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Inter-Professional and Inter-Cultural Competence Training as a Preventive Strategy to Promote Collaboration in Encountering New-Coming Refugees in the Reception Programme – A Case Study

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1. Introduction

Every encounter with a patient/client in the mental health and social services constitutes a challenge for the responsible staff or organisation. Meeting a patient/client from a culture other than the one to which the caretaker/case manager belongs accentuates this challenge. The challenge will be even greater in the future because the number of refugees at mental health facilities is steadily increasing around the world. One of many aspects of the challenge is the language barrier. This may be a problem even when an interpreter makes the work of communication function smoothly (Farooq & Fear, 2003). A qualitative study by O'Donell et al. (2007) researched various aspects of health care for immigrants in the UK. Overall the participants were satisfied with the help they got from interpreters, but lacked help from them at key moments during their treatment. The participants also felt that the interpreters did not tell the GP what the patient had actually said and were not familiar with medical terminology, which impeded information sharing. This undermined trust. The participants stressed the importance of mental health services and the lack of care they received.

When the patient facing a clinician is a refugee from another culture (in some cases he/she could be a refugee from the clinician's own country of origin) the assessment or treatment will be even more complicated. Having access to the care to which the patient has a right is essential for refugees' mental health. Silove (2002) reports some of the consequences which the new Australian policy with detention centres had for refugees: an increase in self-harm behaviours, hunger strikes and riots at detention camps for refugees in Australia.

Regardless of the refugee's grounds for deciding to move from his/her country of origin to a reception country, the goal is to avoid death, secure a better future, avoid persecution and discrimination or leave a war zone to avoid being killed. The decision to move will have consequences for the refugee's entire life as well as for his/her family and will affect their health, economy and general welfare.

The migration process can be divided into two stages: pre- and post-migration. The pre-migration stage covers the time up to the decision to leave the place of residence as well as the journey to a new place in which to live; its duration will vary with the circumstances. Lindencrona, Ekblad and Hauff (2008) identified four dimensions of resettlement stress among recently resettled refugees from the Middle East in Sweden: social and economic strain, alienation, discrimination and loss of status, and violence and threats in Sweden. To remain where they came from would have exposed them to psychological and physical abuse.

The goal of this chapter is to prepare mental health and social service staff to cope with the challenges posed by the above at every level of the organization. An important part of this is to get tools to be able to assess and understand the inherent potential that refugees carry within the clinical and social service space. At the same time it is of significance to pay attention to resilience factors (Antonovsky, 1988); why some cope better than others, to bear in mind the strengths which these people possess. The chapter aims to provide an introduction to refugees' mental health and the challenges and gaps which health and social care staff meet in encounters with this target group. The topic is highly relevant as the world becomes increasingly globalised. Refugees' health, especially mental health, is thus a world problem. The competence training is presented as a Case from Sweden but it can be generalized to other countries in similar situations.

Keywords and definitions of key concepts are specified below.

1.1 Key words

Refugees, mental health, mental disorder, prevention strategies, resilience, SOC, mental health promotion, collaboration, inter-professional, inter-cultural communication

1.2 Definitions of key concepts

Collaboration: a fluid process whereby a group of diverse and autonomous actors undertakes a joint initiative, addresses shared concerns or otherwise achieves common goals (Fear & Barnett, 2003).

Health: according to WHO, as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (www.who.org).

Health promotion: the process of enabling people to increase control over their health and its determinants, and thereby improve their health. A core function of public health that contributes to the work of tackling communicable and non-communicable diseases and other threats to health (WHO, 1986).

Inter-cultural communication: occurs when two or more people with different backgrounds interact and communicate with each other. An optimal cultural communication means that those involved are affected; a real encounter is established where understanding arises despite different backgrounds in behaviour, perceptions and values/attitudes.

Inter-professional training: occurs when two or more professions learn with, from and about each other to improve collaboration and quality in health care (www.caipe.org).

2. Background

The process of globalization challenges our awareness of people's diverse backgrounds, especially for social service and health professionals. Human migration, voluntary or otherwise, has transformed Western countries into multicultural societies. This global phenomenon has significantly changed the number and nature of impacts on the health of individuals and populations (Zimmerman, Kiss and Hossain, 2011). Sweden as a case grants asylum, in accordance with the Geneva Convention, to those who have reason to fear persecution in their native country due to race, nationality, religious or political beliefs, gender, sexual orientation or membership of a particular social group (www.migrationsverket.se). Those who may qualify for asylum also include persons who have a well-grounded fear of suffering the death penalty or torture or who need protection due to an international or external conflict or a natural disaster in their native country. Further, family reunification is a possibility. In Sweden the proportion of immigrants, i.e. foreign born or born in Sweden to parents who are both foreign born (Statistics Sweden, 2011), has increased to 19 % in 2010 (December 31) of the nine million inhabitants. Until the mid-1970s this was primarily a matter of labour force immigration, mostly from elsewhere in Europe. More recently, increasing numbers of refugees and their relatives have come from non-European countries.

Up to now there has been a lack of coordinated policy approaches to deal with modern migration's impacts on health. This is an ethical responsibility in that all human beings have a right to autonomy, dignity and responsibility. Development, manifestations and illnesses vary with the context. An association between trauma and increased morbidity, lower life expectancy and higher risks of medical problems was identified more than fifteen years ago (Friedman and Schnurr, 1995). A systematic review and meta-analysis (Steel et al 2009) shows that pre-migration stress is associated with the diagnoses post traumatic stress disorder (PTSD, DSM-IV, APA 1995) and depression. Increasing levels of trauma lead to higher rates and severity of PTSD and depression, i.e. a dose-effect relationship (Mollica et al 1998, Sledjeksi et al 2008). Post-migration factors, e.g. the period of waiting for asylum, also have impacts on refugees' mental health (Carswell, Blackburn, and Barker, 2011). Vulnerable groups among migrants are refugees in general and, in particular, asylum seekers, temporary mass-evacuees, women and those with co-morbid PTSD and depression. A prospective study by Roth (2006) of mental health among mass-evacuated Kosvo Albanians in Sweden showed that the prevalence of PTSD was 37% at baseline and increased to an extremely high level (80%) at the 18 month follow-up and highest among those who decided to stay in Sweden; participants with PTSD had significantly lower cortisol levels. Depressive symptoms and aggression followed the same pattern as PTSD, while Sense of Coherence (SOC) was lower and aggression scores higher among participants with PTSD and co-morbid depression (Roth, 2006). Lindencrona, Ekblad and Hauff (2008) report that for many refugees the period after obtaining a permanent residence permit is extremely stressful as they may have a demanding social life with constant stress and perceived ill-health. According to a Swedish public health report (2009), foreign-born people have a lower rate of perceived health than the Swedish-born population. The literature shows that compared to age-matched general populations in western countries, refugees resettled in those countries could be about a tenfold greater risk of post-traumatic stress disorder (Fazel, Wheeler and Danesh, 2005) and social exclusion (Johansson Blight, Ekblad, Lindencrona and

Shahnavaz, 2009). Being a refugee is also associated with depression (Carta et al, 2005) and public health diseases, e.g. cardiac and vascular diseases, diabetes (Kinzie et al, 2008). Consequences of the disorder are not only a range of psychiatric symptoms but also individual suffering. There are also cognitive impairments that effect the everyday functioning of the patient/refugee. Several meta-analyses and reviews have been carried out regarding PTSD and changes in cognitive functioning. However, the conclusions that can be drawn are limited by co-morbidity and substance abuse and the level of individual functioning before the event that caused the onset of PTSD. A meta-analysis by Johnsen & Asbjorsen (2008) showed that patients had impairments in verbal memory. Brewin (2008) found that patients diagnosed with PTSD had memory impairments regarding neutral verbal and visual memory.

In a pilot study of whether neuropsychological impairments were alleviated after patients received trauma-focused treatment, Walter, Palmieri and Gunstad (2010) found that the patients improved in multiple aspects of executive functioning. Although the study needs to be replicated with a larger sample, the authors of this chapter suggest that patients' impairments can decrease with therapy, thereby contributing to a better everyday life. For refugees, this means better chances of establishing a functional life in the country of reception.

A register study of mental health differences between refugee and non-refugee immigrants, independent of the area of origin, assessed using purchase of prescribed psychotropic drugs as a proxy measure of mental ill health; it showed that refugee women who have lived in Sweden, a high-income country, for up to ten years have more mental ill health than other immigrant women and men, but do not seek health care (Hollander et al 2011). Refugees usually seek primary health care for their perceived illness, described as somatic complaints, as it is easier to communicate mental illness with somatic symptoms (Ekblad and Hollander, 2011). Further, cultural as well as language barriers, expectations of treatment and compliance between clinical staff and refugee patients may affect the outcome. Insufficient language entails a need for an interpreter, but the interpreter's competence and the patient's confidence in the interpreter are essential for an adequate inter-cultural health communication between the patient and the clinical staff (Fathai et al 2010, Farooq and Fear, 2003).

While the need for inter-cultural competence and the need for evidence-based practice in mental health services of patients with an immigrant background are complementary, there is little cross-fertilization in the literature (Whaley and Davis, 2007). A review reports that there is limited evidence of the effectiveness of inter-cultural competency training and service delivery (Bhui et al 2007). A public health report fourteen years ago from the Swedish National Board of Health and Welfare (Brisfjord, 1997) draws attention to the fact that training for health professionals allows little time for training in multicultural health care, including psychiatric care, and social service. Competence training in migration and health is constrained by sector silos, often with different goals. Thus, staff encountering new-coming refugees in the reception countries (mainly Western) are quite often unprepared to meet the refugees' needs, due to a lack of inter-professional and inter-cultural communication competence and collaboration in preventive strategies involving both health care and social service care (Ekblad, 2011). Collaboration is a recognized strategy in health promotion for dealing with this gap in health and social care, but not yet in the context of

refugees. A health-promoting introduction model according to Lindencrona (2008, Abstract) "includes network building blocks, setting qualities, the health promoting spiral of personal capacities, outcomes and environmental facilitators and long-term health, social and economic outcomes at the individual, group and societal levels". According to WPA guidance, adequate resources for training, including competency training, should be available (Bhugra et al 2011). Training of both evidence based knowledge and collaboration strategies between mental health professionals as well as municipal staff in refugee reception must therefore be increased in order to improve the refugees' situation (Lindencrona, 2008). Results from a study among general practitioners in the management of mental health disorders highlight self-professed interest and prior training in mental health (Browne, Lee and Prabhu, 2007). A Danish study provides evidence that health professionals (doctors, nurses and assistant nurses) obtain their knowledge about immigrants mainly through the media and patient contact, and less through travel, courses and colleagues (Michaelsen et al 2004).

Screening and follow-up according to needs are vital when it comes to securing mental health among refugees. The common diagnoses among refugees, PTSD and Depression, impair the ability to function in everyday life in the new society. The complexity of the case demands collaboration. With the increasing demands on this group, it is important to assess the refugee's ability to perform. In Sweden, refugees are enrolled in classes to learn Swedish and are expected to be able to work shortly (within two years) after their permission to stay in Sweden. For most refugees, this may be an unattainable goal. For a refugee who is suffering from mental illness, the first part of the stay in Sweden can have a negative effect on his/her mental and physical health. Conclusion from a research study in Sweden is that collaboration between agencies leads to better care for new-coming refugees (Lindencrona, 2008).

During Spring 2010 the two authors conducted and evaluated a university course at Karolinska Institutet, Stockholm, Sweden, entitled *Refugee-related stress and mental health – local collaboration,* 7.5 ECT points, based on evidence and clinical experience. Details of the course are given in Table 1. One of the aims of the course was that the participants would establish a platform and produce new policy documents for their organization regarding encounters with refugees in the local context. The main question was whether inter-professional and inter-cultural competence training can promote collaboration in refugee reception?

2.1 Setting, participants and methodology

The explorative study concerns a Swedish refugee reception program and Södertälje municipality, not far from the capital, Stockholm, as a Case. Södertälje municipality and Stockholm county council commissioned competence training, 7.5 ECT (one week full-time course), from Karolinska Institutet (the first author was in charge of the course) during a one-year project entitled "Health promoting strategies in the reception of refugees with mental disorders and disabilities – a platform collaboration". The participants who encountered the target group were invited and participated voluntarily. The training took three full days and a half-day workshop, with homework in between. The participants had an obligatory list of references to read and homework during the course.

The syllabus was approved by the Board of Education at Karolinska Institutet under the provisions of Higher Education. The course was Commissioned by the Municipality of Södertälje and Stockholm County Council.

The course aimed to
• Introduce and provide guidance on mental health and its determinants from a refugee reception perspective
• Introduce theories of exclusion, segregation and discrimination processes and their relation to mental health for vulnerable groups (asylum seekers, refugees and their relatives)
• Introduce and develop an inter-cultural communication perspective to respond to, analyse, and propose actions to be quality-assured to promote mental health in a refugee reception perspective
• Make participants aware of their own and other's 'cultural spectacles'
• Provide opportunities to increase an understanding of their own and other's professional roles and to obtain information about the various actors' organizations, including the implementation of user organizations, their responsibilities, mission and values in a refugee reception perspective

The course would encourage co-education across professional boundaries in order to raise awareness and develop the ability to highlight and respond to mental illness/health and what promotes mental health in the given gender and diversity context. The course was designed to complement the knowledge the participants had received in their basic training.

Learning outcomes
After completing the course, participants will be able to:

Knowledge and understanding:
• explain the concept of mental health and its determinants from a refugee reception perspective
• orient themselves on different theories of exclusion, segregation and discrimination processes and their relation to mental health for vulnerable groups (asylum seekers, refugees and their relatives)
• describe how important organizational and inter-organizational strategies for collaboration can be developed to influence the determinants of mental health in vulnerable groups (asylum seekers, refugees and their relatives)

Skills and abilities:
• use an inter-cultural perspective to respond to, analyse, and propose actions to become quality-assured to promote mental health in a refugee reception perspective
• apply the principles of WHO Health Promotion to develop an overall strategy for the interaction of mental illness in the reception of refugees with mental illness and mental impairment
• apply the models to identify and plan for the relevant organizational and inter-organizational strategies for the development of refugee reception, which can promote

mental health
• apply case-methodology under supervision

Values and attitudes
• critically examine their own 'cultural spectacles'
• reflect on and consider the ethical implications of their professional conduct
• discuss their own and other's roles in and around the mental health field

Focus of education (pedagogics):
Lectures, observation of the local context, and laboratory exercises in small and large groups according to the general and specific information related to their profession. Case-method according to the Harvard Model under supervision.

Theme titles of the compulsory course days during Spring 2010:
Day 1 (April 7) Introduction to local actors in asylum and refugee reception
Day 2 (May 5) Primary health care perspective
Day 3 (June 2) Specialist psychiatric care

Participation:
Participation in lectures and group work for three days, homework under supervision for 2 days and follow-up days, a total of 5 days is compulsory. In the event of absence, compensatory task discussed with course leaders. The prerequisite for getting the course certificate is to answer the evaluation questions before and after the course.

Examination:
Written examination and oral presentation.

Grading:
U/ G

Course Evaluation:
The course is evaluated in writing in accordance with guidelines established by the KI (survey sample) at the end of the course. Rationale for participation and open-ended questions about expectations before the course and follow-up after the course are planned. Course evaluation also retrieves relevant issues from the course leader's cooperation with the Harvard Program in Refugee Trauma (http://www.hprt-cambridge.org). The evaluation (pre- and post-evaluation) will guide the implementation of the future course of the report to the National Board of Health and Welfare.

Reading List:
Separate list to the participants

Table 1. Course: Refugee-related stress and mental health – local collaboration, 7.5 ECT points.

3. Methods

3.1 Evaluation methodology: quantitative and qualitative

The course was evaluated in several steps. A questionnaire was distributed to the participants at the onset and end of the course (Table 2). The course was evaluated, using an

11-item questionnaire (both quantitative and qualitative) which had been developed by the two authors (SE, DF). The quantitative questions covered how challenging the participants thought that the course would be and how challenging it actually was; also, how demanding the course would be and how demanding it actually was. Other items were about the demands and control which participants exercised over their work situation and how much knowledge they had acquired. Their responses were made on a standard Likert scale from 1 to 5, where 1 was "a little" and 5 was "a lot". The questionnaire was distributed to the course participants on the first day of the course before the course programme started and at the end of the last course day. Participation was voluntarily and responses were anonymous.

The qualitative questions from the questionnaire surveyed the participants' expectations of the course, their ability to gain new knowledge during the course, whether the course contained content relevant to the participants' work situation and how they were going to implement the new policy documents. In this chapter, the focus is on their expectations and whether the course contained relevant material. The ability to implement the new policy documents will also be discussed briefly.

Questions in the questionnaire distributed at the onset of the course	**Questions in the questionnaire distributed at the end of the course**
1) Have you attended a similar course before?	1) Were your expectations of the course fulfilled?
2) What are your expectations of the course?	2) What were your opportunities to learn during the course?
3) How do you view your opportunities to learn during the course?	3) Did the course contain relevant knowledge for you as a professional?
4) Does the course contain relevant knowledge for you as a professional?	4) What in the course material can you use in meetings with refugees?
5) Estimate how big a challenge you suppose the course will be?	5) Does your organization adhere to the policy documents?
6) Estimate how the competence you have enables you to apprehend the course material?	6) What can you do to enhance the use of the new policy documents in your organization?
7) How much control do you have over your work situation?	7) How much new knowledge did you gain during the course?
8) How do you regard the demands placed on you in your work situation?	8) How big a challenge was the course?
9) Other comments?	9) Estimate how the competence you had before the course enabled you to apprehend the course material?
	10) How much control do you have over your work situation?
	11) How do you regard the demands placed on you in your work situation?
	12) Other comments?

Table 2. Evaluation questions before and after the course.

The participants also had the opportunity to leave verbal commentaries on the course at the end of training. Also, each of the three sessions included in the course started off with a round among the participants to see if there were any questions regarding the course and its content. One of the aims of the course was that the participants would produce new policy documents for their organization regarding refugees. The documents were supposed to be created from the new knowledge derived during the course.

The results from the course evaluations will be presented below. Kirkpatrick's Evaluation Model (Alliger et al, 1997) will be presented to further clarify the results.

The two versions of the questionnaire had the same set of questions with the exception of questions 4, 5 and 6 in the questionnaire distributed at the end of the course. These questions focus on the results of the course as a whole for the participant and the organization the participants belong to.

Questions 5, 6, 7 and 8 in the questionnaire distributed at the onset of the course and questions 7, 8, 9, 10 and 11 distributed at the end of the course required the participants to rate their answer on a 5-point Likert scale ranging from "Very little" to "A lot". The other questions in both of the questionnaires were open-ended and the participants were supposed to write more extensive comments.

3.2 Data analysis

The quantitative answers from the questionnaires were analysed by descriptive statistics with PASW V.18. The quantitative analysis comparison of pre- and post-survey scores was conducted with a non-parametric test.

The basic categorization of the qualitative answers followed the items in the questionnaire. The responses to each question were summarized without knowledge of the participant's occupational background or sex. This content categorization yielded various themes. The frequency of the answers was categorized according to the system proposed by Hill et al. (2005). The term "general" is used when a majority of the participants answered the same way; "typical" is used when about half of the sample answered in that way and "variant" is used when about a quarter or less of the answers dealt with that topic. Revisions of the system proposed by Hill et al. (2005) were made to suit the questionnaire distributed to the participants. All written answers to each question were read through before any categorization was done. The field notes during the course days were read several times to obtain a sense of the whole. Citations will be reported as examples of exploring the results.

3.3 Ethical issue

The data from the study did not include information which according to law must have ethical approval. We got consent from the participants and answering the questions was voluntary and the results were on group level.

4. Results

4.1 Participants

Thirty-two participants took part in the course; twenty-eight (87.5%) passed it and received a diploma. Table 3 presents the number of participants in the course, in total and by profession, gender and workplace.

Participants' workplace	Profession	Total	Men	Women
Introduction/municipal	3 assistants, 1 counsellor	4		4
Income support/municipal	6 assistants	6	2	4
Swedish language course	1 teacher, 1 counsellor	2	1	1
Public employment service	Employment service officers	7	2	5
Primary care	1 nurse, 1 counsellor, 2 physicians, 1 social worker/psychotherapist	5	2	3
Speciality/county council	1 nurse assistant, 1 psychologist	2	1	1
Care/municipality	2 social workers, 2 assistants	4		4
NGO/Red Cross	2 NGOs	2		2
TOTAL		**32**		

Table 3. Number of students on the course, in total and by profession, gender and workplace.

4.2 Outcome

4.2.1 Before the course

1. Have you gone on a similar course before? If so, when, who organized it and what did you learn?

Twenty-three (82%) participants had not attended a similar course before, five responded that they had taken various courses in the field, such as previous courses the current course providers have given, courses at the Transcultural Centre, courses on migration at the Karolinska Institutet and Stockholm University.

2. What are your expectations of the course?

Some participants mentioned a number of things, so the answers are not representative of the whole group. Nine (42.9%) participants said they would create contacts/get a larger network. Twelve participants reported that they will get more knowledge. Two participants were hoping to refresh old knowledge. Two other participants stated that they will have more tools. In addition, a few more things were mentioned once only. They are related to the expectations set out. The following quotations illustrate how the participants formulated their expectations:

- to increase my competence regarding my and other people's work.
- networking and to gain better knowledge of how the situation for the refugee can be and what potential obstacles the refugee might need help with.

3. How do you see your opportunities for learning during the course (based on workload and other commitments)?

Eleven participants (39.3%) saw their learning opportunities as very good or good, while five (17.9%) wrote that they had to work in their leisure time to absorb the course content. Another five participants (17.9%) gave different answers about a high workload. A quarter

of the participants (n=7) did not respond at all or gave an answer that cannot be understood on the basis of the question. Some quotes exemplify the participants' thoughts:

- I am interested in what the course has to offer, so I'll be fine, but the assignments for the course have to be prepared in my spare time.
- The possibilities for learning are not great if I don't use my spare time for preparations.

4. Does the course content include relevant knowledge from your work?

Twenty-five (89.3%) participants considered that the course contains relevant knowledge based on their work situation, while one each answered a bit, do not know or did not respond. The following quotes are examples of how students responded:

- Yes, absolutely since I work with newly arrived refugees who many times are stressed due to traumatic events.
- The content of the course seems very interesting and will help me a lot and make my teaching less difficult.

5. What challenge do you think the course will involve? Four participants did not answer. The mean was 3.3 "moderate challenge" (from 1-5, 1 = small challenge, 5 = very challenging)
6. How can you assimilate course content on the basis of the skills you possess? Two participants did not answer the question (from 1-5, 1 = little skill, 5 = very high level of expertise). The mean was 4. There seems to be a feeling that they have the skills to be able to integrate knowledge.
7. Based on your work situation, estimate (from 1-5, 1 = little control, 5 = much control) how much control you feel over your job? One participant did not answer. Group mean 3.9, meaning they feel they have relatively good control over their work.
8. Based on your work situation, estimate (from 1-5, 1 = low demands, 5 = very high demands) how much demand is there in your work situation? One participant did not respond. Group mean 3.8. The participants feel they have relatively high demands in their work situation.
9. Other comments: Twenty-two participants (78.6%) made no other comment. Two participants mentioned the importance of collaboration. Three participants referred to the course in positive terms, and one had a perspective on the course setup. Here are some comments:

- A major challenge is how to coordinate the management and political levels. Will there be room to develop and interact? Difficult to see that the opportunity will be given.
- The importance of cooperation cannot be emphasized enough! Prestige aside, and above all training to create an understanding of the work of others and focus on the individual.

4.2.2 After the course

A total of 26 (81.30%) of the 32 participants responded to the evaluation questionnaire at follow-up after the course. Table 3 summarizes the mean values of closed responses before and after the course.

1. Were your expectations of the course met?

Twenty-two (84.5%) of the 26 participants responded that their expectations were met. The following quotes from some participants illustrate the quantitative results:

- Yes, I have gained a better understanding of the problems that other vocational groups are working with and I have also had the opportunity to defend the organization that I represent.
- Yes! New thoughts and reaffirmation regarding collaboration between organizations.

2. Did you have your learning opportunities during the course (based on workload and other commitments)?

Just under half (46.1%) of the participants answered that their learning opportunities during the course were good. Three out of ten (30.8%) reported that they did not have time to do homework during working hours and were forced to do it in their spare time or were not able to spend time on the course because of heavy workloads. Here are some quotes that illustrate this:

- Have a big workload so I wish I had more time for this course. Asked my boss if I could do 2 days of study but that wasn't possible. During the course I participated in the group exercises.
- I learned a lot during the classes. Assignments in my spare time. The work load has been high or rather high. I can, however, say that the course has been educational and it was rewarding to meet other professionals working with the same clients.

3. Did the course contain relevant knowledge for your work?

The majority (80.8%) of the participants wrote that the course contained relevant knowledge based on their work situation. Here are some quotes that describe these responses:

- It certainly did. I come into contact with mental illness basically every day when I meet my clients.
- Yes, relevant to be able to guide individuals to the right service so they will receive adequate help.

4. What in the training can you use in responding to this target group?

The course participants' responses reflected their professions and work places but the following four themes dominated the responses: 1. How different organizations in the field work, 2. What resources are available, 3) How to improve the attempts of refugees, and 4) How to improve cooperation. These themes are mentioned four to five times. Further topics were presented in two responses: networking and to better understand refugees arriving in Sweden. The following quote substantiates the students' responses:

- The knowledge I have gained will help me to assess if a person suffers from psychiatric disorders or has been through a traumatic experience.
- A lot, since I now know much more regarding what differences mean and in which way different agencies work and with what groups they work. A lot of new knowledge.

5. What is your organization's policy document describing the process of the target group?

Just under a quarter (23.1%) of the participants answered that they follow current policy well or very well. Just over one in ten (15.4%) of the participants said they do not have a policy document in their organization. Four in ten (42.3%) misunderstand the question and responded about other aspects, such as working with the policy. The following quote illustrate the responses:

- We have no such documents, the aim is for our "new knowledge and method" received to be our policy.

6. How can you work to ensure that the new policy (Establishment Act as of December 1, 2010, when the Swedish Public Employment Service would take over the reception of refugees from the municipalities) becomes a reality in organizations?

A common response among four out of ten participants (38.5%) was that they intend to inform colleagues in their organization to improve the policy in their organization. One in ten of the participants (11.5%) wrote that they plan to increase cooperation with other organizations in the field. Four (15.4%) answered that they had policy documents in their organization. Some citations illustrate the results:

- To enhance collaboration between different agencies on different levels. We can work with specific cases on another day.
- To inform the management regarding what I encounter on an everyday basis, I try to influence the policy through that.

7. Estimate (from 1-5, 1 = some knowledge, 5 = much knowledge) how much knowledge you gained during the course?

The participants wrote that they have medium knowledge (mean 3.3). Table 4 shows the results from mean value before and after the course on challenge, competence, perceived control and perceived demands.

8. Estimate (from 1-5, 1 = small challenge, 5 = very great challenge) how challenging the course was?

The course posed a mediocre challenge (mean 3.0)

9. Estimate (from 1-5, 1 = low competence, 5 = very high level of expertise) how the competency you possessed made you able to assimilate the course content?

The participants estimated that they possessed great skills (mean 3.7) to be able to understand the course content.

10. Based on your work situation, estimate (from 1-5, 1 = little control, 5 = much control) how much control you feel you have over your work?

The participants considered that after the course they had more control (mean 4.1) of their duties.

11. Based on your work situation, estimate (from 1-5, 1 = low demands, 5 = very high demands) how great the demands are on your work situation.

After the course, the participants perceived that the requirements of their work situation were higher than before the start of the course (mean 4.3)

12. Other comments during the seminars

- I have received new information and also confirmed that a number of my thoughts and ideas are shared by several others.
- I have been strengthened in my profession because I realize that I am doing a good job with a strong client perspective.

- Good Reading! Key speakers! Good research rooted!
- What is important in everything we do is COLLABORATION, and not to work separately.
- A hope that the participants could be called to a follow-up meeting one year after the end of the course
- To discuss how the collaborative model developed. But it's certainly not money.
- The objective of 'good work on Health' increases an individual's participation in society, democracy and expression, which is the basis for a 'good and humane society'.

Question	Mean value before the course (N=28)	Mean value after the course (N=26)
Challenge	3.3	3.0
Competence	4.0	3.7
Perceived control	3.9	4.1
Perceived demands	3.8	4.3

Table 4. Mean values before and after the course.

In summary, the results were adapted to Kirkpatrick's Learning Evaluation Model (Table 5).

Level	Evaluation: what is measured	Evaluation: description and characteristics	Evaluation: tools and methods	Outcome
1	Reaction	To what the delegates felt about the training experience.	Verbal reactions from the course evaluation.	The participants expressed that they were pleased with the course during the training occasions.
2	Learning	Measurement of the increase in knowledge – before and after.	Questionnaire	The results from the questionnaire before and after training showed that the participants felt that their knowledge had expanded.
3	Behaviour	The extent of back-on-the-job implementation.	Questionnaire	The questionnaire showed that the participants thought that the content of the course was relevant for their work.
4	Results	The effect on the business or environment by the trainee.	Policy documents	New policy documents were supposed to be implemented after the course's completion.

Table 5. Adaptation to Kirkpatrick's Learning Evaluation Model (Alliger et al 1997).

5. Discussion

5.1 Results

The majority considered that the course included relevant and practical knowledge, prevention strategies that are evidence-based and learnt by experience. They wanted to

implement the new knowledge from the course. The perception of demands and control seems to be similar, but increased during the course.

A majority of the participants answered that they expected to broaden their knowledge base and create new contacts and professional networks during the course. They also thought that the course contained relevant information that they could apply in their work situation. After the course the majority thought that their expectations of the course had been met and that the content of the course had been relevant for their work situation. The expectations mirrored the need among the participants to have more knowledge regarding refugees coming to Sweden. The fact that they thought that their expectations were met indicates that the participants actually gained new knowledge regarding refugees. This conclusion was confirmed during the rounds of verbal commentaries at the onset of every course day.

The participants also had new ideas about how to implement the new policy document in their organization. Before the onset of the training the participants had a vague idea of what was in the policy documents regarding refugees. Some even said that they did not know if they had policy documents regarding refugees. They also seemed to grasp the importance of having these policies as a guideline in their work.

Results were not only observed on an individual level. Due to the participants' enthusiasm and the organizations involved in the project, a new course was created to further build the participants' knowledge base and further enhance collaboration in the community.

Looking at the participants on a group level, they went from an understanding that their own work situation was related to working with refugees to a better understanding of how other professionals work with refugees. They also became more aware of the factors that influence the psychological and physiological wellbeing of refugees.

Further resources need to be allocated to study whether and how the situation for the refugees improved after the course in Södertälje. This is a difficult question to answer due to changes in directives for refugee care (a new from as of 1 December 2010). However, an established platform network with professionals working with refugees will provide the best chance of making transitions between different directives within refugee care.

5.2 Constraints, possibilities and lessons learnt

Despite the limitations of the study, such as that the data are based on a single course, a single context and a single group of mental health and social service staff, the results are promising for increasing inter-professional and cultural competence. On the path towards cultural competence, the review by Bhui et al (2007) showed that "a developmental process was proposed moving from cultural awareness to improved cultural knowledge and improved skills through encounters" (p.7). Reflexivity, i.e. practitioners looking within themselves, "is necessary to develop empathy through a better understanding of the patient's predicament, avoid assumptions and stereotypes, and to be aware of one's own attitudes and prejudices."

The majority of the participants mentioned in the evaluation that they had limited time to read the material during working hours and did this in their leisure time.

Due to the new law on introduction activities for certain newly arrived immigrants (2010:197) from December 1, 2010, when the organization of refugee reception moved from

the municipalities to the Swedish Public Employment Service (www.arbetsformedlingen.se), the participants indicated that they wanted to continue with a new course in order to keep the platform alive as there were new actors.

Anyone between the ages of 20 and 64 (or 18 and 19 with no parents in Sweden) who has received a residence permit as a refugee or for reasons similar to being a refugee has the right to special support in order to get work as quickly as possible. This also applies to those who are in the same age group and came to Sweden because they have a relative who got a residence permit as a refugee or for reasons similar to being a refugee, provided that they have applied for a residence permit no later than two years after the relative was admitted to a municipality.

After the course, the participants and their superiors, a total of 40 persons, met on a workshop day and discussed the future collaboration model and what each actor/organisation needs to pay attention to in order to collaborate in the refugee reception in Södertälje.

The participants wanted to continue the course for the whole of 2011 (10.0 ECT points), which resulted in an application to the same funder and was approved. At present the majority of the participants are continuing and there are also new participants from the Swedish Public Employment Service. The participants have compulsory course days about once a month, with theory and discussion of Case from an inter-cultural communication and inter-professional training point of view. They also visit the actors' workplace. The development of a platform "Södertäljeplattormsanda" has started and is being stabilised. This process is not a quick fix; it takes time as the participants need to explore the settings and reflect.

5.3 Conclusions

Very few of the participants had experience of a course in the subject before this course started. The majority found that the new knowledge gained was relevant. They had the ambition to spread the knowledge to their colleagues in the respective organization. The participants had got to know "a face" of the other collaborators, which facilitated future contacts.

The participants' responses imply that the course made them more conscious of the issue, with an increased perception of workplace demands and control over their work. The most significant findings from the evaluation were that the participants had received preventive strategies, so inter-professional collaboration in the municipality's refugee reception could be improved, obtained information about which interventions are relevant, and had "faces" that created options for inter-professional exchanges with others in the refugee reception.

In inter-cultural communication training there is a need to achieve a balance between attention to "difference", attention to self and attention to power relations (Beagan, 2003).

A summary, presented below, of important aspects to treatment, learning and collaboration, as well as lessons learned from the study, can also be implemented in other reception settings.

Summary of important aspects

- Early screening and treatment are vital. For physical as well as mental illnesses, early screening is important for preventing the development of illness.
- Co-morbidity is prevalent among refugees. PTSD and depression are two common diagnoses among the refugee population. Treatment plans need to take this into account.
- PSTD and depression have major consequences for the patient's everyday functioning. Their ability to meet demands that they succeed depends on this and has consequences for learning and functioning and integration into society.
- Be aware of the complexity when meeting a refugee who seeks assistance. Language, culture, roles and expectations, both from the mental health professionals/public employment service and from the patient, can result in the loss of vital information.

Lessons learned from participation in the course

- Most of the participants thought that the course had been useful and that it had given them an opportunity to learn and network. Participants created a platform for future learning.
- To use local participants' own experiences of working with refugees as a tool for learning.
- Helping the participants to create a platform ensures future collaboration among agencies. You have a "face" at an agency to whom you can turn.
- Make sure that the participants are able to attend the course (anchor participation at all levels in the organization). To maximize learning, networking and future collaboration and evaluation, the participants need time to complete the course work.

Competing interests

None

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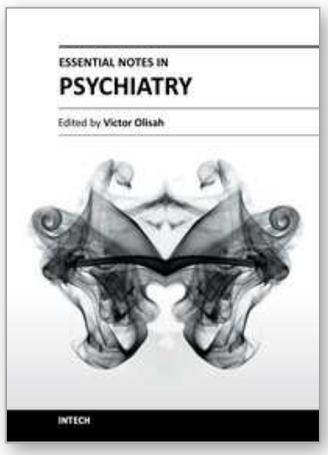

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