Title page

Title: Association between doses of the "Welcome to School" intervention and mental health and resilience among young newcomer immigrants and refugees

Short title: *Association between doses of the WTS intervention and mental health and resilience*

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Abstract

Aims: Youth with an immigrant or refugee background face elevated mental health risks. Schools have been proposed as a suitable setting for mental health interventions for this group, but evidence on effects is limited, and even less is known on dosage impact. Using variations in intervention exposure due to COVID-19 school closures, this study examined the association between the number of modules of the Welcome to School (WTS) intervention and mental health and resilience outcomes among young immigrant and refugee newcomers.

Methods: In 2019-2020, 11-22-year-old newcomer immigrants and refugees in Denmark, Belgium and Norway were cluster randomized by schools/classes into a control and intervention group. Mental health and resilience outcomes were measured at baseline and following the intervention using the Strengths and Difficulties Questionnaire and the Child and Youth Resilience Measure. Due to COVID-19 school closures, the intervention group received different amounts of the 14-modules WTS intervention. Using data from 147 participants, multiple linear regression analyses were performed.

Results: Adjusting for age, gender, resettlement country, and migration reasons, the analyses showed that the emotional symptoms score decreased by 0.19 (95%CI = [0.06; 0.32]) per WTS module received. No significant dose-response associations were found for resilience scores or the other studied mental health outcomes (i.e., total difficulties, conduct problems, hyperactivity, peer problems, and prosocial behavior).

Conclusions: The WTS intervention appears to have the potential to reduce emotional difficulties among young newcomers in case of sufficient intervention dose. Further studies are needed to assess the effectiveness of the full intervention.

Keywords

Intervention; Immigrants; Refugees; Youth; Adolescent; Mental health; Resilience; Welcome to School; SDQ; Dose-Response;

Introduction

Young people with an immigrant or refugee background face elevated risks of poor mental health (1) due to pre- and post-migration experiences and the migration process itself, including traumatic events, cultural and linguistic adaptation, discrimination, and uncertainty (1–4). While it is important to recognize that this population is highly heterogeneous, with significant differences shaped by factors such as gender, age, socio-economic background, ethnicity, and individual experiences, newly arrived children and youth often share certain experiences. Many have relocated from their countries of origin under circumstances largely beyond their control and must now adapt to unfamiliar environments. This includes navigating a new school system, learning a new language, and adjusting to different norms and expectations — all while trying to rebuild a sense of belonging and social connection (5). Schools have been suggested as a suitable setting to promote the mental health of this group as schools can offer a safe space, a structured environment with trained staff, who can detect needs, support interventions, and facilitate social integration and belonging (1,6)

A meta-analysis has found that school-based interventions can enhance socio-emotional well-being in youth with an immigrant or refugee background. Although intervention characteristics were not specified by the review, it did note that most of the reviewed interventions were teacher-delivered (7). Two systematic reviews have shown that school-based interventions have the potential to reduce mental health and well-being problems among young refugees (6,8). That said, the included studies mainly examined the curative effect on specific mental illnesses such as depression or trauma sequelae. Most school-based interventions have been evaluated on refugees alone, and with limited sample sizes (6).

To strengthen the evidence base on the role of school-based interventions in promoting well-being among youth with an immigrants or refugee background, the Horizon2020-funded RefugeesWellSchool project (RWS) was initiated (9). As part of this project, the Welcome to School (WTS) intervention was implemented in Belgium, Denmark, and Norway during 2019-2020, where immigrants and refugees constitute 12.4-17.3%

of the total population (10,11). WTS seeks to promote social capital within the group of participants, hypothesizing that social support and peer relations is key to their psychosocial well-being (12). While WTS has been acknowledged for its potential to improve mental well-being (13), the program has not been systematically evaluated prior to RWS. However, COVID-19-related school closures in Belgium, Denmark, and Norway (14) affected both the WTS intervention implementation and follow-up data collection. It was not possible to continue the intervention through distance learning or once the schools had reopened. Subsequently, the students received very different intervention dosages (Figure 1). A previous RCT study, following the preregistered protocol evaluating the effectiveness of the WTS intervention on a range of student outcomes, found no significant differences between the intervention and control group (14).

Given the unplanned variation in the dosages of the intervention received by participants in the context of COVID-19, the objective of this study was to examine the association between the amount of WTS intervention modules received and mental health and resilience outcomes among young newcomer immigrants and refugees residing in Belgium, Denmark, and Norway. Conducting a dose assessment is also important to avoid misjudging an intervention as ineffective when it has not been fully implemented. Such analyses can also help identify the optimal number of sessions needed to achieve meaningful change from both a practical and economical perspective.

Methods

Study Design, Participants, and the Welcome to School Intervention

This study builds on a cluster-randomized intervention study conducted in Belgium, Denmark, and Norway in 2019-2020 using an observational study design (trial registration number: ISRCTN10386208.). Participants were 11-22-year-old immigrants and refugees in newcomer classes randomized into a control group and an intervention group using classes as clusters in Belgium and Denmark, and schools as clusters in Norway. These

differences in randomization method reflect practical circumstances such as variations in how newcomer classes were organized in the school system within each country. In all three countries, newcomer classes are specifically designed —based on policy goals— to help newly arrived immigrant and refugee adolescents adjust to the education system, learn the resettlement country language as well as facilitate cultural integration.

Recruitment occurred via schools. In Belgium, the schools were approached through educational networks in the Dutch-speaking regions. In Denmark, researchers contacted all municipalities to identify and invite schools with newcomer classes. In Norway, selected municipal school authorities within two hours' of travel from Oslo received invitations. Eligible students were invited to participate at the class-level.

The original 21-module WTS, developed by Pharos in the Netherlands (12), was shortened to 14 modules for this study in collaboration with the original authors, focusing on themes like migration, identity, social relations, and discrimination (14). WTS relies on a combination of verbal and non-verbal creative elements, creating space within the classroom for students to share experiences with peers, reflect on their own resources, and navigate the challenges that can accompany resettlement (12). The intervention was translated and adapted into a Belgian, Danish, and Norwegian context, respectively, by professional translators and the involved researchers. The modules in two-hour lessons were delivered by the teacher in chronological order. The teachers did not receive training prior to delivering the intervention but were sent the intervention manual with instructions to review it thoroughly. They were also given the opportunity to ask questions if they found any aspect unclear. This approach was chosen to reflect a more realistic scenario of how the manual might be used in practice, ensuring that the findings could inform potential future implementation.

Data collection

The questionnaire included items on instruments to measure mental health and resilience, as well as socio-demographic characteristics, and was translated and back-translated from English into 22 languages. The

timing of the data collection differed somewhat in the three countries (Figure 2). In Belgium, the participants completed the baseline questionnaires on paper and received assistance from interpreters if needed, whereas follow-up questionnaires were completed online at home due to the school closures, with the offering of audio files for language assistance in six languages (i.e., Arabic, Pashto, Dari, Somali, Turkish, Kurmanji). In some schools that had (partly) reopened, students completed online questionnaires in class with teacher support. In Denmark and Norway, baseline and follow-up data were collected digitally in class. In Denmark, the teachers, and in some classes also the researchers, assisted the participants with the questionnaires. In Norway, researchers and teachers assisted the participants at baseline, while only the teachers assisted at follow-up. In Norway and Denmark, follow-up data were collected shortly after schools reopened. A total of 650 students from 39 schools were recruited to participate in the study; yet only 177 participants completed baseline and follow-up questionnaires (Figure 3). Omitting participants with missing items, this resulted in a total of 147 participants, with 101 participants in the intervention group and 46 participants in the control group.

Mental health was assessed using the Strengths and Difficulties Questionnaire (SDQ) (15). SDQ has shown acceptable validity and reliability and consists of 25 items that cover five sub-scales, including four difficulties scales (emotional symptoms, conduct problems, hyperactivity, peer relationship problems) and one strengths scale (prosocial behavior) (16). The respondents use a 3-point Likert scale ("Not True", "Somewhat True", "Certainly True") (16). "Somewhat True" is scored as 1, while "Not True" and "Certainly True" are scored as 0 or 2, depending on the item (15). Outcomes included five sub-scales ranging from 0-10 and a total difficulties score ranging from 0-40, calculated by summing scores from the four difficulties scales (15).

Resilience was measured using the Child and Youth Resilience Measure (CYRM-12) (17). CYRM-12 consists of 12 items covering relationships with family and community and coping with daily life. Each item is rated on a 5-point scale ranging from "1: not at all" to "5: a lot", and a total score ranging from 0-60 is generated by

summing up the scores from the 12 items (17). Higher scores indicate higher levels of characteristics associated with resilience (17). Kankaanpää et al. reported a solid reliability score, concluding that the content validity merits its use as a screener for resilience (18).

Statistical analyses

Descriptive statistics of sociodemographic characteristics and baseline mental health and resilience outcomes were conducted. Based on data from both intervention and control group participants, multiple linear regression models were used to assess the association between the number of WTS modules and the SDQ mental health outcomes (total difficulties, emotional symptoms, conduct problems, hyperactivities, peer relationship problems, prosocial behavior) and CYRM-12 resilience outcomes. Two multiple linear regression models were performed for each outcome; the first model included baseline score, the number of modules, and group allocation (intervention or control) as control variables. The second model was additionally adjusted for age, gender, resettlement country, and migration reasons. The assumptions of linearity and homogeneity were assessed using residual plots, while normality was evaluated using QQ-plots.

Migration reasons were dichotomized into those who fled their country of origin for reasons of war or persecution (labeled “refugees”) and those who migrated for other reasons, such as parents’ labor migration or family reunification (labeled “immigrants”). The allocated group (intervention/control) was included as a covariate to assess any difference between the participants in the intervention group and the control group. In this context, the parameter estimate for the group variable in the regression models can be interpreted as the mean difference between control and intervention group participants who received zero modules.

Three sensitivity analyses were conducted on the total sample. First, the participants who received zero modules were excluded from the multiple linear regression analyses. Second, the analyses were repeated but with an alteration of the migration reason variable differentiating between 1) labor immigrants, 2) family

reunited, and 3) refugees. Third, the analyses were repeated on the participants who received 10 modules or fewer, since only a few (n=6) received more than 10 modules.

To assess whether the association between the number of modules and the outcomes differed with age and gender, interaction between the intervention and age and gender, respectively, were assessed for all outcomes. The p-values for these interactions were adjusted for multiple testing using the Bonferroni method. Data was analyzed using IBM SPSS version 28.

Ethics

The Belgian study procedures were endorsed by the ethical committee of the Faculty of Psychology and Educational Sciences at Ghent University and the KU Leuven ethics review board. In Denmark, the intervention was implemented in line with Danish legislation and the ethical procedures of the University of Copenhagen. In Norway, the Regional Committee for Medical and Health Research Ethics approved the study. All participants completed an informed consent form which emphasized that participation was voluntary, that they could withdraw their consent at any time, and that their decision to participate or not would have no positive or negative consequences for their residence permit or access to any type of support. In Belgium and Denmark, both the parents and the participants consented if the participant was aged below 14 and 15 years, respectively. For older participants, parents were informed about their child's participation and allowed to refuse. In Norway, students aged 12-16 consented to participation, following Norwegian legislation grounded in a recognition of adolescents' evolving capacity for autonomy (19). The research was conducted with careful attention to the safety, dignity, and well-being of all participating adolescents, which aligns with ethical standards for research involving minors in potentially vulnerable situations. Data processing complied with GDPR.

Results

The intervention group had a mean age of 15.3, a slight overweight of males and of Denmark as resettlement country, and the majority originated in the Middle East and had migrated for labor reasons of the parents (Table 1). Figure 1 illustrates the number of modules received: the median number was seven, while 14 participants never received any modules.

In unadjusted regression analysis, emotional symptoms on the SDQ emotional symptoms subscale decreased by 0.17 for every added module (95%CI = [0.04; 0.29]) (Table 2). This means that if a participant was to complete all 14 intervention modules, this would result in an estimated mean decrease in emotional symptoms score of 2.38 (95%CI = [0,56; 4,06]). In adjusted regression analysis, emotional symptoms decreased by 0.19 for every added module (95%CI = [0.06; 0.32]) on the SDQ emotional symptoms subscale, resulting in an estimated mean decrease in emotional symptoms score of 2.66 (95%CI = [0.84; 4.48]) following 14 intervention modules. No significant associations were found between modules received and the remaining outcomes in both the unadjusted and adjusted models. No significant interactions with age and gender were present.

The mean emotional symptom score for participants in the intervention group not receiving any modules was 0.3 higher (95%CI = [-0.7; 1.4]) than for participants in the control group in the unadjusted model, and 1.2 higher (95%CI = (-0.6; 3.0]) in the adjusted model (results not shown). This indicates that there were no differences in the emotional symptom outcome between participants in the control and intervention group who received zero modules.

Sensitivity analyses

When the participants who received zero modules were excluded, emotional symptoms decreased by 0.28 on the SDQ emotional symptoms subscale for every added module in unadjusted analysis (95%CI = [0.03; 0.52]) and by 0.28 in adjusted analysis (95%CI = [0.03; 0.54]). The results did not change notably when the categorization of migration reasons was altered (results not shown). When the participants who received more than 10 modules were excluded, emotional symptoms decreased by 0.17 (95%CI = [0.004; 0.34]) in the unadjusted and 0.21 (95%CI = [0.01; 0.41]) in the adjusted analysis. The results remained insignificant for the other outcomes.

Discussion

This study utilized data from a randomized controlled trial to examine the association between the number of WTS modules received and mental health and resilience outcomes among young newcomers aged 11-22 in Belgium, Denmark, and Norway. The findings indicated an association between the number of WTS modules received and reductions in emotional symptoms. No associations were found between modules received and the other mental health and resilience outcomes.

The findings suggest that WTS has the potential to reduce emotional difficulties among young newcomers. This is in line with the findings from previous studies evaluating other school-based interventions targeting this group (6,8,20–21). Rousseau et al. found that creative expression workshops, which also rely on a combination of verbal and creative activities as WTS, reduced mental health symptoms, including internalizing symptoms, among 7-13-year-old immigrant and refugee children (22). This suggests that the combination of verbal activities and non-verbal creative elements has the potential to reduce internalizing symptoms. Other types of school-based interventions have also been shown to be effective in reducing emotional symptoms among immigrants and refugees (6,8). Ehntholt et al. found a significant decrease in emotional symptoms

among refugee children following six group-based cognitive behavioral therapy (CBT) sessions (20), while Fazel et al. found a significant decrease in emotional symptoms among refugee children following a multitier school-based intervention that involved collaboration with teachers and parents (21). It is possible that the effects found from various delivery methods of school-based interventions partly arise from the setting where the interventions are delivered and that newcomers in general may benefit from an increased focus on mental well-being at school, irrespective of the delivery methods.

No associations were found between modules received and the outcomes other than emotional symptoms in our study. An explanation for this could be that the intervention does not relate to these outcomes or insufficient statistical power to detect such associations. Other studies have shown the effects of school-based interventions on these outcomes. For instance, Durà-Vilà et al. found effects on the SDQ scales total difficulties, hyperactivity, peer problems, and conduct problems scores among young refugees following a community-based mental health service for refugee children and their families delivered at schools (23). This six-month intervention was more comprehensive than WTS and included collaboration between several actors. This may partly explain the difference in results, together with the fact that only a few participants completed the WTS intervention in the present study.

One US study, which evaluated a school-based intervention among youth served by an Assessment, Support, and Counseling Center using a dose-response approach, found a non-linear dose-response relationship for 14 individual CBT sessions, where the improvements were greatest in the beginning of the program, then flattened, and increased again (24). It is possible that a non-linear association would have been present in the current study sample if a similar measurement approach using multiple time points throughout the intervention had been used. Furthermore, the study was affected by COVID-19, which may have influenced the results. It is, however, impossible to distinguish between the COVID-19 and intervention effects.

COVID-19 and the related school closures have caused negative mental health impacts among children and adolescents (25,26). Young immigrants and refugees may have been at particular risk (4), since they may be less likely to benefit from digital infrastructure and have a higher chance of residing in multigenerational housing arrangements that may hamper their distance learning capability. Santiago et al. found that newcomer students expressed that the school closures due to COVID-19 reinforced struggles with settling in the new country (27). The participants in this study likely experienced similar negative impacts from COVID-19, which may cause an underestimation of the actual association between the intervention and the mental health and resilience outcomes.

Other studies on students have, however, been unable to detect negative impacts from the school closures on loneliness and school belonging (28), and one study found a decrease in aggressiveness and disruptive behavior (25). It is possible that immigrant and refugee students may be more familiar with interruptions of their schooling, or that these students found ways to develop feelings of school belonging otherwise, e.g. through online platforms (28) or have obtained skills through their recent migration trajectory that were useful during the pandemic context. For some students, the school closures may also have been a relief, as it allowed them to spend more time at home and to be less exposed to external stimuli (25). It is therefore also possible that the school closures did not cause negative impacts or that they had a positive impact on some participants, which would, in the latter case, overestimate the association between the WTS intervention and a decrease in emotional symptoms.

Methodological considerations

When compared to SDQ UK norms (29), the participants showed relatively good SDQ scores equivalent to good mental health at baseline. Although CYRM-12 norm values are not yet developed, our study participants showed relatively high resilience levels. Thus, a ceiling effect may have compromised the ability to detect the association between the intervention and changes in these outcomes. However, as the UK SDQ norms of mean values are only validated on 11–15-year-olds in the United Kingdom (29) this interpretation should be made with caution. Likewise, using SDQ—originally developed for self-reports among 11- to 17-year-olds—with this expanded age range presents a limitation, which may affect the validity and reliability of the measured outcomes.

Although we found no deviations from linearity and hence no signs that the respective intervention modules had different impact on the outcomes, the current analyses may provide a simplified description of the actual association between the number of modules received and the outcomes. Multiple linear regression, assuming equal effects for each intervention module, may be inadequate for several reasons. The individual modules cover different topics that may impact each outcome. It is possible that the modules placed in the beginning of the WTS intervention generated the largest association with emotional symptoms but less so on the remaining outcomes. The latter modules, which only very few participants completed, focused more on strengthening the ability to self-care and creating resilience. Thus, the impact on, for instance, resilience scores may not have emerged until later in the intervention. It is, however, not possible to draw any conclusions on the association between specific modules and the outcomes. Also, the context, mechanisms of change and outcomes in an intervention are, in general, closely intertwined (30). Consequently, the specific modules implemented may likely be less influential as long as some form of intervention takes place. In the WTS qualitative evaluation, some students expressed increased peer connectedness and better mutual understanding following the intervention (14), indicating that mental health changes may also be related to how the classroom dynamics change over time and not only the specific module themes.

The study's strengths include the “dose-response” approach, which enables a more refined analysis of associations between the intervention and outcomes when participants receive varied amounts. Other strengths are that the schools or classes were randomized, and the use of validated questionnaire measures that were translated into 22 languages as well as both negative (difficulties) and positive outcomes (strengths and resilience) were studied. Limitations include the high rate of participants lost to follow-up, introducing a risk of attrition bias, which is particularly relevant in the context of COVID-19 and the heightened vulnerability of some newcomer students during school closures. While school-based interventions typically exhibit lower dropout rates, newcomer classes are inherently more fluctuating, with students transitioning to the regular school system when they are considered ready. This inherent fluctuation, compounded by the instability brought on by the pandemic, likely exacerbated the loss to follow-up in these classes. The fact that schools had reopened in Denmark and Norway and had only partly reopened in Belgium at follow-up may explain the higher loss to follow-up in Belgium. Due to COVID-19 school closures, having limited contact with the intervention might also impact respondents’ connection to the study. As a result, the findings may be influenced by the disproportionate exclusion of certain groups, who are also less connected to the study, potentially affecting the estimated strength of the associations negatively and the generalizability of the results.

Further limitations include the small study sample and, hence, limited power, that only very few participants completed the last modules, and that the analysis did not consider cluster effects. The school context differed between countries; the Norwegian teachers had fewer newcomer students per class compared to their Belgian counterparts, reflecting the lower number of newcomer children in Norway at the time of data collection. Such differences in class composition could have influenced the results, as smaller class sizes with fewer students with special needs and vulnerabilities may allow for more individualized attention and better implementation of the intervention. Conversely, larger class sizes might affect the dynamics and outcomes differently, potentially diluting the impact of the intervention. However, the COVID-19 school closures mitigated

potential influences from shared environmental factors within school clusters. Additionally, in the adjusted regression analysis, the resettlement country was added as a control variable to account for the country impact.

While comparing results across countries would be interesting, we ultimately pooled the data for a sufficient sample size. This decision was necessary due to the relatively low number of newcomer children in European countries at the time of data collection, in contrast to the situation in 2015-2017 with the large arrival of mainly Syrian children, when RWS was designed. Although the WTS intervention is designed to accommodate a diverse student body, the country or region of origin may be an important potential confounder, as cultural background could influence the intervention's effectiveness. However, due to the small sample sizes for each region of origin, we were unable to analyze this factor. A further limitation of this study is the lack of data on the length of stay in the resettlement country, limiting our ability to explore its impact on the intervention's effectiveness.

Since follow-up data were collected shortly after the WTS intervention was interrupted or completed, the results should be regarded as immediate effects. There is also a risk of social desirability bias if some participants were afraid to share their feelings or exaggerated the severity of their struggles. Selection bias should also be considered, as many participants were either lost to follow-up or excluded due to incomplete questionnaires. Still, the effect on the results cannot be further determined. Furthermore, the study lacks information on the quality of implementation, which limits the ability to assess how consistently and effectively the intervention was delivered across settings. The broader contextual factors, such as policies of exclusion and public discourses on othering, may also influence how such interventions are received and experienced. Indeed, we recognize that WTS and this paper may inadvertently contribute to this discourse. Future high-quality research using mixed methods that include detailed implementation data, which engages with these contextual realities, is needed to more accurately evaluate the effectiveness of the WTS intervention.

Conclusion

The study suggests that the WTS intervention has the potential to reduce emotional symptoms among young newcomers, with greater doses of the intervention received associated with more substantial observed reductions in emotional symptoms. These findings indicate that implementing supportive interventions like WTS in newcomer classes may be useful in promoting mental well-being. Such programs may not only support individual students but also contribute to greater social cohesion within schools. Future research is needed to examine the full effects of the intervention and to better understand how such programs can be adapted and scaled to support diverse student populations and, ultimately, fulfil their life chances.

Conflict of interest

None

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Data availability statement

The data that support the findings of this study are not publicly available due to concerns of fully anonymity for this vulnerable population.

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