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Shifting from Burden Sharing to Task Sharing: Advancing Community-Initiated Care in MHPSS for Refugee Resettlement

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Abstract: The complexities of refugee resettlement in the U.S. require comprehensive mental health and psychosocial support (MHPSS) strategies, yet significant gaps persist due to resettlement policies prioritizing short-term self-sufficiency over long-term mental health and well-being. This study explores the shift from traditional “burden sharing” to “task sharing” models that emphasize community-initiated care (CIC). Using a two-phase qualitative method, 27 refugee leaders and bilingual service providers from 14 refugee communities, including Afghan, Bhutanese, Burmese, Congolese, Somali, and Sudanese communities, across four states participated in focus groups or key informant interviews. Thematic analysis revealed that peer support models play a critical role as bridges between cultures, service sectors, and formal and informal networks. However, peer support remains insufficient without structural reform, as refugees face barriers such as lack of professional development and power imbalances with professionals while managing their own life challenges. This study emphasizes formalizing CIC models that empower refugees to lead the sharing process in collaborative care. Intersectoral collaboration and supportive policy frameworks are necessary to sustain peer support and build long-term leadership capacity. The findings highlight the need for a system-level shift to ensure equitable responsibility for care, fostering sustainable, community-driven MHPSS solutions in refugee resettlement.

Keywords: community-initiated care; task sharing; peer support; refugee resettlement; community empowerment; mental health and psychosocial support (MHPSS)

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1. Introduction

The U.S. resettlement program plays a critical role in providing a pathway for refugees fleeing conflict, persecution, and instability worldwide. Despite its intent to offer safety and stability, however, the program falls short in addressing the complex and long-term health and mental health needs of resettled refugees (Betancourt et al. 2012; Kumar et al. 2021; Nguyen et al. 2023). The prevailing policy approach emphasizes rapid self-sufficiency, primarily through employment—often in short-term, low-wage jobs—while sidelining comprehensive mental health care and long-term integration support (Brick et al. 2010; Brown and Scribner 2014). Access to mental health support is critical during resettlement, as untreated trauma and stress can compound over time, leading to severe psychological distress, impaired functioning, and reduced capacity to integrate into new communities (Grasser 2022; Kirmayer et al. 2011; Miller and Rasmussen 2017). The unrealistic resettlement timeline of 30 to 90 days often exacerbates long-term challenges, including chronic poverty, limited access to health care, and deteriorating health outcomes,

particularly in terms of mental health (Kerwin and Nicholson 2021; Kumar et al. 2021). Consequently, many refugees are left to grapple with unresolved psychological trauma, ongoing stressors, and the challenges of cultural adaptation in a system that ultimately hinders their long-term psychosocial well-being (Afkhami and Gorentz 2019; Forrest-Bank et al. 2019). The current emphasis on achieving financial independence from federal or state funding as the primary measure of successful resettlement inadvertently marginalizes mental health and community support, exposing a significant gap in the U.S. resettlement framework (Barkdull et al. 2012; Hess et al. 2019).

1.1. Burden Sharing in U.S. Refugee Resettlement

In response to the scale and complexity of refugee needs, many host nations, including the United States, have adopted a “burden sharing” approach to refugee care. This practice assigns primary responsibility for refugee support to formal institutions such as resettlement agencies, social services, and health-care providers, while supplementing these efforts with informal community assistance—often provided by refugees themselves (Brown and Scribner 2014; Gonzalez-Benson 2021). While this framework is well intentioned and pragmatically appealing, it exhibits substantial limitations in addressing the diverse and multifaceted needs of refugee populations.

A critical shortcoming of current burden-sharing practices is their tendency to centralize authority within formal institutions, relegating refugees to passive roles in their own care. This dynamic undermines refugees’ agency, perpetuates dependence, and fosters disempowerment, limiting opportunities for self-determination and integration (Ager and Strang 2008; Kerwin 2012; Eastmond 2007; Thomson 2022). Refugees are often positioned as supplementary actors in their resettlement process, rather than active participants. This exclusion reinforces systemic inequities and misses opportunities to incorporate refugees’ unique knowledge and lived experiences into responsive and sustainable support systems. Additionally, these practices inadequately address cultural and linguistic barriers, often resulting in superficial solutions that fail to engage meaningfully with refugee communities. Formal service providers frequently lack the cultural competencies and language support required to build trust and ensure effective communication, resulting in the underutilization of mental health services and persistent health disparities (Gerritsen et al. 2006; Miller and Rasmussen 2017). These challenges are further exacerbated by the structural reliance on underfunded community resources, which are expected to compensate for gaps in institutional capacity. Refugee communities themselves often bear this additional burden, despite limited resources and their own resettlement challenges.

Moreover, the structural limitations of burden-sharing practices are compounded by chronic underfunding, overburdened resettlement agencies, and fragmented care pathways. Resettlement agencies—initially established as voluntary organizations (VolAgs)—increasingly depend on stretched community resources and unpaid volunteers to address systemic gaps, which creates a patchwork system of support that is incoherent and unsustainable (Hynie 2018). Such fragmentation undermines continuity of care, particularly for refugees with chronic or complex mental health needs, perpetuating cycles of unmet needs and inadequate outcomes (Silove et al. 2017; DeSa et al. 2022). Ultimately, these reactive burden-sharing measures, though administratively convenient, fail to holistically address the structural, cultural, and psychosocial dimensions of refugee care. Without systemic reforms—including enhanced funding, strengthened institutional capacity, and the active inclusion of refugees as co-designers of their care—this approach will continue to fall short in supporting long-term integration and well-being for refugee populations.

1.2. Toward a Task-Sharing Paradigm: The Case for Community-Initiated Care (CIC)

In recent years, there has been a growing recognition of the need to transition from reactive burden-sharing practices to more inclusive and collaborative models, such as “task sharing.” Task sharing decentralizes the responsibilities of mental health and psychosocial support (MHPSS), engaging a broader network of actors—including refugee community members, peer supporters, and local leaders—alongside formal service providers (Patel et al. 2018; Singla et al. 2021). This paradigm reflects the principles of community empowerment and participatory health by positioning refugees as active co-creators of support systems, rather than passive recipients of aid (Naslund et al. 2019; Kohrt et al. 2023). By redistributing the responsibility for care, task sharing has the potential to bridge systemic gaps, enhance cultural relevance, and foster sustainable MHPSS frameworks rooted in community involvement (Chiumento et al. 2021; van Ginneken et al. 2021).

A particularly promising task-sharing model is community-initiated care (CIC), which capitalizes on the lived experiences, cultural knowledge, and unique insights of refugee community members to address MHPSS needs (Kohrt et al. 2018, 2023; Siddiqui et al. 2022). CIC equips refugees with training and support to serve as peer supporters and community leaders, enabling them to provide culturally attuned mental health care, foster trust, and offer guidance within their communities. This approach acknowledges the inherent strengths and resilience within refugee communities, recognizing that community members often possess a deeper understanding of their peers’ needs than external professionals. By leveraging these assets, CIC bridges cultural and linguistic divides that frequently hinder access to formal care systems, while mitigating stigma and distrust regarding mental health issues (Breuer et al. 2023; Giusto et al. 2024; Tol et al. 2021). Peer support within the CIC framework creates culturally congruent and accessible pathways to mental health care, addressing longstanding gaps in service uptake (Woodward et al. 2022). Moreover, CIC reframes refugees not as passive recipients of aid, but as active agents shaping the systems designed to support them. This shift transforms task sharing from a logistical approach to a holistic strategy that empowers refugee communities, enhances integration, and promotes equitable and effective MHPSS outcomes.

1.3. Peer Support in Bridging Formal and Informal Care Networks

Central to the CIC model is the concept of peer support, where refugees act as cultural brokers, advocates, and support figures within their communities (Mahon 2022; Crooks et al. 2022). Peer support has been shown to significantly enhance MHPSS outcomes by fostering trust, reducing stigma, and improving service accessibility—particularly in communities where cultural norms create barriers to seeking formal care (Mahon 2022; Sun et al. 2022). Unlike conventional mental health services, peer support operates within the culturally familiar and safe confines of the community, making it more accessible and acceptable to many refugees (Gagne et al. 2018; Gower et al. 2022). By serving as critical links between formal service systems and refugee communities, peer supporters help individuals navigate complex care pathways and access necessary resources (Block et al. 2018; Swartz et al. 2014; Wachter et al. 2021). This dual role—bridging formal and informal networks—not only facilitates timely care but also strengthens the relevance and effectiveness of interventions, including those targeting refugees resettled in the U.S. (Solatan et al. 2022; Verbillis-Kolp et al. 2024).

Despite these promising outcomes, the literature reveals a notable gap in understanding the experiences and perspectives of refugee peers who assume these vital roles (Ponzoni et al. 2017; De Graaff et al. 2023). Many peer-led MHPSS programs face challenges in fully documenting or integrating the perspectives of refugees as active stakeholders in the foundational design and leadership of peer support initiatives (Cohen and Yaeger 2021; Filler et al. 2021). Moreover, in high-income resettlement countries, task-sharing programs

remain relatively limited (Hoeft et al. 2018), and there is insufficient exploration of how refugee-led efforts can enhance the effectiveness and sustainability of such models. While CIC frameworks demonstrate potential, gaps in the literature highlight the need for greater understanding of how refugees' lived experiences and cultural knowledge can be systematically incorporated to inform program development and implementation (Woodward et al. 2022). This oversight risks diminishing cultural relevance and limits the potential for long-term success (Naslund et al. 2019). Refugees bring invaluable cultural knowledge and firsthand experiences that are crucial for tailoring MHPSS interventions to align with community values and needs (Hynie 2018).

Furthermore, little attention has been paid to the capacity of refugees to independently initiate and sustain peer support networks. This lack of focus represents a missed opportunity to explore pathways to greater community empowerment and self-sufficiency (Patel et al. 2018). Addressing these gaps requires a shift toward participatory research and practice that positions refugee communities as co-creators in the development of CIC models. By actively engaging refugees in the design, implementation, and evaluation of these initiatives, programs can align more closely with community priorities, enhancing both their effectiveness and sustainability (Warner et al. 2021; Singla et al. 2021). Such an approach not only strengthens the cultural congruence of peer support models but also fosters a sense of ownership and empowerment among refugee communities. This participatory framework holds the potential to set a new standard for MHPSS within refugee contexts by ensuring that interventions are both scalable and deeply rooted in the lived realities of the populations they serve (Greene et al. 2022; Im et al. 2023).

The objective of this study is to examine, through the perspectives of refugee community leaders, the challenges and opportunities within task-sharing approaches to MHPSS. By capturing their insights directly, this study seeks to illuminate the cultural, structural, and relational dynamics that influence the success and sustainability of CIC models in resettlement contexts. Specifically, it aims to explore (1) community leaders' perceptions of peer support within task-sharing models, (2) the barriers they identify in implementing community-initiated mental health care, and (3) their perspectives on the support systems necessary for sustaining such interventions effectively. Through this focused analysis, the research aspires to contribute a nuanced understanding of how community-led strategies can foster resilience, empowerment, and agency among refugees, addressing key systemic gaps in the existing resettlement paradigm.

2. Methods

2.1. Research Design

This study employed a two-phase qualitative research design to explore the perspectives of refugee community leaders and service providers on community-initiated care (CIC) models for mental health and psychosocial support (MHPSS). The two-phase design, comprising focus group discussions (FGDs) followed by key informant interviews (KIIs), was selected to capture both communal and individualized insights. Focus groups allowed for an initial broad exploration of themes in a collaborative setting, enabling participants to engage with one another's perspectives. The subsequent key informant interviews provided deeper, individualized insights, allowing for nuanced follow-up on key themes identified during the focus groups. This approach facilitated a comprehensive understanding of the barriers to and opportunities for CIC in refugee MHPSS.

2.2. Data Collection and Participants

The focus groups were initially formed as part of a larger community initiative, the Refugee Community Leaders Council (RCLC), an established platform designed to

promote dialogue between refugee communities and service providers. Initially composed of a small group of community leaders, the RCLC expanded to 23 participants to ensure broader representation of refugee voices. For this study, three FGDs conducted during the council's first year were analyzed, with each session lasting approximately 90 min. These discussions were guided by a semi-structured protocol, encouraging participants to reflect on mental health and psychosocial needs, existing gaps in traditional service models, and opportunities for community-led support. Key themes included the role of peer support in bridging cultural divides, the interplay of formal and informal support networks, and perceptions of structural barriers impacting MHPSS delivery.

Building on the insights from the FGDs, the second phase involved 18 KIIs with refugee community leaders and bilingual service providers across ten resettlement sites in four states, encompassing both urban and rural locations. The resettlement sites varied in their maturity, with some programs operating for decades and others representing newer initiatives. Political environments also differed, ranging from supportive to hostile, further shaping the services available to refugees. These interviews, each lasting 45–60 min, provided deeper, individualized perspectives on CIC implementation. Participants were asked about the roles and contributions of peer supporters in their communities, the challenges faced in delivering MHPSS, and their vision for future improvements. Questions such as “What forms of community-initiated care or support have you experienced, whether as a participant, initiator, or supporter?” and “What support or changes are needed to strengthen community-initiated care and ensure sustainability?” facilitated a nuanced exploration of the participants' experiences and recommendations.

This study included 27 participants: 9 refugee community leaders in FGDs (G1–G9) and 18 key informants (I1–I18) from 15 countries, including Afghanistan, Bhutan, and Congo. The sites studied varied in community diversity, with some resettlement locations attracting long-established ethnic groups and others primarily hosting newer arrivals where resettlement programs were the primary driver of migration. Roles varied among community/religious leaders, interpreters, and service providers, with years in the U.S. ranging from 2 to 14 years. The gender distribution was nearly balanced, with 12 females and 15 males (see Table 1). Criteria for participation required individuals to hold leadership roles within refugee communities or to work directly in MHPSS or case management in resettlement agencies, ensuring a mix of personal and professional insights into the needs, challenges, and strengths of CIC models for refugee MHPSS.

Table 1. Participant demographics.

ID	Country of Origin	Role in Community	Gender	Years in the U.S.
Focus Group Participant				
G1	Afghanistan	Community Leader	F	4
G2	Bhutan	Religious Leader	M	7
G3	Burma	Community Leader	M	10
G4	Congo	Interpreter	F	11
G5	Bhutan	Service Provider	M	8
G6	Kenya	Religious Leader	M	13
G7	Burundi	Interpreter	M	3
G8	Bhutan	Community Leader	F	7
G9	Bhutan	Community Leader	M	10
Individual Interview Participant				
I1	Afghanistan	Community Leader	M	6
I2	Bhutan	Service Provider	F	13
I3	Syria	Interpreter	M	4
I4	Congo	Community Leader	F	11

I5	Afghanistan	Interpreter	M	2
I6	Ethiopia	Interpreter	F	8
I7	Burundi	Community Leader	M	9
I8	Cuba	Service Provider	M	10
I9	Eritrea	Service Provider	M	5
I10	Sudan	Service Provider	M	12
I11	Somalia	Interpreter	M	10
I12	Rwanda	Community Leader	M	6
I13	Iraq	Service Provider	M	13
I14	Afghanistan	Community Leader	F	4
I15	Bhutan	Interpreter	M	6
I16	Burundi	Service Provider	F	7
I17	Afghanistan	Service Provider	F	3
I18	Somalia	Community Leader	F	14

Four research assistants contributed to data collection and transcription for both FGDs and KIIs. All sessions were audio-recorded with participants' consent and subsequently transcribed verbatim. Ethics approval was obtained from the author's institution, and all participants provided informed consent, acknowledging their voluntary participation and understanding of the study's purpose and potential risks. Confidentiality was maintained by de-identifying transcripts and securely storing data in encrypted files accessible only to the research team. This comprehensive data collection approach, combining communal perspectives from the FGDs with individualized insights from the KIIs, offered a holistic understanding of CIC's potential to transform refugee MHPSS. By capturing both shared and unique experiences, the study was able to identify key systemic gaps and opportunities for community-driven care models.

2.3. Data Analysis

Thematic analysis was conducted to systematically examine the data, following an inductive approach aimed at capturing patterns and themes across focus group and interview transcripts (Braun and Clarke 2006). This method was chosen for its flexibility and suitability for identifying nuanced insights in qualitative data, particularly when exploring complex social phenomena such as refugee resettlement journeys and community-initiated care (Nowell et al. 2017). The analysis proceeded through multiple stages to ensure a comprehensive and in-depth exploration of the data. First, the author conducted an open-coding process where recurring ideas and concepts were identified, allowing for the emergence of themes without predetermined categories (Saldaña 2016). Following this, thematic grouping was conducted to consolidate similar codes into broader categories, which provided a structured yet flexible framework for understanding key themes relevant to the research questions (Miles et al. 2014). Finally, iterative refinement was undertaken, where emerging themes were reviewed and adjusted to ensure that they accurately and meaningfully represented participants' perspectives and experiences (Creswell and Poth 2018).

To enhance the rigor and validity of the analysis, peer debriefing sessions were conducted to provide opportunities to discuss and critically evaluate emerging interpretations, thereby contributing to a more balanced and reflective analysis (Lincoln and Guba 1985). Additionally, member checking was performed with selected participants to validate key findings and ensure that the interpretations authentically reflected the voices and intended meanings of the refugee leaders and service providers involved in the study (Birt et al. 2016).

3. Results

3.1. *Everyday Language and Cultural Practices in Community-Initiated Care*

The concept of community-initiated care was not something refugee participants described in formal terms, nor was there a single, unified model. Instead, they used familiar, everyday language that reflected the peer support they relied on within their communities. Many spoke about “looking out for each other,” capturing the sense of making sure everyone is okay and helping when needed. Others described it as “helping hands,” emphasizing the practical, day-to-day support that people provide to make life a little easier. Some participants talked about “being there” for one another, offering comfort and a listening ear during difficult times. They also referred to “our own group” or “our people” to describe a safe, trusted circle within the community where they feel understood. Regular “checking in” was mentioned frequently, reflecting how people visit or call each other to ensure that everyone is managing well.

Cultural and religious gatherings are an important form of CIC, providing natural spaces for people to connect, share, and care for one another. Participants described gatherings at community centers, places of worship, and cultural celebrations as times that bring everyone together, reinforcing bonds and creating opportunities to support each other. “We celebrate together, the whole community, like on Eid or Independence Day. It’s not just a party; it’s a way to remember who we are, to show our children where we come from” (I10). Such events provide more than mere recreation: they reinforce a sense of belonging and identity that can help counter the isolation and cultural dislocation that refugees may feel in a new country.

Through these gatherings, people also “share stories” and “pray together,” which provides comfort, strength, and a reminder that they are not alone in their struggles. Religious and cultural events were described as “healing time” or “blessing time,” where people feel uplifted and reconnected to their roots and values.

We meet every Friday for Jummah, and afterwards, we have tea and talk. For many of us, faith is what keeps us going. Just being together with people who believe as you do can be incredibly comforting. When we pray together, it’s like the worries get lighter. (I18)

The phrase “staying together” came up often, highlighting the importance of unity and standing strong as a community during tough times. Others described it as “holding each other up,” helping one another stay strong through challenges. For many, this support felt like “family” or “like a family,” with people viewing each other almost as brothers, sisters, or extended family members. Participants also referred to “word of mouth” help—information or advice shared through community connections—which enables them to find support or resources without navigating complex systems. Advice, support, and even job leads often flow through these networks, making life in a new place a little easier. These everyday terms reflect how peer support is woven into the fabric of their daily lives, showcasing the natural, community-based support that grows from cultural and religious traditions, making a meaningful difference in their shared experiences.

3.2. *Peer Support as Essential Survival Mechanism*

Participants described peer supporters as essential cultural bridges who bring unique value to resettlement process, not merely as supplementary agents but as indispensable links that facilitate trust, understanding, and access. These supporters are often viewed as “insiders” who possess a deep knowledge of cultural norms, values, and the social nuances of refugee communities, allowing them to mediate and contextualize mental health services in ways that formal providers may struggle to achieve. A community leader from Afghanistan explained, “When a peer supporter speaks to us, we feel understood because

they've been through what we are going through. They know what it's like to start from nothing in a new country, to have fears and insecurities that others may not understand" (G1).

For many participants, peer support extended beyond simply bridging cultural gaps—it was seen as a critical survival mechanism. This role went beyond mere facilitation and encompassed both practical and emotional support. Participants emphasized that these supporters were not merely optional facilitators but vital figures who help refugees navigate complex social and health systems. A Bhutanese community leader added:

Go to social services, resettlement agencies, DMV, clinics and other places. You rarely see people from my community. They are doing their best, but we sometimes have communication challenges even with interpreters. We don't know who they are, they don't know who we are. We just do our best, but still, we feel frustrated and disappointed and don't get what we need. (G8)

The absence of community members in formal roles was a recurrent theme, with many expressing the need for community-initiated involvement to create a sense of safety and understanding. An interpreter from Somalia stated, "Sometimes, it's hard to open up to someone who hasn't experienced what you've experienced. But with peer supporters, there's already that trust" (I11). This cultural bridging is particularly important in mental health settings where stigma or misunderstandings about mental health conditions can impede engagement with formal services. A community leader from Bhutan noted, "Mental health is a sensitive topic in many of our communities, but when we speak about it, people are more open because they see us as one of them" (G8). This insider status allows peer supporters to build trust with refugees, reducing stigma and helping individuals feel safe in accessing support.

3.3. (Dis)Empowerment through Evolving Community Care across Contexts

Community-initiated care (CIC) emerged as a transformative model that empowers refugees to play an active role in their own mental health and psychosocial support. Unlike traditional, top-down approaches that often render refugees passive recipients, CIC gives individuals and communities a voice, enabling them to shape services that resonate with their unique cultural and social contexts. For many participants, this shift represents not only a form of empowerment but also a reclamation of agency and leadership in a resettlement system that can feel disempowering. A community leader from Congo expressed:

Being part of the decision[-making process] is important to us. We don't need to just be told what to do; we want to be part of the solution. They [community initiatives] make us to feel valued, like we have something to contribute to our own people and community. (I4)

This sentiment was echoed by many other community leaders, including a community leader from Bhutan, who stated, "Through CIC, we are not just beneficiaries; we are leaders and partners. It gives us dignity to know that our voices matter" (G9). Participants emphasized that CIC fosters a sense of ownership and self-determination, critical factors for mental well-being and resilience. By leading peer support and other community-based initiatives, refugees can harness their strengths and experiences to aid others, creating a positive feedback loop of empowerment within their communities. "When we help each other, we don't just heal as individuals; we grow stronger as a community," noted a community leader from Rwanda (I12), highlighting how CIC enables both personal and communal growth.

While the transformative potential of CIC is evident in many communities, the absence or underdevelopment of such initiatives presents significant challenges,

highlighting stark disparities in empowerment and cohesion across different refugee contexts. Participants from multiple refugee communities consistently highlighted pervasive disempowerment during the resettlement process and fragmentation of the community, which were often exacerbated by systemic neglect and the insufficient prioritization of community-building efforts. The absence of cohesive community structures and trust emerged as critical barriers to collective action. Participants described a community characterized by individualized priorities and a pervasive desire for anonymity, often rooted in distrust and reluctance to engage in shared initiatives. As one participant observed, “We don’t really know each other or trust anyone enough to come together. Everyone has their own problems, and it feels safer to stay quiet” (I8). This lack of cohesion resulted in heightened social isolation and limited opportunities for peer support or community-driven interventions. Even among individuals who expressed interest in CIC models, the absence of trust and a formal community framework rendered implementation efforts infeasible. Participants further noted that resettlement agencies routinely neglected the need for trust-building and community engagement, thereby reinforcing cycles of isolation and disempowerment.

Similar concerns were expressed by other refugee community leaders, who underscored the challenges posed by small, dispersed community segments, coupled with prolonged histories of oppression and displacement, silenced many voices within their population. One Burundian leader remarked, “We have strong desires to come together as a community, but no one listens to us or cares about what we need” (G7). This lack of recognition and support from both external organizations and resettlement agencies hindered efforts to build a unified community voice or advocate for shared needs.

3.4. Structural Barriers Facing Peer Supporters

Despite the numerous benefits of CIC, peer supporters encounter significant structural barriers that hinder their effectiveness and sustainability. The most frequently cited challenges included a lack of access to professional development, entrenched power imbalances with health-care providers, and financial instability. Peer supporters often find themselves positioned in informal or marginal roles, without the resources or authority to influence decision-making processes in meaningful ways. A peer supporter from Eritrea shared, “We do a lot of the frontline work, but we’re not seen as ‘real’ professionals. There’s this feeling that we’re helpers, not experts, and that limits what we can do” (I9). This sentiment underscores the power dynamics that exist between peer supporters and formal health-care providers, who may view peer supporters as supplementary rather than integral to the MHPSS system.

Another structural barrier is the lack of opportunities for career advancement or skill development. An interpreter from Ethiopia explained, “There’s no clear place for us to grow or learn new skills. We want to improve, to get training, but there’s nothing” (I6). Without access to professional development, peer supporters are unable to enhance their knowledge or strengthen their impact within the community. Additionally, financial instability is a common challenge, as peer support roles are often low-paid or volunteer-based. “We can’t keep ourselves running on what we’re paid; it’s not enough to live on,” commented a service provider from Sudan, highlighting the precarious financial situation many peer supporters face (I10). This financial insecurity creates a precarious situation where peer supporters may need to prioritize other work, reducing their capacity to support their communities effectively. Additionally, participants criticized the short-term, project-based funding model that characterizes much of the MHPSS landscape. As one refugee leader who wanted to stay anonymous pointed out, “They fund us for a year, maybe two, then they leave. There’s no long-term vision. It’s just a band-aid, not a real solution.” This critique highlights the need for sustained investment in CIC and peer

support systems to ensure their long-term impact and effectiveness. It also underscores the inherent limitations of the formal service structure in refugee resettlement, which struggles to provide sustainable, community-centered solutions due to its short-term, fragmented approach.

Even among communities with demonstrated enthusiasm for CIC initiatives, such as the Bhutanese refugee population, systemic barriers remained a persistent challenge. Bhutanese leaders emphasized that their community's relatively well-organized networks and demonstrated capacity for collective action were not matched by the necessary institutional support. Ethnic community-based organizations (ECBOs), which are integral to grassroots initiatives, often operated without adequate resources or recognition from formal systems. Leaders described being overburdened and unsupported, despite their critical role in fostering community resilience and engagement. As one Bhutanese leader noted, "We try to build something for our people, but the agencies don't care. They give us no support, and we are left doing everything on our own" (G5). While the Bhutanese community demonstrated a stronger organizational framework and readiness for CIC compared to other groups, the lack of institutional investment undermined the sustainability of their initiatives. Leaders frequently expressed frustration over having to address their community's needs with insufficient resources, ultimately constraining the potential of even well-prepared communities to fully realize the benefits of CIC.

3.5. Balancing Peer Supporters' Personal and Professional Lives

The dual role of peer supporters—as individuals navigating their own resettlement challenges and as key providers of mental health and psychosocial support—creates significant strain, underscoring the inequities within the refugee resettlement system. Participants described how this compound responsibility often results in emotional exhaustion and logistical challenges, particularly in contexts where institutional support is insufficient. A service provider from Bhutan observed, "We're carrying a lot, not just for others but for ourselves too. Sometimes it feels like we're stretched too thin" (G5). This reflects the layered burdens faced by peer supporters, who must juggle personal and professional roles while simultaneously addressing the systemic gaps left by overburdened resettlement programs.

These systemic shortcomings effectively transfer institutional responsibilities to refugee communities, amplifying the strain on peer supporters. Participants noted how stretched resources within resettlement agencies exacerbate the pressure, leaving peer supporters to shoulder much of the care infrastructure. "We need a space to share what we're going through, to support each other, just like we support our communities," emphasized a service provider from Burundi (I16). The lack of dedicated spaces for peer supporters to process their own challenges not only affects their well-being but also weakens the broader community's capacity for sustainable care.

Additionally, the emotional labor inherent in peer support roles intensifies the psychological toll. Many participants described the difficulty of providing constant care while being immersed in others' trauma, with an Afghan community leader sharing, "It's hard to listen to so much pain and not feel affected by it" (I1). This pervasive exposure to trauma, compounded by the lack of access to mental health resources, places peer supporters at heightened risk of burnout and secondary trauma.

The absence of systemic safeguards to mitigate these challenges highlights a critical oversight in the resettlement framework. Participants consistently called for mental health resources tailored specifically to peer supporters, including peer-led support groups and training programs that promote resilience. These interventions are vital not only for individual well-being but also for maintaining the long-term viability of community-initiated care models.

3.6. Cross-Sectoral Collaboration and Policy Support

Participants stressed the importance of cross-sectoral collaboration and supportive policy frameworks to formalize and sustain CIC models. They highlighted that the current service landscape for refugees lacks coordinated support across sectors, including health care, social services, housing, employment, and education. Effective CIC requires an intersectoral approach that can bridge these systems, creating a network of resources to support peer supporters and refugee communities more broadly. “We need all kinds of service providers working together—health, DMV, schools. Right now, it’s too separated, and that puts all the burden on us,” explained a Somali interpreter (I11). The burden often falls on peer supporters, who act as the glue holding together this fragmented system, bridging gaps between disconnected services. Without formalized structures or policy support, CIC initiatives risk being inconsistent and unsustainable, relying too heavily on the individual efforts of peer supporters without long-term institutional backing. A community leader shared a similar concern, saying:

Case managers know me well, and they call me when there is a crisis. I told him [case manager], please call me before this becomes a crisis. I’d be happy to walk the family through, but when you call me it is late oftentimes and things got worse. (G6)

This quote underscores the reactive nature of the current support system, where peer supporters are often contacted only when issues escalate, placing additional strain on both peer supporters and the families they assist. Policy support is essential for recognizing and institutionalizing the role of peer supporters in MHPSS. A community leader emphasized, “We need the government to acknowledge what we’re doing and provide support, not just short-term funding but real investment in our role” (I18). Formalizing CIC through policy can ensure that peer supporters are adequately resourced, reducing burn-out and fostering continuity in MHPSS delivery.

4. Discussion

This study highlights the critical need to shift from reactive burden-sharing frameworks to more collaborative and sustainable task-sharing approaches in refugee mental health and psychosocial support (MHPSS). Drawing on the insights of refugee community leaders, this research reveals both the opportunities and systemic barriers embedded within current practices. The findings affirm the potential of community-initiated care (CIC) to enhance resilience, trust, and empowerment within refugee communities by positioning peer supporters as cultural brokers and advocates. Existing scholarship, such as Ong’s *Buddha is Hiding* (Ong 2003), Besteman’s *Making Refuge* (Besteman 2016), and Abdi’s *Elusive Jannah* (Abdi 2015), underscores the pivotal role of community-driven efforts in refugee integration and offers critical insights into how CIC can complement formal systems. These roles provide culturally responsive mental health promotion—an urgent need, as untreated trauma and social isolation can undermine long-term resettlement outcomes (Kirmayer et al. 2011; Ellis et al. 2019)—and serve as a scalable framework for integrating comprehensive support across resettlement programs and beyond (Fuhr et al. 2019; Naslund et al. 2019; Ventevogel and Whitney 2022).

The findings underscore that cultural alignment and trust are fundamental prerequisites for both service uptake and broader community integration. However, despite its promise, CIC remains hindered by systemic shortcomings in the U.S. resettlement framework. Participants in this study emphasized the limitations of current resettlement approaches, which predominantly place the onus of refugee support on formal institutions operating within constrained resources, including insufficient time frames, funding, and staffing. These inadequacies leave critical gaps in addressing the complex and enduring

needs of refugee populations, inadvertently transferring these unmet responsibilities back to refugee communities themselves. This reliance on burden-sharing structures not only positions refugee communities as passive recipients but also reinforces dependence and undermines the provision of culturally responsive, sustainable care.

Moreover, this study identifies significant barriers faced by peer supporters within task-sharing models, such as the lack of formal recognition, inadequate financial compensation, and limited access to professional development opportunities. Such structural inequities perpetuate power imbalances between peer supporters and formal service providers, ultimately reducing the efficacy of task-sharing approaches. The resettlement system's dependence on refugee communities to compensate for the shortcomings of underfunded agencies exacerbates vulnerabilities among peer supporters. This overreliance risks not only exhausting community resources but also leading to further marginalization if refugee communities lack access to broader support systems and opportunities for meaningful integration with host communities (Im 2021; Tyeklar 2016). Many of these individuals are simultaneously navigating their own resettlement challenges, trauma, and financial instability, resulting in an undue and inequitable burden on those already at the margins. Refugee resettlement agency programs operate largely through the efforts of caseworkers with refugee backgrounds, who serve as vital cultural brokers within the resettlement process. These individuals navigate complex dual identities, balancing their roles as community leaders and formal service providers while contending with significant challenges stemming from their insider–outsider positioning. As Fee (2024) elucidates in her discussion of “casework as vocation,” such roles impose considerable emotional and professional demands on these service providers. This intricate dynamic underscores the critical need for formalized systems of support for both the staff and the communities they serve, ultimately enhancing the effectiveness and sustainability of resettlement efforts. Institutionalizing CIC across resettlement domains could bridge systemic gaps, foster resilience, and promote equity in diverse resettlement contexts.

To address these barriers, CIC in the refugee community necessitates structural reforms that institutionalize the roles of community-based mental health workers, establish clear pathways for professional growth, and provide peer supporters with robust access to training, resources, and mental health support. Without these measures, CIC risks being relegated to an under-resourced interim solution rather than evolving into a transformative model for refugee MHPSS. Evidence from task-sharing initiatives in low-resource settings underscores the efficacy of sustained investment, formalized roles, and comprehensive support systems in enhancing program outcomes and fostering meaningful community engagement (Cohen and Yaeger 2021; Patel et al. 2018; van Ginneken et al. 2021). At the policy level, international examples actively involving local communities in refugee integration, such as Canada's Private Sponsorship of Refugees (PSR) program and Australia's Community Refugee Integration and Settlement Pilot (CRISP), illustrate the transformative potential of community-driven resettlement models. PSR, for example, has demonstrated how grassroots engagement can create durable support systems and promote self-reliance among refugees, while CRISP mobilizes trained volunteers to facilitate social and economic participation, reducing reliance on formal services (Beiser 2003; Hyndman et al. 2017; Settlement Services International 2022). These models exemplify community-led principles by prioritizing grassroots engagement, shared responsibility, and intersectoral collaboration, providing scalable and culturally responsive frameworks for sustainable resettlement globally (Kumin 2015; Lenette and Ingamells 2015). Their success highlights the importance of embedding community leadership and social capital at the core of resettlement policies to achieve long-term outcomes that are both inclusive and impactful.

The CIC approach inherently fosters social capital—both bonding and bridging—by empowering community members to strengthen intra-ethnic ties that provide critical emotional and practical support (Im and Rosenberg 2016; Im and Swan 2019; Ventevogel and Whitney 2022; Villalonga-Olives et al. 2022), while fostering broader connections with host communities to expand resources, reduce community burdens, and promote balanced integration (Putnam 2000; Ager and Strang 2008; Cheong et al. 2007). Social capital both supports and is built through CIC, with different forms playing distinct roles depending on the resettlement context. Established refugee communities may benefit from strengthening bonding capital to address immediate needs and preserve cultural identity (Ager and Strang 2008; Parvin et al. 2023). In newer resettlement destinations lacking established networks, fostering bridging capital through partnerships with local organizations, civic groups, and virtual platforms is crucial (Phillimore et al. 2022). Aligned with acculturation theory, which highlights the importance of balancing societal participation with cultural preservation (Berry 1997; Schwartz et al. 2014), CIC requires a context-sensitive approach to avoid the risks of social isolation from inadequate bridging capital or limited opportunities due to overreliance on bonding capital. Emerging evidence also suggests the potential of virtual social capital as an innovative strategy to enhance CIC's adaptability and impact (Almohamed and Vyas 2019; Koh et al. 2018). By adopting flexible, evidence-based strategies, CIC can promote equitable and sustainable resettlement outcomes that integrate cultural preservation with societal inclusion.

This study also emphasizes the critical role of cross-sectoral communication and resource alignment in mitigating the excessive burdens placed on peer supporters. Participants highlighted that the current resettlement infrastructure and refugee mental health services operate in silos, forcing peer supporters to navigate fragmented services with limited guidance or coordination. For CIC to function effectively, task-sharing models must be embedded within an intersectoral framework that bridges health care, social services, education, and community-based organizations. Collaborative approaches allow service providers, community leaders, and policymakers to jointly address the immediate mental health needs of refugees while tackling the broader social determinants of health that shape resettlement outcomes (Singla et al. 2021). Policy frameworks that incentivize and institutionalize intersectoral partnerships are essential to integrating CIC into the resettlement ecosystem. By embedding mental health interventions within a coordinated, system-level framework, CIC can transcend its current limitations. Such an approach would alleviate pressures on peer supporters, enabling them to focus on their roles as cultural brokers and advocates. Ultimately, this integration would ensure that CIC is not only culturally responsive but also sustainable and scalable, offering a viable pathway for addressing the complex and evolving mental health needs of refugee communities.

This study has several limitations that warrant consideration. First, the qualitative nature of the research, while valuable for capturing in-depth perspectives, inherently limits the generalizability of the findings. Although the diversity of participants strengthens the study's applicability across varied refugee contexts, the absence of quantitative data restricts broader, population-level conclusions. Future research would benefit from employing mixed-method approaches, integrating quantitative measures to complement qualitative insights and enhance the robustness and scope of the findings. Second, the geographic focus of this study—specific refugee communities within select regions of the United States—constrains its applicability to other contexts. Variations in resettlement environments, such as differences between urban and rural settings or regions with differing levels of institutional support, may shape the implementation and outcomes of CIC in unique ways. Further studies should explore how CIC functions in diverse resettlement settings, including those with distinct sociopolitical and resource landscapes. Although data saturation was achieved, further exploration of intersectional factors, such as gender,

legal status, and socioeconomic conditions, could provide deeper insights into the heterogeneity of refugee needs and capacities. Such an approach would inform more equitable and tailored interventions, addressing gaps identified in this study. By addressing these limitations, future research can build on this foundation to advance evidence-based, community-driven approaches to MHPSS.

5. Conclusions

This study emphasizes the transformative potential of CIC in addressing the limitations of current refugee resettlement frameworks. By empowering refugees to take active roles in their own care, CIC bridges cultural gaps, fosters trust, and enhances the accessibility of MHPSS. However, realizing this potential requires a fundamental shift in institutional systems. Structural reforms must prioritize sustained investment in CIC, formalize peer support roles, and foster intersectoral collaboration to reduce fragmentation and ensure sustainability. CIC offers a promising pathway to address not only immediate mental health needs but also broader resettlement domains such as housing, employment, and education to enhance service delivery, promote self-reliance, foster holistic integration, and address the systemic inequities that shape refugee resettlement. By embedding community-initiated care within a coordinated and equitable framework, policymakers and practitioners can advance a task-sharing paradigm that fosters resilience, empowerment, and equity in refugee care. The findings of this study provide a foundation for such efforts, underscoring the critical need for comprehensive and systemic change.

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References

- Abdi, Cawo M. 2015. *Elusive Jannah: The Somali Diaspora and a Borderless Muslim Identity*. Minneapolis: University of Minnesota Press.
- Afkhami, Amir A., and Katy Gorentz. 2019. Addressing the Invisible Affliction: An Assessment of Behavioral Health Services for Newly Resettled Refugees in the United States. *Journal of International Migration and Integration* 20: 247–59. <https://doi.org/10.1007/s12134-018-0603-z>
- Ager, Alastair, and Alison Strang. 2008. Understanding integration: A conceptual framework. *Journal of Refugee Studies* 21: 166–91.
- Almohamed, Asam, and Dhaval Vyas. 2019. Rebuilding social capital in refugees and asylum seekers. *ACM Transactions on Computer-Human Interaction (TOCHI)* 26: 1–30.
- Barkdull, Carenlee, Bret Weber, Amy Swart, and Amy Phillips. 2012. The changing context of refugee resettlement policy and programs in the United States. *Journal of International Social Issues* 1: 107–19.

- Beiser, Morton. 2003. Sponsorship and resettlement success. *Journal of International Migration and Integration/Revue de l'integration et de la Migration International* 4: 203–15.
- Berry, John W. (1997). Constructing and expanding a framework: Opportunities for developing acculturation research. *Applied Psychology* 46: 62–68.
- Besteman, Catherine. 2016. *Making Refuge*. Durham: Duke University Press, p. 376.
- Betancourt, Theresa S., Elizabeth A. Newnham, Christopher M. Layne, Soeun Kim, Alan M. Steinberg, Heidi Ellis, and Dina Birman. 2012. Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. *Journal of Traumatic Stress* 25: 682–90.
- Block, Azadeh Masalehdan, Leslie Aizenman, Adam Saad, Stephanie Harrison, Amanda Sloan, Simone Vecchio, and Vanessa Wilson. 2018. Peer support groups: Evaluating a culturally grounded, strengths-based approach for work with refugees. *Advances in Social Work* 18: 930–48. <https://doi.org/10.18060/21634>.
- Braun, Virginia, and Victoria Clarke. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3: 77–101.
- Breuer, Erica, Angelika Morris, Laura Blanke, Miriam Pearsall, Roxana Rodriguez, Benjamin F. Miller, John A. Naslund, Shekhar Saxena, Satchit Balsari, and Vikram Patel. 2023. A theory of change for community-initiated mental health care in the United States. *Cambridge Prisms: Global Mental Health* 10: e56.
- Brick, Kate, Amy Cushing-Savvi, Samia Elshafie, Alan Krill, Megan McGlynn Scanlon, and Marianne Stone. 2010. *Refugee Resettlement in the United States: Challenges and Opportunities*. Washington, DC: Migration Policy Institute.
- Brown, Anastasia, and Todd Scribner. 2014. Unfulfilled promises, future possibilities: The refugee resettlement system in the United States. *Journal on Migration and Human Security* 2: 101–20.
- Cheong, Pauline Hope, Rosalind Edwards, Harry Goulbourne, and John Solomos. (2007). Immigration, social cohesion and social capital: A critical review. *Critical Social Policy* 27: 24–49.
- Chiumento, Anna, Leah Billows, Annette Mackinnon, Rachel McCluskey, Ross G. White, Naila Khan, Atif Rahman, Grahame Smith, and Christopher Dowrick. 2021. Task-Sharing psychosocial support with Refugees and Asylum Seekers: reflections and recommendations for practice from the PROSPER Study. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas* 19: 67–74.
- Cohen, Flora, and Lauren Yaeger. 2021. Task-shifting for refugee mental health and psychosocial support: A scoping review of services in humanitarian settings through the lens of RE-AIM. *Implementation Research and Practice* 2: 2633489521998790.
- Creswell, John W., and Cheryl N. Poth. 2018. *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*, 4th ed. Thousand Oaks: SAGE.
- Crooks, Claire V., Nataliya Kubishyn, Amira Noyes, and Gina Kayssi. 2022. Engaging peers to promote well-being and inclusion of newcomer students: A call for equity-informed peer interventions. *Psychology in the Schools* 59: 2422–37.
- De Graaff, Anne M., Pim Cuijpers, Jos WR Twisk, Barbara Kieft, Sam Hunaidy, Mariam Elsayy, Noer Gorgis et al. 2023. Peer-provided psychological intervention for Syrian refugees: results of a randomised controlled trial on the effectiveness of Problem Management Plus. *BMJ Mental Health* 26: e300637.
- DeSa, Sarah, Akalewold T. Gebremeskel, Olumuyiwa Omonaiye, and Sanni Yaya. 2022. Barriers and facilitators to access mental health services among refugee women in high-income countries: a systematic review. *Systematic reviews* 11: 62.
- Eastmond, Marita. 2007. Stories as lived experience: Narratives in forced migration research. *Journal of Refugee Studies* 20: 248–64.
- Ellis, B. Heidi, Jeffrey P. Winer, Kate Murray, and Colleen Barrett (2019). Understanding the mental health of refugees: Trauma, stress, and the cultural context. *The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health* 253–73.
- Fee, Molly. 2024. Resettlement Knowledge: The Expertise of Service Providers. *Refugee Survey Quarterly* hdae008. <https://doi.org/10.1093/rsq/hdae008>.
- Filler, Tali, Pardeep Kaur Benipal, Nazi Torabi, and Ripudaman Singh Minhas. 2021. A chair at the table: A scoping review of the participation of refugees in community-based participatory research in healthcare. *Globalization and Health* 17: 1–10.
- Forrest-Bank, Shandra S., Mary L. Held, and Aubrey Jones. 2019. Provider perspectives of services addressing the mental health needs of resettled refugee youth. *Child and Adolescent Social Work Journal* 36: 669–84.
- Fuhr, Daniela C., Benedict Weobong, Anisha Lazarus, Fiona Vanobberghen, Helen A. Weiss, Daisy Radha Singla, Hanani Tabana, Ejma Afonso, Aveena De Sa, and Ethel D'Souza et al. 2019. Delivering the Thinking Healthy Programme for perinatal depression through peers: An individually randomised controlled trial in India. *The Lancet Psychiatry* 6: 115–27.
- Gagne, Cheryl A., Wanda L. Finch, Keris J. Myrick, and Livia M. Davis. 2018. Peer workers in the behavioral and integrated health workforce: opportunities and future directions. *American Journal of Preventive Medicine* 54: S258–66.

- Gerritsen, Annette AM, Inge Bramsen, Walter Devillé, Loes HM van Willigen, Johannes E. Hovens, and Henk M. Van Der Ploeg. 2006. Physical and mental health of Afghan, Iranian, and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology* 41: 18–26.
- Giusto, Ali, Noah S. Triplett, Jordan C. Foster, and Dylan G. Gee. 2024. Future Directions for Community-Engaged Research in Clinical Psychological Science with Youth. *Journal of Clinical Child & Adolescent Psychology* 53: 503–22.
- Gonzalez Benson, Odessa. 2021. Refugee-run grassroots organizations: responsive assistance beyond the constraints of US resettlement policy. *Journal of Refugee Studies* 34: 2124–41.
- Gower, Shelley, Zakia Jeemi, David Forbes, Paul Kebble, and Jaya AR Dantas. 2022. Peer mentoring programs for culturally and linguistically diverse refugee and migrant women: an integrative review. *International Journal of Environmental Research and Public Health* 19: 12845.
- Grasser, Lana Ruvolo. 2022. Addressing mental health concerns in refugees and displaced populations: is enough being done? *Risk Management and Healthcare Policy* 15: 909–22.
- Greene, M. Claire, Annie Bonz, Rachel Isaacs, Maria Cristobal, Carolina Vega, Lena S. Andersen, Alejandra Angulo, Andrea Armijos, María Esther Guevara, Lucia Benavides, and et al. 2022. Community-based participatory design of a psychosocial intervention for migrant women in Ecuador and Panama. *SSM-Mental Health* 2: 100152.
- Hess, Julia Meredith, Brian L. Isakson, Suha Amer, Eric Ndaheba, Brandon Baca, and Jessica R. Goodkind. 2019. Refugee mental health and healing: Understanding the impact of policies of rapid economic self-sufficiency and the importance of meaningful work. *Journal of International Migration and Integration* 20: 769–86.
- Hoeft, Theresa J., John C. Fortney, Vikram Patel, and Jürgen Unützer. 2018. Task-sharing approaches to improve mental health care in rural and other low-resource settings: a systematic review. *The Journal of Rural Health* 34: 48–62.
- Hyndman, Jennifer, William Payne, and Shauna Jimenez. 2017. The State of Private Refugee Sponsorship in Canada. *Journal of International Migration and Integration* 17: 149–64.
- Hynie, Michaela. 2018. The social determinants of refugee mental health in the post-migration context: A critical review. *Canadian Journal of Psychiatry* 63: 297–303.
- Im, Hyojin. (2021). Falling through the cracks: Stress and coping in migration and resettlement among marginalized Hmong refugee families in the United States. *Families in Society* 102: 50–66.
- Im, Hyojin, Sasha Verbillis-Kolp, Shadin Atiyeh, Annie G. Bonz, Shrina Eadeh, Nicole George, and Ann Malluwa Wadu. (2023). Implementation Evaluation of Community-Based Mental Health and Psychosocial Support Intervention for Refugee Newcomers in the United States. *Health & Social Care in the Community* 2023: 6696415. <https://doi.org/10.1155/2023/6696415>
- Im, Hyojin, and Rachel Rosenberg. 2016. Building social capital through a peer-led community health workshop: A pilot with the Bhutanese refugee community. *Journal of Community Health* 41: 509–17.
- Im, Hyojin, and Laura ET Swan. 2019. Qualitative exploration of critical health literacy among Afghan and Congolese refugees resettled in the USA. *Health Education Journal* 78: 38–50.
- Kerwin, Donald. 2012. The faltering US refugee protection system: Legal and policy responses to refugees, asylum-seekers, and others in need of protection. *Refugee Survey Quarterly* 31: 1–33.
- Kerwin, Donald, and Mike Nicholson. 2021. Charting a course to rebuild and strengthen the US Refugee Admissions Program (USRAP): Findings and recommendations from the Center for Migration Studies Refugee Resettlement Survey: 2020. *Journal on Migration and Human Security* 9: 1–30.
- Kirmayer, Laurence J., Lavanya Narasiah, Marie Munoz, Meb Rashid, Andrew G. Ryder, Jaswant Guzder, Ghayda Hassan, Cécile Rousseau, and Kevin Pottie. 2011. Common mental health problems in immigrants and refugees: general approach in primary care. *Cmaj* 183: E959–67.
- Koh, Lee Cheng, Rae Walker, Dennis Wollersheim, and Pranee Liamputtong. 2018. I think someone is walking with me: The use of mobile phone for social capital development among women in four refugee communities. *International Journal of Migration, Health and Social Care* 14: 411–24.
- Kohrt, Brandon A., Laura Asher, Anvita Bhardwaj, Mina Fazel, Mark JD Jordans, Byamah B. Mutamba, Abhijit Nadkarni, Gloria A. Pedersen, Daisy R. Singla, and Vikram Patel. 2018. The role of communities in mental health care in low-and middle-income countries: a meta-review of components and competencies. *International Journal of Environmental Research and Public Health* 15: 1279.
- Kohrt, Brandon A., Benjamin F. Miller, and Vikram Patel. 2023. Community initiated care: A blue-print for the practical realization of contextual behavioral science. *Journal of Contextual Behavioral Science* 27: 54–60.

- Kumin, Judith. 2015. *Welcoming Engagement: How Private Sponsorship Can Strengthen Refugee Resettlement in the European Union*. Brussels: Migration Policy Institute Europe, pp. 1–35.
- Lenette, Caroline, and Ann Ingamells. 2015. Mind the gap! The growing chasm between funding-driven agencies, and social and community knowledge and practice. *Community Development Journal* 50: 88–103. <https://doi.org/10.1093/cdj/bsu024>
- Lincoln, Yvonna S., and Egon G. Guba. 1985. *Naturalistic Inquiry*. Beverly Hills: SAGE.
- Mahon, Daryl. 2022. A scoping review of interventions delivered by peers to support the resettlement process of refugees and asylum seekers. *Trauma Care* 2: 51–62.
- Miles, Matthew B., A. Michael Huberman, and Johnny Saldaña. 2014. *Qualitative Data Analysis: A Methods Sourcebook*, 3rd ed. Thousand Oaks: SAGE.
- Miller, Kenneth E., and Andrew Rasmussen. 2017. The mental health of civilians displaced by armed conflict: An ecological model of refugee distress. *Social Science & Medicine* 70: 1–9.
- Naslund, John A., Kelly A. Aschbrenner, Lisa A. Marsch, and Stephen J. Bartels. 2019. The future of mental health care: Peer-to-peer support and social media. *Epidemiology and Psychiatric Sciences* 28: 602–13.
- Nguyen, Amanda J., Molly E. Lasater, Catherine Lee, Indika V. Mallawaarachchi, Kate Joshua, Lucy Bassett, and Kirsten Gelsdorf. 2023. Psychosocial support interventions in the context of forced displacement: A systematic review and meta-analysis. *Journal of Migration and Health* 7: 100168.
- Nowell, Lorelli S., Jill M. Norris, Deborah E. White, and Nancy J. Moules. 2017. Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods* 16: 1–13.
- Ong, Aihwa. 2003. *Buddha is Hiding: Refugees, Citizenship, the New America*. Univ of California Press, vol. 5.
- Parvin, Gulsan Ara, Nina Takashino, Md Shahidul Islam, Reazul Ahsan, Mohammad Golam Kibria, and Md Anwarul Abedin. 2023. Does social capital contribute to resilience? Exploring the perspectives of displaced women living in urban slums in Khulna city. *International Journal of Disaster Risk Reduction* 94: 103838.
- Patel, Vikram, Shekhar Saxena, Crick Lund, Graham Thornicroft, Florence Baingana, Paul Bolton, Dan Chisholm, Pamela Y. Collins, Janice L. Cooper, Julian Eaton, and et al. 2018. The Lancet Commission on global mental health and sustainable development. *The Lancet* 392: 1553–98.
- Phillimore, J., Davino Gabriella, Papoutsi Anna, Strain-Fajth Veronika, and Ziss Paladia. 2022. *Refugee Resettlement Policy and Practice: A Systematic Literature Review*. Birmingham: Institute for Research on Superdiversity, University of Birmingham.
- Ponzoni, Elena, Halleh Ghorashi, and Sylvia van der Raad. 2017. Caught between norm and difference: narratives on refugees' inclusion in organizations. *Equality, Diversity and Inclusion: An International Journal* 36: 222–37.
- Putnam, R. D. (2000). *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon Schuster.
- Saldaña, Johnny. 2016. *The Coding Manual for Qualitative Researchers*, 3rd ed. Thousand Oaks: SAGE.
- Settlement Services International. 2022. *Community Refugee Integration and Settlement Pilot: Annual Report*. Canberra: Settlement Council of Australia.
- Schwartz, Seth J., Vivian L. Vignoles, Rupert Brown, and Hanna Zagefka. 2014. The identity dynamics of acculturation and multiculturalism: Situating acculturation in context. *The Oxford Handbook of Multicultural Identity* 57–93.
- Siddiqui, Saher, Daniel J. Ikeda, Shekhar Saxena, Benjamin F. Miller, Vikram Patel, and John A. Naslund. 2022. Scaling up community-delivered mental health support and care: A landscape analysis. *Frontiers in Public Health* 10: 992222.
- Silove, Derrick, Peter Ventevogel, and Susan Rees.. 2017. The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry* 16: 130–139.
- Singla, Daisy R., Brandon A. Kohrt, Laura K. Murray, Arpita Anand, Bruce F. Chorpita, and Vikram Patel. 2021. Psychological treatments for the world: Lessons from low- and middle-income countries. *Annual Review of Clinical Psychology* 17: 71–95.
- Soltan, Fatima, Doriana Cristofalo, David Marshall, Marianna Purgato, Henock Taddese, Laura Vanderbloemen, Corrado Barbui, and Eleonora Uphoff. 2022. Community-based interventions for improving mental health in refugee children and adolescents in high-income countries. *Cochrane Database of Systematic Reviews* 5: CD013657. <https://doi.org/10.1002/14651858.CD013657.pub2>.
- Sun, Jing, Xunbao Yin, Changjiang Li, Wuyi Liu, and Hongwei Sun. (2022). Stigma and peer-led interventions: a systematic review and meta-analysis. *Frontiers in Psychiatry* 13: 915617.
- Swartz, Leslie, Sanja Kilian, Justus Twesigye, Dzifa Attah, and Bonginkosi Chiliza. 2014. Language, culture, and task shifting—An emerging challenge for global mental health. *Global Health Action* 7: 23433.
- Thomson, Marnie Jane. 2022. The Invisible Burdens of Burden-Sharing. *Frontiers in Human Dynamics* 4: 668321.

- Tol, Wietse. A., Suzan Song., and Mark. J. D. Jordans. 2021. Annual research review: Resilience and mental health in children and adolescents living in areas of armed conflict—A systematic review of findings in low- and middle-income countries. *Journal of Child Psychology and Psychiatry* 62: 559–79.
- Tyeklar, N. 2016. The US refugee resettlement process: A path to self-sufficiency or marginalization. In *Refugee Resettlement in the United States: Language, Policy, Pedagogy*. Edited by Emily M. Feuerherm and Vaidehi Ramanathan. Bristol: Multilingual Matters, pp. 152–71.
- van Ginneken, Nadja, Prathap Tharyan, Simon Lewin, Girish N. Rao, S. M. Meera, Jessica Pian, Sudha Chandrashekar, and Vikram Patel. 2021. Non-specialist health worker interventions for the care of mental, neurological, and substance-abuse disorders in low- and middle-income countries. *Cochrane Database of Systematic Reviews* 11: CD009149.
- Ventevogel, Peter, and Claire Whitney. 2022. Why social work methodologies are so important in delivering mental health and psychosocial support interventions for refugees in humanitarian settings. In *Integrative Social Work Practice with Refugees, Asylum Seekers, and Other Forcibly Displaced Persons*. Cham: Springer International Publishing, pp. 307–32.
- Verbillis-Kolp, Sasha, Kristen Guskovict, Mahad Hassan, and Seth Cohen. 2024. A Refugee and Immigrant Peer Support Program in the United States. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas* 22: 3–10.
- Villalonga-Olives, Ester, T. R. Wind, A. O. Armand, Meg Yirefu, Robert Smith, and Daniel P. Aldrich. 2022. Social-capital-based mental health interventions for refugees: A systematic review. *Social Science & Medicine* 301: 114787.
- Wachter, Karin, Jessica Dalpe, Annie Bonz, Hayley Drozdowski, and Janice Hermer. 2021. A scoping review of social support interventions with refugees in resettlement contexts: implications for practice and applied research. *Journal of Immigrant & Refugee Studies* 19: 557–72.
- Warner, Georgina, Zaruhi Baghdasaryan, Fatumo Osman, Elin Lampa, and Anna Sarkadi. 2021. “I felt like a human being”—An exploratory, multi-method study of refugee involvement in the development of mental health intervention research. *Health Expectations* 24: 30–39.
- Woodward, Aniek, Anne M. de Graaff, Marjolein A. Dieleman, Bayard Roberts, Daniela C. Fuhr, Jacqueline EW Broerse, Marit Sijbrandij, Pim Cuijpers, Peter Ventevogel, Barend Garretsen, and et al. 2022. Scalability of a task-sharing psychological intervention for refugees: A qualitative study in the Netherlands. *SSM-Mental Health* 2: 100171.

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