diversos e dependem da idade, das experiências traumáticas e do apoio familiar e social durante a crise¹³¹⁻¹³⁴.

A reflexão, exploração e descrição das experiências de transição de vida dos requerentes de asilo não faz justiça ao sofrimento incomensurável que vivenciam. Neste sentido a caracterização da transição desenvolvimental, situacional, de saúde/doença e organizacional, num padrão múltiplo e simultâneo, parece não ser suficiente para descrever a experiência da jornada de sobrevivência dos jovens requerentes de asilo. Esta caracterização não aglutina a representação das múltiplas e extremas ruturas repentinas na estrutura física e psicológica dos jovens requerentes de asilo que vive num limbo entre a esperança e a desesperança, confinados em locais de acolhimento europeus na espera de obterem autorização ao usufruto dos direitos de cidadania. Neste sentido, uma nova

designação emerge com o intuito de representar as transições de jovens requerentes de asilo, **a transição de vida extrema e avassaladora**¹¹⁴.

Alguns estudos alertam para que, no âmbito das migrações, os indivíduos vivem certamente pelo menos dois tipos de transições^{111,135,136}, destacando que, paralelamente às transições situacionais face às experiências migratórias, ocorrem transições de desenvolvimento e de saúde/doença. Nestes estudos, os indivíduos tinham potencial para alcançar transições de vida saudáveis, seja através de ação direta ou com o apoio de pessoas como familiares, amigos ou profissionais de saúde. Porém, uma experiência migratória forçada retira o direito à autodeterminação, à possibilidade de mudança e a possibilidade de procura pela melhor solução para resolver qualquer situação da vida do indivíduo. Além disso, nenhum dos estudos aborda a experiência simultânea de todos os tipos de transições, o que, devido à sua inter-relação, impossibilita a operacionalização de qualquer transição saudável, a par das exigências de um confinamento aos locais de acolhimento que, por si só, são castradoras de transições saudáveis. Estas são as duas principais características para a adequação desta nova categoria às transições de vida vividas pelos jovens requerentes de asilo: i) a experiência de todos os tipos de transições simultaneamente que se influenciam mutuamente, e ii) incapacidade de alcançar qualquer uma das transições de forma saudável. Esta designação enfatiza a extrema autofragmentação que coloca as pessoas no limite da sua sobrevivência¹¹⁴.

Os jovens requerentes de asilo não desenvolvem um sentimento de pertença nos locais de acolhimento temporário, especialmente quando as políticas governativas implementadas tendem a repelir ao invés de integrar⁶⁶⁻⁶⁹. Neste sentido, não será justo considerar que fazem uma integração fluida da identidade enquanto requerentes de asilo¹¹⁴ já que se entende este estatuto como um período de moratória.

A resolução saudável da transição situacional dependerá sempre da resolução do estatuto legal de refugiado quando estiverem totalmente integrados num país de acolhimento, ou de regresso ao seu país de origem com condições de sobrevivência, sendo que esta se encontra associada à definição e redefinição de papéis sociais, familiares e pessoais que o jovem requerente de asilo enfrenta. Numa transição transcultural são prováveis mudanças relacionadas com os papéis e tarefas desempenhadas por cada um dos membros da família^{137,138}. Contudo, em particular no caso dos jovens requerentes de asilo é importante ressaltar que, muitas vezes, são obrigados a assumir o papel de cuidadores de irmãos mais novos, ou familiares dependentes, e/ou a serem responsáveis por si próprios enquanto órfãos, mudando de papéis e tarefas na família e na sociedade. Não obstante, os jovens requerentes de asilo são menores, o que lhes confere uma dificuldade acrescida na tomada de decisões sobre si próprios ou sobre os outros. Esta incorporação

de tarefas e papéis inerentes à sua integração na sociedade e à gestão da sua rede familiar ficam impossibilitadas pela imposição de normas impostas pela transição organizacional que os tutela e lhes retira a autodeterminação. Este é o tipo de transição mais complexo que se pode imaginar porque a espera por uma definição legal que reconheça a sua necessidade de proteção, limita os direitos, deveres e garantias comparativamente com outros seres humanos considerados cidadãos no país que os recebeu. A par disso, vivem na iminência de serem repatriados e, portanto, em estagnação pessoal, familiar e social durante meses ou anos, o que lhes impede o processo de integração fluida de uma identidade já que este período é uma moratória e não o fim de uma etapa. Vivenciar e completar uma transição saudável requer uma autoredefinição num novo contexto social adaptando os comportamentos e redefinindo os significados das experiências vividas, o que só é possível quando são finalmente considerados cidadãos do país de entrada ou de origem. Esta experiência de estagnação é ainda influenciada negativamente pelo longo período de retenção em locais de acolhimento indignos e pela convivência com pessoas de outros países com antecedentes socioculturais e religiosos diferentes, dificultando que todos tenham um sentimento de pertença. Nestes locais, todos devem obedecer às regras impostas pelas normas europeias, que privam os indivíduos de qualquer poder de decisão. É nesta perspectiva que a transição organizacional pode ser fonte de sofrimento, uma vez que o local onde permanecem não constitui o contexto final de integração social. Esta particularidade deixa os jovens em estado de ambivalência de viver de acordo com as regras ou de as desafiar ilegalmente, fugindo destes locais. Estes jovens requerentes de asilo constituem, em boa verdade, uma geração marcada pela perda da infância que vivencia uma interrupção abrupta no seu desenvolvimento. Continuam a desenvolver-se biologicamente, mas, em resposta às experiências traumáticas, a grande maioria não ultrapassa satisfatoriamente as fases de desenvolvimento. A mudança de funções e tarefas individuais, familiares e sociais aumenta esta dificuldade. São jovens forçados a tornarem-se adultos, sendo responsáveis pelos seus atos e decisões, mas sem poder para executá-los. Este fato dificulta ainda mais o entendimento sobre que tarefas e papéis é suposto desempenhar. Mais uma vez, a estagnação do seu desenvolvimento e a falta de pertença tornam inatingível uma transição de desenvolvimento saudável. Estas são as experiências e vivências traumáticas que potencializam o aparecimento de doenças físicas e mentais e agravam as pré-existentes, culminando num tempo de espera que perpetua sofrimentos, tornando inatingível a resolução da transição saúde/doença até que a organizacional e situacional se resolvam¹¹⁴.

1.2. CUIDAR DE JOVENS REQUERENTES DE ASILO

O ACNUR trabalha em parceria com organizações governamentais e ONGs para garantir o acesso dos jovens requerentes de asilo às necessidades básicas³². A maioria das ONG não profissionais é composta por pessoas da sociedade civil sem formação ou competências específicas para trabalhar com populações vulneráveis, como os requerentes de asilo³³⁻³⁵. Além da falta de formação, ou formação desadequada, a inexperiência de trabalho, quer com requerentes de asilo, quer em contextos precários, deixa estes voluntários das ONGs mais vulneráveis, principalmente às perturbações da saúde mental. As pessoas sem formação adequada não têm a capacidade de avaliar as ameaças à segurança, as potenciais estratégias de mitigação e a tolerância ao risco pessoal, portanto não estão preparadas para lidar com situações de doenças, lesões, incapacidades ou morte, tão frequentes em contextos precários em que são acolhidos os jovens requerentes de asilo¹³⁹.

Os profissionais, que não os da saúde, e os voluntários, doravante apenas designados na generalidade como voluntários, realizam atividades mais simples como atividades de educação formal e não-formal, distribuição de bens e alimentos, e atividades de entretenimento. No entanto, ainda que estejam a realizar tarefas simples, enfrentam o grande desafio diário de lidar com o sofrimento dos milhares de requerentes de asilo que integram os locais de acolhimentos. Estes voluntários são expostos às vivências das trajetórias traumáticas antes, durante e após o processo migratório dos requerentes de asilo¹⁴⁰, quer nas atividades do dia-a-dia, quer nas situações de mediação de cuidados. Importa lembrar que, frequentemente, são estes voluntários que ajudam os requerentes de asilo no acesso aos serviços de saúde, educação, proteção legal tornando-se mediares de processos e cuidados. Além disso, os contextos pós-migratórios indignos em que voluntários e jovens requerentes de asilo se encontram são, por si só, uma nova fonte geradora de experiências traumáticas¹⁴¹.

A falta de experiência e formação estão significativamente associadas às perturbações de stress pós-traumático em voluntários despreparados^{141,142}, fatores esses que contribuem para a maior vulnerabilidade dos voluntários à ansiedade, *burnout*, sentimentos depressivos, de apatia e insensibilidade, défices de autoestima, aumento de comportamentos destrutivos, sentimentos de conflito interpessoal, envolvimento excessivo com requerentes de asilo e stress traumático secundário^{36-38,143}. O sofrimento psicológico desenvolvido pelos voluntários varia de acordo com a existência de formação prévia para

trabalhar com esta população nos contextos³⁹⁻⁴¹, o qual é menos evidente quando há formação prévia em saúde mental^{42,144}.

Embora se ressalve a necessidade de formação dos voluntários que trabalham com jovens requerentes de asilo existem poucos programas/ações de formação disponíveis para leigos em saúde e ou saúde mental, principalmente com foco nas competências em saúde mental, para trabalhar com requerentes de asilo^{44,45}. A maioria destes materiais encontrase disperso ou está acessível diretamente nos websites das páginas das ONGs que, na generalidade, optam por gerir a própria formação aos seus voluntários através de experiências prévias de voluntários mais antigos ou com mais experiência prática⁴³. Pese embora a sua necessidade premente e atual, os poucos programas /formações existentes são desadequados à maioria dos voluntários que integram as ONGs não profissionais, seja porque se focam apenas em diagnósticos psiquiátricos médicos, por se enquadrarem numa realidade tão específica que impede a compreensão e adequação a outra realidade contextual, ou por serem de autoadministração não permitindo a monitorização das aprendizagens adequadas⁴⁴. Estes factos evidenciam uma clara necessidade de desenvolvimento de programas de formação no âmbito das competências em saúde mental mais inclusivos, capazes de serem utilizados e adaptados a diferentes contextos e, principalmente, ministrados por pessoas com competências nesta área capazes de poder orientar e de dar um suporte fidedigno às aprendizagens das pessoas sem formação de base em saúde e/ou saúde mental para trabalharem com jovens requerentes de asilo.

Através do aumento da literacia em saúde mental, os voluntários serão capazes de participar eficazmente nos esforços para colaborar com os profissionais de saúde na prevenção, os cuidados, o tratamento e a defesa da saúde mental dos requerentes de asilo. A necessidade de formação não serve apenas como forma de preparação e de segurança em termos de saúde mental para os voluntários, mas também como forma de prestar melhores cuidados, reconhecendo sinais e sintomas de que os indivíduos precisam de ajuda especializada e sendo capazes de os ajudar nessa procura de ajuda⁴⁴. O ACNUR defende, inclusivamente, que as intervenções para a promoção do apoio psicossocial com requerentes de asilo podem ser fornecidas por voluntários não especializados em saúde mental, desde que devidamente treinados e supervisionados¹⁴⁵. Estas relações vão ao encontro da comprovação de que voluntários capacitados para tomar decisões mais precoces e corretas em termos de prevenção, deteção e encaminhamento apropriado para cuidados de saúde mental especializados, ajudam a reduzir o estigma e a discriminação, melhorando os direitos dos requerentes de asilo^{145,146}. As competências em saúde mental requerem a capacidade de empoderamento dos voluntários para ajudar os requerentes de asilo na procura de profissionais especializados em saúde mental⁴⁴, contudo estas devem

ser alicerçadas noutras competências igualmente importantes e transversais às da saúde mental, em particular quando falamos de requerentes de asilo com diferentes backgrounds culturais, linguísticos e religiosos, como são as competências de comunicação, culturais, de gestão e de trabalho em equipa³⁴.

A evidência reforça a importância dos programas de formação em saúde mental para voluntários que trabalhem com jovens requerentes de asilo, contudo a investigação científica com voluntários e sobre o seu trabalho com requerentes de asilo está a aumentar lentamente¹⁴⁶. É necessária uma visão abrangente e sistemática para compreender que tipo de formação em competências de saúde mental está disponível para preparar os voluntários para o seu trabalho com requerentes de asilo, se a formação disponível vai ao encontro das necessidades formativas sentidas por estes voluntários e, apenas posteriormente, se parte para a construção de um programa que dê resposta às necessidades reais de formação dos voluntários que trabalham com esta população. Em boa verdade, esta lacuna representa uma necessidade urgente de intervenção de profissionais de saúde qualificados, nomeadamente os Enfermeiros Especialistas em Enfermagem de Saúde Mental e Psiquiátrica (EEESMP), como os agentes de formação mais próximos das comunidades e capazes de dar resposta em termos formativos, no âmbito da saúde mental de leigos que trabalham com as populações mais vulneráveis e que, de mais cuidados, precisam¹⁴⁷. Ao apostarem no aumento da literacia em saúde mental, em particular dos que cuidam de forma não profissional dos mais vulneráveis, os EEESPM estão a contribuir para a proteção destas populações, para a defesa dos direitos humanos, para a equidade de cuidados e para a justiça social. Esta premissa vai ao encontro das competências de promoção da saúde dos enfermeiros, permitindo dotar os cidadãos comuns de conhecimentos, capacidades, atitudes e valores que o ajudem a fazer escolhas e a tomar decisões adequadas para si e na sua relação com os outros¹⁴⁸.

Para colmatar esta lacuna, foi desenvolvido o Projeto APT4U2 – Programa de Formação em Saúde Mental e Bem-Estar Para Voluntários e Profissionais, que não os de Saúde, trabalharemos com Requerentes De Asilo – que se apresenta nesta Tese de Doutoramento. Este desenvolveu-se, dando resposta às lacunas identificadas, em três grandes objetivos:

- i) Mapear a evidência científica relativamente aos programas de formação no âmbito das competências em saúde mental para profissionais e voluntários, sem formação em saúde e/ou saúde mental, para trabalharem com requerentes de asilo em qualquer contexto;
- ii) Identificar as necessidades formativas de voluntários e profissionais, que não os da saúde, para trabalharem com jovens requerentes de asilo;
- iii) Desenvolver o Programa APT4U2.

CAPÍTULO II

ENQUADRAMENTO METODOLÓGICO

CAPÍTULO II - ENQUADRAMENTO METODOLÓGICO

O desenvolvimento de um programa de formação em saúde mental e bem-estar para pessoas sem formação em saúde e ou saúde mental se sentirem capacitadas para trabalhar, em qualquer contexto, com jovens requerentes de asilo oriundos de diferentes partes no mundo, pode ser considerado extraordinariamente complexo. Facto que é exacerbado quando os próprios voluntários podem ser provenientes de diferentes partes do mundo divergindo em idiomas, crenças, atitudes e comportamentos. É com este entendimento, refletido na complexidade dos elementos, que se justifica pelo número significativo de componentes que interagem e que podem criar dificuldades subjacentes ao desenvolvimento do programa, que esta tese segue como referencial teórico metodológico o Modelo das Intervenções Complexas do *Medical Research Council* (Figura 1), desenvolvido em 2008^{149,150}, o qual foi sendo melhorado ao longo dos anos. Este modelo utiliza uma *framework* de ação guiada, estruturalmente, por quatro fases distintas: desenvolvimento da intervenção ou identificação da intervenção (*develop intervention or identify intervention*); viabilidade/pilotagem (*feasibility*); avaliação (*evaluation*); e implementação (*implementation*)^{150,151}.

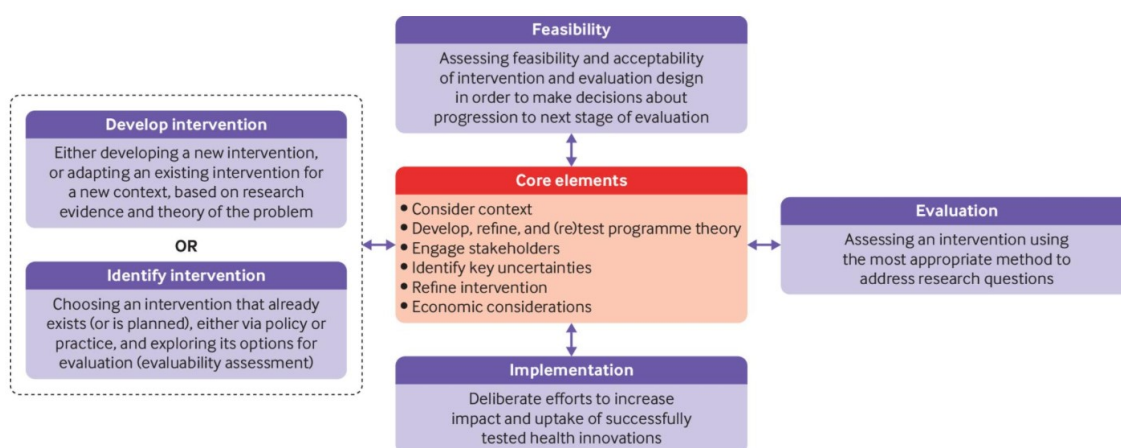


Figura 1 - Modelo das Intervenções Complexas do *Medical Research Council*

Um projeto de desenvolvimento de uma intervenção complexa pode começar em qualquer fase e estas não são necessariamente sequenciais, dependendo das principais incertezas sobre a intervenção em questão. Cada fase tem um conjunto de elementos centrais (*core elements*) que direcionam o investigador para poder: considerar o contexto (*consider*

context), desenvolver e refinar a teoria do programa (*develop, refine and (re)test programme theory*); envolver as partes interessadas (*engage stakeholders*), identificar as principais incertezas (*identify key uncertainites*), refinar a intervenção (*refine intervention*) e atender às considerações económicas da intervenção (*economic considerations*) caso seja possível e pertinente¹⁵¹.

Este projeto foca-se na Fase de Desenvolvimento do modelo teórico, a qual foi otimizada em 2018¹⁵². Do modelo original constavam três etapas, nomeadamente: identificação da evidência de base (*systematically identifoing the evidence*); identificação ou desenvolvimento de teoria (*identifying or developing theory*); modelagem do processo e resultados (*modelling process and outcomes*)¹⁴⁹. A estas acrescentaram-se: a identificação e definição do problema (*problem identification and definition*), a qual sustente a necessidade do projeto de investigação; determinar as necessidades (*determine the needs*) e, por último, examinar a prática e o contexto atual (*examine curret practice & context*)¹⁵² (Figura 2).

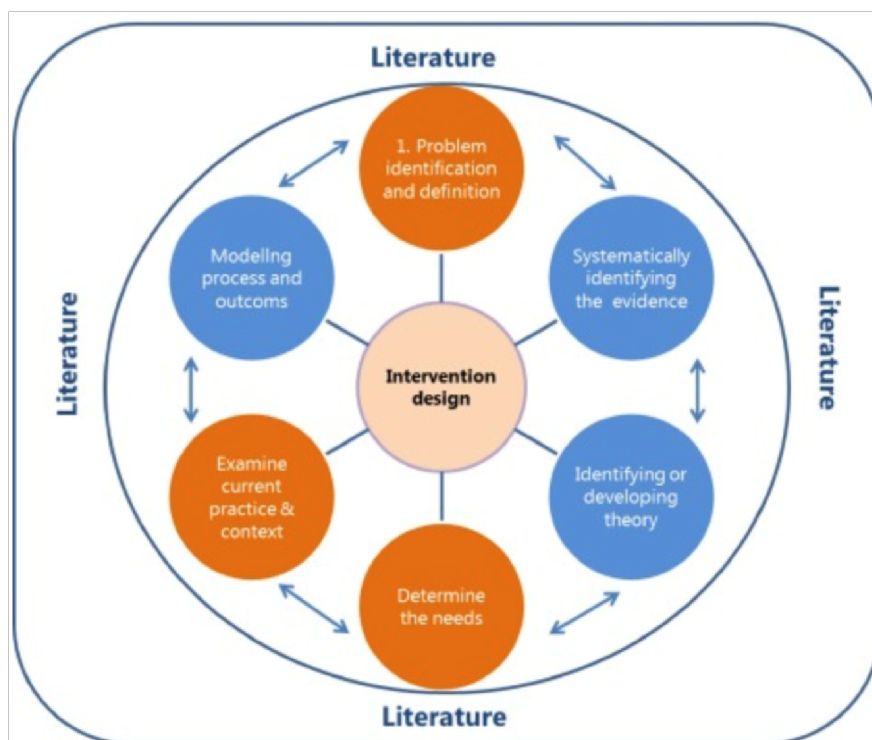


Figura 2 - Fase de Desenvolvimento otimizada do Modelo de Intervenções Complexas do *Medical Research Council*

Com o intuito de dar resposta ao objetivo geral da tese (desenvolver um programa de formação em saúde mental e bem-estar para voluntários e profissionais, que não os de saúde, para trabalharem com jovens requerentes de asilo), correspondente à fase de desenvolvimento do modelo supramencionado, foram desenvolvidos diferentes estudos. As etapas de desenvolvimento desta intervenção complexa (Programa APT4U2), as tarefas associadas e os estudos realizados e os artigos que daí resultaram apresentam-se na figura 3.

Esta tese parte de um enquadramento exaustivo das considerações conceptuais quanto aos fluxos migratórios e como estas se refletem nas transições de vida dos jovens requerentes de asilo. Estas considerações partem de um estudo prévio a este doutoramento e culminaram e culminaram num ensaio teórico-filosófico que propõe uma nova configuração teórica para uma transição de vida extrema e avassaladora, disruptiva do sentido da vida e que apresenta uma compreensão das vivências dos jovens querentes de asilo em período de requerimento de proteção internacional¹¹⁴. Embora seja uma perspetiva que parte de estudo prévio da autora desta tese, em colaboração com outros coautores dos artigos incluídos nesta tese, serviu de gatilho ao desenvolvimento aos pressupostos que conduziram à idealização do projeto de doutoramento já que a reflexão teórica emerge com o intuito de dar continuidade à investigação previamente desenvolvida²⁹.

Para dar resposta ao objetivo específico 1, mapear a evidência científica relativamente aos programas de formação no âmbito das competências em saúde mental para profissionais e voluntários, sem formação em saúde (na qual se inclui saúde mental), trabalharem com requerentes de asilo em qualquer contexto, foram escritos os artigos 1 e 2. O artigo 1 representa o protocolo de revisão *scoping*, já que a complexidade da pesquisa de evidência científica em diversas fontes de informação exigia uma rigorosa apresentação da metodologia a utilizar; e, o artigo 2, apresenta o mapeamento a evidência científica disponível relativamente aos programas disponíveis. Com o intuito de dar resposta ao objetivo específico 2, identificar as necessidades formativas de voluntários e profissionais, que não os da saúde, para trabalharem com jovens requerentes de asilo, foram escritos os artigos 3 e 4. O artigo 3 permitiu o desenvolvimento de questionários que permitem identificar necessidades formativas de voluntários para trabalharem com a população alvo e o artigo 4 apresenta os resultados dessas necessidades formativas. Por fim, o artigo 5 faz uma apresentação do desenvolvimento do Programa APT4U2, que resulta do seguimento da Fase de Desenvolvimento otimizada do Modelos das Intervenções Complexas que se apresenta neste enquadramento metodológico. Este artigo, para apresentar o Programa APT4U2 e seus materiais, incluiu, tal como previsto nesta metodologia, a validação teórica por um grupo de peritos.

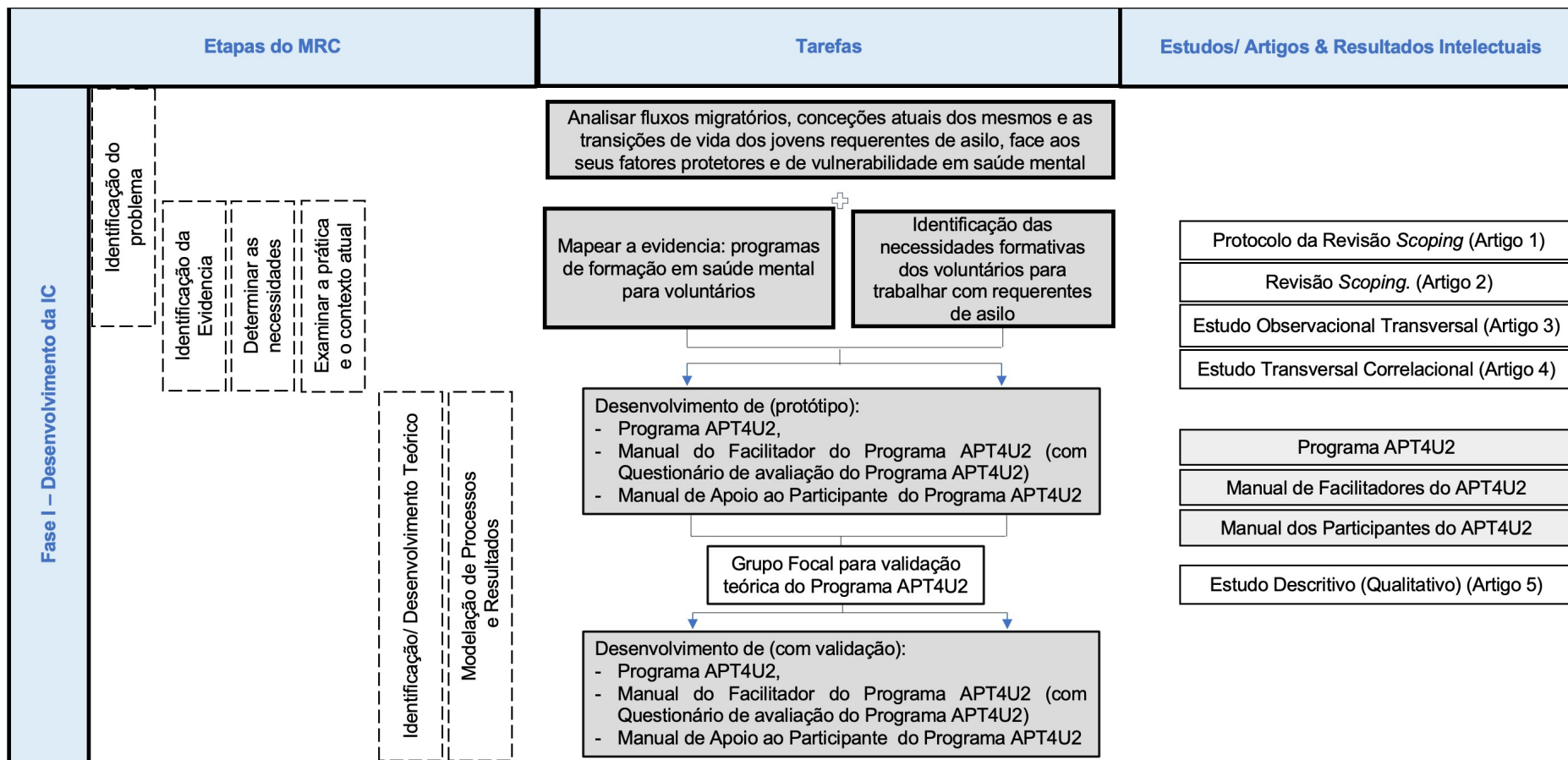


Figura 3 – Enquadramento metodológico e resultados do desenvolvimento do Programa APT4U2

CAPÍTULO III ESTUDOS EMPÍRICOS

ARTIGO 1

Teixeira-Santos L, Ventura F, Teixeira L, Cardoso D, Abreu W. Mental health training programs for non-health professionals and volunteers working with asylum seekers and refugees: A scoping review protocol. *Nursing Reports*. 2022;12(1):90-99. doi:10.3390/nursrep12010010

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Study Protocol

Mental Health Training Programs for Non-Health Professionals and Volunteers Working with Asylum Seekers and Refugees: A Scoping Review Protocol

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Abstract: The number of people forcibly displaced worldwide is increasing. It is an imperative challenge to provide mental health training for non-health professionals and volunteers who work with those vulnerable populations. The objective is to identify mental health training programs for non-health professionals and volunteers, without mental health training, to work with asylum seekers or refugees in any context. Literature about mental health training programs for adults, non-health professionals and volunteers without mental health training, working, or who have worked, or will work, with asylum seekers or refugees will be considered. Literature published in English, Swedish, Portuguese, Spanish, and French will be considered. Literature reporting training programs exclusively for professionals or volunteers in the health or mental health domains will be excluded. The following electronic databases will be searched: MEDLINE, CINAHL, PsycINFO, Psychology & Behavioral Sciences Collection, SCOPUS, ERIC, RCAAP, and OPEN GREY. Other sites to be searched: ClinicalTrials, UNHCR, IOM, WHO, Save the Children, IMISCOE, and IFRC. The screening process will entail two steps carried out by two independent reviewers: firstly, screening by title and abstract, and secondarily, by full text. Data will describe the literature according to the review research questions that were defined following the PPC mnemonic, and presented graphically with a narrative.

Keywords: asylum seekers; education; mental health; refugee; training program

1. Introduction

By the end of 2020, as a result of conflicts and violence, more than 82.4 million people were forcibly displaced worldwide. Of those, more than 26.4 million have refugee status, and 4.1 million seek asylum [1]. Most refugees came from just five countries: 6.8 million from the Syrian Arab Republic; 4.9 million from Venezuela; 2.8 million from Afghanistan; 2.8 million from South Sudan; and 1.1 million from Myanmar. Turkey is the host country that receives the largest number of refugees worldwide, with a registration of 4 million people. Colombia follows with a register of 1.7 million refugees, Germany registers 1.5 million refugees, and Pakistan and Uganda register 1.4 million refugees each [1,2]. The forcibly migratory fluxes are a concern to the European Union. In recent years, the number of people seeking protection in Europe has grown considerably. From 2014 until December 2020, European countries such as Italy, Cyprus, Malta, Greece, and Spain received 2,176,820 million sea and land arrivals [3]. While COVID-19 has temporarily led to a reduction in the number of asylum seekers in the last months, the underlying factors related to global conflicts remain unaddressed [1]. Therefore, it is important to invest in the improvement of host countries' reception conditions.

Oftentimes, forcibly displaced people must abruptly leave all belongings except the extremely necessary. They do not only lose material resources such as housing, education, and access to health and security, but also identity references, social relationships, and sociocultural supports [4,5]. Forced migration requires multiple adaptations in short periods of time, and people become more vulnerable to mental health problems. The way people are received, protected, and assisted in host countries may aggravate pre-existing problems [6]. Several studies were conducted to understand the impact of those kinds of situations on asylum seekers' and refugees' mental health. A recent systematic review and meta-analysis on 26 studies that provides results about 5143 adult refugees and asylum seekers, from all over the world, concludes that refugees and asylum seekers have high and persistent rates of post-traumatic disorder, depression, anxiety, and psychosis, and highlights the need for ongoing, long-term mental health care [7]. These rates have been linked to traumatic events such as violence, separation, sexual abuse, trafficking, harassment, and lack of basic needs [8–10]. Moreover, the mental health of refugees seems to be distinct from the experiences of other traumatized populations. such as veterans or sexual assault victims, due to their specific traumatic experiences and the stress in the acculturation process after resettlement related to new cultures, practices, settings, and lack of familiar support systems [11]. As a consequence of some countries' political arrangements, the asylum seekers are getting stopped at the borders. If arriving in a host country, they must wait a long period to obtain refugee status, oftentimes in untenable conditions, which leads to an increased vulnerability in mental health [4,12]. To wait for refugee status, asylum seekers are escorted to common facilities, reception centers, community shelters, refugee camps, or camps with surveillance. The conditions in such locations are highly variable, but most of them are inhumane [13].

The United Nations High Commissioner for Refugees (UNHCR) maintains strategic partnerships with more than 900 partners, most of whom are Non-Governmental Organizations (NGOs) [14], with the purpose to safeguard the rights and well-being of refugees. Volunteers from civil society and from local or international NGOs are the main group working with asylum seekers and refugees in the reception locations guaranteeing the chain of humanitarian assistance, solidarity, and inclusion in society [15]. Even with a high capacity for self-help and resilience, staff and volunteers aiding asylum seekers and refugees on the move are repeatedly exposed to personal tragedies. They may also live and work under physically and psychologically demanding and unpleasant working conditions [6,16]. Volunteers might experience moral anguish over the choices they have to make, increasing adverse consequences such as anxiety and depressive feelings, over-involvement with beneficiaries, callousness, apathy, self-destructive behavior, and interpersonal conflict [6]. Not only for themselves, but also to provide better and adequate care for the asylum seekers and refugees who wait for their refugee legal status for long periods in reception centers, shelters, or refugee camps, it is important to invest in some mental health basic competencies that empower them to make earlier and correct decisions. Improving the skills and knowledge of volunteers, who are non-health professionals, in mental health management will have a very positive impact in terms of prevention, early detection and appropriate referral, reducing stigma and discrimination, and improving their rights [17–19]. For the UNHCR, mental health and wellbeing psychosocial support primary activities with refugees and asylum seekers can be provided by people who are not specialized in the field, but who have been trained and supervised [19].

The research on the volunteers, who are often some of the first people to develop close contact with asylum seekers and refugees, is increasing slowly [18], and lacks the systematic overview to understand what kind of mental health competencies training the volunteers have that allows them to work with asylum seekers and refugees. Mental health competence is understood as the ability to participate effectively in efforts to promote prevention, care, treatment, and advocacy for mental health. As volunteers and non-health professionals working with asylum seekers, they should have knowledge and skills to recognize people's suffering based on cultural competencies. Mental health competence

also requires empowerment skill to help these vulnerable populations daily and help them to seek specialized mental health professionals.

A review is needed to systematize the mental health training programs that are carried out, in which specialist mental health nurses can contribute and improve. Thus, this scoping literature review aims to identify and describe the mental health training programs for non-health professionals and volunteers who work, have worked, or will work with asylum seekers or refugees in any context. The review seeks to examine whether there are different types of mental health training programs and courses for civil society, who do not have a health domain background, but need to develop those skills to deal with asylum seekers and refugees. The review will also be fundamental to understanding the settings in which these training programs take place, who conducts these mental health training programs, and the kind of educational domains and strategies used.

This aim was established following the Participants, Concept, Context (PCC) mnemonic as recommended by Joanna Briggs Institute for scoping reviews [20]. A preliminary search of PROSPERO, MEDLINE, the JBI Evidence Synthesis, and OFS was conducted, and no current or underway scoping reviews on the topic were identified.

2. Materials and Methods

2.1. Review Questions

What are the mental health training programs that have been used in the preparation of non-health professionals and volunteers, who do not have mental health training, to work with asylum seekers and refugees in the most varied contexts?

This review will seek to describe the training programs by answering the following sub-questions:

- (a) Who are the trainers conducting the training programs in mental health competencies for non-health professionals and volunteers working with asylum seekers and refugees?
- (b) At which settings are the mental health training programs for non-health professionals and volunteers working with asylum seekers and refugees occurring?
- (c) What are the educational domains composing the training programs in mental health competencies available for non-health professionals and volunteers working with asylum seekers and refugees?
- (d) What pedagogical strategies are being used for the training of non-health professionals and volunteers working with asylum seekers and refugees in mental health competencies?

2.2. Inclusion Criteria

2.2.1. Participants

This review will consider studies that include literature reporting on training in mental health competencies of adults aged ≥ 18 years, non-health professionals and volunteers, who do not have mental health training, and who work, are working, or will work with asylum seekers or/and refugees. It will include studies with participants independent of their educational level, who may have received or are receiving training in mental health competencies. The studies retrieving training programs exclusively for health personnel or mental health professionals, such as psychologists, will be excluded. Although the studies cannot be specifically for people with a health degree or mental health background, studies about mental health training programs for volunteers of civil society which have in their sample health professionals or people with mental health backgrounds (e.g., programs for volunteers independent of their professional background) will be included.

2.2.2. Concept

This review will consider literature that reports training programs aiming to improve mental health competencies of non-health professionals and volunteers. For the purpose of the current review, a mental health training program is considered to be any course or program carried out by trainers (e.g., health or social sciences educators, NGO professionals,

or NGO volunteers), irrespective of the duration, with the aim of developing or improving the competencies in the mental health domain. The educational strategy might include face-to-face or online programs, with or without practical training to develop or improve mental health competencies. This review will consider mental health competencies to be defined as the knowledge, skills, abilities, and personal attributes of non-health professionals and volunteers to effectively identify people experiencing mental health suffering and in need of professional support, and provide mental wellbeing support as non-health professionals or volunteers. The analysis of the identified training programs in mental health will constitute the basis to map and understand their characteristics in relation to the educational domains, strategies, and settings, as well as the trainers and trainees guiding their structure.

2.2.3. Context

This review will consider literature that focus on the mental health training performed irrespective of the settings, including but not limited to NGOs, host countries, governmental institutions who receive and support asylum seekers or refugees, community contexts, universities, polytechnics, shelters, detention centers, and refugee camps. Literature will be included irrespective of geographic location without a specific racial- or gender-based criteria.

2.2.4. Types of Sources

This scoping review will consider primary studies, quantitative, qualitative, mixed- and multi-method study designs, and reviews for inclusion in several databases described in the search strategy section. In addition, several relevant websites will be searched to identify information that will not be available in scientific databases, namely websites of reputable non-governmental organizations and websites that provide studies in progress. This information is more fully described in Section 2.3.1. Conference abstracts and text opinion papers will also be considered for inclusion in the proposed scoping review.

2.3. Methods

The proposed scoping review will be conducted in accordance with the JBI methodology, chapter 11, for scoping reviews [12], which encompasses the work of Arksey and O'Malley [14] with refinements by Levac, Colquhoun and O'Brien [15]. The development of the protocol for the current review complies with the Extension for Scoping Reviews of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-ScR) [16].

2.3.1. Search Strategy

The search strategy will aim to locate both published and unpublished primary studies. An initial limited search of MEDLINE (PubMed) and CINAHL (EBSCO) was undertaken to identify articles on the topic. Furthermore, a search in the WHO website was also made. The text keywords contained in the titles and abstracts of relevant articles, and the index terms used to describe the articles, were used to develop a full search strategy for MEDLINE (EBSCO), CINAHL (EBSCO), PsycINFO, Psychology & Behavioral Sciences Collection, SCOPUS, ERIC, RCAAP, and OPEN GREY (see Table A1 Appendix A). All articles available up to the day of the database search will be included.

The search strategy, including all identified keywords and index terms, will be adapted for each included information source. The reference lists of articles included in the review will be screened for additional papers. The search will also include the websites of ClinicalTrials, United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM), World Health Organization (WHO), Save the Children, International Migration, Integration and Social Cohesion in Europe (IMISCOE), and International Federation of Red Cross and Red Crescent Societies (IFRC). The NGO websites listed as sources of information were provided by a WHO Guidance Note that identify them as NGOs with developed work on protecting and supporting the mental health and psychosocial wellbeing of refugees, asylum seekers, and migrants [6].

Articles published in English, Swedish, Portuguese, Spanish, and French, without a time range, will be included.

2.3.2. Study/Source of Evidence Selection

Following the search strategy presented above, all identified records will be collated and uploaded into EndNote™ X8 (Clarivate Analytics, Philadelphia, PA, USA) and duplicates removed. Following a pilot test, titles and abstracts will then be screened by two independent reviewers for assessment against the inclusion criteria for the review. Potentially relevant papers will be retrieved in full and their citation details imported into the JBI System for the Unified Management, Assessment and Review of Information (JBI SUMARI; JBI, Adelaide, Australia) [21]. The full text of selected citations will be assessed in detail against the inclusion criteria by two independent reviewers. Reasons for exclusion of full-text papers that do not meet the inclusion criteria will be recorded and reported in the scoping review. Any disagreements that arise between the reviewers at each stage of the selection process will be resolved through discussion or with a third reviewer. The results of the search will be reported in full in the final scoping review and presented in a PRISMA-ScR flow diagram [22].

2.3.3. Data Extraction

Data will be extracted from papers included in the scoping review by two independent reviewers using a data extraction tool developed by the reviewers. The data extracted will include specific details about the mental health training programs available for non-health professionals and volunteers, without mental health training, who have worked, work, or will work with asylum seekers, irrespective of settings where the training might occur, and other relevant findings to the review question. The data will be exported to Microsoft Excel® (Redmond, WA, USA). A draft extraction tool is provided (see Table A2 in Appendix A). The draft data extraction tool will be modified and revised as necessary during the process of extracting data from each included paper. Modifications will be detailed in the full scoping review. Any disagreements that arise between the reviewers will be resolved through discussion or with a third reviewer. Authors of papers will be contacted to request missing or additional data, where required.

2.3.4. Data Analysis and Presentation

Results will be reported graphically with tables when possible. Tables will be developed and refined throughout the data extraction to reflect the purpose and objective of the review. The results will be classified under the following categories: study identification (ID); reasons for inclusion or exclusion; characteristics of study population/paper, regarding the participants, settings, educational mental health domains, and the strategies that are being used for the training; and a category about research methods used in the study/paper.

A narrative will accompany the result tables and will describe the characteristics of the body of literature related to mental health training programs available for the training of non-health professionals and volunteers, without mental health training, in any context. Data synthesis and analysis will be conducted using a thematic analysis.

3. Results

Most of the existing mental health training programs are developed for health professionals, often targeting specific mental health diagnoses, or do not contemplate the mental health of people under 18 years. With the proposed scoping review, we will map and synthesize the evidence regarding the mental health training programs for non-health professionals and volunteers working with young asylum seekers. With this work, we will also identify the mental health trainers conducting these kinds of programs for the population of interest and point out the setting used for the training. In addition, we

expect to identify which educational domains are included in the programs and which pedagogical strategies are used.

4. Conclusions

With the overwhelming growth of forcibly displaced people worldwide, it is necessary to understand what mental health training is received by non-health professionals and volunteers who work with people living the most traumatizing moments of their lives. To map these mental health training programs will not only help us to identify the mental health training programs available in databases, but also in the sites of the most relevant NGOs working with displaced people. It is crucial to synthesize this evidence in a scoping review, not only to understand if the mental health training programs for non-health professionals and volunteers exist, but also to understand how and by whom they are conducted, and what mental health competencies are learned.

Author Contributions: Conceptualization, L.T.-S. and F.V.; methodology, L.T.-S., F.V. and W.A.; software, L.T.-S. and F.V.; validation, L.T.-S., D.C. and W.A.; resources, L.T.-S., L.T. and F.V.; writing—original draft preparation, L.T.-S. and F.V.; writing—review and editing, F.V., L.T., D.C. and W.A.; supervision, W.A.; project administration, L.T.-S. and W.A.; funding acquisition, L.T.-S. All authors have read and agreed to the published version of the manuscript.

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Institutional Review Board Statement: The study was conducted under a major project named APT4U2, and thus was approved by the Ethics committee of the Health Sciences Research Unit: Nursing (n.º. 0 P742 12/2020).

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analyzed in this study. Data sharing is not applicable to this article.

Conflicts of Interest: The authors declare no conflict of interest.

Appendix A

Table A1. Search Strategy for MEDLINE (EBSCO) Search conduct on 16 December 2021.

Search	Query	Records Retrieved
#1	MH "Mental Health" OR TI Mental OR AB mental OR TI (well-being or wellbeing or "well being") OR AB (well-being or wellbeing or "well being")	481,858
#2	MH education OR TI (training * OR course * OR "educational model *" OR program * OR approach * OR procedure * OR method * OR strateg *) OR AB (training * OR course * OR "educational model *" OR program * OR approach * OR procedure * OR method * OR strateg *)	7,846,056
#3	MH Refugees OR MH "Refugee Camps" OR MH "United Nations" OR TI (refugee * OR "asylum seeker *" OR "forced migrant *") OR AB (refugee * OR "asylum seeker *" OR "forced migrant *")	23,658
#6	#1 AND #2 AND #3	1553
	Limited to English, Swedish, French, Portuguese, Spanish	1511

= Research line, * = Truncation.

Table A2. Data Extraction instrument.

Study ID	1.	Study Number	
	2.	Authors	
	3.	Year	
	4.	Article Title	
	5.	Journal	
	6.	Issue no.	
	7.	Vol.	
Reason for inclusion or exclusion	8.	Did the study or source of information present a mental health training program?	1: Yes 2: No—exclude
	9.	Did the study or source of information involve training programs for non-health professionals and volunteers, without mental health training, who have worked, who work, or will work with asylum seekers or refugees?	1: Yes 2: No—exclude
	10.	Did the literature include the training of mental health competencies provide by professionals with training?	1: Yes 2: No—exclude
	11.	Are there other reasons for exclusion?	1: Yes 2: No
	11.1.	Specify other reason for exclusion	Specify in own words reason for exclusion
	12.	Inclusion of paper?	1: Yes 2: No

Table A2. Cont.

	13. Which non-health professionals and volunteers are target in the study?	1. Non-specified 2. Other, specify
	13.1. Sample size	Specify the number
	14. Who are the trainers conducting the mental health training programs?	1. Medical Staff 2. Nurses 3. Psychologists 4. Social Workers 5. Health educators 6. Midwives; 7. Sociologists 8. Anthropologists 9. Multidisciplinary team 10. NGO's professionals 10.1. Describe which NGO 11. Other, specify
	15. Setting of the study or settings where supposed to teach the mental health training program	1. Recreational /cultural groups that supports asylum seekers and refugees locally 2. Refugee camps 3. NGOs 4. Universities and Polytechnics 5. Detention Centers for migrants 6. Refugee camps 7. Prison or custodial settings 8. Other, please specify
Characteristics of study population/paper	16. Name of the program	Specify the name
	17. The domains included in the mental health training program	1. Transcultural Mental challenges 2. Prevalence Mental Health Disorders 3. Psychological Support 4. Social Support 5. Values and Beliefs in mental health assistance 6. Communication 7. conflict resolution 8. Ethical and moral approach of asylum seekers and refugees 9. Exercises to practice mental health competencies 10. Other, please specify
	18. The strategies used in the training program	1. Mandatory Participation 1.1. Online 1.2. Face-to-Face 2.Expository Method 3. Role Play 4. Practical interaction with asylum seekers and refugees in the fieldwork 5. Other, please specify
	19. There are any models or theories or principles or specific guidelines used to conceptualize the training	1. Yes, Please describe. 2. Not described

Table A2. Cont.

	20. Is this training programs provided by NGOs or International organizations considered relevant for the topic?	1: Yes 2: No
	21. Is the study experimental?	1: Yes 2: No
	21.1. If experimental—what type?	1. Classic experiment/RCT 2. Experiment without randomization 3. Experiment without control group 4. Not experimental
Research methods used in the study/paper or description of other sources. Studies will be categorized according to the methodology or methodologies employed, and whether or not the data collected is numeric.	21.2. What instruments are used to measure outcomes?	Please identify the instruments (i.e., Scales, Questionnaires)
	22. Is the study observational?	1: Yes 2: No
	22.1. If observational—what type?	1. Correlational (retrospective) 2. Correlational (prospective) 3. Cross sectional 4. Case control 5. Other Descriptive 6. Not observational
	23. Is it a qualitative study?	1: Yes 2: No
	23.1. How is data collection performed?	Please describe them (e.g., Focus groups, interviews)
	24. Is the study is a multi-method study?	1: Yes 2: No
Summary the study	25. Make a short summary of the article.	Describe them.
Comments to review from reviewers	Describe them.	

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ARTIGO 2

Teixeira-Santos LM, Ventura FI, Santos JA, Almeida IF, Abreu WC. Mental health training programs for non-health professionals and volunteers working with asylumseekers and refugees: Scoping review. *Revista da Escola de Enfermagem da USP*. 2023;57(spe). doi:10.1590/1980-220x-reeusp-2022-0447en

Métricas do Jornal	
E-ISSN	1980-220X
Disciplina	Enfermagem
Scimago Journal & Country Rank (SJR®)	0,247
H-index	33
Quartil:	Q3
Indexação (bases principais)	WEB OF SCIENCE, MEDLINE, CINAHL, SCOPUS, LILACS, LATINDEX, CUIDEN-Plus, PERIÓDICA, BDEF, DOAJ, ULRICH'S, PUBMED CENTRAL



Mental health training programs for non-health professionals and volunteers working with asylum-seekers and refugees: scoping review

Programas de treinamento em saúde mental para profissionais, que não de saúde, e voluntários que trabalham com solicitantes de asilo e refugiados: revisão de escopo

Programas de formación en salud mental para profesionales no sanitarios y voluntarios que trabajan con solicitantes de asilo y refugiados: revisión de alcance

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ABSTRACT

Objective: To identify and describe the mental health training programs for non-health professionals and volunteers who work, have worked, or would work with asylum seekers and/or refugees. **Method:** Scoping review following JBI methodology. Search carried out in MEDLINE, CINAHL, ERIC, SCOPUS, PsycINFO, Psychology & Behavioral Sciences Collection, RCAAP, ProQuest, and websites of Clinical Trials, UNHCR, International Organization for Migration, WHO, Save the Children, International Migration, Integration and Social Cohesion in Europe, and International Federation of Red Cross and Red Crescent Societies. Studies written in English, Portuguese, French, Spanish and Swedish. **Results:** Of the 8954 articles identified, 16 were included reporting on 11 training programs: Mind-Spring, PM+, MHFA, Cognitive-Behavioral Training for Community and Religious Leaders, EmpaTeach, Suicide Prevention Education Program, Teaching Recovery Techniques, Handbook for Teachers of Vietnamese Refugee Students, PFA, Psychosocial support of volunteers and CBP&MHPSS. **Conclusion:** Training programs from scientific literature focus on mental health disorders, while non-governmental organizations' documents focus on resilience and self-care. The current mental health training programs might be insufficient.

DESCRIPTORS

Refugees; Mental Health; Education; Nursing.

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INTRODUCTION

The world as we know is changing, especially due to worldwide migrations. As a result of wars, violence, persecution, human rights violations, and events that seriously disturb public order, 89,3 million individuals worldwide were forcibly displaced by the end of 2021⁽¹⁾. Of the 89,3 million people, 27,1 million are refugees, 53,2 million are internally displaced people, 4,6 million are asylum seekers⁽²⁾. Almost 70% of refugees came from the Syrian Arab Republic (6,8 million); Venezuela (4,6 million); Afghanistan (2,7 million); South Sudan (2,8 million); and Myanmar (1,1 million). The low- and middle-income countries hosted 83% of refugees, being Turkey the host country that receives the largest number of refugees worldwide (3,8 million), followed by Colombia (1,8 million), Uganda (1,5 million), Pakistan (1,5 million) and Germany (1,3 million)^(1,2).

In the last years, the forcibly migratory fluxes have been a concern to the European Union as the number of people seeking protection in Europe has grown considerably. From 2014 until the end of 2021, Italy, Cyprus, Malta, Greece, and Spain received 2,300,881 million sea and land arrivals⁽³⁾. These data focus on forced displaced people by the end of 2021. Along with the war in Ukraine in early 2022, which caused until now 7 million people to be internally displaced and 6 million people refugees, the statistics on influxes of European migration are dramatically changing⁽¹⁾.

Forcibly displaced people are obligated to abruptly leave all belongings and often their family members to seek international safety and protection. The loss of material resources (e.g., house, clothing, belongings), identity references (e.g., social and cultural relations), as well as adequate access to essential care and resources such as health and education, are factors of vulnerability in mental health^(4,5). Forced displacement is increasing and several mental health studies are being conducted to understand the impact of this situation on people's mental health. A recent systematic review of psychiatric disorders in refugee and internally displaced persons after forced displacement, including 38 studies that provided data from 39,518 participants from 21 countries, show that participants suffer from post-traumatic stress, depression, and anxiety disorders⁽⁶⁾. Mental health disorders are linked with pre-, ongoing, and post-migration situations and involve traumatic events, such as violence, separation, sexual abuse, trafficking, harassment, and lack of basic needs⁽⁷⁻⁹⁾. The lack of basic needs is not only present in the country of origin. As a result of some countries' political arrangements, asylum seekers are getting stopped at the borders. For example, if asylum seekers arrive in Europe, they must wait years for the refugee legal status to have the right to get out of a refugee camp/shelter/reception centre, most of them with inhumane conditions⁽¹⁰⁾.

To maintain safety, well-being and safeguard the asylum seekers' rights, the United Nations High Commissioner for Refugees (UNHCR) works in partnership with 900 entities, most of them Non-Governmental Organizations (NGOs)⁽¹¹⁾, which are mainly composed of civil society volunteers⁽¹²⁾. Motivational factors drive volunteers to spend their time working on helping others. Yet they have the major challenge of dealing with the suffering of asylum seekers and refugees (AS&R) as they listen about the serious traumatic trajectories in their pre, during, and post-migration period on a daily basis⁽¹³⁾.

Volunteers working with AS&R in a chronic stress environment may increase their vulnerability to adverse consequences, such as anxiety, burnout, and depressive feelings, over-involvement with AS&R, callousness, apathy, self-destructive behaviour, interpersonal conflict, and secondary traumatic stress⁽¹⁴⁻¹⁶⁾. Several studies show that volunteers' psychological distress can vary depending on previous training⁽¹⁷⁻¹⁹⁾. Psychologically trained refugee-helpers had lower burnout values and somatic symptoms when compared with untrained aid workers⁽²⁰⁾.

Psychological training is relevant not only for volunteers' mental health preparation and safety but also to provide better and adequate care for AS&R. Improving mental health competencies, skills, and knowledge of volunteers, non-health professionals, i.e., who do not have a mental health background education, is likely to have a positive impact in the AS&R' health. Mental health training for volunteers working with AS&R has shown evidence of empowering them to make earlier and correct decisions about prevention, early detection, and appropriate referral for specialized mental care, reducing stigma and discrimination, and improving AS&R rights^(21,22). The UNHCR defends that interventions towards the promotion of psychosocial support with AS&R can be provided by non-specialized mental health volunteers, yet they must be trained and supervised⁽²²⁾. This evidence reinforces the importance of mental health training programs for volunteers in this fieldwork.

The scientific research with volunteers and their work with AS&R is slowly increasing⁽²¹⁾. A systematic overview to understand the kind of mental health competencies training available to prepare volunteers for their work with AS&R is demanded. Mental health competence is understood as the ability (attitudes, knowledge, skills, and behaviours)⁽²³⁾ to effectively promote prevention, care, treatment, and advocacy for mental health. This competence requires knowledge to protect their self-mental health; to recognize people's suffering, based on their cultural competencies; to provide basic psychosocial support to vulnerable populations during their overwhelming life transitions; and an empowerment skill to refer people for specialized mental care or to mental health professionals⁽²⁴⁾.

Nurses are vital in the promotion of health and health literacy^(25,26), and they are the key factor in the health responses of these populations^(27,28). Therefore, this scoping literature review aims to identify and describe the mental health training programs for non-health professionals and volunteers who work, have worked, or will work with AS&R regardless of the context, i.e., mental health training programs and courses available for the civil society members, who do not have a health or mental health background but need to develop those skills to deal with AS&R. This review is fundamental to understand the people conducting these training programs, the places where the training takes place, and the educational domains and strategies that are used.

METHOD

DESIGN OF STUDY

This scoping review was conducted according to the JBI methodology for scoping reviews^(29,30), following an *a priori* published protocol which describes the methodological procedures used⁽²⁴⁾.

The PCC (Population, Concept, and Context) mnemonic^(29,30) was used. P representing studies with or addressed or designed for participants aged ≥ 18 years, volunteers, and non-health professionals, without mental health training, independent of their educational level, who had work, were working, or would work with asylum seekers or/and refugees. C represented studies reporting on the training of adults in mental health competencies. C was considered to be any environment where the study was developed. The review aimed to respond to the main research question: What are the mental health training programs that have been used in the preparation of non-health professionals and volunteers who do not have mental health training to work with AS&R?

An initial search was carried out in MEDLINE (PubMed) and CINAHL (EBSCO) databases to analyse the terms used to describe the articles relevant to the study. Then, a full search strategy described in Chart 1 with terms adapted for each source, was carried out in the MEDLINE (EBSCO), CINAHL (EBSCO), ERIC, SCOPUS, PsycINFO, Psychology & Behavioral Sciences Collection, and in the grey literature databases The Scientific Open Access Repository of Portugal (RCAAP), and ProQuest. In the scoping review protocol⁽²⁴⁾, the authors identified as a source of grey literature the OpenGrey database. However, OpenGrey was discontinued in 2021. To be able to integrate international grey literature in this review,

the authors came to the consensus of including the ProQuest database. The scoping review search also included the websites of ClinicalTrials, UNHCR, International Organization for Migration (IOM), WHO, Save the Children, International Migration, Integration and Social Cohesion in Europe (IMISCOE), and International Federation of Red Cross and Red Crescent Societies (IFRC). The NGO websites listed as sources of information were provided by a WHO Guidance Note that identifies them as NGOs with developed work on protecting and supporting the mental health and psychosocial well-being of refugees, asylum seekers, and migrants⁽³¹⁾. In the NGO websites, the search was made through the search bottom, in the documentation section, with the common words "mental health training" or "training". On the ClinicalTrials website, the search included six combinations of common words: i) mental health training AND refugees; ii) mental health training AND asylum seekers; iii) mental health training AND refugee volunteers; iv) mental health AND asylum seekers volunteers v) mental health AND refugee workers; vi) mental health AND asylum seekers workers.

SELECTION CRITERIA

The review considered studies reporting training or training protocols of mental health competencies for adults, non-health professionals and volunteers without mental health training,

Chart 1 – Scoping review databases' search strategy – Porto, Portugal, 2021.

Information resource	Search strategy
MEDLINE (EBSCO)	(MH "Mental Health" OR TI Mental OR AB mental OR TI (well-being or wellbeing or "well being") OR AB (well-being or wellbeing or "well being")) AND (MH education OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (MH Refugees OR MH "Refugee Camps" OR MH "United Nations" OR TI (refugee* OR "asylum seeker*" OR "forced migrant*") OR AB (refugee* OR "asylum seeker*" OR "forced migrant*"))
CINAHL (EBSCO)	(MH "Mental Health" OR TI Mental* OR AB mental OR TI (wellbeing or well-being or "well being") OR AB (wellbeing or well-being or "well being")) AND (MH education OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (MH Refugees OR MH "Refugee Camps" OR MH "United Nations" OR TI (refugee* OR "asylum seeker*" OR "forced migrant*") OR AB (refugee* OR "asylum seeker*" OR "forced migrant*"))
ERIC	(DE "Mental Health" OR DE "Mental Health Programs" OR TI mental OR AB mental OR TI (well-being or wellbeing or "well being") OR AB (well-being or wellbeing or "well being") OR TI emotional OR AB emotional OR TI psychological OR AB psychological) AND (DE education OR DE training OR DE "Volunteer Training" OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (DE Refugees OR DE migration OR TI (refugee* OR "asylum seekers") OR AB (refugee* OR "asylum seekers"))
SCOPUS	((TI=("mental health" OR well-being or wellbeing or "well being")) OR AB=("mental health" OR well-being or wellbeing or "well being")) AND ((TI=(educational OR training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) OR AB=(educational OR training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND ((TI=(Refugee* OR "asylum seeker*" OR "forced migrant*")) OR AB=(Refugee* OR "asylum seeker*" OR "forced migrant*"))
PsycINFO	(MA "Mental Health" OR TI Mental OR wellbeing OR well-being OR "well being") OR AB (Mental OR wellbeing OR well-being OR "well being") AND (MA education OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (MA (refugees OR "refugee camps" OR "United Nations") OR TI (refugee* OR "asylum seeker*" OR "forced migrant*")) OR AB (refugee* OR "asylum seeker*" OR "forced migrant*"))
Psychology and Behavioral Sciences Collection	(MH "Mental Health" OR TI Mental OR AB mental OR TI (well-being or wellbeing or "well being") OR AB (well-being or wellbeing or "well being")) AND (MH education OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (MH Refugees OR MH "Refugee Camps" OR MH "United Nations" OR TI (refugee* OR "asylum seeker*" OR "forced migrant*") OR AB (refugee* OR "asylum seeker*" OR "forced migrant*"))
RCAAP	i) TXT ((mental health) AND training AND refugee) ii) TXT ((mental health) AND training AND (asylum seeker))
ProQuest	ab("mental health") AND ab(refugee OR "asylum seeker") AND (volunteer OR "non-health professional") AND ab(training)

who had work, are working, or will work with asylum seekers or/and refugees without the context restrictions, available in English, Swedish, Portuguese, Spanish, and French. For this review it was considered for inclusion primary studies, quantitative, qualitative, mixed- and multi-method study designs, reviews, protocols, conference abstracts and text opinion papers with relevant information until December of 2021. In addition, several relevant websites were searched to identify information that might not be available in scientific databases, such as the websites of reputable NGOs, as described in the previous section. Specially from these sources the participants could be named as field workers, which is a common designation for someone who works in the humanitarian field.

DATA COLLECTION

Data collection took place from December 15th to December 31st of 2021. Initially, all the articles found were uploaded into EndNote™ X8 software, and the duplicates were removed. After this process, the studies were uploaded into the Rayyan software to proceed with the initial screening of titles and abstracts by two independent reviewers. The full text of selected citations was assessed in detail against the inclusion criteria by two independent authors. At each stage, the doubts about the article’s selection were discussed by reviewers and ultimately decided by the principal investigator. The selection process was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist⁽³²⁾.

DATA ANALYSIS AND TREATMENT

Two independent authors extracted data from the sources included in the scoping review using a data extraction tool developed by the reviewers presented in the published scoping review

protocol⁽²⁴⁾. The principal investigator gathered and compiled in tables all the extracted information according to the developed tool. All members of the team were involved in the development of the data extraction form. The form was piloted test independently by two researchers (LTS, FV). The form was then revised in consultation with an experienced reviewer (WA) to promote consistent and reliable extraction. The extracted information was analysed according to the following categories: study identification (ID); reasons for inclusion or exclusion; characteristics of study population/paper, participants, settings, educational mental health domains, and the strategies that were used for the training; and a category about research methods used in the study/paper.

Data extraction was performed independently by five researchers (LTS, FV, JS, LT, IA) and reviewed by a senior researcher with extensive review experience (WA). Conflicts were discussed, and where necessary, a third author was consulted (LTS) in consultation with an experienced reviewer (WA).

ETHICAL ASPECTS

The reliability and fidelity of the information extracted from the selected publications were ensured through proper referencing and rigour in data treatment and presentation. This review was conducted under a PhD project named APT4U2, which was approved by the Ethics Committee of the Health Sciences Research Unit: Nursing (no. 0 P742 12/2020).

RESULTS

The search strategy identified a total of 8,954 publications. After excluding the 5,562 duplicates, 3,392 studies were selected for title and abstract analysis. A total of 167 were selected for full reading analysis, with the remaining 16 articles included in the review, as shown in Figure 1.

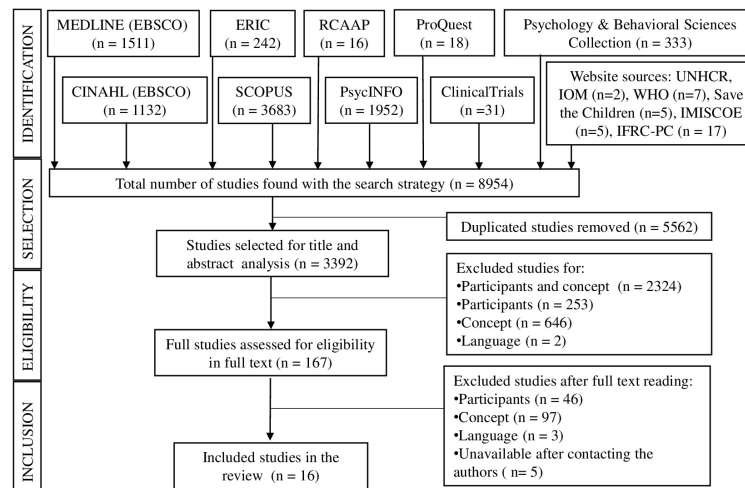


Figure 1 – Scoping review structure flowchart. Porto, Portugal, 2022.

Chart 2 – Studies included in the scoping review – Porto, Portugal, 2022.

ID	Study's name	Year
1	Handbook for Teachers of Vietnamese Refugee Students ⁽³³⁾	1977
2	Psycho-education and psychosocial support in the Netherlands; a program by and for refugees ⁽³⁴⁾	2005
3	Psychological first aid: Guide for field workers ⁽³⁵⁾	2011
4	Caring for Volunteers, A Psychosocial Support Toolkit ⁽³⁶⁾	2012
5	Psychological first aid: Facilitator's manual for orientating field workers ⁽³⁷⁾	2013
6	Caring for volunteers: Training Manual ⁽³⁸⁾	2015
7	Mental health first aid training for the Bhutanese refugee community in the United States ⁽³⁹⁾	2015
8	Expanding mental health services delivery for depression in the community from burma in North Carolina: A paraprofessional training program ⁽⁴⁰⁾	2016
9	Community-based protection & mental health psychological support ⁽⁴¹⁾	2017
10	Effectiveness of a peer-refugee delivered psychological intervention to reduce psychological distress among adult Syrian refugees in the Netherlands: study protocol ⁽⁴²⁾	2020
11	Lay-therapist-delivered, low-intensity, psychosocial intervention for refugees and asylum seekers (PROSPER): Protocol for a pilot randomised controlled trial ⁽⁴³⁾	2020
12	The EmpaTeach intervention for reducing physical violence from teachers to students in Nyarugusu Refugee Camp: A cluster randomised controlled trial ⁽⁴⁴⁾	2021
13	An Evaluation of Suicide Prevention Education for People Working with Refugees and Asylum Seekers: Improvements in Competence, Attitudes, and Confidence ⁽⁴⁵⁾	2021
14	Islamic Trauma Healing: Integrating Faith and Empirically Supported Principles in a Community-Based Program ⁽⁴⁶⁾	2021
15	Task-Sharing Psychosocial Support with Refugees and Asylum Seekers: Reflections and Recommendations for Practice from the PROSPER Study ⁽⁴⁷⁾	2021
16	Readiness of Allied Professionals to Join the Mental Health Workforce: A Qualitative Evaluation of Trained Lay Trauma Counsellors' Experiences When Refugee Youth Disclose Suicidal Ideation ⁽⁴⁸⁾	2021

The 16 studies included in the scoping review are presented in Chart 2.

All the articles included were published in English, and those from the website sources^(35–38,41) were translated into at least three more languages. Eleven articles were taken from scientific databases^(33,34,39,40,42–48), six of which were experimental studies carried out in the Netherlands⁽³⁴⁾, United States of America^(39,40), Tanzania⁽⁴⁴⁾, Australia⁽⁴⁵⁾, and Sweden⁽⁴⁸⁾. Of the other five studies, two were randomized controlled trial protocols to be carried out in the Netherlands⁽⁴²⁾, and the United Kingdom⁽⁴³⁾, and three studies described an intervention without results from implementation^(33,46,47). Of the five included from website sources, two are from OMS^(35,37), two from the Psychosocial Centre of the IFRC^(36,38), and one from UNHCR⁽⁴¹⁾. All of these reported interventions for training in mental health competencies to work with AS&R but did not describe examples of implementation.

As for the year of publication, the first study that was made available on the databases concerning this subject dates back to 1977⁽³³⁾. The number of scientific publications on the topic has increased since 2015, and 2021 was the year with the highest number of records (n = 5)^(44–48).

Answering the main question of this study, different programs were identified as training programs in mental health competencies for lay people working with AS&R, namely Mind-Spring⁽³⁴⁾, Problem Management Plus (PM+)^(42,43,47), Mental health first aid (MHFA)⁽³⁹⁾, Cognitive-Behavioral Training (CBT) for Community and Religious Leaders⁽⁴⁰⁾, EmpaTeach⁽⁴⁴⁾, Suicide Prevention Education Program⁽⁴⁵⁾, Teaching Recovery Techniques (TRT)⁽⁴⁷⁾, and a Handbook

for Teachers of Vietnamese Refugee Students⁽³³⁾. From the organization's website sources, five documents reported on interventions on training in mental health competencies for field workers to work in crises situations. Although not specific to work with AS&R, the included documents present case scenarios, activities or the description of crises situations involving situations with AS&R, namely: Psychological First Aid (PFA)^(35,37), Psychosocial support of volunteers^(36,38), Community-based protection and Mental health psychological support (CBP & MHPSS)⁽⁴¹⁾.

The studies' characteristics regarding the trainers, educational domains and strategies used are presented in Chart 3.

DISCUSSION

AS&R experience mental health challenges that reduce their well-being not only related to the experiences in their country of origin but also when in transit and with the reception on arrival, including accesses to housing or healthcare. The contact made between AS&R and the healthcare system is often crisis-driven and mediated through NGOs, whose staff lack knowledge and skills in the management of distress^(4,43).

To respond to the shortage of health professionals in the world⁽⁴⁹⁾, especially in low- and middle-income countries where conflicts, disasters, and poverty is more common, thereby leading to an increase in AS&R, the WHO proposes professional training of lay counsellors to provide mental health interventions⁽⁵⁰⁾. Additionally, the Inter-Agency Standing Committee recommended guidelines for emergency relief efforts and proposed that mental health interventions could be delivered by trained,

Chart 3 – Studies included in the scoping review – Porto, Portugal, 2022.

ID	Study characteristics				
	Program name, intervention	Participants	Trainers	Domains included	Strategies used
1	Handbook for Teachers, a guidebook suggesting approaches to specific problems, habits and culture of Vietnamese refugee students ⁽³³⁾ .	Teachers working with Vietnamese refugees in American schools.	Self-guidebook.	Religious beliefs and practices, cultural values, personal characteristics, holiday customs, traditional expectations for children's behavior at home and at school, Vietnamese educational institutions, pupil orientations, cultural awareness.	The book includes seven short case studies illustrate problems with coeducation, food habits, climate and clothing, illnesses and medication, adjustment, motivation, and the language barrier of Vietnamese refugees' students to help teachers to understand the cultural differences. The book also presents a culture-sensitive assessment practices for determining grade placements.
2	Mind-Spring, a community-based intervention to provide psychoeducation and psychosocial support ⁽³⁴⁾ .	People with background as a refugee or asylum seekers, who spoke at least Dutch and/or English, and an education background in (para)medics, psychology, social work, teaching, or education, living in Netherlands.	Coach from the Dutch mental health care system trains the refugee trainers who will implement the intervention with other refugees and asylum seekers.	The training of trainers consists in 2 parts. The 1 st part (10 sessions of 4h) includes theory and exercise focused on mental health issues as trauma, stress, mourning, feelings of guilt, depression, somatic complaints, identity, and acculturation. The second part is a short internship at a local mental health institute in the Netherlands.	1 st part: Trainees are shown exercises to learn about coping strategies (cognitive approach), relaxation exercises, how to empower people, developing a helping attitude, how to stay healthy themselves and most the skills and tools of a good trainer. These subjects and exercises are learnt in the Mind-Spring manual for trainers, and they use regularly the role playing to exemplify. 2 nd part: The internship, requires completing one psycho-education course for asylum seekers or refugees which consists in 8 sessions of 2 hours each. In the internship, the trainee works with a mental health professional who also receive a Mind-Spring training.
3	PFA, a manual for people in a position to help others in ways that respect their dignity, culture, and abilities ⁽³⁵⁾ .	Field workers.	Self-guide manual.	Understand PFA (crisis situation, implementation of PFA), how to help responsibly (cultural knowledge and awareness), providing PFA (communication, preparation, action, refer), caring for themselves and colleagues.	The guide presents each chapter with full description of the domains included including images and several examples who to apply the instructions. At the end presents 3 case scenarios to intervene in disaster, violence and displacement and accidents.
4	Psychosocial Support of volunteers (Toolkit), a manual to prepare and support volunteers for their work during and after disasters, conflicts, and other crisis events ⁽³⁶⁾ .	Field workers.	Self-guide manual.	Five contents: Resilience, risk, and responsibility; Communicating the Message; Response Cycle and Volunteer Psychosocial Support: Before, During and after; Psychological first Aid for Volunteers; and Monitoring and evaluation of Volunteer support.	The toolkit present support activities to intervene in several emergency situations, different worksheets regarding the training; strategies and tips for peer support and collect useful information; indicators to evaluated complex emergencies.
5	PFA, a manual for orienting field workers ⁽³⁷⁾ .	Field workers.	Self-guide manual.	Step-by-step orientation to implement PFA (definition and framework; applying PFA; and PFA role plays and wrap-up, self and teams care, evaluation).	The guidebook contains orientation modules to implement the PFA and presents supporting materials to implement PFA as: PFA pocket guide, option pre/posttest, simulation instructions, case scenario instructions, communication exercises, exercises to help children and vulnerable populations, evaluation form, self-relaxation exercise and an example of full-day of orientation agenda.
6	Psychosocial support of volunteers ⁽³⁸⁾ , a 2-day training program that complements the toolkit presented in Study ID n° 4.	Field workers, staff or volunteers who are responsible for other volunteers. This program can be manage by people that who participate in the Training of Trainers (ToT). For this specific training should have a back-ground in health, mental health, social welfare, or human resources and have a good understanding of psychosocial support.	Master Trainer in psychosocial support minister the ToT program and then the ToT trainer can manage the psychosocial support for volunteers.	3-day training: 1 st day: Understanding psychosocial support; Risks, resilience, and protective factors; Self-care; Peer support and Psychological first aid for volunteers. 2 nd day: Setting up psychosocial support systems for volunteers; Monitoring and evaluation of volunteer support; Communicating the message; Developing an action plan and Evaluation.	The manual sets out a basic training in the psychosocial support of volunteers. The manual is also used for the ToT together with a separate set of training notes. The ToT do a 3-day training program using the basic program supplemented by half a day on facilitation techniques and half a day for preparing practice training activities. The Psychosocial support training manual includes: Icebreakers, check-in and check-out activities and energizers, Evaluation questionnaire, Handouts, Self-care scenarios and a Workshop planner.

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ID	Study characteristics				
	Program name, intervention	Participants	Trainers	Domains included	Strategies used
7	MHFA, an 8-hour training course performed in one full day ⁽³⁹⁾ .	Bhutanese refugees (n=120) from 26 cities in USA' 13 states participated in the MHFA program (classes with 30 participants each).	Eight qualified instructors from the National Council for Behavioral Health (2 instructors and 1 bilingual interpreter per class).	Risk factors, warning signs and common treatments for depression, anxiety, trauma, psychosis, eating disorders, substance use disorders, self-injury, and suicidal behaviors. They also learn a five-step action plan to help people who may be developing a problem or who are already in a crisis.	The course used role-playing and simulations to demonstrate how to assess a mental health crisis, select interventions, provide initial help, and connect persons to professional, peer and social supports as well as self-help resources.
8	CBT for Community and Religious Leaders, a 4-session of 12-hours training program ⁽⁴⁰⁾ .	Community leaders (n=38) from Burma in North Carolina (Refugee Resource Center and Five Oaks Seventh-Day Adventist Church)	One psychologist and two facilitators (one Karen-speaking and one Burmese-speaking)	Signs and symptoms of depression and related problems, including intergenerational conflicts, substance abuse, domestic violence, and suicide; CBT skills, Awareness of stigma toward treatment-seeking for depression and its related risk factors.	As an interactive training program, presents exercises to support the skills development, several examples of homework for the participants, several quizzes, techniques to implement the program and promote the participants involve and a program evaluation form.
9	CBP & MHPSS, a guide to help community-based protection actors and MHPSS practitioners work together to contribute to the wellbeing and protection of forced displacement people ⁽⁴¹⁾ .	Field workers.	Self-guide manual.	MHPSS: Definition, approach, and intervention. Intervention pyramid: social considerations in basic services and security, strengthening community and family supports, focused psychosocial supports and clinical services. Linkages between MHPSS and Community-based intervention.	Several examples about social inclusion and participation are present to the readers to promote reflexive thinking. Also, some case studies and activities are shown to strengthen community and family support.
10	PM+, a Protocol for a program implementation with 5 weekly face-to-face sessions of 90 minutes ⁽⁴²⁾ .	PM+' facilitators are men and women refugees who speak Arabic, with a background in education, social work, health, or a related field, fluent in German and English.	Licensed mental health care professionals.	Common mental disorders, basic counselling skills, delivery of intervention strategies and self-care.	The facilitator received 8 days of training, follow by 2 practice cases, with close supervision of trained PM+ trainers and supervisors who also received training to supervise.
11	PM+, a protocol for a randomised controlled trial implemented in local NGOs delivering the PM+ for AS&R by lay people (PROSPER pilot) ⁽⁴³⁾ .	Two Wellbeing Mentors appointed by the of the Person Shaped Support – a health and social care charity – (group 1) and 15 people with asylum experience (group 2).	PM+ Master Trainers	Group 1: delivery of the PM+ intervention strategies in both individual and group modalities, skills in training and supervising lay therapists Group 2: education in mental disorders, basic helping skills, delivery of intervention strategies and self-care.	Group 1: 5 days of intensive training from two PM+ Master Trainers and monthly supervision to become Wellbeing Mentors and supervise the lay therapists. Group 2: 8 days of training to trained to deliver either individual or group PM+. This was followed by training cases and a competency assessment.
12	EmpaTeach – a self-guided teacher training intervention designed to reduce and prevent teachers' use of corporal punishment in the classroom, learned in 12 sessions ⁽⁴⁴⁾ .	85 Teacher from fourteen schools of Nyarugusu Refugee Camp.	Three persons: 1 from the Behavioural Insights Team, 1 from the International Rescue Committee education technical unit staff and 1 local refugee.	Self-regulation, alternative discipline techniques, and classroom management strategies.	EmpaTeach inter-vention used empathy-building exercises and group work. Some of the sessions have videos that were produced locally as part of the intervention, in other sessions is necessary to play to apply learned concepts and they learn how to co-create classroom rules with students.
13	Suicide Prevention Education, a 2-day training program for people working with AS&R ⁽⁴⁵⁾ .	Staff, volunteers, and students from NGOs who provide case management, support, or counselling, to AS&R across Australia, primarily in the community, but also in held detention.	Members of Australian Red Cross and an asylum seeker.	Evidence concerning suicide and suicide prevention, the development of the asylum seeker suicidal mind, trauma-informed practice, risk and protective factors, ideation to action theories of suicide, cultural considerations, compassion, and hope when engaging with suicidal persons, safety planning, postvention, and self-care.	2-day training program (15h): lecture-style presentations (3 h), interactive discussions (4.5 h), small group activities/role plays (1.5. hr), and case studies (2 h). All attendees received a take-home workbook, including the presentation slides, worksheets, and literature. Questionnaire pre-training, post training and 4-6 months follow-up.

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ID	Study characteristics				
	Program name, intervention	Participants	Trainers	Domains included	Strategies used
14	Islamic Trauma Healing, a 6-session of 2-hours, lay-led group intervention developed within a Somali Muslim community that integrates evidence-based trauma-focused cognitive-behavioral therapy principles ⁽⁴⁶⁾ .	Adults who practice Islam.	2 Lay leaders of the same gender facilitate each group of 5-7 people members, and they must have knowledge of the Qur'an but need no prior training in mental health	Sessions contents: Trauma, post-traumatic growth, reconciliation with others using prophets' narratives. Structure: i) Community and spiritual preparation; psychoeducation, describing programs, prophet narratives, and turning to Allah (informal prayer).	The lay-leaders also receive a two 4-hour sessions, including motivational stage setting, didactic and competence components. The Islamic Trauma Healing is carried out in mosques and formal diagnostic labels are not used.
15	PM+, reflections and recommendations to deliver the PM+ for AS&R by lay people (PROSPER) ⁽⁴⁷⁾ .	Peer Lay therapists (n=12)	PM+ Master trainer and two Well-being Mentors	PM+ ToT which includes basic helping skills and the PM+ sessions.	The skills in training others were possible conducting role plays and providing feedback and leading supportive supervision. Wellbeing Mentors each completed three individual PM+ practice cases with volunteers. Wellbeing Mentors have received monthly supportive supervision with one master trainer and the Person Shaped Support team leader lasting between 1.5 and 2 hours, complemented by e-mail and telephone discussions. The Peer Lay Therapist Training was separated into Group PM+, and Individual PM+, and were carried out once a week for 8 weeks. The supervision of Peer Lay Therapist Training was led by the Wellbeing Mentors. Collective informal engagement such as shared lunches during training and sightseeing tours helped build intervention team cohesion within and beyond PM+ roles.
16	TRT ⁽⁴⁸⁾ , a community-based intervention utilizing trained lay counsellors in a stepped model of care for refugee youth experiencing trauma symptoms, one a week for 7 weeks.	TRT trained lay counsellors with experience working with unaccompanied refugee minors: Professionals, such as teachers, nurses, or social workers (n=50).	Swedish non-governmental organisation Children's Rights in Society (n=2).	TRT comprises 2 sessions for caregivers and 5 sessions for youth including: psychoeducation, affective modulation skills, cognitive coping and processing, in vivo mastery of trauma reminders, guided exposure and exploring plans and hopes for the future.	Techniques like positive self-talk, dual attention and relaxation are used. The focus is on symptoms and tools rather than trauma narrative and processing. The intervention tries to normalize the trauma' symptoms in the group environment as this is assumed to relieve youth from shame and fear.

nonprofessional community members⁽⁵¹⁾. In light of the results of this review, the number of scientific studies researching on programs and/or interventions to train mental health competencies of the volunteers, which includes community members, and NGO staff, with no health or mental health background to work with AS&R is insufficient. Most are protocols focused on specific mental health problems or cultural and religious backgrounds, incapable of being used in several contexts or self-administrated without control of the acquired knowledge. However, the number of articles about the topic has been increasing, especially since 2015. This increment might be related to the exponential increase of forcibly displaced people since 2015, the highest since World War II⁽⁵²⁾. Altogether these situations led to a forced exodus of populations to neighbouring countries.

The investment in mental health training of community workers or volunteers and staff with no background in the health

domain is aligned with the principle that non-specialists can help to increase access and effectively provide mental health interventions in low-resource communities⁽⁵³⁾. As shown, all the included studies in this review aimed to guide the volunteers on how to provide humane, supportive, and practical help to adults and children AS&R experiencing crisis events. Most of the articles are designed for lay providers regarding their educational backgrounds. Two articles are specific for teachers, one is a handbook to guide American teachers to deal with Vietnamese refugee children⁽³³⁾, and another one is a self-guided teacher training intervention designed to reduce and prevent teachers' use of corporal punishment in the refugee camps' classrooms in Tanzania⁽⁴⁴⁾. The manuals of WHO^(35,37), IFRC^(36,38), and UNHCR⁽⁴¹⁾ are designed for field workers, i.e., people who support others during or immediately after extremely stressful events. The remaining studies published in the

scientific databases focused mainly on training people with refugee^(34,39,40,42,43,47) or asylum seekers' backgrounds⁽³⁴⁾, NGO volunteers, and professionals working in the incoming countries^(43,44,46). Although lacking specifications regarding the educational background, some of the studies indicated that participants should preferably be psychologists, social workers, teachers, nurses, leaders, volunteers' managers, or workers in related fields.

Regarding the domains included, the WHO^(35,37), IFRC^(36,38), and UNHCR⁽⁴¹⁾ manuals focused essentially on PFA^(35,37) and MHPSS⁽⁴¹⁾ to help people in crises and psychosocial support for volunteers approaching resilience, risks, and self-care^(36,38). The articles from the databases focused mainly on common mental health disorders^(42,43) such as trauma^(34,40,45,46,48), stress, mourning, feelings of guilt, somatic complaints, identity and acculturation⁽³⁴⁾, depression^(34,39,40), psychosis, eating disorders, substance use disorders^(38,40), self-injury, and suicidal behaviours^(39,40,45). The PM+, which is an individual psychological help for adults developed by the WHO, was modified to be an evidence-based psychosocial intervention delivered by lay staff to help AS&R with basic counselling skills, delivery of intervention strategies and self-care^(43,47). All articles and documents included in this review broadly agree that psychological support can be facilitated by lay people for vulnerable populations, such as AR&R, which in most cases can be people with previous asylum experience or people with high interest and willingness to help these populations. However, due to the cultural background of each population, they all agree that any programs that are considered a model need to be adapted appropriately to the local context and the culture of the people who will be assisted by volunteers. Although most lay facilitation programs address similar domains, the time devoted to training is quite diverse. Lay-facilitators' programs duration was found to last eight hours in a single day⁽³⁹⁾, to a two-day training of 15h⁽⁴⁵⁾, six-sessions of two hours⁽⁴⁶⁾, four-session of 12-hours⁽⁴⁰⁾, five weekly face-to-face sessions of 90 minutes⁽⁴²⁾, 10 sessions of four hours each, including internship⁽³⁴⁾, three-day training⁽³⁸⁾, and seven weeks without specification of hours⁽⁴⁸⁾.

The current findings may be important for health authorities, policymakers, and other stakeholders planning to provide mental health training to NGO volunteers and staff in the incoming countries or even in humanitarian settings. In particular, for people preparing others to work in humanitarian settings, which is increasing worldwide due to forced migrations, the use of lay mental health providers could be a valuable, first-tier psychological support service for people in underserved communities such as AS&R.

The heterogeneity of the interventions used in the included studies is both a strength and a weakness. On the one hand, the diversity in the type and length of training shows both the investment that is being made to respond to emerging local needs and a concern to train the volunteers and the staff of community helpers under supervision to make the provision of support to a greater number of people in need possible. On the other hand, this diversity challenges the results' interpretation regarding the training programs and their comparison. In some of the studies, the training is self-guided by manuals or handbooks with no facilitator, which could lead to a

misunderstanding of contents. Other studies did not describe the supervision conditions as part of or after the training.

Further research is needed on mental health training of non-health professionals and volunteers that are in places where mental health needs outrun professional resources (e.g., refugee camps, shelters, and reception centers), whether in humanitarian crisis contexts or the reception of refugees in host countries. Furthermore, research should explore the psychological impact of becoming a lay facilitator and the influence of the mental health training programs on their well-being and the well-being of the AS&R they assist. This is especially important in the case of interventions recruiting members from the same community that has been exposed to similar experiences. In addition, it would be interesting to evaluate the impact of mental health training programs on the relationships between staff or volunteers and AS&R and the acculturation process.

Regarding the limitations of the study, some articles or documents did not provide a satisfactory description of the intervention or the participants' characteristics. Furthermore, data about settings, hours, strategies of training sessions, and the kind of participants' supervision during or after the training was also absent. Additionally, the studies included did not specifically address work with AS&R; they were rather included as they presented training to work in the humanitarian field or crisis situations by using examples of scenarios with displaced people.

Although the programs in mental health competencies for non-health professionals or volunteers to work with AS&R are scarce, we identified eleven training programs or interventions with this purpose, some of them being self-guided sources of training. Even though lay people have a promising role to play in assisting the AS&R and referring them to specialized care, the number of mental health training programs to train the volunteers is insufficient. In addition, the fact that working with AS&R is often voluntary work means that prior training is not required, and this could be the reason why greater and better investment is not made in training those who take care of the AS&R. This review demonstrates the need to invest in the development and implementation of mental health training programs in which nurses can play a vital role. As the ICN highlights, nurses are the key to caring for migrant populations²⁷. Nursing care is indispensable for the easement of human distress and for the promotion of comfort and coping. Nurses also have an essential role in advocating for policies that will enhance AS&R's access to health and mental health care and address barriers irrespective of AS&R status. By becoming aware of the existing challenges regarding access to mental health professionals and care, nurses' intervention, support, and training of those caring for AS&R can help in different ways. In mental health training of non-health professionals and volunteers working with AS&R, mental health nurses, as qualified mental health educators, stand out for their ability to develop, coordinate, and implement mental health training programs which are activities aligned with the mental health and psychiatric field of nursing⁽²⁵⁾. Mental health training provided by mental health and psychiatric nurses encourages the empowerment of the non-health professionals and volunteers to deal with the AS&R's overwhelming life transitions; enhances the ability to refer people who need specialized mental health care; makes possible earlier care for

those who have the luck of having someone trained who can help and recognized their needs; and promotes the non-health professionals and volunteers' self-mental health care.

CONCLUSION

Sixteen articles aboard eleven training programs to promote mental health competencies training: Mind-Spring, PM+, MHFA, Cognitive-Behavioral Training for Community and Religious Leaders, EmpaTeach, Suicide Prevention Education Program, Teaching Recovery Techniques, Handbook for Teachers of Vietnamese Refugee Students, PFA, Psychosocial support of Volunteers and CBP&MHPSS.

Training programs from scientific literature focus mainly on mental health disorders, while non-governmental organizations' documents focus on resilience and self-care. The eleven training programs included in this review might not be sufficient to meet the training needs of non-health professionals and volunteers

working with AS&R. It is important to highlight that some studies are focused on specific cultural backgrounds or religious beliefs or based on the capacity of self-education of each person, which can contribute to lack of training to work in several countries, and to misinterpretation of the training concept as information available in the self-guided manuals. NGO volunteers and professionals with no educational background in the health domain need comprehensive training to deal with others' mental health suffering without jeopardizing their mental health. This implies recognizing signs and symptoms of mental health problems that allow them to refer people to specialized care, understand how cultural background influences the suffering manifestations, and acquire strategies to take better care of themselves.

To fill this gap, mental health nurses should be on the front line to help people improve their mental health competencies to work with AS&R attending their cultural backgrounds.

RESUMO

Objetivo: Identificar e descrever os programas de treino em saúde mental para profissionais, que não de saúde, e voluntários que trabalham, trabalharam ou gostariam de trabalhar com requerentes de asilo e/ou refugiados. **Método:** Revisão de escopo seguindo a metodologia JBI. Pesquisa realizada na MEDLINE, CINAHL, ERIC, SCOPUS, PsycINFO, Psychology & Behavioral Sciences Collection, RCAAP, ProQuest e sites do ClinicalTrials, ACNUR, Organização Internacional para as Migrações, OMS, Save the Children, Migração Internacional, Integração e Coesão Social na Europa e Federação Internacional das Sociedades da Cruz Vermelha e do Crescente Vermelho. Estudos escritos em inglês, português, francês, espanhol e sueco. **Resultados:** Dos 8.954 artigos identificados, 16 foram incluídos relatando 11 programas de treinamento: Mind-Spring, PM+, MHFA, Treinamento Cognitivo-Comportamental para Líderes Comunitários e Religiosos, EmpaTeach, Programa de Educação para Prevenção do Suicídio, Técnicas de Recuperação de Ensino, Manual para Professores de Estudantes refugiados vietnamitas, PFA, apoio psicossocial de voluntários e CBP&MHPSS. **Conclusão:** Os programas de treino na literatura científica focam nos transtornos de saúde mental, enquanto os documentos das organizações não governamentais focam na resiliência e no autocuidado. Os atuais programas de treino em saúde mental podem ser insuficientes.

DESCRIPTORIOS

Refugiados; Saúde mental; Educação; Enfermagem.

RESUMEN

Objetivo: Identificar y describir los programas de formación en salud mental para profesionales no sanitarios y voluntarios que trabajan, han trabajado o gustaría de trabajar con solicitantes de asilo y/o refugiados. **Método:** Revisión de alcance según la metodología JBI. Búsqueda realizada en MEDLINE, CINAHL, ERIC, SCOPUS, PsycINFO, Psychology & Behavioral Sciences Collection, RCAAP, ProQuest, y sitios web de ClinicalTrials, ACNUR, Organización Internacional para las Migraciones, OMS, Save the Children, Migración Internacional, Integración y Cohesión Social en Europa, y Federación Internacional de Sociedades de la Cruz Roja y de la Media Luna Roja. Estudios escritos en inglés, portugués, francés, español y sueco. **Resultados:** De los 8954 artículos identificados, se incluyeron 16 que informan sobre 11 programas de capacitación: Mind-Spring, PM+, MHFA, Capacitación cognitiva conductual para líderes comunitarios y religiosos, Empa Teach, Programa de educación para la prevención del suicidio, Enseñanza de técnicas de recuperación, Manual para maestros de Estudiantes refugiados vietnamitas, PFA, apoyo psicossocial de voluntarios y CBP&MHPSS. **Conclusión:** Los programas de formación en la literatura científica se centran en los trastornos de salud mental, mientras que los documentos de las organizaciones no gubernamentales se centran en la resiliencia y el autocuidado. Los actuales programas de formación en salud mental pueden ser insuficientes.

DESCRIPTORIOS

Refugiados; Salud mental; Educación; Enfermería.

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ARTIGO 3

Teixeira-Santos L, Bobrowicz-Campos E, Sousa B, Abreu W. Empowering volunteers to work with asylum seekers and refugees: conceptual and psychometric considerations of new inventory assessing training needs. *Journal of Immigrant and Minority Health* (submetido), 2024.

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Empowering volunteers to work with asylum seekers and refugees: conceptual and psychometric considerations of new inventory assessing training needs.

Abstract

The number of people displaced worldwide increases every day. Most of the in-the-field helpers are people with lack of training to work with asylum seekers and refugees. We present an observational cross-sectional study with the conceptual framework and the psychometric properties of an inventory consisting of four questionnaires focusing on organizational management, cultural ability, communication and health-related needs to determine the volunteer's perception about the needs of training to work with asylum seekers and refugees. Ninety-one 91 worldwide non-health professionals and volunteers with interest in working with asylum seekers and refugees participated in the study. The inventory-pool of items was developed based on the literature review and validated by a committee of experts. The items were distributed by four questionnaires, according to the conceptual frameworks. To evaluate these questionnaires' reliability and construct validity, Cronbach's and exploratory factor analyses were conducted. From the factor extraction using principal component analysis and direct oblimin rotation eight-component structure of the inventory were revealed. The Organisational Management domain included components of Accountability & Management, Learning Share, and Team Collaboration. The Cultural Ability domain comprised components of Knowledge & Awareness and Encounter & Engagement. The Communication domain showed to be unidimensional. The Health domain included Physical Health and Mental Health components. The Cronbach's alpha values, calculated for each component, ranged from 0.85 to 0.94. Our findings show that the questionnaires are easy-to-use for assessing the perception of the training needs of people working with asylum seekers and refugees and have adequate validity and reliability.

Keywords: asylum seeker; refugee; volunteer; outcomes assessment; training; psychometrics.

1. Introduction

In 2023, more than 108 million individuals worldwide were forcibly displaced due to wars, poverty, climate change, and human rights violations¹. To guarantee the safety, protection and assure access to the basic needs of asylum seekers and refugees (AS&R), the United Nations High Commissioner for Refugees (UNHCR) works together with different governmental and non-governmental organisations (NGOs)². The non-professionals NGOs are mainly composed by diversified civil society members without specific educational or training backgrounds to work with AS&R³. Unlike paid staff, volunteers receive limited training and possess no disciplinary knowledge even their work have huge social impact⁴. Untrained and inexperienced people working with AS&R are more vulnerable to mental health problems⁵⁻⁷.

The few training programs available are dispersed mostly in NGOs websites and based on the workforce' front-line experience⁸. Although non-health professionals and volunteers (NHPV) are the majority of NGOs members, the scientific literature reveals a lack of information about their trainings to work with AS&R. A recent scoping review, aiming to map the mental health training programs for NHPV to work with AS&R, showed that the few interventions existed focused on a specific mental health problem, are self-delivered, sometimes based on religious or cultural backgrounds, and always standard, which makes difficult to use them in contexts for which they were not designed. Most programs not even reveal the category of professionals who deliver the trainings or the instruments for evaluating the knowledge learned^{8,9}. This shows the necessity to develop more inclusive programs, capable of being used and adapted to different contexts where people are working with AS&R.

Health professional, such nurses, are the key to care for AS&R^{10,11} but they can't address all the worldwide people in need. Nonetheless, it's not impossible to be the workforce on the training of people who daily help AS&R during their overwhelming life transitions. To do so it's crucial to consult NHPV working (or considering) with AS&R to understand what competencies they consider important to develop to do their daily work and how health professionals can help them. With this in mind, we present an observational cross-sectional study with the conceptual framework and the psychometric properties of an inventory focused in major competencies (organizational management, cultural ability, communication and health) to work with AS&R and provide the first exploratory analyses of its psychometric characteristics.

2. Methods

2.1. Conceptual considerations in developing an inventory item-pool to assess training needs for people engaged with AS&R

An initial inventory pool of 49-items to assess the training needs of people working with AS&R was developed based on literature about theoretical models as UNHCR competency framework^{12,13}, Campinha-Bacote's model of cultural competence¹⁴ and Giger and Davidhizar Transcultural Assessment Model¹⁵ as we recognize the importance of aligning practical skills with cultural competences to effectively operate in multicultural contexts. Each of the 49 items in the inventory represents a potential essential training need for individuals working with AS&R, focusing on four major domains. The item-related

domains were categorized into 4 distinct questionnaires, each meticulously crafted to address *Organizational Management*, *Cultural Abilities*, *Communication*, and *Health* skills separately.

The UNHCR Competency Framework¹² reflects a set of competency domains to work effectively in humanitarian contexts as a basic staff member. The domains are communication, teamwork, planning and organizing, accountability, creativity, client orientation, commitment to continuous learning and technological awareness. They reflect the management of resources to improve peoples' lives, working collaboratively and effectively with people irrespectively their linguistic, cultural, religious background, using all types of communication to work, learn and share experience and knowledge^{12,13}. This framework domains were used to develop the 16 items included in the *Organizational Management Questionnaire*.

The UNHCR Competency Framework was also used to develop the 8 items-related to the communication domain into the *Communication Questionnaire*. Effective communication with AS&R is one of the most used skills in (in)formal daily interactions¹⁶. As communication include facial expressions, behaviours, gestures and conversation¹⁷, and it can be affected by the interlocutors' cultural skills, the items' questionnaire also welcomed contributions from Campinha-Bacote¹⁴ and Giger and Davidhizar¹⁵ models. According to UNHCR framework cultural skills are key factors to develop other necessary skills to work with AS&R^{12,13}.

To formulate the items pertaining to cultural proficiency, leading to the creation of the 16-item *Cultural Ability Questionnaire*, we referenced two globally renowned models for navigating interactions with individuals from diverse cultural backgrounds: the Campinha-Bacote¹⁴, and the Giger and Davidhizar¹⁵ models. These two models are widely used in the nursing field, but also by several other health and human services¹⁸, as health and social providers can have different educational backgrounds. The Campinha-Bacote model¹⁴ highlights cultural awareness, knowledge, skill, encounter, and competency, and has been widely applied as a guide in empirical research, development of educational interventions, and framework for cultural competence education programs and outlines the process of how care providers can become more culturally competent¹⁹. Meanwhile, Giger and Davidhizar¹⁵ allows users assist others according to their cultural characteristics taking into consideration the six cultural phenomena evident in all cultural groups (environment, time, communication, social organization, space, and biological variations).

In the health domain, we carefully assembled a 9-items *Health questionnaire*, each thoughtfully crafted to delve into physical and mental health dimensions. To understand health and disease behaviours, the NHPV should be culturally competent, meaning it should possess the ability to grasp health statuses and behaviors taking into consideration the domains highlighted on the Transcultural Assessment Model¹⁵, as it is a tool developed to assess the peoples' cultural values about health and disease behaviours and their effects¹⁵. Just considering the cultural elements^{20,21} the NHPV are capable to daily assess the AS&R needs.

The questionnaires underwent a rigorous validation process utilizing a content validation strategy, which involved assessing their relevance, clarity, simplicity, and ambiguity trough a scale of agreement. This evaluation was conducted by a panel of judges consisting of five ONG professionals proficient in English, each holding either specialist or master's degrees, and possessing empirical knowledge in humanitarian contexts. Importantly, these professionals hailed from diverse hierarchical positions within ONGs and were from different countries, ensuring a broad range of perspectives. Despite their diverse

backgrounds, they collectively showcased a strong consensus regarding the items in each questionnaire. This is especially noteworthy considering that the questionnaires, while presented in English, are intended to evaluate the training needs of NHPV working with AS&R, regardless of their nationality, as long as they are proficient in English. Due to this consensus among the expert panel, there was no need to remove or add new items to the questionnaires. These professionals hailed from diverse hierarchical positions within NGOs and had extensive experience working with AS&R²². Remarkably, due to the high level of agreement among the expert panel, there was no need to remove or add new items to the questionnaires. This underscores the robustness of the developed questionnaires, ensuring their suitability for accurately assessing the needs of people working with AS&R populations in each domain.

2.2. Validation of the inventory item-pool to assess needs of training for people working with AS&R

The validation process to assess training needs for individuals working with AS&R in the aforementioned domains involves a policy of engaging citizens from civil society, including those with a particular interest in AS&R work. In this regard, this study, conducted as part of the APT4U2 project, has received favorable approval from the Ethics Committee of the Health Sciences Research Unit: Nursing (Opinion no. 0 P742 12/2020). This committee ensured that the project adheres to ethical standards and appropriate regulations. Additionally, each participant involved in the study provided informed consent before their participation.

2.2.1. Sample selection

To continue the validation process globally, volunteers worldwide were invited to participate in this study, adhering to specific criteria: being a NHPV, aged 18 years or older, and having prior experience or currently working, or intending to work with AS&R. Participants with health or mental health educational backgrounds were excluded²³. The sample size was estimated using the following equation $N = 5 \times \text{number of items}^{24}$.

2.2.2. Data collection and procedures

The recruitment process was carried out between April-June 2022, in collaboration with NGOs contacted through email and social networks. The invitations with the eligibility criteria and a link to the online survey were posted in nine social media of NHPV' groups. The online survey (Google Forms) was composed by two parts, sociodemographic characteristics, training, and work experiences with AS&R (Table 1), and the preliminary version of the inventory developed, separated in the four explained questionnaires. The inventory items were rated on a 5-point scale for the importance of being included in the training for NHPV working with AS&R. The response options varied from "not at all important to include" (one-point answer) to "very important to include" (five-point answer).

Table 1

Sociodemographic characteristics included in the Inventory.

I) General characteristics	
Sex	1. Feminine 2. Masculine

Age	_____ years
Country	
Marital status	<ol style="list-style-type: none"> 1. Single 2. Married 3. Separated 4. Divorced 5. Widowed 6. Other
Years of Education	_____ years
Profession	
Occupation	<ol style="list-style-type: none"> 1. Student 2. Unemployed 3. Employed part-time 4. Employed full-time
II) My working experience with asylum seekers	
1. Have you worked, are you working or are you going to work with asylum seekers?	<ol style="list-style-type: none"> 1. Yes, I have worked with asylum seekers 2. Yes, I work with asylum seekers 3. Yes, I will work with asylum seekers in the future 4. I would enjoy working with asylum seekers
2. Please identify if it was, or will be like:	<ol style="list-style-type: none"> 1. Volunteer in an organization 2. Worker of an organization 3. Freelancer (not affiliated with an organization) 4. Not defined net
3. If you have worked with asylum seekers, identify the period of time (total time of your experience).	<ol style="list-style-type: none"> 1. ≤ 3 months 2. 4-6 months 3. 7-9 months 4. 10-12 months 5. ≥ 13 months 6. Not applicable
4. If you have not worked with asylum seekers yet, but would like to do so, identify for how long.	<ol style="list-style-type: none"> 1. ≤ 3 months 2. 4-6 months 3. 7-9 months 4. 10-12 months 5. ≥ 13 months 6. Not applicable
5. Through which organization have you worked, work or would you like to work with asylum seekers? (Please specify).	<ol style="list-style-type: none"> 1. Non-governmental organization 2. Government Organization 3. Freelance (Not a ffiliation with an organization) 4. Other 5. Not defined yet
6. In which country have you worked, or will you work with asylum seekers? (Please specify. If more than one country, separate by commas).	_____
7. In what settings did you work? (You can select one or more options)	<ol style="list-style-type: none"> 1. Refugee Camp 2. Reception Center 3. Shelter for Asylum Seekers 4. Facilities of Non-Governmental Organizations 5. Government facilities (e.g., city councils, municipal cultural and recreational centers) 6. Other

	7. Not defined yet
8. What kind of work have you done, will you do or would you like to do with asylum seekers? (You can select one or more options)	<ol style="list-style-type: none"> 1. Formal educational activities 2. Informal learning activities 3. Distribution of food and/or materials 4. Organizational Logistics Activities 5. Translation activities 6. Others
9. Have you ever received any training to work with asylum seekers? (If no, please skip to question 17.)	<ol style="list-style-type: none"> 1. Yes 2. No
10. You received this training:	<ol style="list-style-type: none"> 1. Before starting work with asylum seekers 2. While working with asylum seekers 3. After working with asylum seekers
11. Which entity is responsible for your training?	_____
12. In which language was the training carried out?	_____
13. Who were the trainers?	<ol style="list-style-type: none"> 1. NGO professionals/volunteers 2. Health professionals 3. Education professionals 4. Multidisciplinary Team 5. Other
14. Where did you receive this training?	<ol style="list-style-type: none"> 1. In my country 2. In the country of the humanitarian mission / Project development 3. Other
15. Where did you receive this training?	<ol style="list-style-type: none"> 1. Facilities of the NGO where I am a volunteer/professional 2. In another NGO that provides training to volunteers or professionals 3. Government facilities (e.g., town halls, cultural and recreational centers) 4. Refugee camps 5. Reception Center for Asylum Seekers 6. Shelter for Asylum Seekers 7. Online 8. Other
16. a) Regarding the training obtained, please indicate the number of hours (h): b) Regarding the training obtained, please indicate the topics covered:	<p>_____</p> <p>_____</p>
17. To what extent do you agree with the following sentence: "Professionals and volunteers who work with asylum seekers should be trained to perform their role":	<ol style="list-style-type: none"> 1. I totally disagree 2. I partially disagree 3. I neither disagree nor agree 4. I partially agree 5. I absolutely agree
18. In your opinion, what is the most important reason for training volunteers and professionals who work with asylum seekers:	<ol style="list-style-type: none"> 1. Clarify about forced migration issues and their consequences on asylum seekers 2. Increase knowledge about the contextual and legal conditions in which asylum seekers live 3. Increase knowledge about ways to help asylum seekers

	4. Increase knowledge about strategies to help asylum seekers and volunteers themselves to 5. deal with stressful situations 6. Other
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2.2.3. Data Analysis

Exploratory factorial analysis (EFA) using principal component analysis (PCA) and direct oblimin rotation with Kaiser normalisation method was performed to reduce in an interpretable way the dimensionality of each of the four questionnaires²⁵. The choice of the rotation method was based on the theoretical assumption pointing to the possible existence of correlations between the factors²⁶.

To assess the suitability of data for PCA, we first used the Kaiser–Meyer–Olkin (KMO) measure, considering as mandatory to obtain values greater than 0.5. We also used Bartlett's test of sphericity, expecting to obtain significant results. Posteriorly, the inter-item correlation matrix and the anti-image matrices of covariance and correlation were examined²⁷. Based on the guidelines defined by Young and Pearce (2013), it was established that the suitability of data for PCA will be indicated by the presence of a large number of inter-item correlations with coefficient $> +/- 0.3$ (to warrant that there is a patterned relationship amongst the variables under study) and $< +/- 0.9$ (to warrant that the data don't have a multicollinearity problem). In the case of the anti-image correlation matrix, the cut-off point for the diagonal value, representing a measure of sampling adequacy, was set at 0.5. As for the anti-image covariance matrix, it was expected that the values under the diagonal would be as close as possible to zero²⁸. The retention of components considered the eigenvalues > 1 , in line with the scree plots and the percentage of the total variance explained. The average extracted communalities were also consulted.

To estimate internal consistency of each questionnaire and each component, the Cronbach's alpha coefficient was calculated. The statistical treatment of data also included comparative analyses which, due to non-normal distribution of data, were performed based on the Mann–Whitney test. The effect size was estimated according to the following formula: $r = Z / \sqrt{N}$ ²⁹. For the covariance analysis, non-parametric ANCOVA was used. The effect of covariate on the dependent variable was determined based on statistic F, calculated according to the Quade Method that involves testing the equality of the residuals between groups obtained through linear regression of the ranked dependent variable on the ranked covariate. Finally, Spearman correlations were used to examine the magnitude of associations between continuous variables.

Statistical analyses were performed using IBM SPSS Statistics software (version 25, IBM SPSS, New York). Probability levels of 0.05 were considered significant.

3. Results

3.1. Sample' study

Ninety-four participants showed interest to participate in the study and 91 met the eligibility criteria. The final sample included 62 females and 29 males from 6 continents and 35 countries, with an average age of 41.53 years (± 13.66 ; 20-73) and an average education level of 14.46 years (± 3.69 ; 3-17). More information about the sample can be found in another study²³.

3.2. Inventory to assess needs of training for people working with AS&R

The literature review enabled the selection of 49 initial pool of items, maintained by the pool of judges, and they were distributed into four questionnaires: 16-item *Organisational Management* (table 2); 16-item *Cultural Ability* (table 3); 8-item *Communication* (table 4); and 9-item *Health* (table 5). As explained in Section 2.2.2, the NHPV reviewed each item and assigned a rating from 1 to 5 based on its perceived importance for inclusion in the training for NHPV working with AS&R. Response options ranged from 'not at all important to include' (assigned one point) to 'very important to include' (assigned five points).

Table 2

Organisational Management Questionnaire

1. Mission, values and priorities of action of the Organization that I belong to
2. Different dimensions of the Organization's work with asylum seekers
3. Plan of action and planned tasks of the Organization in working with asylum seekers
4. Different governmental and non-governmental organizations' areas of intervention and support which are working in the context where I will work with asylum seekers
5. Creating and managing collaborative partnerships with other organizations
6. Skills to work in a team
7. Complementary training while working with asylum seekers
8. Dissemination of the Organization's work, its partnerships, goals, and results
9. Plan for integrating new volunteers and/or professionals into my organization
10. Legal status of asylum seekers (rights, duties, forms of applying for asylum)
11. Logistics for reception, registration, accommodation of asylum seekers in refugee camps, shelters, reception centers
12. Factors that can help or hinder integration in the host countries
13. Effective strategies to fulfil the objectives of the Organization I work for
14. Management of priorities for intervention with asylum seekers
15. Construction and adaptation of action plans taking into account the real needs of field immersions with the resources available
16. Boundaries between being a professional, a volunteer and a friend

Table 3

Cultural Abilities Questionnaire

1. Cultural characteristics of asylum seekers (culture, beliefs, values)
2. Religious and spiritual characteristics of asylum seekers
3. Asylum seekers' life transitions (Living in the origin society, Decisions to leave the origin country, relocation process, cultural shock)
4. Family relationships (hierarchy and responsibilities within the family)
5. Factors that may help or hinder the asylum seekers' integration into reception places (religious or spiritual practices, sense of belonging, environment, expectations, etc.)
6. Personal characteristics (qualities or preconceptions) that may influence my relationship with asylum seekers
7. Characteristics (qualities or preconceptions) that may influence the relationship between asylum seekers with different cultural, social, linguistic and religious characteristics

8. Cultural values and practices that may be related to the emerging needs (Professor, community, health...) of asylum seekers
9. Conditions for the cultural encounter between myself and asylum seekers
10. Cultural elements that influence the cultural encounter
11. Factors that promote interpersonal relationships with asylum seekers
12. Factors that promote cultural encounters between asylum seekers who live in the same community
13. Strategies to facilitate the desire to engage with asylum seekers
14. Strategies to facilitate the desire to meet asylum seekers of different nationalities, cultures and/or religions.
15. Strategies to spread openness to asylum seekers in society
16. Interpersonal, communicational, cultural, and relational characteristics that make me able to work with asylum seekers

Table 4

Communication Questionnaire

1. Predominant language at the location
2. Other identified languages
3. Asylum seekers' language proficiency
4. Communication with asylum seekers (verbal and non-verbal)
5. Basic principles in cross-cultural communication: how to approach the individual, family, community, etc.)
6. Factors that affect communication (contextual, cultural, religious)
7. Silence Management
8. Strategies to communicate in the event of a disability.

Table 5

Health Questionnaire

1. Physical needs manifested by the asylum seekers
2. First aid basics
3. Referral to local healthcare (organizations providing local healthcare)
4. Mental health strategies to maintain my own well-being
5. Basic mental health training to understand attitudes, behaviors, manifestations of suffering, sadness, self-esteem (...) of asylum seekers
6. Main psychiatric disorders present in asylum seekers
7. Health beliefs and care systems in the origin country
8. Referral of asylum seekers to mental health care or organizations, governmental or non-governmental, providing such care
9. Basic mental health principles to provide psychosocial support to asylum seekers during their stay in refugee camps, shelters, reception centers

3.3. Sustainability of Principal Component Analysis

The KMO confirmed the suitability of data for PCA, showing to be very good (> 0.9) for the *Organizational Management Questionnaire* and good (> 0.8 and ≤ 0.9) for the *Communication, Cultural Ability, and Health* questionnaires. The Bartlett's test of sphericity, performed separately for each

questionnaire, was significant (Table 6). In all questionnaires, the items significantly correlated with each other and, in most cases, the correlation coefficients were in the range between 0.3 and 0.9. The exceptions were found in the *Organizational Management* questionnaire for item 1 and item 5 ($r = 0.256$), item 5 and item 16 ($r = 0.295$), and item 2 and item 16 ($r = 0.299$), and in the *Cultural Ability* questionnaire for item 9 and item 10 ($r = 0.921$). The suitability of data for PCA was further supported by the values of the diagonals of the anti-image correlation matrices, which largely exceeded the limit of 0.5, and the values under the diagonals of the anti-image covariance matrices, which, in most cases, had zero to, at least, the first decimal place. Regarding this last criterion, the *Organizational Management Questionnaire* presents 7.5% of matrix elements that did not have zero in the first decimal place. In the *Communication* and the *Cultural Ability Questionnaires*, these percentages reached the values of 11 and 5, respectively. The *Health Questionnaire* showed the highest number of elements that did not have zero in the first decimal place (17%), even so, the overall results were satisfactory. Consequently, it was decided that no items should be removed prior to analysis.

Table 6

Criteria confirming the sustainability of Principal Component Analysis.

	Organizational Management Questionnaire	Communication Questionnaire	Cultural Abilities Questionnaire	Health Questionnaire
KMO statistics	0.906	0.879	0.885	0.817
Bartlett's test of sphericity				
- X ² approximation	994.432	568.760	1382.975	685.816
- significance level	< 0.001	< 0.001	< 0.001	< 0.001
- degree of freedom	120	28	120	36
Inter-item correlations range	0.256 – 0.795	0.494 – 0.857	0.343 – 0.921	0.360-0.894
Anti-image correlations range*	0.843 – 0.954	0.840 – 0.936	0.811 – 0.956	0.744 – 0.906
Anti-image covariance range**	-0.173 – 0.082	-0.186 – 0.067	-0.136 – 0.084	-0.176 – 0.064

* Values of the diagonals

** Values under the diagonals

3.4. The latent correlational structure and internal consistency

The results of PCA and direct oblimin rotation, correlation study and internal consistency analysis are described separately for each questionnaire.

Organizational Management Questionnaire. Based on Kaiser's criteria, three components were retained, accounting for 67.83% of the variance. The first component showed eigenvalue of 8.52 and explained 53.27% of the variance, the second component showed eigenvalue of 1.24 and explained 7.75% of the variance, the third component showed eigenvalue of 1.09 and explained 6.81% of the variance. An absolute value of 0.3, recommended as the cut-off value for factor loading³⁰ was obtained in all 16 items (Table 7). The item numbered 7 is shared by component 1 (loading of 0.494) and component 3 (loading of -0.574). Considering the higher loading, it was decided to include item 7 in component 3.

The observed commonalities within the data varied from 0.523 to 0.752, demonstrating that the retained components are appropriate to describe the latent correlational structure between the questionnaire items.

In the next phase, the correlation study for the scores of each of the three components and the overall score of the questionnaire was performed. The coefficients obtained were 0.905 for the first component, 0.805 for the second component and 0.922 for the third component. The correlation study for the scores obtained in the three components of the questionnaire was also carried out. All correlations showed to be positive and of moderate (Team Collaboration x Accountability & Management =0.674; Accountability & Management x Learning Share =0.620) to strong (Team Collaboration x Learning Share =0.747) magnitude.

Finally, the internal consistency of the questionnaire and the questionnaire components was assessed using Cronbach's alpha statistics. Regarding the total questionnaire, the Cronbach's alpha value was 0.941 and the item-total correlations varied from 0.597 (item 1) to 0.819 (item 14). All these correlations were significant ($p < 0.01$) and had moderate (items 1, 3, 5, 6, 10, 11, 16) to strong (items 2, 4, 7, 8, 9, 12, 13, 14, 15) magnitudes. The three questionnaire components also showed to have good internal consistency (Team Collaboration =0.874; Accountability & Management = 0.850; Learning Share component =0.900), with all item-total correlations (calculated for each component) having strong magnitudes (for more details, see Table 7).

Table 7

Characteristics of the correlational structure of Organizational Management Questionnaire, obtained based on the principal component method and direct oblimin rotation.

Components	Items	Loadings	Communalities	Variance explained	Cronbach's alpha	Item-component correlations
Component 1 (Team Collaboration)	Item 6	0.653	0.523	53.27%	0.874	0.727
	Item 10	0.800	0.708			0.802
	Item 11	0.813	0.721			0.754
	Item 12	0.733	0.653			0.816
	Item 15	0.375	0.605			0.776
	Item 16	0.721	0.534			0.713
Component 2 (Accountability & Management)	Item 1	0.830	0.743	7.75%	0.850	0.860
	Item 2	0.804	0.752			0.827
	Item 3	0.675	0.718			0.842
	Item 13	0.428	0.605			0.771

Component 3	Item 4	-0.647	0.728	6.81%	0.900	0.787
(Learning	Item 5	-0.859	0.701			0.789
Share)	Item 7*	-0.574	0.749			0.807
	Item 8	-0.707	0.700			0.825
	Item 9	-0.654	0.721			0.828
	Item 14	-0.495	0.692			0.796

Rotation converged in 11 iterations

* item with loadings in component 1 nnt 3

Cultural Ability Questionnaire. Following Kaiser's criteria, two components were retained. The first component showed eigenvalue of 9.46, accounting for 59.12% of the variance. The second component showed eigenvalue of 1.46, accounting for 9.13% of the variance. The total variance explained by two components was of 68.25%. The components loadings ranged from 0.435 to 0.986, showing that all items should be kept. As for the observed commonalities, they ranged from 0.492 to 0.839, proving that the latent correlational structure between the questionnaire items is appropriately described by two retained components (Table 8).

The correlation study of the different scores identified the presence of significant associations with strong and very strong magnitudes. The correlation coefficients were 0.958 for the scores of the first component and the total questionnaire, 0.939 for the scores of the second component and the total questionnaire, and 0.816 for the scores obtained in two components.

The internal consistency proved to be very good both for the total questionnaire (0.953) and for the two components (Encounter & Engagement = 0.942; Knowledge & Awareness = 0.911). The item-total correlations, calculated for the total questionnaire, varied from 0.691 (item 2) to 0.871 (item 9). All correlations were significant ($p < 0.01$) and all, except for one (item 2), were of strong magnitude. As for the item-total correlations, calculated for each component, they varied from 0.739 (item 16) to 0.915 (item 9) and were of strong and very strong magnitude (for more details see Table 8). All of them were significant ($p < 0.01$). The internal consistency of the questionnaire was not affected by deleting the items, confirming that all items should be maintained.

Table 8

Characteristics of the correlational structure of Cultural Abilities Questionnaire, obtained based on the principal component method and direct oblimin rotation.

Components	Items	Loadings	Communalities	Variance explained	Cronbach's alpha	Item-component correlations
Component 1	Item 5	0.548	0.690	59.12%	0.942	0.824
(Encounter & Engagement)	Item 7	0.736	0.658			0.848
	Item 8	0.655	0.627			0.822
	Item 9	0.986	0.837			0.915
	Item 10	0.967	0.839			0.912
	Item 11	0.925	0.785			0.837
	Item 12	0.839	0.729			0.866
	Item 13	0.570	0.632			0.748

Component 2	Item 1	0.889	0.798	9.13%	0.911	0.851
(Knowledge &	Item 2	0.904	0.679			0.779
Awareness)	Item 3	0.885	0.728			0.858
	Item 4	0.762	0.631			0.774
	Item 6	0.435	0.492			0.748
	Item 14	0.540	0.643			0.778
	Item 15	0.505	0.650			0.779
	Item 16	0.539	0.500			0.739

Rotation converged in 9 iterations

Communication Questionnaire. The use of Kaiser's criteria allowed for retention of one component, with eigenvalue of 5.40, that accounted for 67.49% of the variance. The component loadings varied from 0.749 to 0.894, and the observed commonalities from 0.561 to 0.799 (Table 9), showing that the choice of items included in the questionnaire was adequate and that it is appropriate to consider this questionnaire as unidimensional.

The internal consistency of this questionnaire proved to be very good (0.930), and all item-total correlations were significant ($p < 0.01$) and of strong magnitude (Table 9). The analysis of Cronbach's alpha values if item deleted confirmed that all items should be maintained, as removing any one of them did not improve the internal consistency of the questionnaire.

Table 9

Characteristics of the correlational structure of Communicational Questionnaire, obtained based on the principal component method and direct oblimin rotation.

Components	Items	Loadings	Commonalities	Variance explained	Cronbach's alpha	Item-component correlations
Component 1 (Communication)	Item 1	0.807	0.652	67.49%	0.930	0.829
	Item 2	0.749	0.561			0.746
	Item 3	0.806	0.649			0.793
	Item 4	0.849	0.720			0.783
	Item 5	0.894	0.799			0.827
	Item 6	0.856	0.733			0.837
	Item 7	0.799	0.639			0.786
	Item 8	0.804	0.647			0.784

Since only one component was extracted, rotation was not performed

Health Questionnaire. The use of Kaiser's criteria revealed a 2-component solution that accounted for 73.82% of the variance. The components eigenvalues were 5.59 and 1.06, explaining 62.06% and 11.76% of the variance, respectively. The range of components loadings was between 0.465 and 0.974 (Table 10). One item (number 6) was shared by two components, having loadings of 0.478 in the first component and of 0.419 in the second component. Based on the item's content and considering the loading values, it was decided to include it item in component 1. All remaining questionnaire items were kept. The

analysis of the observed commonalities also obtained satisfactory results (range from 0.541 to 0.859), demonstrating that the two retained components adequately describe the latent correlational structure between the questionnaire items.

According to the Spearman coefficients analysis, the score of the total questionnaire correlated significantly with the scores of the first ($r = 0.968$) and second components ($r = 0.860$). The magnitudes of these correlations were very strong and strong, respectively. The presence of a strong correlation was also verified for the scores of the two components ($r = 0.727$).

The Health Questionnaire also showed very good internal consistency (0.921), with all item-total correlations being significant ($p < 0.01$) and of strong magnitude (range from 0.755 for item 1 to 0.840 for item 6). The values of Cronbach's alpha, calculated for the first and the second components, were 0.913 and 0.857, respectively. The range of the item-total correlations, calculated for each component, was between 0.801 (item 4) and 0.909 (item 1). All these correlations were significant ($p < 0.01$) and all, except for one (item 1), were of strong magnitude (Table 10). The Cronbach's alpha values if item deleted did not differ much from the original values, pointing to the adequacy of the choice of included items.

Table 10

Characteristics of the correlational structure of Health Questionnaire, obtained based on the principal component method and direct oblimin rotation.

Components	Items	Loadings	Commonalities	Variance explained	Cronbach's alpha	Item-component correlations
Component 1 (Mental Health)	Item 4	0.833	0.736	62.06%	0.913	0.801
	Item 5	0.952	0.837			0.812
	Item 6*	0.478	0.648			0.847
	Item 7	0.465	0.541			0.828
	Item 8	0.841	0.761			0.834
Component 2 (Physical Health)	Item 9	0.974	0.859	11.76%	0.857	0.819
	Item 1	0.959	0.815			0.909
	Item 2	0.882	0.792			0.887
	Item 3	0.730	0.654			0.868

Rotation converged in 6 iterations

* item with loadings in both components

3.5. Influence of sociodemographic variables on the scores obtained

According to the Mann-Whitney test, in all questionnaires and in all components, the differences observed between female and male participants were not significant ($p > 0.05$) (Table 11).

To analyse whether the scores obtained on the four questionnaires and the respective components could be influenced by age of years of formal education, the non-parametric ANCOVA was conducted. After adjusting for initial between-group differences, the scores obtained from the female and male participants remained equivalent ($p > 0.05$). However, it should be noted that the age variable was shown to have a

potential influence on the responses obtained in the first component of the *Organizational Management Questionnaire* ($p=0.051$) and in the second components of the *Health Questionnaire* ($p=0.068$).

Table 11

Descriptive and inferential statistics of scores obtained on different questionnaires and components.

Questionnaires	Total (n = 91)	Female (n = 62)	Male (n = 29)	Age	Education
	Mean ± DP	Mean ± DP	Mean ± DP	Z (p)*	Z (p)*
Organizational management					
Total	60.08 ± 14.05	61.97 ± 11.60	56.03 ± 1.79	1.858 (0.176)	1.110 (0.295)
Team Collaboration	23.92 ± 5.63	24.81 ± 4.71	22.03 ± 6.93	3.909 (0.051)	1.802 (0.183)
Accountability & Management	21.37 ± 5.99	22.23 ± 4.96	19.55 ± 7.54	1.932 (0.168)	1.824 (0.180)
Learning Share	14.78 ± 3.98	14.94 ± 3.51	14.45 ± 4.89	0.129 (0.720)	0.008 (0.928)
Communication					
Total	30.33 ± 7.34	30.31 ± 6.91	30.38 ± 8.32	0.058 (0.811)	0.529 (0.469)
Cultural Abilities					
Total	60.90 ± 14.69	62.61 ± 13.64	57.23 ± 16.37	2.295 (0.133)	1.136 (0.289)
Encounter & Engagement	30.23 ± 8.17	31.06 ± 7.95	28.44 ± 8.47	2.709 (0.103)	1.609 (0.208)
Knowledge & Awareness	30.67 ± 7.42	31.55 ± 6.28	28.79 ± 9.25	1.220 (0.272)	0.473 (0.493)
Health					
Total	34.85 ± 8.46	35.92 ± 7.31	32.55 ± 10.28	1.734 (0.191)	1.027 (0.314)
Mental Health	23.56 ± 5.96	24.19 ± 5.14	22.21 ± 7.34	0.590 (0.445)	0.276 (0.601)
Physical Health	11.29 ± 3.24	11.73 ± 2.89	10.34 ± 3.76	3.408 (0.068)	2.101 (0.151)

* Non-parametric ANCOVA statistics with corresponding significance levels

4. Discussion

This study presents a conceptual framework and the psychometric properties of an inventory distributed in four questionnaires focused on *Organizational Management Cultural Ability, Communication* and *Health*-related needs showing the volunteers' perception about their training needs to work with AS&R.

Organizational management questionnaire: Through the EFA three components were identified (table7). All the items in the "Team Collaboration" component are related the abilities to work effectively with colleagues and AS&R, irrespectively their background or function. Team collaboration means knowing about the who, what, when and how to do it, maintaining effective relationships being an example of action^{12,13}. The 15th item, related with the ability to construct and adapt action plans in field immersions, was maintained in the 1st component, with loading of 0,375. To decide on removing or keeping an item, the

loading values were analysed and items with underload or cross-load were identified. The item loading cut-off was established at 0.32³⁰. In the case of cross-loading, the removal of the item from the analysis depended on the presence of strong loadings (≥ 0.5) on each factor³⁰. When this criterion was not met, the item was considered for inclusion based on the highest loading. It should be noted that Cronbach's alpha value, if item deleted, did not improve, so no items were removed.

In the "Accountability & Management" component the items present the training needs related with the NHPV' role in the organization (action plan, strategies, and resources) assuming a professional conduct of responsibility about the outcomes^{12,13}.

The items in the "Learning Share" component reflect the importance of learning and share ways of work, experiences, and organizational outcomes. The item number 7 has a load for two components, number 1 with 0.494 and number 3 with -0.574. Item 7 fits into the "Learning Share" component as it integrates the ability to invest in continuous learning to share with others^{12,13}, and it's where the item presents the higher loading. This items component present negative loadings meaning that although the items are important (great loadings), the participants can consider not essential for training to work with AS&R. In future could be important explore the causes, rephrase or requoted the items, and consider if they should be included in a training program.

Cultural ability questionnaire: Two components were identified: 'Encounter & Engagement' and 'Knowledge & Awareness'. In the 1st component saturates items linked with the perception about how the individual or social factors, and their cultural elements, can influence their own perception about the desire to provide the cultural encounter and engagement¹⁴ to help AS&R. In the 2nd component saturates items related with putting learned and conscious knowledge into action.

All items reflect the *cultural ability* that makes NHPV to provide adequate care and support¹², which are widely recognized as a critical component of effective service delivery on health care, social services, employment, and education^{14,15}, services often provide by NHPV as they are the first point of contact to AS&R and play a critical role in helping them to adjust to their new life¹⁶.

Communication questionnaire: The items questionnaire reveals adequate psychometric functioning. In the NHPV daily work communication is crucial to engage with colleagues, partners, and AS&R with different cultural, religious, linguistic backgrounds¹⁰ and advocate for resources and support. Their ability to communicate, based on their cultural capacities¹¹, is the key to understand behaviours, cultures, and ways to help AS&R.

Health questionnaire: This questionnaire items saturates in two components physical health and mental health. The 6-item, shared by both components, remained in this mental health component for two reasons higher loading value and content related to mental health. All the other items reveal adequate psychometric functioning.

The individual's cultural beliefs, values and attitudes contribute to their concept of health¹¹ as well as manifestations of physical or mental illness. The assessment of needs and advocacy for resources depend

on how culturally competent^{19,20} are the volunteers, how integrated they are in organizational tasks on the field¹² and how able they are to communicate with different stakeholders, partners and AS&R¹⁰.

While not the primary focus of this study, certain findings emerge as particularly intriguing upon analysis of the collected data. It is important to highlight there are no statistically significant differences in the reported needs as a function of sociodemographic variables. So, if the questionnaires-items were included in a training program, it does not seem to be necessary to adjust the intervention program according to gender, age, years of education. This suggests a universal applicability of the developed materials, reinforcing their potential effectiveness across diverse demographic groups. Such findings underscore the robustness and versatility of a future training approach based on the needs present in these questionnaires, facilitating its implementation across various contexts and populations.

Communication, cultural ability, and health are domains of the nurses' corpus of knowledge so they can be a huge asset to train NHPVs for their daily work. For organizational management, nurses have technical skills and theoretical knowledge that allows them to cooperate with other professionals, government agencies, community groups, and non-governmental agencies as humanitarian organizations³⁰.

The results show that the use of theoretical models for the questionnaires-items formulation meets the perceived training needs of NHPV to work with AS&R and the questionnaires items reveal adequate psychometric functioning. The results reveal crucial information regarding the NHPVs' perceptions about their needs to work with AS&R. Training based on the identified needs can be offered by the nurses who work daily with these vulnerable populations and with the organizations that care for them^{10,11,31}. Nurses are often the AS&Rs' first contact with health services so they should be at the forefront of NHPV training. However, a multidisciplinary approach can be considered to respond to training needs.

This study's major strength is that it determined the good validity and reliability of these questionnaires as a tool to identify the needs of training perceived by NHPV that could easily be used to construct and adapt a training program as needed. The study participants show that all items could be included in a training program to prepare NHPV to work with AS&R. The limitations of this study are the sample size, if larger, it could have made it possible to carry out the confirmatory analysis. However the sample size follows the indication of

, and the inclusion of participants with interest in the topic as they were recruited through NGOs or social media groups focused on helping AS&R.

The results of this study demonstrate that, with these easily accessible and user-friendly questionnaires, it is possible to quickly assess the training needs of NHPV, thereby making a substantial contribution to the development of targeted and effective training programs. Armed with the insights gleaned from these questionnaires, organizations will be better equipped to design training initiatives that address the documented lack of programs for NHPV working with AS&R, as noted in the literature⁸. The items incorporated in the questionnaires developed in this study appear to provide a theoretical foundation for constructing a training program tailored to NHPV working with AS&.

For future studies, a larger sample is needed to do a confirmatory factor analysis.

Conclusion

Based on the study results, it is evident that the questionnaires serve as a valuable tool for comprehensively assessing the training needs of NHPV across key domains including Organizational Management, Cultural Abilities, Communication, and Health, all essential for effective engagement with AS&R populations. This insightful information can be leveraged to develop targeted training programs that address the specific needs identified by NHPV themselves. Moreover, the questionnaires demonstrate robust reliability and validity, indicating their suitability for widespread use without the need for adjustments based on sociodemographic characteristics. Furthermore, it is noteworthy that these questionnaires integrate several theoretical models and concepts, especially from the field of nursing sciences. An interdisciplinary approach increases the comprehensiveness of the assessment but highlights the potential role of nurses in leading training efforts for the NHPV. By embracing these questionnaires, nurses can play a pivotal role in empowering NHPV to enhance their skills and competencies, ultimately improving the quality of care provided to AS&R populations. Therefore, the questionnaires not only fulfil the role of assessing needs but also empower nurses to proactively shape the training and development landscape for NHPV, thereby assisting organizations that work daily with AS&R populations.

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ARTIGO 4

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How can we help? A training needs assessment for non-health professionals and volunteers working with asylum seekers and refugees

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Abstract

Aim To understand the perceptions of volunteers and non-health professionals who worked, work, or will work with refugees and asylum seekers, about their training needs and to know if these perceptions are influenced by the training and/or experience background.

Subject and methods A cross-sectional study was conducted. Ninety-one worldwide participants completed the online survey. The survey consisted of a sociodemographic questionnaire collecting data on previous working and training experience, and four experimental questionnaires assessing organizational management-, cultural abilities-, health-, and communication-related needs.

Results Approximately 80% of participants had previous working experience with asylum seekers and refugees, although only 48% had some kind of training in this area. The training received was quite diversified in terms of format and content. Of the total sample, 74% agreed that volunteers should undergo training to enhance their ability to assist vulnerable populations and cope with stressful situations. All the participants, regardless of training background or working experience with asylum seekers and refugees, considered it important that training programs included content related to organizational management, cultural, communication, and health.

Conclusion Non-health professionals and volunteers receive limited training and possess no disciplinary knowledge to perform their work, even though it has a huge social impact. It is crucial to develop more inclusive programs, capable of being used and adapted to different contexts where people are working with asylum seekers and refugees. Future studies could explore the effectiveness of innovative training methods and compare the training needs between non-health and health professionals.

Keywords Mental Health · Training Programs · Educational · Nursing · Refugees · Asylum seeker

Introduction

More than 108 million individuals worldwide have been forcibly displaced. Of those, more than 35 million are refugees, 62 million internally displaced people and 5.4 million asylum seekers (United Nations High Commissioner for Refugees [UNHCR] 2023).

Nearly 83% of refugees are hosted by low- and middle-income countries, which puts a strain on host communities and resources (European Commission 2022). The UNHCR works with non-governmental organizations (NGOs) to guarantee the AS&R access to basic needs (UNHCR 2017). Most of the non-professional NGOs are composed of people without educational or specific skills to work with vulnerable populations (European Economic and Social Committee

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2017). People without proper training do not have the capacity to evaluate the safety threats, potential mitigation strategies, and personal risk tolerance. Untrained people are not prepared to deal with illness, injury, disability, or death (Bailey and Kaplan 2022). Even if they are doing simple tasks, non-health professionals and volunteers (NHPV) face the major challenge of dealing with the asylum seekers and refugees (AS&R) suffering as they are exposed to their traumatic pre-, during, and post-migration trajectories (Wirth et al. 2019). NHPV intend to help AS&R in post-migration scenarios, when they are facing conditions that contribute to experiences of post-migration stress (Gleeson et al. 2020). However, lack of experience or training may strongly lead to post-traumatic stress disorder in unprepared volunteers (Aldamman et al. 2019; Jaffe et al. 2012) increasing the volunteers' vulnerability to anxiety, burnout, depressive feelings, apathy, callousness, self-destructive behaviour, interpersonal conflict, over-involvement with AS&R and secondary traumatic stress (Bundesministerium für Familie Senioren, Frauen und Jugend 2017; Apostolidou 2016; Guhan and Liebling-Kalifani 2011). The psychological distress that volunteers may suffer can variate according to the previous training (Deering 1996; Birck 2001; Collins and LONG 2003).

The trainings available are dispersed mostly in NGO websites, developed based on their front-line expertise and mainly focused on one or two topics (Teixeira-Santos et al. 2022, 2023). Therefore, it is crucial to understand the NHPV' training needs to develop and improve training programs and make them useful. Even the NGOs applying the selection criteria and giving them basic training to work in a project/mission, does not mean that it suits their training needs.

This study aims to understand the perception of NHPV who worked, work or will work with AS&R, about their training needs in organizational management, communication, cultural abilities, and health domains through four experimental questionnaires developed for the purpose of this study. It also intends to know if training or experience background can influence the perception about the training needs for their work role.

Methods

This study is part of the APT4U2, a PhD project, funded by the Portuguese Foundation for Science and Technology (FCT), that aim to develop, validate, and assess feasibility, adequacy, and meaningfulness of the APT4U2 program, a mental health and well-being training program for NHPV to work with AS&R. The study employed a cross-sectional design based on a self-administered online survey. Data was collected between April–June of 2022. The project was

approved by the Ethics Committee of the Health Sciences Research Unit: Nursing (Opinion n° 0 P742 12/2020) and each participant provided an informed consent before engaging in the study. Participants did not receive any type of incentive.

Study sample

The study targeted worldwide NHPV, aged ≥ 18 years, who had worked, are working, or intend to work on projects involving asylum seekers and/or refugees. Individuals with educational backgrounds in health or mental health were excluded, as the study aimed to explore the training needs of laypersons in healthcare matters, encompassing mental health.

Instruments

The participants were invited to complete the online survey (sociodemographic questionnaire and four questionnaires as a training needs assessment). The sociodemographic questionnaire was divided into two parts, the first focused on the participants' general characteristics, and the second was dedicated to their training and work experiences with AS&R. The training needs assessment comprised a total of 49 items organized into four questionnaires, namely 16-item Organisational Management Questionnaire, 16-item Cultural Ability Questionnaire, 9-item Health Questionnaire, and 8-item Communication Questionnaire. The questionnaire items were developed based on literature review and theoretical models, including the UNHCR competency framework (United Nations 2017a, b), the Giger and Davidhizar Transcultural Assessment Model (Giger and Davidhiza 1999), and the Campinha-Bacote's model of cultural competence (Campinha-Bacote 2002). A multidisciplinary focus group of NHPV with work experience with the population of interest in multicultural contexts was undertaken to establish content validity of the questionnaires' items. Based on the feedback provided, the questionnaires' items were revised and refined whenever necessary. A previous exploratory factor analysis revealed a presence of three components (Accountability & Management; Learning Share; and Team Collaboration) in the *Organisational Management Questionnaire*, two components (Knowledge & Awareness; and Encounter & Engagement) in the *Cultural Ability Questionnaire* and two components (Mental Health and Physical Health) in the *Health Questionnaire*. Below, these domains are denominated as components. *Communication Questionnaire* showed to be unidimensional. In all questionnaires, Cronbach's alpha coefficient was greater than 0.9.

In the present study, participants were asked to rate each item on a 5-point scale for the importance of being included

in training for NHPV. The response options varied from “not at all important to include” to “very important to include.”

Procedures

The assessment of training needs through the questionnaires was conducted in Portuguese and English, through the Google Forms platform. The participants were recruited through three NGOs and nine European NHPV social media groups. The invitation included the participation criteria and the link to assess the informed consent and the survey.

Statistical analysis

Due to the non-normal distribution of the results, non-parametric statistical tests were used in the comparative analyses. The variance of continuous variables for two groups was analyzed using the Mann–Whitney U test, with the effect size being calculated based on the following formula: $r = Z / \sqrt{N}$. For intragroup comparisons, the Friedman test was used. In this case, the effect size was indicated by Kendall’s W value. If differences were statistically significant, pairwise comparisons were performed. The probability of type I error (α) of 0.05 was considered. Data were analyzed using IBM SPSS Statistics software (version 25, IBM SPSS, New York).

Results

Participants profile Ninety-four adults responded to the invitation to participate in the study; of those, 91 (62 women and 29 men from 6 continents and 35 countries, with an average age of 42 years and an average formal education of 14 years) completed the survey and were considered in further analyses (Table 1).

Most respondents (80%) claimed to have experience of working with AS&R. In most cases, this experience was gained in European countries (62%), in the context of voluntary work (47%) in NGOs (75%) and lasted 13 months or more (52%). The intention to collaborate with NGO for a period of 13 months or more also stood out in the responses of the participants with no previous experience of working with AS&R (50% and 33%, respectively). However, a great number of these respondents have not yet defined the work context and/or the geographic destination of the future collaboration (Table 2). Only 48% of respondents claimed to have training to work with AS&R. The training received was quite diversified in terms of format and content (Table 3). Still, it’s worth emphasizing the role of NGOs in providing facilities (39% of reported cases) and trainers (52% of reported cases), necessary for the implementation of training actions.

Training needs assessment The assessment of training needs began with the question about the extent to which the

Table 1 Sociodemographic characteristics and geographical distribution of the study sample

Variables	
Gender: female/male	68%/32%
Age (years): mean \pm SD (range)	41.53 \pm 13.66 (20–73)
Education (years): mean \pm SD (range)	14.46 \pm 3.69 (3–17)*
Marital status	42% single, 41% married, 12% separated or divorced, 5% other
Occupation	42% employed full-time, 24% employed part-time, 23% unemployed, 11% student
Background to work with refugees and asylum seekers	42% with training and work experience 38% with only work experience 13% with no training and work experience 7% with only training experience
Geographical setting: continent (countries)	13% from Africa (Cameroon, Democratic Republic of the Congo, Ghana, Kenya, Nigeria, South Africa, Tanzania, Uganda) 13% from Asia (Afghanistan, Bangladesh, India, Iran, Iraq, Malaysia, Myanmar, Pakistan, Palestine) 55% from Europe** (Albania, Cyprus, France, Germany, Greece, Hungary, Italy, Luxembourg, Macedonia, Poland, Portugal, Spain, Sweden, United Kingdom) 8% from North America** (United States of America) 7% from South America (Brazil, Venezuela) 5% from Australia and Oceania (Australia)

* In counting education years, a maximum of 17 years was established, regardless of the number of undergraduate or postgraduate courses taken, or the achievement of academic titles equivalent to or higher than the PhD

** One participant has dual citizenship, of the United Kingdom and the United States of America

Table 2 Summary of actual or planned work experience with refugees and asylum seekers

	Participants with previous experience		Participants with plan or intention to work in the future
	Present (n = 33)	Past (n = 40)	Plan/intention (n = 18)
Actual or planned work context			
Freelancer (without affiliation)	21.2%	12.5%	5.6%
worker of an organizations	30.3%	42.5%	27.8%
volunteer in an organization	48.5%	45.0%	27.8%
not defined yet	-----	-----	38.9%
Actual or planned work time*			
≤ 3 months	21.2%	30.0%	16.7%
4–6 months	12.1%	7.5%	-----
7–9 months	6.1%	5.0%	5.6%
10–12 months	-----	10.0%	16.7%
≥ 13 months	60.6%	45.0%	33.3%
Not applicable	-----	-----	27.8%
Actual or planned organization			
Non-governmental organization	72.7%	77.5%	50.0%
government organisation	6.1%	7.5%	-----
without affiliation with organization	12.1%	10.0%	5.6%
other	6.1%	5.0%	5.6%
not defined yet	-----	-----	38.9%
Actual or planned destination			
Anywhere	-----	5.0%	38.9%
African countries	6.1%	12.5%	11.1%
Asian countries	3.0%	2.5%	11.1%
European countries	69.7%	55.0%	11.1%
North American countries	6.1%	-----	5.6%
South American countries	3.0%	7.5%	16.7%
Australian and Oceanian countries intercontinental	9.1%	5.0%	-----
	3.0%	12.5%	5.6%
Actual or planned setting**			
Refugee camp	18.2%	47.5%	27.8%
reception centre	18.2%	40.0%	11.1%
shelter for asylum seekers	18.2%	25.0%	27.8%
non-governmental organization facilities	42.4%	32.5%	22.2%
government facilities	12.1%	12.5%	-----
other	51.5%	15.0%	5.6%
not defined yet	-----	-----	38.9%
Actual or planned activities**			
Formal education activities	27.3%	40.0%	33.3%
Informal learning activities	48.5%	47.5%	38.9%
distribution of food and/or materials	45.5%	40.0%	61.1%
organizational logistic activities	30.3%	35.0%	22.2%
translation activities	27.3%	25.0%	22.2%
others	63.6%	27.5%	27.8%

* One person with past work experience did not provided an answer for this question

** Multiple answer question

participants agree that NHPV who work with the population of interest should be trained to perform their role. Of all 91 participants, 74% agree. Partial and total disagreement rates were 10% each. Remaining answers fall into the category “neither disagree nor agree.” There were no significant differences in the level of agreement between participants with and without work experience ($U=550.50$; $p=0.217$). However, participants with training experience presented

a significantly higher level of agreement than participants without training ($U=759.50$; $p=0.011$), although the effect size was small (0.266).

The participants were also asked to select the most important reason for training to work with AS&R. Most respondents (55%) pointed to increase knowledge about strategies to help these vulnerable populations and themselves to deal with stressful situations. This selection did not depend

Table 3 Summary of training experience to work with refugees and asylum seekers

	Participants with previous training experience (n = 44)
Time of training delivery	45.5% before starting work with asylum seekers 50.0% while working with asylum seekers 4.5% after working with asylum seekers
Trainers' profiles	52.3% NGO professionals or volunteers 13.7% educational professionals 4.5% health professionals 22.7% multidisciplinary team 6.8% other
Country of training delivery	70.5% country of origin 27.3% country of the humanitarian mission/project development 2.3% other location
Setting of training delivery	34.1% NGO facilities where study participants have worked as volunteers or professionals 4.5% another NGO that have provided training for volunteers or professionals 11.4% government facilities (e.g., town halls, cultural and recreational centers) 13.6% refugee camps 4.5% reception center for asylum seekers 13.6% online training 18.2% other
Duration of training delivery	27.3% between 1 to 9 h 20.5% between 10 to 29 h 27.3% between 30 to 59 h 20.5% 60 h or more 4.4% missing responses
Topics covered in training*	31.8% mission logistics 27.3% legislation 15.9% inclusion-related topics 11.4% cultural interpreting 4.5% asylum seekers cultural harmful practices 11.4% personal skills 9.1% safeguarding 6.8% physical health – first aid 9.1% mental health – self protection 22.7% mental health – psychosocial support 2.3% ethical and moral issues 22.7% did not specify topics covered by training
Number of topics covered in training	34.1% received one topic-focused training 29.5% received two topics-focused training 6.8% received three topics-focused training 2.3% received four topics-focused training 2.3% received five topics-focused training 2.3% received eight topics-focused training

NGO, non-governmental organization

* Open-ended question with answers categorized by study authors

on working or training background. The second and third most frequently mentioned reasons were related to increase in knowledge about the contextual and legal conditions in which they live (23%) and to clarification about forced migration issues and their consequences on population of interest (11%), respectively. Increase in knowledge about ways to help the population of interest was the least selected reason (10%).

Intergroup comparisons The means and standard deviations for all questionnaires and components, organized according to work and training background, are presented in Table 4. Comparison of questionnaires scores showed no significant differences in the importance given to the training needs by participants with different backgrounds of work (Organization Management $U = 642.00$, $p = 0.881$; Cultural Ability $U = 621.50$, $p = 0.723$; Health $U = 618.50$, $p = 0.700$;

Table 4 Means and standard deviations of scores obtained in the assessment of training needs

	Work background		Training background	
	With work experience (n = 73)	Without work experience (n = 18)	With training experience (n = 44)	Without training experience (n = 47)
Organizational management	60.85 ± 12.25	56.94 ± 19.91	59.30 ± 14.33	60.81 ± 13.90
Team collaboration*	24.29 ± 4.97	22.44 ± 7.74	23.14 ± 5.82	24.66 ± 5.40
Accountability & management	21.63 ± 5.43	20.33 ± 7.99	21.23 ± 5.54	21.51 ± 6.45
Learning share	14.93 ± 3.55	14.17 ± 5.46	14.93 ± 4.10	14.64 ± 3.90
Cultural ability	61.25 ± 14.37	59.49 ± 16.27	58.75 ± 14.62	62.91 ± 14.62
Encounter & engagement knowledge & awareness	30.62 ± 7.99	28.65 ± 8.94	29.59 ± 8.03	30.82 ± 8.34
	30.63 ± 7.25	30.83 ± 8.30	29.16 ± 7.45	32.09 ± 7.19
Health	34.86 ± 7.99	34.78 ± 10.41	33.73 ± 8.85	35.89 ± 8.04
Mental health	23.71 ± 5.42	22.94 ± 7.93	22.91 ± 5.83	24.17 ± 6.07
Physical health	11.15 ± 3.21	11.83 ± 3.38	10.82 ± 3.46	11.72 ± 2.99
Communication	30.47 ± 7.17	29.78 ± 8.21	29.00 ± 7.64	31.57 ± 6.91

* The subscales vary in the number of items. The Cultural Ability questionnaire has two components with eight items each. The Team Collaboration, Accountability & Management, and Mental Health components are composed of six items each. The Learning Share component includes four items, and the Physical Health subscale includes three items

Communication $U=638.00$, $p=0.850$) and training (Organization Management $U=962.50$, $p=0.570$; Cultural Ability $U=852.00$, $p=0.148$; Health $U=891.50$, $p=0.256$; Communication $U=832.00$, $p=0.108$). Participants with and without work experience also did not differ in components scores. As for participants with and without training experience, one significant difference was found, namely in the importance given to the Encounter & Engagement-related needs, although the effect size was small ($U=779.00$, $p=0.042$, $r=0.21$).

Intragroup comparisons Regarding the importance given to the training needs addressed in the four questionnaires, intragroup comparison of the proportions of the total scores obtained, performed for the total sample, did not show significant differences ($\chi^2_F(3)=5.492$, $p=0.139$). The same was verified in relation to the subgroups with and without work experience ($\chi^2_F(3)=2.923$, $p=0.404$; $\chi^2_F(3)=4.200$, $p=0.241$; respectively) and with and without training experience ($\chi^2_F(3)=3.568$, $p=0.312$; $\chi^2_F(3)=5.039$, $p=0.169$; respectively). However, when the analyses considered components scores, the differences observed revealed to be statistically significant in the total sample ($\chi^2_F(7)=41.585$, $p<0.001$, $w=0.07$), in the subgroups with work and training experience ($\chi^2_F(7)=36.335$, $p<0.001$, $w=0.07$; $\chi^2_F(7)=20.807$, $p=0.004$, $w=0.07$; respectively) and in the subgroup without training experience ($\chi^2_F(7)=28.397$, $p<0.001$, $w=0.09$). In the subgroup without work experience, the differences remained non significant ($\chi^2_F(7)=13.228$, $p=0.067$).

Pairwise comparisons performed for the total sample showed that greater importance was given to training needs related to Accountability & Management as compared to Learning Share, Team Collaboration and Communication, as well as to training needs related to mental health as compared to Learning Share and Communication. In the subgroup with work experience, Accountability & Management-related needs were valued more than needs from the scope of Learning Share, Communication, and Physical health, and Mental health-related needs were more valued than Learning Share-related needs. Participants with and without training experience recognized as more important Accountability & Management-related needs as compared to Learning Share-related needs. The subgroup without training experience also valued more mental-health related needs than Learning Share-related needs.

Discussion

Organizational management, communication, cultural abilities, and health competences are the main domains on which the participants had to decide whether they should be included in a training program to work with AS&R. All the participants considered it important to include the competencies presented in the questionnaires, regardless of the training background or working experience with AS&R.

This study's results show that NHPV agree with the inclusion of content promoting organizational management

competences in the training programs. Meaning they are aware of the importance of knowing how to manage resources to improve peoples' lives, working collaboratively and effectively with all people irrespective of their background or function, and assuming a professional conduct of responsibility about the outcomes (United Nations 2017a, b). While *Accountability & Management* training competences are more related to the NHPV' role in the organization (action plan, strategies, and resources), topics related to the *Learning Share* and *Team Collaboration* concern sharing knowledge and increasing the effectiveness of work with others through contributions of health professionals with fieldwork experience.

Cultural abilities are the ones that most interest NHPV and the trained participants seem to care more about *Encounter & Engagement*-related competences than untrained ones. Nonetheless, to enhance the cultural *Encounter & Engagement & Awareness* to respect AS&R norms and cultural beliefs (European Union 2019). It is no coincidence that cultural abilities are of most interest, as they can influence the way people relate to each other, and how people understand the others' needs and behaviors (Bundesministerium für Familie Senioren, Frauen und Jugend 2017; Jaffe et al. 2012). Cultural abilities training is of paramount importance for those working in multicultural complex contexts. Health professionals such as nurses, as the AS&R's first contact with health services and as health educators par excellence, are the cornerstones of caring for AS&R (International Council of Nurses [ICN] 2019; ICN 2018, 2006). Nurses can contribute with in-depth knowledge about cultural competencies helping NHPV to learn about AS&R cultural and religious characteristics; and they know these characteristics influence relationships and encounters.

In multicultural contexts, communication is one of the most necessary skills to work and it is also one of the major barriers for AS&R (UNHCR 2021a), as it can easily be influenced by interlocutors' cultural competencies. NHPV use verbal and non-verbal communication to engage with AS&R, colleagues, and partners, who have different cultural, religious, linguistic backgrounds (European Union 2019; ICN 2019). NHPV ability to communicate, based on cultural abilities (European Union 2019; ICN 2019, 2018), is the key to understand behaviors, cultures, and ways to help AS&R. In this field, health professionals can provide training on basic principles of cross-cultural communication, contextual, cultural, and religious factors that affect communication and strategies to communicate.

Regarding the health domain, participants unanimously agree about the need for training in physical and mental health. In this study, the health concept highlights the physical and mental needs related to the asylum process, such as referring to specialized health care and providing first-aid

support. Training by health professionals, who are prepared to teach how an individual's beliefs, values, and cultural attitudes contribute to the AS&R concept of health (ICN 2018) and the manifestations of physical or mental illness, is crucial for the NHPV, as they need to be alert to daily manifestations of diseases or the help-seeking behavior. With proper training by health professionals, NHPV can advocate for the health rights and resources for AS&R, but only if they are aware of AS&R' needs and strategies to help them.

The literature about the capacity building of the refugee-related workforce reveals that the training in health and well-being topics covers child protection, women empowerment, and violence, even for those volunteers without a health background (Teixeira-Santos et al. 2023). These facts are corroborated in the survey's descriptive part of this study where participants described the topics, they would include in a training program.

This study's results also show that participants agree that mental health training is essential to empower them to deal with stressful situations. Surprisingly, participants found learning the basic principles of helping others to be just as important as learning about the strategies for protecting their own mental health, revealing that they are aware that working with AS&R can lead to mental health challenges. In fact, mental health training is crucial not only for providing adequate care for AS&R, but also for the NHPV' mental health preparation and safety. Psychologically trained refugee helpers had lower burnout levels and somatic symptoms when compared with untrained aid workers (De Jong et al. 2021; Jobst et al. 2018; Pell 2013). The UNHCR defend that primary well-being intervention with AS&R can be provided for trained and supervised non-specialized mental health volunteers (UNHCR 2021b).

Most of the participants (74%) agreed that it is necessary to receive training to work with AS&R, especially to increase knowledge about strategies to help refugees, asylum seekers, and themselves to deal with stressful situations. Although there are no significant differences in the level of agreement between participants with and without professional experience, participants with training had a significantly higher level of agreement than participants without such background.

In this study, most of the participants (62%) had experience working with AS&R acquired in European countries as part of voluntary work in NGOs for more than a year. These findings may have been influenced by the invitation through NGO groups with greater intervention in Europe as they are dealing with the largest number on record of forcibly displaced people (UNHCR 2023; World Economic Forum 2022; Carrera 2019; Kalogeraki 2018; Bernát et al. 2016).

Even though the majority of NHPV agree with prior training to work with AS&R, as there is no specific and mandatory training to work/intervene with AS&R (Godin

2020), less than half (48%) of the NHPV with field experience, included in this study, have training to work with AS&R. When the training-related information is analyzed, it is possible to verify that 50% of participants receive the training while working with AS&R and that, on average, the training covers just one topic and has a duration of 1 to 9 h. The average of topics per training and the training duration do not seem to meet the training of competencies that participants revealed to need when completing the questionnaires of this study.

Volunteers often receive inadequate training (Jobst et al. 2018; Save the Children 2017; Fletcher 1987). Moreover, the training is frequently under-emphasized because most volunteers are perceived as competent and employed professionals who are donating their spare time (Kende et al. 2017; Starnes and Wymer 2001). Consequently, unexperienced volunteers must rely on unsupervised on-the-job training as well as solicited support from other volunteers (Save the Children 2017; Guhan and Liebling-Kalifani 2011; Fletcher 1987). Experienced volunteers usually have a diverse range of skills, including logistics, human resources, finance, health, engineering, and so on, and we can assume that most participants have differentiated skills due to the average of 14 years of education. However, given the diversity of field situations and the fact that most experienced participants have worked more than a year in the field, they should also have competencies across a whole set of other areas, including management, communication, negotiation, teamwork, etc. (Dempsey-Brench and Shantz 2022; Clarke et al. 2019).

This study's results clearly show a deficit in the training of NHPV who can identify training needs beyond those they received, being in line with the conclusions of a recent scoping review that denounce the insufficiency of training programs for NHPV (Teixeira-Santos et al. 2023) and their ineffectiveness in meeting the training needs identified by this study's participants as necessary to work with AS&R.

This study's major strength is that we can use the questionnaires to construct or adapt a training program as needed. The level of agreement between NHPV with different training and working background regarding the concepts of interest show that all of them could be included in training programs that prepare NHPV to work with AS&R.

These results show that health professionals could invest in training NHPV not only to better prepare them for their daily work but also to empower them to care for and refer AS&R to health care. This study indicates that organizational management, communication, cultural abilities, and health domains are fundamental to design training programs for NHPV working with AS&R where health professionals can lead.

The limitation of this study is the inclusion of participants with specific interest in the topic as they were recruited through NGOs or social media groups focused on helping AS&R. Future studies could increase the sample size and include people with more diversified educational and professional backgrounds. In future research, it would also be valuable to investigate the efficacy of novel training approaches and to contrast the training requirements of volunteers and non-healthcare professionals with those of healthcare professionals aiding refugees and asylum seekers.

Conclusions

NHPV receive limited and inadequate training to work with AS&R. They unanimously agree that organizational management, communication, cultural abilities, and health domains should be included in training programs. Health professionals can have a vital role in developing and improving the training programs for NHPV working with AS&R, which can easily be adapted to the training needs and contexts using this study's questionnaires.

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Contributions Conceptualization: LTS, EBC, and WA; Methodology: LTS and EBC; Formal analysis and investigation: LTS and EBC; Writing—original draft preparation: LTS and EBC; Writing—review and editing: LTS, EBC, and WA; Funding acquisition: LTS; Resources: LTS; Supervision: WA.

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Data availability The data that support the findings of this study are available from the corresponding author upon request.

Code availability Not applicable.

Declarations

Ethical approval This study is a part of the APT4U2, a PhD project which was approved by the Ethics committee of the Health Sciences Research Unit: Nursing (no. 0 P742 12/2020).

Consent to participate All participants were required to consent to participate at the start of the electronic survey.

Consent for publication Not applicable.

Conflict of interest The authors declare that they have no conflict of interest.

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ARTIGO 5

Teixeira-Santos L, Abreu W. Mental Health Nurses leading the way in the training of lay people working with young asylum seekers: The APT4U2 Program. *International Journal of Mental Health Nursing* (submetido), 2024.

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ORIGINAL ARTICLE

TITLE

Mental Health Nurses leading the way in the training of lay people working with young asylum seekers: The APT4U2 Program

ABSTRACT

Introduction: Worldwide non-health professionals and volunteers in humanitarian settings assist asylum seekers and they need to be empowered to recognize and refer people with mental health problems and provide psychosocial support in multicultural contexts. The APT4U2 program, aligned with mental health nurses' competencies, addresses this gap.

Aim: The aim of this study was to present the development of a standardized training program for NHVP work with young asylum seekers.

Method: Following the development phase of the Medical Research Council's Complex Interventions methodology, the study follows the main steps: I – Mapping existing evidence on mental health training programs for NHPV working with asylum seekers and refugees; II – Identifying NHPVs' training needs and experiences; and III – Developing the APT4U2 Program. The program underwent validation by eight experts in mental and psychiatric nursing, education, public health and psychology.

Results: The APT4U2 Program is prepared for 11 hours and consists of 3 Modules and 5 Lessons.

Discussion: The APT4U2 Program is an easy-to-use training program constructed and to be administrated by mental health nurses to NHPV who want to work with young asylum seekers.

Implications for Practice: This evidence can guide mental health nurses in training worldwide NHPV who work with asylum seekers.

KEYWORDS: nursing; education; asylum seeker; refugee; mental health.

1. INTRODUCTION

In 2023, global migration reached a worrying milestone with over 110 million people displaced due to geopolitical and social instability, resulting in conflicts, human rights violations, and a need for international protection. Significant contributions to this crisis came from conflicts in Syria, Afghanistan, and Ukraine, with 75% of displaced people hosted by low- and middle-income countries, straining their resources and communities (United Nations High Commissioner for Refugees [UNHCR], 2023).

Europe, seen as a haven for asylum seekers, has faced a significant migration crisis since 2014, receiving over 1.3 million asylum applications in 2015 (European Parliament, 2022). This influx posed unprecedented challenges, with over 2.5 million illegal migrants entering the EU from 2015 to 2023, mainly via dangerous Mediterranean and Balkan routes (Frontex, 2024). The large number of asylum seekers led to the creation of temporary reception centers, contributing to political and social instability (International Council of Nurses [ICN], 2009). Despite European governments' efforts to ensure dignity and human rights for asylum seekers, many centers suffer from infrastructure issues and precarious conditions, depriving displaced people of fundamental rights (Grubiša, 2022; Namutebi et al., 2021; Bousiou, 2020).

These adverse conditions, combined with traumatic experiences before and during the journey, significantly impact the physical and mental health of asylum seekers, especially young people who face multiple abrupt life transitions and uncertainty about their future. In these precarious contexts, they are often cared for by non-health professionals and volunteers (NHPVs) integrated into Non-Governmental Organizations (NGOs) (Muraleedharan & Bryer, 2020) who frequently lack the necessary training (Burck & Hughes, 2018). This lack of preparation makes NHPVs more vulnerable to mental health disorders. The literature reports adverse outcomes such as anxiety, depression, burnout, excessive involvement with asylum seekers, apathy, self-destructive behavior, interpersonal conflicts, and secondary post-traumatic stress (Bundesministerium für Familie Senioren, Frauen und Jugend, 2017; ; Apostolidou, 2016; Guhan & Liebling-Kalifani, 2011). These psychological distress symptoms vary based on previous training (Collins, 2003; Birck, 2001; Figley, 1995) and are less evident in volunteers with mental health training (Püttker, Thomsen & Bockmann, 2015).

This need presents an opportunity for mental health nurses to lead the training of thousands of NHPV who work with young asylum seekers daily. Nurses, with their expertise in life transition processes (Meleis, 2010) and the impact of disruptive situations on emotional stability, especially in young people, are well-positioned to provide essential

knowledge to untrained people. Although nurses cannot always work directly on the front lines, they can impart critical skills, attitudes, and values to those assisting vulnerable populations. As excellent health educators (ICN, 2015), nurses play a key role in the care of asylum seekers and refugees, even indirectly, by empowering those who support these individuals worldwide (*Ordem dos Enfermeiros*, 2011).

To address this need, following the APT4U2 Project this study presents the the APT4U2 Program, a structured and evidence-based mental health and well-being training program for NHPVs working with young asylum seekers, led by mental health nurses.

1. AIM

This study presents the development of the APT4U2 Program, following the Medical Research Council's Complex Interventions model. The APT4U2 Program aims to train NHPVs to recognize signs of mental health suffering, refer young asylum seekers to mental health care professionals, and provide emotional and psychological support in complex multicultural contexts.

2. METHODS

The APT4U2 Program's design follows the optimized development phase of the Medical Research Council's (MRC) complex interventions model (Bleijenberg et al., 2018; Craig et al., 2008) (fig. 1). The study report was guided by the Criteria for Reporting the Development and Evaluation of Complex Interventions in healthcare (CReDECI) (Möhler, Köpke and Meyer, 2015). This study, conducted as part of the APT4U2 project, received approval from the Ethics Committee of the Health Sciences Research Unit: Nursing (Opinion no. 0 P742 12/2020). Informed consent was obtained from all participants before each study.

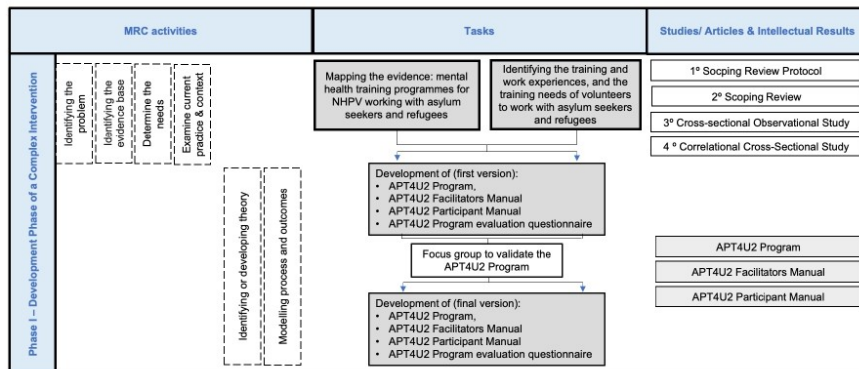


Figure 1 – APT4U2 Program Development

3.1. Starting point: problem identification & definition

Identifying the current problem within a specific context is crucial for designing effective interventions (van Meijel et al., 2004). In this case, a previous study conducted through field immersion in a European refugee camp, including participant observation and semi-structured interviews with NHPVs and young asylum seekers, highlighted the importance of the relationship between NHPVs and under-18s as a significant protective factor (Teixeira-Santos & Monteiro, 2018). However, it also revealed that volunteers lacked mental health training to protect themselves from potential trauma and effectively address the traumatic experiences of the children they cared for (Teixeira-Santos, 2018). This lack of training in working with vulnerable populations, particularly in non-professional NGOs where most individuals work directly in the field, is common (European Economic and Social Committee, 2017). Untrained volunteers working with asylum seekers and refugees encounter substantial challenges due to their lack of preparation (Bailey and Kaplan, 2022). This unpreparedness leaves them vulnerable to psychological issues such as PTSD, anxiety, and burnout (Grim et al., 2017; Bundesministerium für Familie Senioren, Frauen und Jugend, 2017), with the severity often linked to their level of prior training (Gkionakis et al., 2016; Collins & Long, 2003).

2.2. Identifying the evidence base

As the problem appeared to stem from a lack of training among non-professional NGO members, the initial step was to map mental health and well-being training programs for NHPVs working with asylum seekers and refugees. Due to conceptual ambiguity between 'asylum seekers' and 'refugees', both terms were used in the scoping review

protocol (1st study) (fig.1) and the review itself (2st study) (fig.1) (Teixeira-Santos, Ventura, Teixeira, Cardoso & Abreu, 2022; Teixeira-Santos, Ventura, Santos, Almeida & Abreu, 2023). Conducting a scoping review, rather than a systematic one, was necessitated by the scarcity and dispersion of evidence across various sources. Out of 8954 documents reviewed from 16 sources, only 11 addressed the topic, with half focusing on protocol-based approaches, and the other half is focused in specific mental health disorders or are self-administrated without control of acquired knowledge. The results show that the evidence available is insufficient and inadequate (Teixeira-Santos et al., 2023). Subsequent findings from a cross-sectional study (4rd study of fig.1) involving 91 NHPVs reaffirmed the lack of adequate training, despite recognition of its importance in managing stress and protecting mental health (Teixeira-Santos, Bobrowicz-Campos, Sousa & Abreu, 2024; Teixeira-Santos, Bobrowicz-Campos & Abreu, 2024).

2.3. Identifying or developing theory

Identifying and developing the underlying theory for the proposed intervention, the APT4U2 Program, is crucial (Petticrew et al., 2013). Understanding the causes of NHPVs' lack of training allows for defining key components of the intervention based on insights from various reviews. A thorough understanding of these causes is also essential for justifying the intervention, its components, and expected outcomes (Richards and Hallberg, 2015b).

To achieve this, the authors conducted the 3rd and 4th studies (Fig. 1), which included a cross-sectional observational and a correlational cross-sectional study. The main goal was to identify the training and fieldwork experiences and the perceived training needs of NHPVs working with asylum seekers and refugees (Teixeira-Santos et al., 2024a, b). In the 3rd study (Fig. 1), the authors developed a conceptual framework and the psychometric properties of an inventory focused on major competencies for working with asylum seekers and refugees.

An initial 49-item inventory was developed based on theoretical models like the UNHCR competency framework (United Nations, 2017a; United Nations, 2017b), Campinha-Bacote's model of cultural competence (2002), and the Giger and Davidhizar Transcultural Assessment Model (1999). The inclusion of cultural competence models show the importance of aligning practical skills with cultural competences to effectively operate in multicultural contexts with people with multicultural backgrounds. Each of the 49 items in the inventory represented a potential training need and was categorized into four domains: *Organizational Management, Cultural Abilities, Communication, and*

Health skills. These questionnaires were validated by experts with humanitarian experience and were found to be user-friendly, valid, and reliable for assessing training needs (Teixeira-Santos et al., 2024a). This inventory was used to address the training needs of 91 NHPVs worldwide (Teixeira-Santos et al., 2024b), which were incorporated into the APT4U2 Program.

2.4. Determine the needs

Understanding the needs, preferences, and capacities of recipients is crucial for crafting effective interventions. By analyzing the solution from multiple perspectives, developers can tailor interventions to be more feasible, replicable, and user-friendly, ensuring they address real issues (van Meijel et al., 2004). The questionnaires on Organizational Management, Cultural Abilities, Communication, and Health skills, validated for their reliability (Teixeira-Santos et al., 2024a), were used to determine the training needs of NHPVs working with asylum seekers and refugees.

In the 4th study, a sociodemographic survey was also employed to contextualize the training and fieldwork experiences of NHPVs, as these factors could influence their perceptions of training needs. The assessment began by asking participants about the necessity of training for NHPVs to work with asylum seekers and refugees. Among the 91 participants, 74% agreed on the importance of such training, with those having prior training experience showing significantly higher agreement (Teixeira-Santos et al., 2024b). Participants were also asked to identify the most important reason for training. The majority (55%) highlighted the need to increase knowledge about strategies to help vulnerable populations and manage stressful situations, regardless of their work or training background. The findings emphasize the importance of mental health training for those working with asylum seekers and refugees. NHPVs stressed the need to learn how to assist others and protect their own mental well-being, underscoring their awareness of potential mental health challenges. This aligns with UNHCR's (2021) stance that mental health training ensures proper care for asylum seekers and refugees while promoting the well-being and safety of volunteers.

2.3.5. Examine practice

To optimize the successful implementation of an intervention, it's essential to thoroughly understand existing practices (van Meijel et al., 2004). By examining current practices, interventions can be tailored to enhance their effectiveness. Understanding the required

competencies of providers and how they should be trained is also crucial (Conn, Cooper, Ruppap & Russell, 2008).

The 2nd and 4th studies were vital in understanding NHPVs' training practices. The 2nd study revealed that only 11 out of nearly 9,000 documents in a scoping review addressed mental health and well-being training, and those that did were inadequate for NHPVs' training needs (Teixeira-Santos et al., 2023). And the 4th study corroborated this, showing that over 52% of NHPVs (62% with prior experience in European reception centers) had not received any training, and those who did (48%) mostly received training focused on logistical tasks (Teixeira-Santos et al., 2024b).

This phase aims to answer: "What needs to be done to successfully implement a new intervention?" (Bleijenberg et al., 2018). It is necessary to create a feasible, adequate, meaningful and effective training program, based on scientific evidence, but also on the empirical experience of NHPV who work with asylum seekers on a daily basis.

To address NHPVs' training needs, the APT4U2 Program's developers reviewed the literature to identify necessary skills for working with asylum seekers. This search informed the conceptualization of questionnaires in the 3rd study, which were then subjected to a factorial analysis process to assess their validity and reliability.

As explained above, the questionnaires were based on theoretical models (United Nations, 2017a; 2017b; Campinha-Bacote, 2002; Giger & Davidhizar's, 1999), but were scrutinised by those who will be the end users of APT4U2. The 91 worldwide NHPVs were given the opportunity to give their opinion on the competences that the literature advocates as necessary for working as volunteers. In this questionnaire, the volunteers rated their agreement with the inclusion of each of the items in the questionnaire in the APT4U2 Program from 1 to 5 (Teixeira-Santos et al., 2024).

2.3.6. Modelling process and outcomes

This stage involves modeling the active components of the intervention based on synthesized knowledge from previous phases, creating the first prototype of the intervention. This modeling process enhances the intervention's applicability in practice (Hardeman et al., 2005). The goal of the APT4U2 Program was to empower NHPVs to recognize signs and symptoms of mental distress, prompt them to refer young asylum seekers for specialized mental health care and enable them to provide psychosocial support during daily interactions.

The design of the APT4U2 Program incorporated conclusions from the Scoping Review (2nd study) (fig. 1), ensuring the program would be administered by qualified professionals, specifically mental health and psychiatric nurses. It was also designed to be evaluated with a tool to assess knowledge acquisition and be applicable across different cultures and religions for use in various contexts. Additionally, the APT4U2 Program considered the perceived training needs of NHPVs (3rd and 4th studies), based on their opinions about the competencies necessary for volunteering as defined by the literature. At this stage, the research team, composed of specialists in mental health and transcultural nursing, developed and refined the APT4U2 Program prototype. It underwent preliminary evaluation by two experts in humanitarian and mental health nursing fields.

The APT4U2 Program was developed around two main domains: (i) competencies for working with young asylum seekers and (ii) competencies for self-care while caring for others. Although the program focused on training NHPVs in mental health and well-being, it also integrated other essential competencies. These included *organizational management* (e.g., who should approach asylum seekers, how to work in a multicultural team, how to manage and integrate a team, etc), *cultural* (e.g., culturally sensitive behaviour, cultural awareness, knowledge and encounter), and *communication* skills (e.g., what to say, how and when to say it, who to say it to and how to interpret it).

2.3.7. Intervention design

The design phase of the intervention involves creating a full prototype, making decisions regarding its content, ingredients, intensity, and duration (Conn, Rantz, Wipke-Tevis & Maas, 2001). This phase closely integrates with the modelling process (Bleijenberg et al., 2018).

The initial draft of the APT4U2 Program was based on the perceived training needs of NHPVs, supported by theoretical models used to construct questionnaires that identified potential training needs. It also drew from the conclusions of the scoping review and the expertise of researchers experienced in training for mental health and working with asylum seekers in humanitarian contexts.

The APT4U2 Program, along with its Facilitators and Participants Manuals, was validated by a multidisciplinary group of eight experts (table 1). These experts evaluated the content, structure, and duration of the program and manuals through a focus group method using a semi-structured script (Appendix 1) in March 2024. These specialists, all

holding PhDs (six women, two men), have over 10 years of experience in fields such as mental health and psychiatric nursing, public health, education, and psychology.

TABLE 1 *Characteristics of the focus group' experts*

Code	Sex (F – Feminine M- Masculine)	Age (years)	Field of Expertise	Educational Level
I1	F	57	Mental Health Nursing	PhD
I2	F	45	Psychology	PhD
I3	F	58	Mental Health Nursing	PhD
I4	F	65	Nursing	PhD
I5	M	59	Mental Health Nursing	PhD
I6	F	37	Psychology	PhD
I7	M	32	Public Health	PhD
I8	F	56	Mental Health Nursing	PhD

Regarding the regarding the duration, relevance and adequacy of the themes and content included in the APT4U2 Program, the experts refer: I2:” *In terms of the content, I really liked it. It has relevant content, it is quite comprehensive, which allows an overview (...) and I find it interesting how it was designed (...)I think you have gathered the important content in the short time that is the 11hours of training and addressed the topics that I think are the most relevant for volunteers.*”; I4: “*I also find the content interesting. I think it is well structured. It's easy to see the chain (...)this program will certainly help them identify and refer vulnerable young people and will certainly help them to find strategies to improve their own mental health(...) I think the sessions time is adequate.*”; I8:” *Regarding the program contents I think they are very interesting (...)the information is presented in a very systematize in modules and lessons and in an easy way to use in the training(...) If this were more formal training, more hours would be justified. Being for volunteers who often prepare shortly beforehand, I think it is more than enough*” and I8: “*It is very well structured. With great rigor in the design. The design*

is very pleasant, and the presentation is very rigorous and very suitable for its application. It is a huge work with a lot of scientific rigors."

Still regarding the APT4U2 Program, in relation to exercises and complementary activities, one dynamic were recommended to be modified and the change were unanimously decided and approved during the focus group. The proposed dynamic was the role-play of being an asylum seeker and getting on a boat talking about the emotions felt. Some of the experts reported that: I1: *"We have already done a similar exercise and it can trigger negative feelings for people with previous traumatic situations"*; I2: *"People can feel comfortable sharing strong emotions and may trigger the (...) the other activities, I really liked them"*; I8: *"...trigger post-traumatic stress in some people, because some people may have actually experienced a situation like this"* and I5: *"... they may have post-traumatic stress not experienced in the first person but indirectly"*.

The activity was unanimously modified to make NHPVS reflect on the items they would take with them in a bag on a journey if they were to become asylum seekers and the role-play was removed from the APT4U2 Program.

Regarding the manuals, the experts found that APT4U2 Facilitators Manual provided adequate and understandable instructions to help facilitators guide participants through the program: I4: *"Very well structured and explicit regarding the times and strategies for each content and activity. The facilitator has all the very complete material in the manual"*; I3: *"The facilitator has all the material in a very complete manual, very descriptive and well structured"*. The APT4U2 Participants Manual is I2: *"Great manual with the same sections' name of the facilitators manual but as it is for participants need more images and, maybe, subsections"*; I4: *"Well structured(...) It was interesting to have flashy covers with key ideas(...) And I think it's also interesting to have participants evaluating the program in the end, so the program can be improved after it is implemented"* and I7: *"It could have a summary in the end of the section, just to resume the principle ideas"*. As the suggestions for improvement in the APT4U2 Participants' Manual do not change the content, which was considered comprehensible and appropriate to the proposed themes, some illustrative images were included in the manual in accordance with the experts' suggestions.

The experts asked to discuss the eligibility criteria for facilitators and participants. According to the previously defined criteria, APT4U2 Facilitators would have to: a) Be mental health specialized nurses or nurses with mental health and/or psychiatric training; b) speak English fluently; c) have prior experience working directly with asylum seekers, internally displaced people and/or refugees; and d) have successfully completed the

APT4U2 Program; and the Participants should: a) be interested in the topic and motivated to attend the 11-hour training; b) speak English.

Regarding the criteria for being a facilitator, a question was raised related to absolute training in mental health and/or psychiatric nursing, particularly in countries where such categories do not exist. According to experts: I5: *"(...)nurses being the facilitators, it makes sense to me, as the program begins to explain the life transitions associated with migration and the suffering that comes with it... but it can affect the number of facilitators. For example, in some countries this category does not exist";* I7: *"You may be conditioning "facilitators training" if you condition to a mental health nursing category. Why not expand in countries where this category does not exist, to be able to be another mental health specialist with experience in fieldwork?";* I5: *"I agree (...) it is necessary to ensure that absolute criteria are not used for the selection of facilitators(...) we need these training programs"* and I3: *"It seems good to me that we can offer the possibility of other professionals with experience working in the field and with training in mental health if there are no nurses in the context or country".*

Still regarding the APT4U2 facilitators, the experts encouraged the facilitators to have the possibility of providing medium-range support to new facilitators: I4: *"(...)someone behind the scenes to support the facilitators";* I5: *"It's important for facilitators to have(...) someone who can give them support (...)a non-formal monitoring for a while".* With this purpose, small changes to the criteria for being an APT4U2 facilitator were considered. The changes include the possibility that the APT4U2 Program can be administered by non-mental health and psychiatric nurses, who have mental health training and experience working with asylum seekers, especially in contexts where this professional category is not available. Additionally, a new criterion was included: the person who becomes an APT4U2 facilitator must have the possibility and availability to maintain middle-range support contact with the training groups to provide support and share experiences for 6 months to 1 year, for example in non-formal group meetings.

Regarding the inclusion of participants in the APT4U2 Program, possible criteria were discussed. Experts argue that: I6: *"(...)some volunteers, perhaps, are not yet capable of carrying out this work";* I7: *"I understand that you cannot create too many criteria for participants, they are volunteers we cannot prevent them from participating in training. But We can alert facilitators to the possibility of participants who may have little psychological resources to carry out this training";* I4: *"In relation to the participants, if we notice that they are not doing so well, we need to provide support".* The participant criteria

were not changed, but it was emphasized that facilitators need to address warning signs when participants appear to lack the psychological resources to attend the training.

3. RESULTS

The APT4U2 Program and the supporting materials were developed following the development phase of the Medical Research Council's Complex Interventions model. All the material developed was validated by a group of experts. There was a high level of consensus among experts regarding the themes and contents of the APT4U2 Program, regarding the adequacy of the structure and duration of the APT4U2 Program, as well as the high acceptance of the adequacy and relevance of the manuals.

The APT4U2 Program will be facilitated preferably by mental health and psychiatric nurses and will run for 11 hours. It consists of three modules and five lessons. Module 1 "*From the Project to the Program*" starts with an introduction to the project and the program (table 2).

TABLE 2 – *Module 1: From the Project to the Program*

Lesson 1 – A: Introduction to the APT4U2 Program
1.1. Presentations
1.2. APT4U2 Project
1.3. APT4U2 Program: Objectives, Structure and Contents
1.4. Prior appraisal
Total Time – 60 minutes

Module 2, titled "*Young People and The Migration Process*" has two lessons. The first one has an approach to migration processes focuses on global migration with an emphasis on its impact on young asylum seekers and it will cover the explanation about the Overwhelming Extreme Life Transition of young asylum seekers. In a second lesson it will be covered the essential skills needed to work with young asylum seekers (table 3) highlighted by the literature and volunteers in the previous studies (fig 1).

TABLE 3 – Module 2: Young People and the Migration Process

Lesson 2– A: The Young Asylum Seeker	Lesson 2– B: Working with Young Asylum Seekers
2.1. The Young Asylum Seeker	2.2. Working with Young Asylum Seekers
2.1.1. From the journey of survival to temporary reception	2.2.1. Basic Competences
	2.2.1.1. Organizational Management
2.1.2. Repercussions of Migration Processes	2.2.1.2. Cultural Abilities
2.1.3. Young People as Asylum Seekers	2.2.1.3. Communication
2.1.3.1. Overwhelming Extreme Life Transition	2.2.1.4. Health
2.1.3.2. Protection of Young Asylum Seekers	2.2.2. Reflection Activity “Me, in his place”
Total Time – 100 minutes (1:40h)	Total Time – 240 minutes (4h)

Module 3 addresses “*Health and Mental Illness*” and has two lessons. The first one focused in the “*APT Intervention*” (Assess, Plan, Take Over) that will guide volunteers to recognize signs and symptoms of mental suffering, how to make referrals, and how to provide psychosocial support during volunteer role. The second lesson of this module will focus on mental health self-care, enabling volunteers to better care for them and for young asylum seekers (table 4).

TABLE 4 – Module 3: Mental Health and Illness

Lesson 3 – A: From Health to Mental Illness is a migration away	Lesson 3 – B: Taking Care of Us to Take Care of Others
3.1. From Health to Mental Illness is a migration away	3.2. Taking Care of Ourselves to Take Care of Others

3.1.1. APT4u2 Framework	3.2.1. In Preparation
3.1.2. APT Intervention	3.2.2. In Action
3.1.2.1. APT Intervention Assumptions	3.2.3. In Assessment
3.1.2.2. A: Assess	3.3. Final evaluation
3.1.2.2.1. The Person in Acute Stress (to Trauma)	Total Time – 60 minutes (1h)
3.1.2.2.1.1. Complementary Activity No. 5	
3.1.2.2.2. The Person and the experience of Grief	
3.1.2.2.3. The Person and depressive symptoms	
3.1.2.2.4. The Person and Suicidal Behaviours	
3.1.2.2. P: Plan	
3.1.2.3. T: Take Over	
3.1.3. Complementary Activity nº 6	
Total Time – 200 minutes (3:20h)	

The APT4U2 Facilitators Manual is divided into two parts. The "Part I – Introduction To The APT4U2 Program", includes an explanation of the program's origin, its objectives, an overview of the program, and instructions on how to prepare and conduct sessions to guide volunteers throughout the training. This part also addresses the strategies and dynamics for each of the proposed activities, as well as the conditions necessary for the facilitator to successfully carry out the training. The "Part II –APT4U2 Program Modules", covers each of the modules and lessons of the APT4U2 Program. Each module and lesson include a description of the training content, as well as the content itself, with the training strategy inherent to each topic detailed in the trainer's notes (figure 2).

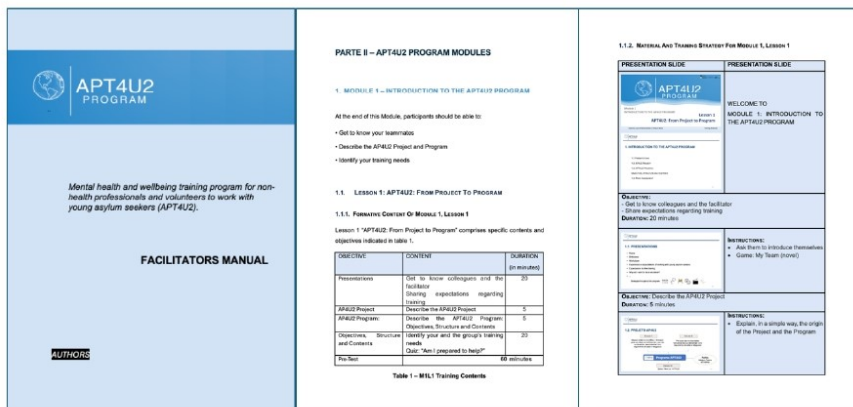


Figure 2 – APT4U2 Facilitators Manual (example)

The APT4U2 Participants Manual is structurally presented by the Modules and Lessons that make up the APT4U2 Program, so the participants can follow the teaching material with additional and more detailed information in its support manual (figure 3).

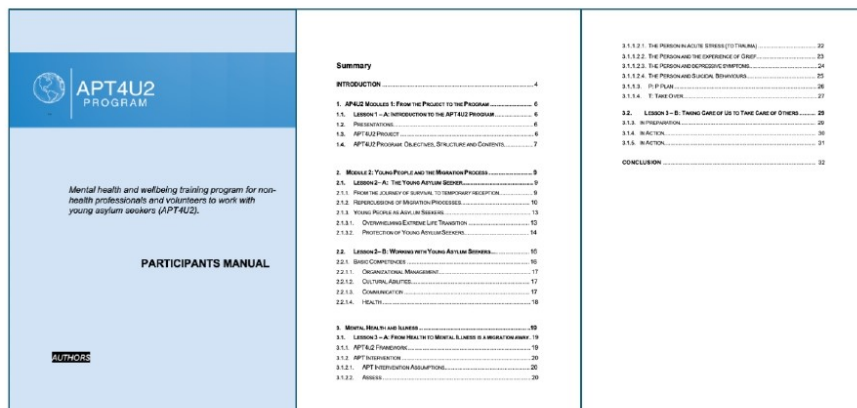


Figure 3 – APT4U2 Participants Manual (example)

4. DISCUSSION

This study aimed to present the development of the APT4U2 Program following the development phase of the Medical Research Council's Complex Interventions model (Bleijenberg et al., 2018; Craig et al., 2008). Our results show in detail how it was possible to build the APT4U2 Program, an evidence-based approach to addressing a critical gap in the training of NHPVs working with asylum seekers. The APT4U2 Program aims to

equip NHPVs with the necessary skills to recognize and address mental health issues among young asylum seekers, providing psychological support to asylum seekers and safeguarding the mental well-being of volunteers.

The development of the APT4U2 Program started with the problem identification highlighting the lack of mental health training among NHPVs, identifying it as a critical gap in the scoping review done in the beginning of this project. The few available programs were often inadequate, culturally limited, or lacked proper control over knowledge acquisition (Teixeira-Santos et al., 2023). Field research in refugee camps (Teixeira-Santos & Monteiro, 2018) and subsequent surveys confirmed that most volunteers lacked adequate preparation, leading to significant mental health challenges (Teixeira-Santos et al., 2024b). These results are in line with what the little literature on NHPVs and their work states. Although NHPVs are considered to have a crucial role in assisting asylum seekers, they lack the training to provide this assistance (Muraleedharan & Bryer, 2020).

Following the evidence base and the identification of theoretical models phases the development of the APT4U2 Program incorporated existing theoretical models and frameworks, such as the UNHCR competency framework (United Nations, 2017a; United Nations, 2017b) and cultural competency models (Campinha-Bacote, 2002; Giger & Davidhizar, 1999) to ensure comprehensive and relevant training content.

The contents of the APT4U2 Program also included the needs assessment, based on the actual practice, and the competency modelling phases. Surveys and studies involving NHPVs identified specific training needs, emphasize the importance of managing stress and protecting mental well-being (Teixeira-Santos et al., 2024a; Teixeira-Santos et al., 2024b). The program development involved creating validated questionnaires to assess competencies in organizational management, cultural abilities, communication, and health skills. These competencies were incorporated into the APT4U2 Program to ensure relevance and effectiveness.

During the intervention design and expert validation phases the APT4U2 Program was designed with input from experts in mental health, public health, education, and psychology. Their feedback ensured that the program was comprehensive, structured, and appropriately tailored to the needs of NHPVs. Adjustments were made to activities that could potentially trigger negative emotions, and the program was refined to balance the needs of asylum seekers and the psychological resilience of volunteers. The APT4U2 Program covers key areas such as recognizing mental suffering, providing psychosocial support, and ensuring volunteers' mental health. The program includes manuals for both

facilitators and participants, ensuring consistency and thoroughness in training delivery. It is prepared to be conducted over 11 hours and has eligibility criteria for facilitators and participants so that it can be as feasible, appropriate, meaningful and effective as possible.

5.1. Limitations

The study had some limitations. First, the cross-sectional design of the 3rd study only captured a single point in time, missing longitudinal changes. Additionally, the sample size of 91 NHPVs, while diverse from 6 continents, might not represent all volunteers working with asylum seekers worldwide, limiting the generalizability of the findings. Lastly, the training program was developed based on the specific contexts and needs of NHPVs, most of whom have experience in European humanitarian contexts, which could limit the program's applicability in other continents.

5. CONCLUSION

The development of the APT4U2 Program exemplifies a thorough, evidence-based approach to addressing a critical training gap for NHPVs working with asylum seekers. Following MRC principles for complex interventions, the program aligns with best practices and theory, offering a replicable and adaptable model for various contexts and populations. Developed by mental health and psychiatric nurses, it is designed to be delivered by these professionals to empower NHPVs without mental health training who care for young asylum seekers undergoing extreme life transitions.

6. RELEVANCE FOR CLINICAL PRACTICE

Addressing this training gap in clinical practice holds substantial relevance. Mental health nurses, with their specialized expertise in managing life transitions and understanding the emotional impact of disruptive events, are pivotal in educating NHPVs. The development and implementation of programs like APT4U2 by mental health nurses underscore their critical role in enhancing the competencies of volunteers. Through such initiatives, volunteers are equipped with essential skills and knowledge, significantly improving their capacity to effectively support young asylum seekers. This not only fills a crucial training void but also fosters better mental health outcomes for asylum seekers through informed and compassionate volunteer assistance. Consequently, the

integration of mental health nurses into volunteer education programs profoundly elevates the standard of care and support provided to these vulnerable populations.

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APPENDICES

APPENDIX 1 – PROJECT APT4U2: VALIDATION OF THE APT4U2 PROGRAM

SEMI-STRUCTURED FOCUS GROUP SCRIPT – EXPERTS VALIDATION

GENERAL OBJECTIVE: Validate the contents, structure, and duration of the APT4U2 Program and manuals.

Objectives	Topic to cover (focus of conversation)	Questions
<p>Objective 1:</p> <p>Obtain information about experts' opinion regarding the relevance and adequacy of the themes and content included in the APT4U2 Program.</p>	<ul style="list-style-type: none"> - Relevance of themes - Relevance of Content - Adequacy of themes and content to the target audience 	<p>GENERAL QUESTION:</p> <ol style="list-style-type: none"> 1. In general, what are the strengths and weaknesses of the APT4U2 Program? 2. In your opinion, do the themes and contents respond to the objectives of the APT4U2 program? 3. Are the themes and content suitable for the target audience? 4. Throughout the program, do you consider that the language is clear and suitable for future facilitators? 5. Are the complementary activities in the different modules suitable for the target audience? 6. Is the evaluation questionnaire appropriate to the contents and objectives of the program?
<p>Objective 2:</p> <p>Obtain information regarding the adequacy of the structure and duration of the APT4U2 program, given the content presented.</p>	<ul style="list-style-type: none"> - Structure into modules and lessons - Duration of the program in relation to the content 	<ol style="list-style-type: none"> 7. In your opinion, is the structure of the program adequate? 8. Regarding the duration of the modules and lessons, do you consider it appropriate for the training developed?
<p>Objective 3: Obtain information about the suitability and relevance of the Facilitator Manual.</p>	<ul style="list-style-type: none"> - Adequacy of APT4U2 Facilitators Manual 	<ol style="list-style-type: none"> 9. Do you consider that the facilitator manual provides adequate and understandable instructions to help facilitators guide participants through the program? 10. What items could be improved in the facilitator's manual?
<p>Objective 4: Obtain information about the adequacy and relevance of the Participant Support Manual.</p>	<ul style="list-style-type: none"> - Adequacy of APT4U2 Participants Manual 	<ol style="list-style-type: none"> 11. In your opinion, does the manual present a comprehensive description of the themes, clarifying the themes and their contents for participants? 12. What items could be improved in the facilitator's manual?

CAPÍTULO IV
DISCUSSÃO GERAL E PERSPETIVAS FUTURAS

CAPÍTULO IV - DISCUSSÃO GERAL E PERSPECTIVAS FUTURAS

Os resultados dos estudos empíricos realizados culminaram no desenvolvimento do Programa APT4U2 – Programa de formação em saúde mental e bem-estar para voluntários e profissionais, que não os de saúde, trabalhem com requerentes de asilo. Como descrito ao longo da tese e nos artigos científicos, o desenvolvimento deste programa segue a Fase de Desenvolvimento otimizada do Modelo de Intervenções Complexas do MRC¹⁴⁹⁻¹⁵².

O desenvolvimento desta tese parte da necessidade de dar resposta aos três grandes objetivos que culminaram no desenho do Programa APT4U2. Para o desenho deste programa de formação procedeu-se: ao mapeamento da evidência científica relativamente à formação no âmbito das competências em saúde mental para profissionais e voluntários, que não os de saúde, trabalhem com requerentes de asilo independentemente do contexto; à identificação das necessidades formativas destes profissionais e voluntários para trabalhem com jovens requerentes de asilo; e, por fim, ao desenvolvimento e validação teórica do Programa APT4U2, que integrou evidências científicas e considerações empíricas das necessidades formativas dos voluntários que trabalham com requerentes de asilo.

O desenvolvimento do Programa APT4U2 (*apto para ti também*) parte de uma questão crítica, muitas vezes negligenciada, no que concerne aos desafios em saúde mental enfrentados pelos requerentes de asilo nas diferentes fases da sua jornada, desde a sua origem até ao destino, e que influencia o seu processo de integração nos países de acolhimento. Os eventos traumáticos a que são expostos aliados às condições indignas de alojamento temporário¹⁵⁻¹⁷ em que são colocados resultam em elevados níveis de sofrimento mental¹⁰⁴⁻¹⁰⁸.

A carência em cuidados de saúde mental a estas populações são um grande desafio para a saúde mental global^{153,154}, especialmente devido à complexidade que os rodeia, nomeadamente barreiras à receção de cuidados de saúde (legais e linguísticas), fatores de aculturação, falta de compreensão sobre como aceder aos cuidados, falta de seguro de saúde e estigma de saúde mental, entre outros¹⁵³⁻¹⁵⁶. Por estas razões, com frequência, o contato entre os requerentes de asilo e os serviços de proteção, educação ou de saúde, são mediados por ONGs^{30,31}, cujos voluntários que as integram carecem de conhecimentos e competências para lidar com o sofrimento destas populações³¹, culminando, não poucas vezes, no desenvolvimento de perturbações da saúde mental para os próprios³⁶⁻³⁸.

Para lidar com a escassez de profissionais de saúde no mundo, especialmente em contextos humanitários, locais de conflitos, desastres e pobreza que, conseqüentemente, culminam num aumento de requerentes de asilo, a OMS propõe a formação em saúde mental de leigos para que possam prestar apoio psicossocial a estas populações¹⁵⁷. Esta orientação da OMS é ainda integrada nas diretrizes recomendadas pela Comissão Permanente Interagências das Nações Unidas que propõe intervenções em saúde mental por membros das comunidades, desde que treinados, para aumentar a resposta na assistência humanitária¹⁵⁸.

Com o intuito de perceber quais os programas disponíveis para a formação em saúde mental dos voluntários leigos que integram as ONGs, realizou-se um estudo de revisão *scoping*⁴⁴. Compreendendo-se que muitas das formações para leigos poderiam não estar disponíveis apenas em bases de dados científicas, a revisão foi precedida por um protocolo de revisão *scoping*⁴⁵ que permitiu direcionar a pesquisa e selecionar dezasseis diferentes fontes de informação das quais se poderiam extrair informações relevantes. A revisão destaca o aumento, em particular desde 2015, do número de estudos científicos relacionados com programas e/ou intervenções para treinar competências em saúde mental de voluntários sem formação na área da saúde para trabalharem com requerentes de asilo. Essa tendência parece ser uma resposta direta ao aumento no número de pessoas deslocadas por razões de sobrevivência nos últimos anos⁴⁴.

Dos 8.954 documentos revistos, destacam-se apenas 11 programas ou intervenções relacionadas com a formação em competências de saúde mental para voluntários que trabalhem com requerentes de asilo. A maioria dos programas ou intervenções existentes focam-se na orientação dos voluntários sobre formas de prestar ajuda humana, solidária e prática aos requerentes de asilo que vivenciam momentos de crise. Contudo, variam consideravelmente tanto na duração, que pode ir desde algumas horas num único dia a algumas semanas; quanto na administração, já que alguns são de autoaprendizagem e outros administrados por líderes ou voluntários com mais experiência⁴⁴.

A diversidade nas intervenções utilizadas nos estudos incluídos na revisão representam tanto uma força quanto uma fraqueza. Por um lado, refletem o investimento que tem sido feito para atender as necessidades locais emergentes dos requerentes de asilo, assim como as necessidades das pessoas que com eles trabalham, para que possam prestar o melhor suporte preservando a sua própria saúde mental. Por outro, a heterogeneidade dos programas incluídos dificultam a interpretação de resultados e a comparação entre eles, até porque alguns dos estudos incluídos eram apenas protocolos de intervenção, não se

podendo inferir qualquer conclusão dos resultados. Os resultados revelaram que, dos poucos programas disponíveis, os existentes são inadequados, focados em diagnósticos psiquiátricos específicos, culturalmente limitados ou careciam de controlo adequado sobre a aquisição de conhecimento⁴⁴.

Estes achados têm implicações importantes para os profissionais de saúde, decisores políticos e outros intervenientes interessados no desenvolvimento e planeamento da formação em saúde mental para voluntários, principalmente integrados em ONGs, que trabalham em contextos de acolhimento na assistência humanitária. Parece haver um interesse no investimento nestes programas de formação em competências de saúde mental para voluntários que trabalham com requerentes de asilo, indo ao encontro da premissa de que os profissionais de saúde, embora não estejam nesta linha da frente, são o veículo de informação fidedigna que permite a estes voluntários fornecerem o apoio psicossocial em comunidades com recursos limitados, desde que devidamente treinados para tal¹⁵⁹.

O desenho do Programa APT4U2 incorporou algumas das considerações apontadas pelos resultados da revisão *scoping* no sentido de minimizar as fraquezas previamente encontradas noutros estudos. Nomeadamente, garantindo que o programa seja administrado por profissionais qualificados, especificamente enfermeiros especialistas em enfermagem de saúde mental e psiquiatria; que seja concebido com um pré e pós-teste que permita avaliar a efetividade da aquisição de conhecimentos; e que possa ser aplicável independentemente da origem cultural, religiosa ou étnica em qualquer contexto, tornando transversal, útil e sustentável. Para permitir que o Programa APT4U2 seja considerado um programa de formação viável, adequado, significativo e eficaz, deve, além de ser baseado em evidências científicas, ser também baseado nas necessidades formativas apresentadas pela experiência empírica dos voluntários que trabalham diariamente com requerentes de asilo¹⁵⁹.

Para compreender as necessidades formativas destes voluntários, a equipa de investigação desenvolveu um inventário inicial com 49 itens, representando cada um deles uma potencial necessidade de formação. Estes itens foram categorizado de acordo com os domínios de competências e divididos por 4 questionários: Gestão Organizacional, Habilidades Culturais, Comunicação e Saúde¹⁶⁰. Este inventário sustentou-se nos quadros de competências utilizados pelo ACNUR para a contratação e formação dos seus voluntários^{161,162}, no Modelo de Competência Cultural de Campinha-Bacote¹⁶³ e no Modelo de Avaliação Transcultural de Giger e Davidhizar¹⁶⁴. A inclusão de modelos no âmbito das

competências culturais mostra a importância de estas estarem alinhadas e guiarem as habilidades práticas que permitem atuar eficazmente em contextos multiculturais. Os questionários foram validados por especialistas com experiência humanitária e foram considerados fáceis de utilizar, válidos e fiáveis para avaliar as necessidades de formação¹⁶⁰. Posteriormente, os mesmos serviram de base à exploração das necessidades formativas de 91 voluntários de 35 países diferentes. Neste estudo também foi utilizado um inquérito sociodemográfico para contextualizar as experiências de formação e trabalho de campo dos voluntários, uma vez que estes fatores poderiam influenciar as suas perceções sobre as necessidades formativas³⁴.

Apesar de 74%, dos 91 participantes, concordaram com a importância dessa formação, sendo que aqueles com experiência anterior de formação apresentaram uma concordância significativamente maior, apenas 52% dos destes receberam formação. A maioria desta formação foca-se em 1 ou 2 tópicos, frequentemente relacionados com questões logísticas. Os resultados contrastam com as necessidades percebidas dos voluntários que destacam como elemento fundamental da formação, a necessidade de aumentar o conhecimento sobre estratégias para ajudar populações vulneráveis e gerir situações de stress. Estes achados são independentemente da sua experiência profissional ou de formação neste âmbito, destacando-se a importância que os voluntários atribuem a ajudar os outros, protegendo o seu próprio bem-estar mental em situações de vulnerabilidade, transparecendo a sua consciência dos potenciais desafios de saúde mental. Estes resultados vão ao encontro da posição defendida pela OMS e pelas Nações Unidas^{157,158} de que é essencial a formação em saúde mental dos voluntários. Considerando que a grande parte dos voluntários é, na maioria das vezes, integrada em ONGs não profissionais ou trabalha em regime *freelancer*, nos quais não existe um processo de seleção criterioso ou de rastreio quanto aos recursos psicológicos individuais para trabalhar com requerentes de asilo, considerou-se não criar voluntários garante cuidados adequados aos requerentes de asilo, enquanto promove o bem-estar e a segurança dos próprios voluntários¹⁵⁹.

No entendimento de que os programas existentes apresentam lacunas e de que os voluntários têm carências de formação adequada, ainda que compreendam a sua importância, a equipa de investigação parte para o desenvolvimento do protótipo¹⁶⁵ do Programa APT4U2, incluindo materiais didáticos e manuais de facilitador e participante. A modelagem do protótipo¹⁵² teve contributos de dois peritos enfermagem humanitária e em enfermagem de saúde mental. O Programa APT4U2 teve em consideração os quadros de competências^{161,162}, modelos identificados^{163,164}, e a perceção das necessidades formativas dos próprios voluntários³⁵, evitando as fraquezas encontradas na revisão inicial⁴⁴

permitindo que se torne uma ferramenta de trabalho eficaz para a formação de voluntários que trabalham com requerentes de asilo¹⁵⁹.

O Programa APT4U2, o seu Manual para os Facilitadores e Manual para os Participantes foram validados por oito peritos, em grupo focal, que avaliaram conteúdo, estrutura e duração. Os peritos destacaram a relevância e adequação dos temas abordados na formação, considerando a estrutura, duração e apresentação do conteúdo apropriadas aos voluntários. As pequenas alterações ou sugestões foram discutidas durante, ficando aprovadas por maioria. Os manuais foram considerados adequados, com sugestões para incluir mais imagens e resumos ao final das seções¹⁵⁹.

Quanto aos critérios de elegibilidade para facilitadores e participantes, decidiu-se flexibilizar os critérios para facilitadores em contextos onde não existam categorias específicas de enfermeiros em saúde mental, permitindo que outros profissionais com experiência e formação em saúde mental possam atuar como facilitadores. É evidente a deficiência dos profissionais de saúde mental, em particular dos enfermeiros de saúde mental¹⁶⁶. Quanto aos participantes, os critérios de elegibilidade para participar na formação são apenas os essenciais, relacionados com o idioma e motivação, já que o aumento da literacia é sempre uma mais-valia. Contudo, os facilitadores deverão monitorizar os sinais dos participantes que transmitam a falta de recursos psicológicos para trabalhar com estas populações vulneráveis, alertando-os sobre a sua preparação e apetência para tal¹⁵⁹. Esta decisão permite que a formação esteja disponível a um maior número de voluntários que trabalham com requerentes de asilo, já que estão expostos a consequências adversas em termos de saúde mental³⁶⁻³⁸, as quais variam de acordo com a formação prévia para este trabalho³⁹⁴¹, sendo menos evidente nos voluntários que a tiveram formação no âmbito da saúde mental⁴².

O Programa APT4U2, facilitado preferencialmente por EESMP, tem uma duração de 11 horas e é composto por três módulos e cinco lições. Tem como objetivos principais que os voluntários sejam capazes de reconhecer sinais de sofrimento mental dos jovens requerentes de asilo, referenciando-os para cuidados especializados; prestar apoio psicossocial durante o processo de requerimento de asilo destes jovens

O Módulo 1, "Do Projeto ao Programa", apresenta uma introdução ao projeto e ao Programa APT4U2, fazendo uma breve explicação do surgimento e desenvolvimento dos mesmos.

O Módulo 2, "Jovens e o Processo de Migração", possui duas lições. A lição 2 A, intitulada "O Jovem Requerente de Asilo" aborda os processos migratórios e a transição de vida extrema e avassaladora que estes jovens vivenciam. A inclusão deste módulo baseia-se na perspectiva de que os voluntários que trabalham com estas populações vulneráveis sujeitam à migração forçada devem entender as transições de vida desde o deslocamento à integração, no sentido de abordar e compreender as suas reais necessidades e garantir a sua segurança¹⁶⁷⁻¹⁶⁸. A compreensão das transições de vida para melhor poder dar resposta às necessidades identificadas e, com isso, ajudar a pessoa a atingir resultados saudáveis após um período de mudanças vivenciado, é também uma das premissas mais defendidas pelos enfermeiros, sendo a teoria das transições uma das maiores influências da prática dos cuidados em enfermagem^{46, 111-113}. A Lição 2 B, intitulada "Trabalhar com Jovens Requerentes de Asilo", aborda as competências básicas para trabalhar com esta população. O saber agir dos voluntários deve ser sustentado na compreensão geral das vivências dos requerentes de asilo que, como explicado anteriormente, causam grande sofrimento psicológico e manifestam-se em comportamentos (verbais e não-verbais) que o voluntário precisa de avaliar para poder providenciar a ajuda necessária. A compreensão da manifestação do sofrimento mental vai muito além das padronizações identificadas na literatura científica. A complexidade das transições vividas e o *background* cultural, religioso, linguístico que influenciam crenças e valores moldam os comportamentos e a compreensão dos mesmos. Neste sentido, a formação adequada em cuidados às populações sujeitas a migração forçada deve envolver formação culturalmente adequada, que inclui autorreflexão e compreensão do contexto de cuidados, dinâmicas de poder, e competências eficazes para se envolver e cultivar práticas de afirmação cultural¹⁷⁰⁻¹⁷³. Além disso, cuidar desta população requer uma compreensão profunda do processo migratório, de aculturação e da dinâmica das políticas de acolhimento, que estão historicamente inseridas em práticas pouco humanas¹⁷⁴⁻¹⁷⁵. É nesta linha de pensamento que o APT4U2 promove a discussão do contexto dos cuidados aos requerentes de asilo, fornecendo exemplos específicos, e potenciando a reflexão e o trabalho de grupo nas atividades complementares, abordando a sinergia entre as diversas competências básicas que permitem trabalhar com requerentes de asilo. Como descrito anteriormente, estas competências de gestão organizacional, culturais de comunicação e em saúde, são o culminar entre o que a literatura refere ser importante e o que os voluntários identificaram nos estudos realizados no âmbito dos trabalhos desta tese^{34,160}.

O Módulo 3, "Saúde e Doença Mental", também apresenta duas lições. A Lição 3 A, "Da Saúde à Doença é uma migração de distância", na qual se aborda a *Framework de Intervenção APT*_{4U2} é uma ferramenta para auxiliar voluntários e profissionais que queiram

trabalhar com jovens requerentes de asilo e, que devido à complexidade das suas necessidades e circunstâncias, precisam de uma orientação para a ação (figura 2).

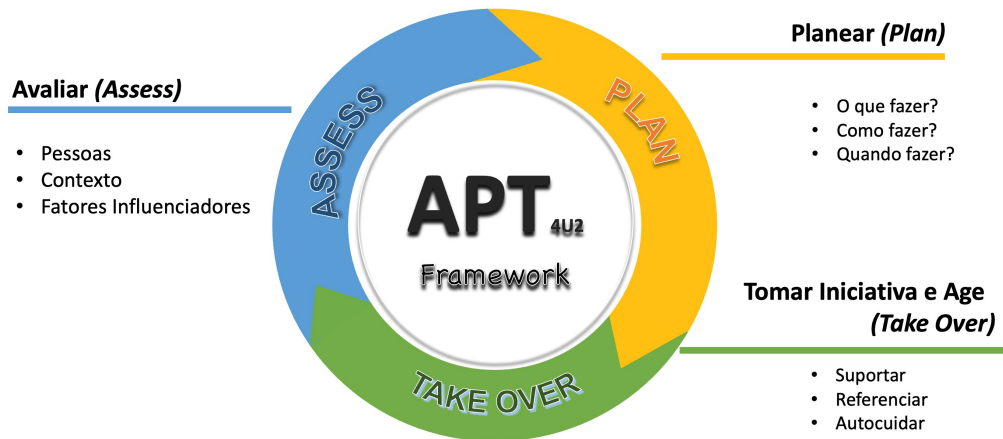


Figura 4 – Framework de Intervenção APT4u2

Esta framework de ação integra a Intervenção APT, a intervenção que se baseia em 3 passos para a ação: Avaliar, Planear e Tomar Iniciativa e Agir (Figura 4), a qual se baseia na simplificação da execução do processo de enfermagem¹⁷⁶ tendo por base a compreensão das transições de vida^{46, 111-113}, que permite guiar o voluntário na sua intervenção no que concerne aos objetivos principais desta formação no âmbito da saúde mental: reconhecer sinais de sofrimento mental nos jovens requerentes de asilo, referenciando-os para apoio especializado disponível e ser capazes de prestar apoio psicossocial aos jovens durante o processo de requerimento de asilo, protegendo a sua saúde mental. No essencial esta ação de intervenção incentiva o voluntário a **Avaliar** pessoas, contextos e fatores influenciadores permite uma compreensão abrangente das experiências individuais e dos desafios enfrentados pelos jovens requerentes de asilo, permitindo ter em consideração aspetos como as experiências de vida, o impacto das mesmas para si, assim como os sentimentos e significados a elas atribuídos^{46, 111-113}. Numa analogia comparativa que guia o trabalho diário dos enfermeiros, o ensino desta fase aos voluntários permitir-lhes-á ganhar destreza para promover o contato inicial, colhendo informações por parte dos jovens requerentes de asilo, e/ou de fontes secundárias quando possível, enquadradas naquele contexto, marcadas pelos fatores influenciadores da pessoa e do contexto^{176,177}. Esta avaliação informada é crucial para a fase de **Planear** uma intervenção eficaz, que deve ser adaptada às necessidades específicas e decisão de cada indivíduo, considerando o que fazer, como fazer e quando fazer para maximizar o impacto

positivo com o jovem requerente de asilo. Esta etapa permite delinear estratégias individuais que abordam as necessidades identificadas durante a avaliação¹⁷⁷. Este planeamento, que pode ser individual discutido com os jovens requerentes de asilo, beneficia muito se for realizado em *brainstorming* de ideias com outros voluntários ou profissionais mais experientes. Pode incluir facilitar o acesso a cuidados ou profissionais especializados de saúde mental, prestar suporte emocional, sensibilizar sobre questões de saúde e bem-estar, fornecer apoio psicossocial. No fundo é a forma como o voluntário preparado pode ajudar o jovem tendo em conta as suas opiniões, necessidades, crenças e desafios que enfrenta no momento. A personalização deste planeamento torna-o relevante, maximizando o potencial de efetividade da intervenção transmitindo segurança ao voluntário que todos os dias cuida destes jovens requerentes de asilo, mas também aos próprios requerentes que se sentem ouvidos e apoiados durante o longo período de requerimento de asilo¹⁵⁹. O voluntário pode, de seguida, **Tomar Iniciativa e Agir**, enfatizando a importância de agir, particularmente no suporte contínuo¹⁷⁷ de que os jovens requerentes de asilo necessitam. O suporte contínuo é vital para garantir que os jovens recebam assistência continuada à medida que enfrentam desafios na sua jornada de integração. A atitude consciente do voluntário querer ajudar e operacionalizar pode passar por ensinar a resolver problemas, a gerir o stress, informar e sensibilizar sobre as manifestações de sofrimento mental, assim como referenciar quando acredita que o jovem beneficia de apoio especializado, ampliando o seu acesso a uma rede mais ampla de suporte¹⁵⁹.

O APT4U2 é ainda constituído por dois manuais. O **Manual dos Facilitadores** do APT4U2 é dividido em duas partes. A "Parte I – Introdução ao Programa APT4U2" inclui a origem do programa, seus objetivos, uma visão geral e as instruções teóricas e estratégicas para preparar e conduzir as sessões. A "Parte II – Módulos do Programa APT4U2" aborda individualmente cada módulo e lição, detalhando os seus conteúdos e as estratégias de ensino. O **Manual dos Participantes** do APT4U2 segue a estrutura dos módulos e lições, permitindo que os participantes acompanhem o material didático com informações adicionais e mais detalhadas¹⁵⁹. A inclusão e disponibilização de manuais em programas de formação para quem presta apoio em saúde mental melhora os seus conhecimentos e competências¹⁷⁸, o que garante a consistência e minuciosidade do programa de formação¹⁵⁹.

Tratando-se do desenvolvimento de um programa de intervenção, e dada a complexidade da intervenção proposta, optou-se por adiar a sua implementação e a consequente apresentação dos primeiros resultados da sua eficácia. No entanto, o desenvolvimento do

trabalho de revisão teórica⁴⁴, assim como o levantamento das necessidades formativas dos voluntários¹⁶⁰, baseados num questionário³⁴ desenvolvido para esse propósito específico, sustentado em quadros de referências e modelos teóricos, permitiu identificar aspetos a considerar no desenho do programa apresentado¹⁵⁹. A inclusão de voluntários de 35 países do mundo, alguns dos quais refugiados com experiências de voluntariado, ainda que sem força representativa no estudo para uma análise comparativa entre grupos, permite ter uma visão abrangente das perspetivas de voluntários com interesse e experiência no trabalho com requerentes de asilo, que deram a sua opinião de forma livre e consciente de que a formação que tiveram foi insuficiente e as necessidades são diversas das temáticas abordadas nos poucos programas disponíveis.

Pese embora as mais valias apresentadas para o desenvolvimento do programa, os estudos apresentam algumas limitações. No estudo de revisão *scoping*, alguns artigos ou documentos não forneceram uma descrição pormenorizada da intervenção ou das características dos participantes que integravam os programas de formação. Em alguns faltavam dados sobre os ambientes, horários, estratégias das sessões de e o tipo de supervisão dos participantes durante ou após o a formação. Com o intuito de não perder informação foram ainda incluídos estudos que, não especificando claramente que serviam de formação para trabalhar com requerentes de asilo ou refugiados, referem tratar-se de formação para trabalham em contextos humanitários com pessoas em situação de deslocamento forçado apresentando exemplos desses cenários⁴⁴. Nos estudos que incluía, voluntários, a amostra é a principal limitação, já que, uma amostra maior poderia ter permitido a realização de análises confirmatórias. Para além disso, estes estudos, ao envolverem participantes com interesse específico na temática, recrutados através de ONGs ou grupos nas redes sociais focados em ajudar requerentes de asilo, pode introduzir viés na quantidade de itens acham pertinentes incluir num programa de formação¹⁶⁰. O desenho transversal do quarto estudo capturou apenas a perceção das necessidades formativas naquele momento, não permitindo a observação de mudanças ao longo do tempo. Embora a amostra dos participantes fosse diversa, abrangendo seis continentes, pode não representar todos os voluntários que trabalham com requerentes de asilo globalmente, limitando a generalização dos resultados. Por fim, o programa APT4U2 foi desenvolvido, em parte, com base nos contextos e necessidades específicas dos voluntários que, na sua maioria, tinham experiência em contextos humanitários europeus, o que pode limitar sua aplicabilidade em outros continentes³⁴.

Ressalva-se que, no sentido de promover a discussão dos resultados, os estudos foram publicados em revistas internacionais de relevo, permitindo uma discussão dos estudos de

forma 'cega' com revisores e editores, abraçando as críticas, sugestões e contributos dos vários intervenientes, numa atitude construtivista que torna o processo de investigação mais transparente e robusto.

No futuro pretende-se implementar o APT4U2 num estudo multicêntrico e avaliar a eficácia deste programa de intervenção para os voluntários que trabalham com jovens requerentes de asilo. Os contributos do estudo multicêntrico permitirão ganhar subsídios de voluntários em diversas partes do mundo garantindo maior robustez ao programa já desenvolvido. Para tal, em termos científicos, a próxima etapa pressupõe a realização de um protocolo de estudo de intervenção e um estudo-piloto da intervenção que poderão contribuir para melhorar o programa tendo em vista a sua viabilidade, adequação, significado e eficácia.

Os produtos científicos e intelectuais resultantes dos estudos incluídos nesta tese produziram evidência para apoiar a otimização da formação dos milhares de voluntários que, diariamente, cuidam de forma não profissional de jovens requerentes de asilo que, por razões de sobrevivência, estão expostos a eventos que condicionam para sempre a sua experiência de vida. O aumento da literacia destes voluntários, que além de cuidarem destas populações vulneráveis são, muitas vezes, mediadores das suas necessidades em saúde, é uma mais-valia, quer para os requerentes de asilo quer para os próprios voluntários que se sentem mais aptos nas suas funções. Adicionalmente, salienta-se a importância da formação ser ministrada pelos EEESMP, sensíveis às características de desenvolvimento e comportamento dos jovens requerentes de asilo, e às implicações que as experiências traumáticas podem ter na vulnerabilidade acrescida às perturbações de saúde mental^{147,148}.

Com competências reconhecidas a nível da formação em saúde, os enfermeiros são os profissionais de excelência que podem e devem estar na vanguarda da formação da população da sociedade civil que, voluntariamente, se disponibiliza para cuidar dos jovens requerentes de asilo que procuram proteção intencional e se encontram a viver a experiência mais desafiadora e traumática das suas vidas^{14,44,160}. Esta formação, sustentada em evidências científicas e ministrada por profissionais qualificados, permite aos voluntários receberem uma formação fidedigna que potencie o desenvolvimento da sua capacidade de dar suporte, de forma efetiva, os jovens requerentes de asilo. Esta formação empodera não só os voluntários, como permite, de forma indireta, aos requerentes de asilo, receberem a ajuda adequada de uma forma mais célere quanto mais literacia tiverem os voluntários que com eles trabalham diariamente¹⁵⁹.

NOTA CONCLUSIVA

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Esta tese de doutoramento teve como objetivo principal apresentar o desenvolvimento do Programa APT4U2, um programa de formação em saúde mental e bem-estar dos voluntários, sem formação em saúde e/ou saúde mental, para trabalharem com jovens requerentes de asilo. Este programa de intervenção visa capacitar estes voluntários para reconhecer sinais de sofrimento mental nos jovens requerentes de asilo, referenciando-os para cuidados especializados, e prestar apoio psicossocial adequado a esta população vulnerável no seu dia-a-dia de trabalho em contextos de vulnerabilidade.

Esta tese vem enfatizar a importância da formação adequada dos voluntários, os quais atuam como intermediários essenciais à integração dos requerentes de asilo nos países de acolhimento. Contudo, estes voluntários encontram-se particularmente vulneráveis pela falta de formação adequada para trabalhar em contextos precários com requerentes de asilo. Considerando a falta de profissionais de saúde mental nos locais de acolhimento destas populações, e a falta de formação dos cuidadores, não formais, os organismos internacionais recomendam a formação de leigos em saúde mental para prestar apoio psicossocial, abordagem que foi adotada pelo APT4U2.

O Programa APT4U2 foi desenvolvido segundo a 1ª fase do Modelo de Intervenções Complexas do MRC, visando mapear evidências científicas, identificar necessidades formativas dos voluntários e desenvolver e validar teoricamente o programa, deixando-o operacional para que possa seguir para a próxima fase metodológica do modelo MRC, a fase de pilotagem. Acreditamos que o APT4U2 representa um contributo significativo para a formação de voluntários, quer por ser sustentado em evidências científicas e por experiências reais de dezenas de voluntários, quer por ser ministrado por EEESMP. O programa pretende melhorar a capacidade dos voluntários para fornecer suporte efetivo, promovendo a integração e bem-estar dos jovens requerentes de asilo, assegurando que recebam ajuda adequada de forma mais célere e eficaz. Para além disso, este programa, ao contribuir para a literacia em saúde mental dos voluntários, permite-lhes adquirir estratégias para proteger a sua própria saúde mental.

A falta de formação adequada evidenciada pelos resultados que se explanam neste documento vieram corroborar a experiência empírica da autora desta tese. Concluídos os trabalhos que conduziram esta tese, importa refletir de onde surge a ideia e a importância do APT4U2 demonstrando de que forma pode ser um contributo significativo para a melhoria de cuidados às populações mais vulneráveis. O desenvolvimento do APT4U2 foi idealizado a partir, principalmente, de três grandes experiências humanitárias da

enfermeira que desenvolveu este projeto de intervenção. A primeira dessas experiências aconteceu em 2015, no contato com os requerentes de asilo sírios que sobrelotavam os hospitais turcos devido à guerra civil que se adensava na República Árabe da Síria. As dificuldades linguísticas, as diferenças culturais e religiosas e, em particular, as experiências traumáticas que estas pessoas relatavam fizeram crescer um interesse absoluto e genuíno em potenciar encontros culturais que permitissem dar respostas mais adequadas às suas necessidades em saúde. À data, a característica mais flagrante na prestação de cuidados era a falta de competências culturais congruentes que minavam o potencial das relações terapêuticas entre enfermeiros e requerentes de asilo. Esta percepção, a par dos relatos de utentes na primeira pessoa e das notícias sobre a temática que, à época, eram recorrentes, fizeram aumentar o interesse pela temática das migrações e pelos cuidados culturalmente sensíveis e congruentes a populações que viveram experiências traumáticas e que apresentam *backgrounds* culturais, linguísticos e religiosos distintas das pessoas ocidentais. Um ano depois, em 2016, a autora desta tese iniciou a colaboração com uma ONG médica e, sozinha, foi destacada para uma missão na Colômbia com o intuito de trabalhar com pessoas deslocadas internamente que fugiram das Forças Armadas Revolucionárias da Colômbia. Durante esta experiência profissional, para além do desafio de trabalhar com pessoas que deixaram tudo para trás por razões de sobrevivência, um dos pontos mais complexos foi a necessidade emergente de dar formação às pessoas leigas que deram continuidade ao projeto de intervenção iniciado com crianças deslocadas internas. Foram vários os acontecimentos que pautaram esta experiência, principalmente aqueles que se relacionaram com a morte de bebés e a incidência de doenças por falta de literacia e cuidados de saúde. Esta missão veio enfatizar ainda mais a necessidade de dar formação aos cuidadores informais de populações vulneráveis, visto que, também neste caso, eram estas as pessoas que mediavam, junto dos profissionais de saúde, os cuidados. E eram estes os informantes-chave que poderiam facultar as informações necessárias para que as pessoas deslocadas internamente no seu país pudessem usufruir de recursos e serviços. Nos anos que se seguiram a esta missão, os meios de comunicação social europeus retratavam histórias hediondas relacionadas com os requerentes de asilo e refugiados na Europa. As notícias não fizeram, e continuam a não fazer, jus ao que foi possível encontrar presencialmente, em 2018, nos campos de refugiados europeus. A última destas três experiências que contribuíram para sustentar empiricamente a necessidade de desenvolver este projeto de intervenção, prende-se com o trabalho diário com crianças (menores de 18 anos) requerentes de asilo alojadas nos campos de refugiados gregos. A realidade é de uma brutalidade indescritível. Os relatos de requerentes de asilo e os relatórios das ONGs sobre as condições indignas em que vivem

os requerentes de asilo exilados nos campos de refugiados gregos não são suficientes para imaginar a realidade.

Nestes campos, cercados por arame farpado e pelo exército de arma em punho, é comum comer-se duas vezes por dia, quando a comida não escasseia; é habitual usar-se um buraco no chão como casa de banho que serve para cada 300 pessoas; é natural viver num contentor ou numa tenda sobrelotada, sem aquecimento ou isolamento adequado. Naqueles campos, a autora desta tese testemunhou o sofrimento estampado nos rostos e nos comportamentos da generalidade da população que ali vive em estados de moratória. Os jovens eram os que mais relatavam as experiências traumáticas, fosse por palavras, por desenhos ou por imitação de jogos que envolvem a morte e as situações de trauma. No dia a dia de trabalho era comum encontrar jovens com alterações relacionadas com o autoconceito e autoimagem, em situação de distress psicológico, com problemas de conduta e dependências, em estados de ansiedade, depressão ou stress pós-traumático e, não poucas vezes, apresentando ideação suicida ou com tentativas de suicídio prévias. Tão triste quanto a realidade, foi verificar que os voluntários, a maioria jovens universitários em paragem de atividades letivas por algumas semanas, não sabiam lidar com tais manifestações e comportamentos. Muitos voluntários, por iliteracia em saúde mental, rotulavam os jovens como “terroristas”, “apáticos”, “esquizofrénicos”, etc., sem perceber que os comportamentos destes jovens eram manifestações de um sofrimento emocional e psicológico atroz que carecia de cuidados de saúde mental prestados por profissionais de saúde especializados. Esta imersão de campo permitiu compreender que, a maioria dos voluntários, investe tempo e dinheiro nestas missões, mas a formação que recebem é escassa e, quando existe, relaciona-se com questões logísticas no desenvolvimento de tarefas. Esta falta de formação adequada acabou por ser bastante debatida nos últimos dias desta missão humanitária. Poucos dias antes do seu *términus*, uma criança de 3 anos faleceu apesar da autora desta tese, a única enfermeira presente, lhe ter prestado os primeiros socorros. A equipa de voluntários presente não foi capaz de lidar com os sentimentos de impotência e de culpa por não terem conseguido reagir de forma adequada e prestável no momento, nem de prosseguir com as suas atividades nos dias seguintes. Após este acontecimento, a autora desta tese abandonou as tarefas previstas no seu plano de atividades para prestar apoio emocional aos voluntários que, devido ao evento traumático, apresentaram algumas alterações nos seus padrões de satisfação de necessidades humanas fundamentais. Depois de ler, ver e ouvir é impossível ignorar.

Esta carência na formação foi tão evidente e transversal aos vários contextos que, como enfermeira, era premente desenvolver intervenções que pudessem ser contributos para dar resposta à falta de literacia destes voluntários que, diariamente, cuidam destas populações

vulneráveis. Ser enfermeiro também implica ter um espírito profunda e genuinamente humano, manifestado pela preocupação com o respeito pelo outro, e pelas ações pensadas e criadas para uma determinada pessoa ou grupo. É com esta ideologia que o Programa APT4U2 é, no nosso entendimento, a exemplificação da essência do espírito profundamente humano que caracteriza a profissão de enfermagem. O programa reflete a preocupação com o respeito pelo outro e a criação de ações específicas para apoiar os que cuidam dos mais vulneráveis. Desta forma, o programa não só capacita os voluntários, como também promove um acompanhamento mais humano e eficaz dos requerentes de asilo, alinhado com os valores fundamentais da enfermagem.

Os EEESMP desempenham um papel crucial na melhoria dos cuidados diretos oferecidos aos jovens requerentes de asilo. Contudo, com este programa, podem ainda contribuir para a capacitação das pessoas que, sem formação em saúde, dedicam a sua vida a cuidar destas populações quando os profissionais de saúde mental não são suficientes para dar resposta às necessidades. O APT4U2 também enaltece o desenvolvimento das ciências de enfermagem destacando a relevância e a expertise da profissão no cenário global de saúde e na necessidade de criar respostas efetivas aos maiores problemas de saúde global que emergem dos problemas sociais. Ao estarem na vanguarda no desenvolvimento e implementação deste tipo de formação, os EESMP demonstram a sua capacidade de liderança e o papel indispensável na promoção da saúde mental e no bem-estar das comunidades, em particular das mais vulneráveis, isto é, das que mais precisam. Esta visibilidade também contribui para a valorização da enfermagem, ampliando o reconhecimento do seu impacto positivo nos sistemas de saúde e na sociedade em geral. O programa vem fomentar ainda mais a necessidade de investimento no desenvolvimento das ciências de enfermagem, potenciando a investigação, inovação e a prática baseada em evidências. É na concretização destes programas que também se inspiram futuras gerações de enfermeiros a contribuir para a resposta às necessidades reais e complexas das populações mais vulneráveis do mundo, independentemente da complexidade e da distância a que estejam, advogando pela defesa dos direitos de todos os seres humanos.

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ANEXOS

ANEXO I – Parecer da Comissão de Ética

COMISSÃO DE ÉTICA

da **Unidade Investigação em Ciências da Saúde: Enfermagem** (UICISA: E)
da **Escola Superior de Enfermagem de Coimbra** (ESEnC)

Parecer N.º P742_12/2020

Título do Projecto: "Mental health and Well-being training program for non-health professionals and volunteers working with asylum seekers (Apt4U2)"

Identificação das Proponentes

Nome(s): Luísa Micaela Teixeira Santos; Ana Paula Teixeira de Almeida Vieira Monteiro; Wilson Jorge Correia Pinto de Abreu; Afaf Ibrahim Meleis

Filiação Institucional: Escola Superior de Enfermagem de Coimbra; Unidade de Investigação em Ciências da Saúde; Fundação para a Ciência e a Tecnologia; Escola Superior de Enfermagem do Porto; Universidade da Pensilvânia – Escola de Enfermagem.

Investigador Responsável/Orientador: Luisa Micaela Teixeira Santos.

Relator: Filomena Girão

Parecer

A – Resumo do Projeto

Este projecto consiste num estudo multicêntrico, quase experimental, com um grupo, que visa a construção, validação e implementação de um programa (Apt4U2) destinado à capacitação em saúde mental de voluntários/profissionais que, não sendo da área da saúde, intervenham em contextos humanitários.

O estudo desenvolver-se-á em duas fases: a primeira destinada à construção do programa (revisão de literatura, construção propriamente dita e realização de dois *focus group*) e a segunda destinada à implementação do projecto-piloto do Apt4U2 em abrigos e/ou centros de acolhimento na Grécia.

B – Identificação das Questões com Eventuais Implicações Éticas

B.1. A pertinência do estudo encontra-se devidamente justificada, surgindo a metodologia proposta como adequada à obtenção de resultados cientificamente válidos.

B.2. Este estudo não apresenta riscos para os participantes visto que se trata de um estudo não invasivo, que consistirá na recolha de informação através de instrumentos de investigação.

B.3. O presente estudo assegura o respeito pela autonomia dos participantes, garantindo que a sua decisão de participação é tomada de forma livre e consciente, após terem sido devidamente informados relativamente à natureza, ao alcance, às consequências e aos riscos do mesmo, bem como do direito de dele se retirarem em qualquer momento.

B.4. O estudo garante a confidencialidade dos dados, na medida em que os ficheiros áudio serão sujeitos a Pseudonimização (através de código alfanumérico para identificação de cada um dos participantes), que ficarão, exclusivamente, na posse do investigador.

B.5. Não existem interesses financeiros nem conflitos de interesse a declarar.

B.6. Os riscos e sobrecarga sobre os participantes resultam proporcionais aos ganhos que se espera obter com o estudo.

C – Conclusões

Face ao exposto, propõe-se que a Comissão de Ética delibere dar parecer favorável à autorização do presente estudo.

O relator: 

Data: 10 /02 /2021 O Presidente da Comissão de Ética: 



INSTITUTO DE CIÊNCIAS BIOMÉDICAS ABEL SALAZAR

