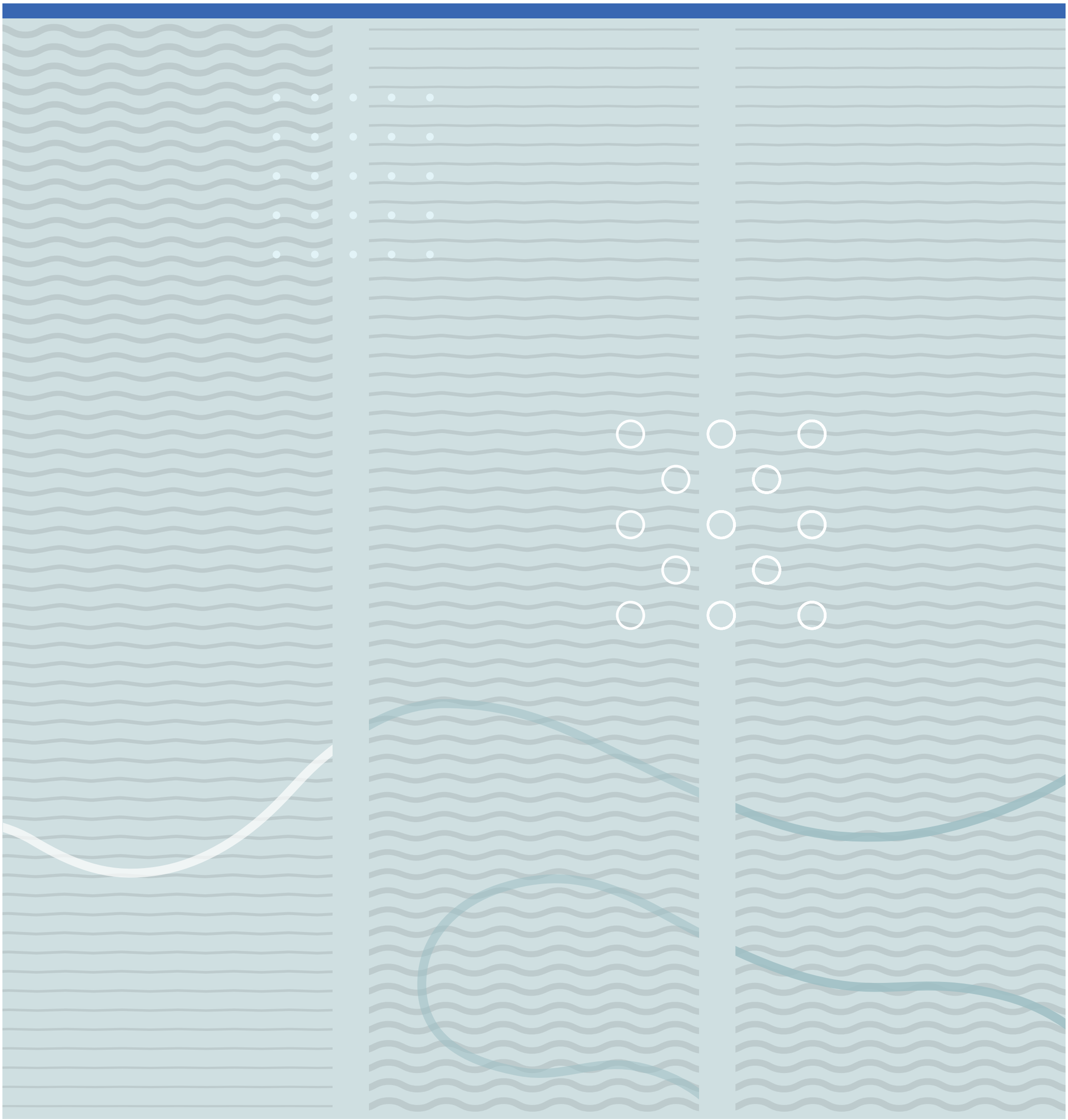
University of South-Eastern Norway
Faculty of Health and Social Sciences
—
Doctoral dissertation no. 163
2023

Prabhjot Kour

Through the eyes of immigrants and health professionals

Coping and treatment experiences of men of immigrant background living with co-occurring substance use and mental health problems in Norway



Prabhjot Kour

Through the eyes of immigrants and health professionals

Coping and treatment experiences of men of immigrant background living with co-occurring substance use and mental health problems in Norway

A PhD dissertation in
Person-centred Health Care

Faculty of Health and Social Sciences
University of South-Eastern Norway
Drammen, 2023

Doctoral dissertations at the University of South-Eastern Norway no. 163

ISSN: 2535-5244(print)
ISSN: 2535-5252 (online)

ISBN: 978-82-7206-778-5 (print)
ISBN: 978-82-7206-796-9 (online)

Print: University of South-Eastern Norway

they have no idea what it’s like

to lose home at the risk of

never finding home again

to have your entire life

split between two lands and

become the bridge between two countries

Immigrant – Rupi Kaur

ਸ਼ੁਕਰਾਨਾ ਵਾਹਿਗੁਰੂ

This work is dedicated to all persons of immigrant background who are living with substance use and mental health problems, globally.

I would also like to dedicate this study to my loving sister, Deepjot Kour, and to my inspiration, my late grandfather, S. Maya Singh Mehta, who himself was an immigrant, the only one in his family to have survived the India-Pakistan partition in 1947. Thinking of the stories he told me about how he had to leave his home alone in Pakistan and migrate to India still give me goosebumps!

Satshriakal, my dearest and beloved father, S. Kanwarjeet Singh,
I dedicate this work to you. Papa, you were an unwavering source of love and support throughout my life. Your encouragement and firm belief in me gave me the courage to pursue this journey. I am grateful for the scarifies you made and countless hours you spent working to make my life easier, and helped me achieve this dream. Your legacy will live on through my work and I hope to honour your memory by making a positive contribution to the world. I love you more than words could suffice and miss you dearly, all the time.
You are forever in my heart, mind and soul, Papa.

Acknowledgements

First of all, I would like to express my profound gratitude to **WAHEGURU** for giving me wisdom, strength, determination and perseverance to complete this study.

I take pleasure in expressing my deepest gratitude and immeasurable appreciation to my supervisory team. A million thanks to my principal supervisor Associate Professor Henning Pettersen, for the help, guidance, support, encouragement and enthusiasm you showed me during the entire period of this research study. I sincerely thank you for all your valuable comments, intellectual challenges, and the positivity you gave me at each meeting, which made me more optimistic and determined. My deepest thanks my co-supervisors, Professor Lars Lien and Professor Stian Biong for supporting and guiding me through their valuable feedback during the entire study period. Thank you for sharing your competent advice and unparalleled knowledge so generously with me throughout the entire period of study. With exceptional skill sets, vast knowledge, and decades of experience in the field, you three were the ideal supervisory team. My dear supervisors, I am grateful to you from the bottom of my heart. Thank you for believing in me.

I wish to place on record my sincere gratitude to Co-Chair Lancet Migration and Special Advisor at the Norwegian Institute of Public Health, Bernadette Kumar, for her valuable feedback throughout the study and unmatched contribution to all three scientific articles that this study has produced. Your guidance has always been encouraging and kind, and you have been a constant support since the time you supervised my master's thesis. Words fall short when describing you and I am extremely blessed to have your presence in my life.

To my co-author, Ole Martin Nordaunet, thank you for collaborating, recruiting and moderating one of the focus groups. Thanks for sharing your knowledge and valuable feedback during the analysis and writing process of Article 3.

I would like to pay my deepest gratitude to the participants of this study who so generously shared their lived experiences with me. Listening to your stories, I have

expanded my thoughts and perceptions, and it has given a new meaning to my life. Thank you for participating in my study.

I would also like to take this opportunity to record my sincere thanks to the members of the “competency group” for their support and contribution. Without you, it would have been impossible to complete this study. Collaborating with you has been the strength of my study and you have inspired me with your critical reflections and insights. Thank you for bringing a fresh perspective to the table.

I would also like to thank both the interpreters for their collaboration and providing an outside perspective to the study.

Thanks to the University of South-Eastern Norway for accepting me in their PhD programme in person-centred healthcare, from which I have learned so much. A special thanks to all my inspiring colleagues and fellow PhD students at the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders and at the University of South-Eastern Norway for having discussions and providing encouraging feedback. Thank you for creating this inspiring community. I could not complete this section without thanking my colleagues from NAKMI (which is now part of the Norwegian Institute of Public Health, NIPH) for their immense support and encouragement since 2016. I would especially like to thank Thor Indseth, Charlott Nordstrøm and Ragnhild Spilker for their continuous support and encouragement during the difficult times I was going through while writing this thesis and working at the NIPH. You are no less than a family to me. In addition, I would like to thank Harald Siem for mentoring me since the beginning of my PhD study. Your support and guidance are invaluable at both the professional and personal level.

I have to give credit where it is due, and would therefore like to thank Innlandet Hospital for funding this study.

Along with the academic support I have received, I would like to thank my family and friends, my loved ones for their presence and support in my life. I take this opportunity to convey my sincere thanks to my sister, Deepjot Kour, for being my unequivocal support at all times. Thank you for being the best person in my life, encouraging me and making me believe that I can do whatever I set my mind on doing. Thank you for always being there and walking with me through every thick and thin aspect of life. I love you more than anything, dear sister.

I would like to pay my deepest regards and gratitude to my dear late grandfather, S. Maya Singh Mehta for teaching me the ways of life, for being my teacher, support and guide. You taught me the lessons of life and made me what I am today. I cannot thank you enough for being my strength. Even if you are not with me, your presence is always felt. I am grateful to you for every single thing you did for me.

A special note of thanks to my parents. To my dearest mother, Mrs. Joginder Kour, for her constant prayers, love and endless support. I am grateful that you are my mamma, and all my achievements are the output of your hard work. You are the epitome of motherhood and I love you beyond measure. To my dearest beloved father, S. Kanwarjeet Singh, for his constant love, support, optimism and encouragement. Thank you so much for everything you have done for me Papa, and I love you with every fiber of my being.

A noteworthy thanks to my aunt, Mrs. Ranjeet Kaur Rehal and my uncle, Mr. Jagdeep Singh Rehal, for their love, care and unmatched support during my entire stay in Norway. This study would not have been possible without your support. Thank you so much for making me feel at home and for being so kind to me. A special note of thanks to my dear aunt, who is no less than a mother to me, thank you for everything you have done for me, Massi. I would also like to thank my cousin Simran for always being there for me, for being friendly and loving.

I want to extend my deepest thanks to my uncle, Mr. Tejinder Singh Mehta, for being my inspiration and guiding me through different ways of life. Thank you so much for being my mentor and teacher, I am grateful to you for your unparalleled support.

I express my gratitude to Usman Chaudhry for displaying his patience and attentively addressing all my worries and concerns. Your immense support and valuable suggestions have helped me in achieving this milestone.

Finally, heartfelt thanks to all my wonderful friends who have been an important part of my life in very many ways. I would especially thank Sumit Gupta for being my right hand in India, for being a son to my parents and taking care of every little thing when needed. Thank you for standing on your toes when papa was in critical condition and had to undergo surgery twice, and I could not come because of COVID-19 restrictions. Nothing would have been possible without you, thank you for taking that responsibility when I was thousands of miles away from them. You are my best friend for life and an exceptional blessing, love you Sumee. Also, I would like to thank Navratan Bagwan for his constant support and encouragement throughout this journey. Your kindness, ability to empathize, understanding and positivity attitude made this experience better and easier for me. Last but not the least, my dear Suman Rathore and Prabu Narayanan, who have been there to support me emotionally when I felt overwhelmed, thank you for encouraging me, cheering me on and having my back always. You guys rock!

Thanks to each and every one of you for being part of my journey. It would not have been possible without you!

Prabhjot Kour

Oslo, December, 2022

Abstract

Recent years have seen an increase in the immigrant population of Norway. Immigrants, due to a variety of pre- and post-migration factors, are considered at risk of developing psychological distress and therefore involvement in substance use, leading to co-occurring substance use and mental health problems (co-occurring problems). Further, there is lower utilization of mental health and addiction services, lower treatment engagement, higher dropout rate and less frequent hospitalizations among immigrants than in the general population. In addition, immigrants face barriers in seeking and accessing mental health and addiction services. No previous studies have been conducted on the subjective understanding of co-occurring problems (COP) in the coping and treatment context in Norway, which implies a clear need to generate this knowledge. Further, health professionals are crucial in providing and promoting mental healthcare in this group. Knowledge is thus also needed on the experiences of health professionals in order to enhance access and engagement in mental health and addiction treatment in Norway.

This thesis has sought to increase scientific knowledge of the experiences of immigrants living with COP, with a particular focus on coping and treatment experiences, in addition to the perspectives of health professionals. The overall aim was to explore the coping and treatment experiences of immigrant men living with co-occurring substance use and mental health problems in Norway, from the perspectives of immigrants and health professionals. This overall aim resulted in two sub-studies and three scientific articles with the following aims: (1) To explore the lived experiences of being an immigrant and living with co-occurring problems in Norway, (2) To explore the treatment experiences of immigrant men living with co-occurring problems in Norwegian mental health and addiction services, and (3) To explore health professionals' experiences with treatment engagement among immigrants with co-occurring problems.

This qualitative project was inspired by phenomenology, using a collaborative approach, and consisted of two sub-studies. Sub-study 1 (resulting in Articles 1 and 2) consisted of ten individual, in-depth interviews with immigrant men living with COP who had

treatment experience from Norwegian mental health and addiction services. Sub-study 2 (resulting in Article 3) consisted of three focus group interviews with health professionals (HP) who had provided various mental health and addiction services to immigrants with COP. Both sub-studies were conducted in the same local context in Norway. A competency group of three persons with lived experience of COP and experience as a family member was involved throughout this project. Individual and focus group interviews were analysed using systematic text condensation.

The findings of the first article described the immigrants' experiences of living with COP in Norway. The overarching theme was how they coped and negotiated their sense of self within self, in the surrounding culture and within different structures of society. Participants described the experiences of "cultural clash" and "living a double life" due to cultural stigma and stigma attached to substance use and/or mental health problems, along with a sense of belonging to a marginalized group, thus lacking the sense of belonging to mainstream Norwegian society. Participants also described experiences of racism in different institutions and hence a lack of trust in them.

The findings of the second article described the treatment experiences of immigrants living with COP as poor connection between them and health professionals, lack of individually tailored treatment, and stigma and discrimination that prevented access to treatment, all of which discouraged them from engaging in treatment. Participants further described how health professionals with multicultural competence, who provided care during and after treatment, improved their treatment engagement, in addition to raising awareness and reducing stigma strategies. Further, participants mentioned the value of being seen and treated as a "person" rather than a diagnosis, which may increase a person's engagement to treatment. They also mentioned the importance of aftercare in preventing relapses.

The findings of the third article described health professionals' experiences with treatment engagement among immigrants with COP. Difficulties due to language barriers, lack of culturally competent services and social factors were among the problems that reduced treatment engagement. Participants highlighted experiences with

interpreters that discouraged immigrant patients from remaining engaged in the treatment. Being curious and flexible enhanced their relationship with immigrant patients and increasing access to mental health and addiction services helped to improve treatment engagement.

All three articles that form the basis for this thesis provided enhanced understanding of the experiences of immigrants living with COP and the health professionals involved. These findings suggest the need for more person-centred and culturally competent approaches in Norwegian mental health and addiction services. Professional interpreters are called for, in addition to strategies that can develop personal skills among immigrants living with COP. Strategies to reduce stigma and racism in different institutions are also needed in order to enhance immigrants' sense of belonging and participation in mainstream Norwegian society.

Keywords: immigrants, co-occurring problems, substance use problems, mental health problems, qualitative methods, lived experiences, treatment experiences, collaborative research, health professionals, mental health and addiction services, Norway.

List of original publications

This thesis is based on the following original publications, which are referred to in the text as Articles 1, 2 and 3:

Article 1

Kour, P., Lien, L., Kumar, B., Biong, S., & Pettersen, H. (2019). Coping and Negotiating a Sense of Self: Immigrant Men's Experiences of Living with Co-Occurring Substance Use and Mental Health Disorders in Norway. *American Journal of Psychiatric Rehabilitation*, *22*(1), 43-63.

Article 2

Kour, P., Lien, L., Kumar, B., Biong, S., & Pettersen, H. (2020). Treatment Experiences with Norwegian Health Care among Immigrant Men Living with Co-Occurring Substance Use- and Mental Health Disorders. *Substance Abuse: Research and Treatment*, *14*, DOI: 1178221820970929.

Article 3

Kour, P., Lien, L., Kumar, B., Nordaunet, O. M., Biong, S., & Pettersen, H. (2021). Health Professionals' Experiences with Treatment Engagement Among Immigrants with Co-occurring Substance Use-and Mental Health Disorders in Norway. *Substance Abuse: Research and Treatment*, *15*, DOI: 11782218211028667.

Abbreviations

COP: Co-Occurring Problems/Disorders

EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

FACT: Flexible Assertive Community Treatment

HP(s): Health Professional(s)

LMIC: Low- and Middle-Income Countries

MHP: Mental Health Problems/Disorders

NBIP: Norwegian Born to Immigrant Parents

NIPH: Norwegian Institute of Public Health

NK-ROP: Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders

PCH: Person-Centred Healthcare

PTSD: Post Traumatic Stress Disorder

SUP: Substance Use Problems/Disorder

Clarification of concepts and definitions used in this thesis

- *Migration:* Migration is understood as the movement of a person or a group of persons, either across an international border or within a country, regardless of its length, composition and causes, including refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification (Kumar & Diaz, 2019). In this thesis, migration is referred to as the movement of a person or group of persons across international borders, especially migration (immigration) to Norway. Further, this thesis uses the terms "migration" and "immigration" interchangeably.

- *Immigrants*: This project uses the definition of Statistics Norway (SSB, 2022), which defines "immigrants" *as "persons born abroad or in Norway of two foreign-born parents and four foreign-born grandparents"*. SSB also uses the term "Norwegian-born to immigrant parents" (NBIP) as *"persons born in Norway with two foreign-born parents and four foreign-born grandparents"*. Further, "immigrants" in this project are understood as persons who were born or whose parents were born in low- and middle-income countries.

  Even though "immigrants" and "immigrant background" are regarded as two different terms, this thesis uses them interchangeably. This thesis will use the term "immigrants" to cover all types of immigrants (migrants), regardless of their reason to migrate and for the sake of simplicity, but I wish to emphasize the fact that in this project they are first and foremost regarded as "persons".

- *Low-and middle-income countries*: Countries are classified based on their gross national income per capita by the World Bank. In 2019, low-income countries were those with a gross national income per capita of $ 995 or less, while low-middle-income countries lie between $ 996 and $ 3895 (World Bank, 2022).

- *General/Majority population*: The population excluding ethnic minority groups. When used in race/ethnicity studies, this phrase is usually used as synonym for white or European (Kumar & Diaz, 2019).

- *Co-occurring problems/disorders*: A co-occurring disorder is understood as the co-existence of substance use problems (SUP) and any combination of mental health problems (MHP) in an individual, with a strong impact on the person's everyday life. In this thesis, co-occurring disorders will be called co-occurring problems in order to place more emphasis on the person than the diagnosis.

- *Lived experience:* "Lived experience" is a phenomenological term, which in a literal sense means "living through something" and indicates the subjective experience of a particular point in time. Van Manen states: "The significance of the idea of lived experience is that we can ask: What is this (primal) experience like?" (Van Manen, 2017). In this thesis, lived experiences are understood as the subjective experiences of the participants.

- *Living with:* "Living with" is conceptualized in this thesis as accepting and dealing with a difficult situation that is likely to continue for a long time. This term has replaced "diagnosed with" in this thesis to emphasize the person as a whole.

- *Immigrants living with co-occurring problems*: This term will be used in this thesis to describe the participants in Sub-study 1, who are persons of immigrant background, living with co-occurring problems. This term will also be used to highlight them in the literature.

- *Patient/User:* Patient/user in this thesis is understood as a person who has used the Norwegian mental health and addiction services. The term “immigrant patients” was used by the study participants (health professionals) in Sub-study 2.

- *Health professional/Provider*: Health professional/provider in this thesis is understood as a person who has provided various mental health and addiction care services to immigrants in Norway.

- *Norwegian mental health and addiction services*: These services are primarily divided into two levels: primary healthcare (based on social, health and welfare legislation, run by municipalities) (Lovdata, 2020) and secondary healthcare (based on specialist healthcare legislation, run by the state) (Lovdata, 2021). The specialist services include various polyclinics and psychiatric centres, including opioid substitute treatment facilities, multidisciplinary specialized addiction treatment centres, district psychiatric centres, and hybrid solutions in partnership with primary healthcare, namely (flexible) assertive community treatment (FACT/ACT) teams.

Table of contents

1 Introduction to the thesis

Substance use and mental health problems are the leading cause of disability worldwide, resulting in 23% of all life years lost. Furthermore, 31 million persons have substance use problems, 3.3 million of whom die each year (WHO, 2019a). Mental health problems and substance use problems often present with a high degree of co-occurrence, resulting in poor quality of life. Persons diagnosed with co-occurring substance use and mental health problems (co-occurring problems) are often referred to as “complex”, “hard to reach” and “difficult to engage” in treatment due to lack of tailored services. Further, co-occurring problems are important risk factors for other diseases such as HIV, cardiovascular diseases and diabetes, as well as intentional and unintentional injuries (WHO, 2019b).

Norway has become an ethnically diverse and multicultural society in recent decades because of a substantial increase in immigration (Abebe, Lien, & Hjelde, 2014). According to the most recent data by Statistics Norway, immigrants constitute 18.5% of Norway’s population, while those from low- and middle-income countries (LMIC) make up 10.8% (SSB, 2021b). Mental health problems are reported to be more prevalent among immigrants from LMIC than in the general population in Norway (Abebe, Lien, & Elstad, 2017; Straiton, Reneflot, & Diaz, 2017) and are considered to be associated with various pre- and post-migration factors, such as acculturative stress, unemployment, low socioeconomic status, discrimination, social exclusion and a feeling of low worth and powerlessness in a new country (Abebe et al., 2014; Chen, Hall, Ling, & Renzaho, 2017).

Although immigrants have a higher risk of developing mental health problems, it has been documented that they have lower rates of utilization of mental healthcare services in Norway than the general population (Abebe et al., 2017; Straiton, Ledesma, & Donnelly, 2018). Moreover, previous studies have shown that immigrants more frequently report unmet needs while in treatment settings, and have lower treatment engagement and higher perceived discrimination, compared to the population at large (Knapstad, Nordgreen, & Smith, 2018; Mbanya, Terragni, Gele, Diaz, & Kumar, 2019; Vrålstad & Wiggen, 2017). Further, research has documented that immigrant groups with SUP and

MHP are at high risk of neglect even in developed healthcare systems; possible reasons include lack of existing healthcare policies for these groups and insufficient funding to target specific areas of immigrants' mental healthcare (Mladovsky, 2007).

Additionally, research has shown that immigrants may have inadequate or no knowledge of available mental health services due to lower integration in mainstream society (Dinos, Ascoli, Owiti, & Bhui, 2017). Immigrants' understandings of mental health problems are shaped by their cultural background, which may influence their perceptions and expectation from the treatment. Culture is also said to influence the way immigrants cope with their SUP and MHP and help-seeking behaviour (Erdal, Singh, & Tardif, 2011; Hagmayer & Engelmann, 2014).

There is strong evidence that completion of SUP treatment is one of the most consistent factors associated with favourable treatment outcome (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). However, immigrants have documented lower treatment engagement and unsatisfied needs leading to frequent relapses and rehospitalizations, making it difficult to provide them with targeted help (De Kock, Decorte, Vanderplasschen, Derluyn, & Sacco, 2017; Dixon, Holoshitz, & Nossel, 2016; Verdurmen, Smit, Toet, Van Driel, & Van Ameijden, 2004). No previous qualitative research has studied coping and treatment experiences from the perspective of immigrants living with COP in Norway. This shows the urgency for research in the area to understand the complexity of the phenomenon. This is one of the reasons for choosing a qualitative study to understand the meaning of a phenomenon through description. Such studies help to develop concepts that aid in the understanding of natural phenomena with emphasis on the meanings, experiences and views of the participants (Al-Busaidi, 2008).

Against this backdrop, the current thesis is based on two qualitative studies (addressed as Sub-studies 1 and 2 in this thesis) with the aim to explore (1) the coping and treatment experiences of immigrant men living with co-occurring substance use and mental health problems in Norway, and (2) health professionals' experiences with treatment engagement among immigrants with co-occurring problems in Norwegian mental health and addiction services.

Further, this thesis draws on the basic assumption that substance use, mental health problems and immigration are disruptive events in life, and an approach inspired by phenomenology was sought to aid the exploration of the meaning of the lived experiences of such discontinuities in life. Such disruptive events apply particularly to the study participants, who have undergone the process of migration for reasons such as war trauma and family reunification after stressful events in their home countries and have used substances in their efforts to cope and make sense of these disruptive changes.

The study has adopted a collaborative design and has drawn on person-centred and cultural competence approaches, which have been considered as promising approaches for improving the quality of healthcare for immigrants (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Saha, Beach, & Cooper, 2008).

This thesis has aimed to generate new insights from immigrants' and health professionals' experiences, while also aiming to inform health and social services in Norway about the problems immigrants are facing, and the importance of understanding their cultural expectations and beliefs, in order to develop treatment strategies that meet the needs of this group, which will hopefully lead to higher treatment engagement.

2 Theoretical background

This chapter presents the conceptual and theoretical background of this study. The main theoretical foundations are migration, person-centred theory, and a cultural competence approach in relation to immigrant background and co-occurring problems. Following an introduction to the concepts of migration and co-occurring problems, I will shed light on the above-mentioned concepts, followed by a description of these concepts in relation to the aim of the thesis.

2.1 Migration

Migration is not a new phenomenon in Europe or worldwide, and it has existed since the beginning of mankind. As an extremely important and complex phenomenon, migration has over time generated both opportunities and challenges, and it has never been more intense than today (Boghean, 2016). According to the United Nations, the estimated number of international migrants worldwide in 2020 reached 281 million, an increase from 248 million in 2015 (UN, 2020). There has therefore been a particular focus on migration and health (Xu et al., 2018).

The reasons for migration vary greatly; they may be political, cultural, economic or environmental. The movement of people as groups or individuals is often determined by landmark events that govern their political, social or geographical conditions (Kumar & Diaz, 2019). Thus, people who migrate for educational or economic reasons may move individually and be joined by their families at a later date, whereas people who migrate in groups are those who migrate due to political reasons, with or without their families (Bhugra, 2004a). Regardless of the circumstances and motivation for migration, the ultimate goal is the search for a better life (Kumar & Diaz, 2019). Further, migration rarely involves a simple journey from one place to another; rather, it could involve complex and diverse patterns based on the social dynamics of people’s mobility or the needs of people on the move (Abubakar et al., 2018).

The process of migration has been described as broadly taking place in three stages: pre-migration, migration, and post-migration. The first stage, pre-migration, involves the decision and preparation to move. The second stage, migration, involves the physical relocation of the individual or group from one place to another. The third stage, post-migration, is defined as “absorption of the immigrant within the social and cultural framework of the new society”. New social and cultural norms need to be learnt in the post-migration stage (Berry & Padilla, 1980; Berry, 2007). Recently, migration has been acknowledged as an independent determinant of health (Marmot, Allen, Bell, Bloomer, & Goldblatt, 2012). Since both migration and health are dynamic by nature, various pre- and post-migration factors can interact and multiply their effects on the health status of immigrants (Zimmerman, Kiss, & Hossain, 2011). Various factors may predispose the individual to mental health problems in different stages of migration. Pre-migration may include forced migration and persecution, and loss of family members before migration. In the post-migration phase, the individual becomes an “immigrant” in the country of arrival. Culture shock, a discrepancy between expectations and achievement, and acceptance by the new culture, in addition to availability and accessibility of support networks are potential post-migration factors (Bhugra & Becker, 2005; Bhugra & Wojcik, 2011).

Immigrants undergo a process of physical and psychosocial change in the country of arrival (Straiton, Blystad, & Reneflot, 2018a). Psychosocial changes are harder to visualize and subtle in nature, including loss of cultural identity and professional status, loss of kin and social network, and difficulty in establishing new relationships in places where societal norms are different. Most of these changes are associated with increased stress levels and hence affect the mental health of immigrants (Bhopal, 2004; Kumar, 2006). Therefore, the process of migration can be regarded as stressful and adjustment to the new culture adds a new set of health risks in terms of mental health (Kumar & Diaz, 2019).

Additionally, in comparison to the general population, immigrants face more challenges in accessing healthcare, leading to unmet health needs (Straiton et al., 2018b). These challenges could be explained by various factors including financial and cultural barriers to the host country's healthcare, racism and discrimination, lower educational levels, underpaid jobs and often self-neglect (Hampshire, 2003).

This process of transition in immigrants may also impose a situation of liminality on them; moving from a more predictable past to an unpredictable future, they suffer from ambiguity (Turner, 1973). Turner argues that the structural invisibility of liminal personae is associated with their two-fold character, which may mean that immigrants are at once no longer classified and yet not classified (Turner, 1973). These persons often opt for substance use and have suicidal behaviour when liminality becomes unbearable for them (Biong & Ravndal, 2009). Hence, the basic assumption about migration in this thesis is that it is a stressful process in life.

2.1.1 Migration and culture

Culture is essential for humans to exist (Singer et al., 2016). Human behaviour is culturally informed (Dressler, Oths, & Gravlee, 2005; Hruschka, 2009), and understanding culture is a prerequisite for understanding the individual (Werneke & Bhugra, 2018). Each individual brings culture to the clinical setting, both provider and user, yet culture is poorly defined and rarely tested in health research (Dressler et al., 2005; Hruschka, 2009).

Culture can be understood as *"a set of beliefs, values, expectations, rites and rituals"* that shapes the way people think, feel, act, and interact with others and with the environment (Werneke & Bhugra, 2018). Further, Kagawa and colleagues state that ***culture is*** not an immutable "thing", but it is constantly evolving, a multidimensional and multi-level process, that enables individuals to adapt and evolve in response to changing circumstances in the physical, social and political environments (Singer et al., 2016). They further explain that what ***culture does*** to the individual or the group members is important to take into consideration as it allows people to interpret the world around them via their shared beliefs, practices, and spiritual and emotional explanations. In this way, cultural norms and tools are created from ways of being in a society, allowing the group members to find meaning in life by gaining a sense of safety, well-being, integrity and belonging, as a contributing member of their social network (Kagawa-Singer, Valdez Dadia, Yu, & Surbone, 2010). This further influences the distribution of power among various groups within the cultural population, such as genders, migrants and service users, along with ideas and behaviours to understand related concepts such as health, illness and death, stigma, help-seeking, and being a useful and contributing member of society (Kagawa-Singer et al., 2010). This implies that understanding culture is essential for understanding how an individual behaves in certain circumstances, and how health outcomes could be improved by mobilizing the cultural processes, which could involve mediating the interactions among multidimensional and multilevel environmental factors (Singer et al., 2016).

When individuals migrate from one culture to another, there is every likelihood that aspects of their cultural identity will change. The degree of change is determined by various factors including individual, kinship and societal elements (Bhugra, 2004a). Further, these individuals do not leave their beliefs or idioms of distress behind, regardless of the reasons for their migration. Thus, their beliefs influence their idioms of distress, which will ultimately affect how they demonstrate their symptoms and help-seeking behaviour (Bhugra, 2004b).

Bhugra and Becker argue that the process of migration in itself can be stressful and affect the mental health of immigrants. Further, the similarity or dissimilarity between culture of origin and culture of host country, and the degree of acceptance by the “majority” culture, influence the prevalence of mental health problems among immigrants. Experiences of non-acceptance by the majority culture and feelings of isolation from the immigrants’ own culture leads to feelings of alienation, a sense of rejection and mental distress (Bhugra & Becker, 2005). Culture plays an important role in presenting these experiences of distress and illness and cultural differences affect how they are diagnosed and treated (Bhugra & Wojcik, 2011). This is especially true in culturally diverse societies where the dominant culture is expressed through social institutions such as a healthcare system and determines the kind of problems and social or cultural differences that are deemed worthy of attention (Kirmayer, 2012).

2.1.2 Migration and mental health problems

Mental health problems (disorders) as a range of problems are characterized by some combination of abnormal thoughts, emotions, behaviours and relationships (WHO, 2019b). However, in this study the MHP were considered as how participants understood their own mental health condition. This was done because there can be different interpretations of mental health problems in each person’s lived experiences as they progress through life. Feely and colleagues suggested that mental health problems could be defined “in the context of each person’s experience of living in their internal and external world during a period of personal despair or when his or her autonomy is temporarily impaired” (Feely, Sines, & Long, 2007). The authors further added that “mental health problems” is a multifaceted phenomenon that is rooted in the realities of person’s lived experiences, which may be of a multidimensional nature (Feely & Long, 2009).

As mentioned in Section 2.1, migration may be associated with mental health problems. People carry their knowledge and expressions of distress with them when they migrate from one nation or culture to another (Bhugra, 2004b). The stressful aspects of migration, including separation from family, cultural and linguistic differences, hostile or racist attitudes in the host country and possible traumatic events in the country of origin predispose immigrants to mental health problems (Bhugra & Jones, 2001). In addition to the various factors (described in Chapter 1) that may cause mental health problems during the migration cycle, Bhugra focused on the nature of the society a person has migrated from and into, along with his/her social characteristics. The author further hypothesizes that persons who migrate from a collectivistic society into an individualistic society are likely to find it difficult to adjust to the new culture. This may be because of the lack of a familiar social support system and disparities between expectations and reality, resulting in lower self-esteem and greater risk of mental health problems (Bhugra, 2005).

Bhugra argued that the process of migration and sense of alienation and dislocation may lead to stress in individuals and their families, even though experiences will vary at group and individual levels (Bhugra, 2004b). In a classic study conducted in 1932, Odegaard studied migration and its connection to the mental health of Norwegian immigrants to the USA. He found that these immigrants had genetically predisposed psychosis and later developed schizophrenia. He pointed out that migration is a precipitating factor for developing mental health problems in persons who are already vulnerable to such problems, due to various barriers that they encounter during the migration cycle (Bhugra, 2004b; Odegaard, 1932).

To provide further support to this notion, Cochrane and Bal postulated four hypotheses (Cochrane & Bal, 1987) to explain the high rates of mental health problems (especially schizophrenia) among immigrants, while Bhugra added a fifth hypothesis (Bhugra, 2004b):

The first hypothesis pointed out that high rates of mental health problems among immigrants are due to the fact that there are high levels of mental health problems in the country of origin.

The second hypothesis of self-selection suggested that those who are at high risk of developing mental health problems are more likely to migrate. Such migration may be attributed to inherent restlessness or wanting to move away from a community that stigmatizes persons with mental health problems.

The third hypothesis states that migration in itself produces stress (due to e.g. loss of social support, effects on cultural identity, family history, stress of adaptation, racial discrimination, economic difficulties, rootlessness) and may contribute to mental health problems.

The fourth hypothesis was that high rates of mental health problems are due to misdiagnosis because healthcare professionals do not understand the cultural background and do not take into consideration the cultural expectations of these persons (Cochrane & Bal, 1987).

An additional fifth hypothesis states that ethnic density has an effect; immigrants live in close proximity, especially with others from the same community, which may be a protective factor for some mental health problems. But high population density may also lead to various mental health disorders and high rates of deliberate self-harm, because of the underlying cultural conflict. This could be understood from the fact that mass migration because of political/economic or natural crises produces a sense of hopelessness and helplessness when living together in a high population density area, thus predisposing immigrants to mental health problems (Bhugra, 2004b).

2.1.3 Migration and substance use problems

The concepts of substance use and substance use problems are not always easily distinguishable (Miele, Tilly, First, & Frances, 1990). Substance use problems are understood as a term that includes harmful use of, and dependency on, drugs and alcohol (NIPH, 2019). However, in this thesis I will apply the term “substance use problems” to a wide range of subjective experiences that arise from using substances such as alcohol and psychoactive drugs (both licit and illicit). This is considered particularly important in this study because the personal significance of using substances is unique to every individual, and researching the person’s individual experiences may add to understanding of the lived experiences of the phenomenon (Stian Biong, 2008).

Migration is a profound, non-normative transitional event with long-term effects on life (Dalla, Antoniou, & Matsa, 2009). The experiences associated with the process of migration may influence immigrants’ health behaviour, including the use of different substances. Further, substance use may vary during the stages of migration, depending on the exposure to different contextual and cultural factors (Zhang et al., 2015). After arrival, the challenges of assimilating into the dominant culture, and those faced when the dominant culture does not welcome diversity, can lead to increased substance use among immigrants (Dalla et al., 2009). Furthermore, assimilation into a new culture may create family conflicts due to different rates of acculturation between parents and children. This can lead to significant tensions between the generations, including personal distress, delinquent behaviour and substance use (Dalla et al., 2009).

Substances may be used as a way of coping with the stressors of migration such as ongoing trauma, isolation, negative emotions and uncertainty (Ballard, Wieling, Solheim, & Dwanyen, 2019). Marquez-Arrico and colleagues suggest that when confronted with new stressors of migration, persons with limited coping strategies have a higher probability of using substances. Among those who use substances, a very high percentage use them as self-medication for the psychological and physical pain they confront on a daily basis, which subsequently leads to the development of substance use problems (Marquez-Arrico et al., 2019).

To explain this behaviour, it may be understood through “cultural stress theory” or the “assimilation (or acculturation) model”. Cultural stress theory (Salas-Wright & Schwartz, 2019) states that cultural stress is a multidimensional construct, composed of various culturally based stressors, including discrimination and a negative context of reception based on ethnic background, and bicultural stress. Cultural stressors are defined as those stressors that deeply affect a person because they are considered as “foreign” due to cultural differences between them and the mainstream cultural context. This sense of foreignness or otherness among immigrants is understood as the root of cultural stress. The sense of rejection due to discrimination and the negative context of reception limits their integration within mainstream society. This rejection also increases bicultural stress, which occurs when the person tries to balance between the cultures but feels “caught between two cultures”, associated with conflicting expectations and demands by both cultures. Cultural stress theory suggests that adverse migration-related experiences including cultural stressors can create disruptions in family functioning and in turn lead to adverse behaviour including substance use (Salas-Wright & Schwartz, 2019). Another possible explanation could be the assimilation model, which suggests that immigrants adopt the host country’s customs and patterns of substance use, thus adopting substance use habits that are more reflective of the current context in order to feel accepted (Ballard et al., 2019). However, Bhugra and colleagues state that there may be more cultural influences on immigrants' substance use from their country of origin, such as the use of khat in Somali and Ethiopian communities (Bhugra et al., 2014).

2.2 Co-occurring problems

Various terms have been used in the literature to describe the coexistence of substance use and mental health problems in an individual (WHO, 2010), such as "dual diagnosis", "dual disorders", "co-occurring disorders" or "co-occurring conditions".

The term "co-occurring disorders" was used in all the three scientific articles, due to its usage in the literature, especially in Norway. This term has become an established concept and is used in the Norwegian national guidelines for diagnosis and treatment of this group (Helsedirektoratet, 2011).

Although "co-occurring disorders" was used in the articles, "co-occurring problems" was preferred for this thesis. Every person has a unique personal significance of using substances and experiencing mental health problems. Researching these individual experiences should use descriptions of their direct experiences. Therefore, in this thesis, I will use the term "co-occurring problems" to refer to the wide range of subjective experiences of the participants that stem from using substances and experiencing mental health problems at the same time, with a strong impact on everyday life. Further, this aligns with the above-mentioned national guideline (Helsedirektoratet, 2011), which focuses more on everyday functioning level than any individual diagnosis.

Research has revealed a high co-occurrence of substance use and mental health problems (Grant et al., 2004; Jane-Llopis & Matytsina, 2006; Long et al., 2017; Torrens, Mestre-Pinto, & Domingo-Salvany, 2015; Torvik et al., 2017). Persons living with mental health problems have an increased risk of developing substance use problems and vice versa (Dom & Moggi, 2016; Torrens et al., 2015). Studies have shown a high prevalence of mental health problems among persons with substance use problems (Dom & Moggi, 2016; Hasin, Stinson, Ogburn, & Grant, 2007; Landheim, Bakken, & Vaglum, 2006).

Similarly, persons with mental health problems such as schizophrenia have higher rates of substance use problems, sometimes leading to substance dependence, than the general population (Grant et al., 2004; Long et al., 2017; Torrens et al., 2015). Further, persons who seek treatment for mental health problems reportedly have a higher rate of substance use problems than the population at large (Helseth, Lykke-Enger, Johnsen, & Waal, 2009; Mordal, Bramness, Holm, & Mørland, 2008; Ringen et al., 2008).

Living with co-occurring problems is associated with a wide range of negative consequences such as increased rates of relapse and hospitalizations (Morojele, Saban, & Seedat, 2012; Najt, Fusar-Poli, & Brambilla, 2011), non-compliance with treatment (Kreyenbuhl, Nossel, & Dixon, 2009; O'Brien, Fahmy, & Singh, 2009), lower levels of hope, resilience and well-being (Ujhelyi, Carson, & Holland, 2016), and increased risk of suicide (Abroms & Sher, 2016). Co-occurring problems are important risk factors for other diseases such as HIV, cardiovascular diseases and diabetes, as well as intentional and unintentional injuries (Mueser, 2003). Persons living with co-occurring problems often face difficult living conditions such as homelessness and unstable housing (Brekke, Lien, Davidson, & Biong, 2017; Landheim, Bakken, & Vaglum, 2002; Ness, Borg, Semb, & Karlsson, 2014). In addition, there are social consequences such as increased crime and legal problems (Lafeuille et al., 2014). Co-occurring problems have also been reported more in prison inmates than among the general population due to higher rates of childhood stressors and socio-economic problems (Friestad & Kjelsberg, 2009). Further, persons living with co-occurring problems face challenges due to lack of integrated treatment, where mental health services refuse to provide care for a co-occurring substance use problem, while substance use services refuse to provide care for a co-occurring mental health problem (Landheim et al., 2002; Ness, Borg, Semb, et al., 2014). This divide has led to a lack of trust in the fragmented services, which are then perceived as irrelevant by the persons in need. In addition, the situation is exacerbated for these persons when they face discriminatory experiences in health services (Avery et al., 2013) and social exclusion in the community (Blank, Finlay, & Prior, 2016). This may imply that substance use, mental health problems and various disruptive life events are intertwined and are associated with multiple factors (Padgett, Smith, Henwood, & Tiderington, 2012).

While substance use and mental health problems commonly co-occur, that does not infer that one causes the other. Theories have been suggested to understand the co-occurrence via four models:

(1) Common factor models: these propose that co-occurrence is a result of shared vulnerabilities of both problems and common risk factors that may contribute to both problems. These are genetic, i.e. running in families, thus inferring that certain genes may be a risk factor. Evidence also suggests that antisocial personality disorders account for increased co-occurrence. Also, environmental factors such as stress or trauma can cause genetic changes that are passed down through generations, in addition to socioeconomic status (K. Mueser, Drake, & Wallach, 1998).

(2) Secondary substance use disorder models: these propose that mental health problems can contribute to substance use problems, and that persons with mental health problems may use different types of substances as a form of self-medication and can eventually develop worse symptoms and dependence. Proponents of the model further suggest that biological vulnerabilities of mental health problems such as alleviation of dysphoria makes them more prone to use substances. Additionally, multiple risk factors may be responsible for substance use, such as social isolation, poor cognitive and interpersonal skills, vocational failure, poverty, lack of structured daily activities and adult responsibilities, association with deviant groups and living in close proximity to areas with high rates of substance availability (Mueser et al., 1998).

(3) Secondary psychiatric illness models: these propose that substance use problems can cause mental health problems, as substances can trigger changes in brain structure and function and lead to the development of psychiatric problems (Mueser et al., 1998).

(4) bidirectional models: these suggest that ongoing, interactional effects between mental health problems and substance use problems causes high rates of co-occurrence. In this way, substance use problems may trigger mental health problems in a biologically vulnerable person, which in turn are maintained by continued substance use problems because of socially learned cognitive factors, such as beliefs and motives for using

substances (Mueser et al., 1998). Migration research has documented that immigrants are at higher risk of developing mental health problems due to various factors (mentioned in Section 1). The crisis of migration and its impact on the self and within the family and community may lead to high levels of stress, acculturative distress, and conflicts within the self, resulting in increased levels of mental health problems and substance use. Some research has also suggested use of substances as an explanation for high incidence of mental health problems among immigrants (Malone, 2015). Although migration research investigates mental health problems and substance use problems separately, there is little documentation of co-occurring problems in the migration context.

2.3 Immigrants living with co-occurring problems: Coping and sense of self

This thesis assumes that immigration, SUP, MHP and co-occurring problems are stressful experiences in a person’s life. According to Lazarus and Folkman, stress is understood as a relationship between the person and environment that is appraised by the person as exceeding his or her resources and putting his or her well-being in danger (Lazarus & Folkman, 1984). Further, Lazarus (1993) argued that stressful situations are associated with harm, loss, threat or challenge, and that if these situations are significant for the person, the person will engage in coping to deal with the perceived harm, loss, threat or challenge (Lazarus, 1993). Additionally, Berry argues that the acculturation theory is deeply grounded in the theory of stress and coping, which implies that acculturation becomes inevitable and is a process that individuals undergo in an effort to cope with the stress caused by migration and coming into prolonged contact with the new, host majority culture (Berry, 1997).

A person of immigrant background living with co-occurring problems may regularly experience hopelessness and powerlessness, leading to challenging and stressful situations on a daily basis. Such a perception in itself may be recognized as a risk factor that has a negative effect on the person's life course, leading to poor health and difficulty in coping in a new environment. Additionally, due to the process of migration and post-migration factors, previous coping mechanisms are assumed in this thesis to no longer function in immigrants.

Understanding the processes of coping and sense of self in persons with prolonged co-occurring problems can provide a basis for them to manage or compensate for the problems, and help them to recover from the problems or cope with living with them.

2.3.1 Coping

Coping is understood as the process in which individuals take actions to handle stressful situations (Bartlett, 1998), and coping is important to understand the lived experiences of the immigrant men living with co-occurring problems in Study 1. The most extensively used definition of coping in mental health research is that of Lazarus and Folkman: "Constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person". This is referred to as a transactional approach to coping, meaning a bidirectional transaction between the person and his or her environment (Lazarus & Folkman, 1984). Further, this definition implies that coping is a process (not an outcome or trait), which involves efforts to manage a stressful situation, such as migration and co-occurring problems. It further requires cognitive appraisal of the environment and resources of the person, thus limiting coping to psychological stress and excluding automatized behaviour (Lazarus, 1993; Lazarus & Folkman, 1984).

The appraisal of the situation by a person may be understood as the cognitive process to ascribe meaning to situations and determines the stress associated with these situations, and the behaviour employed to cope with it. The appraisal also affects how persons choose their coping strategies. Lazarus states that an appraisal process integrates individual factors (such as immigrant and cultural background) with environmental factors (such as the possibility of receiving treatment) (Lazarus, 2006). Lazarus and Folkman further divide coping strategies into two main categories: problem-focused coping and emotion-focused coping. Problem-focused coping is aimed at solving or managing problems, by e.g. seeking social support, whereas emotion-focused coping uses strategies aimed at internal restructuring of emotions activated by stressful encounters, such as avoiding thinking about a threat (Lazarus & Folkman, 1984). In this thesis, coping strategies will be understood as the behaviour that the person employs when facing challenges connected with co-occurring problems.

2.3.2 Sense of self

Migration to a new country can lead to conflicts between the accustomed ways of living and established sense of self and the new cultural reality. Sense of self has been defined in many ways, but in this thesis it is understood as the organized, consistent set of perceptions and beliefs about oneself (Rogers, 1959). Goffman argues that the sense of self is dependent on the everyday social interactions that the person engages in and is determined by the norms, values, beliefs and cultural practices of the person's social group or local community. He refers to the associated behaviours as "front stage" and "back stage" (Goffman, 1959). According to Goffman, persons engage in "front stage" behaviour when they know that they are being watched by and dependent on others; their behaviour is thus shaped by the cultural norms and expectations of the social setting they live in. However, when persons are free of these expectations, they engage in "back stage" behaviour, i.e. they behave in a way that reflects their uninhibited self. Nevertheless, persons are still aware of expectations and norms in "back stage" behaviour, and these guide their thinking and actions (Goffman, 1959).

When a person ignores or is unable to follow the norms and expectations of "front stage" and "back stage" behaviour, it often leads to embarrassment and confusion, and affects their sense of self (Goffman, 1959). A deep sense of alienation, emotional and financial loss, and failure may lead to poor self-esteem, which in turn may distort the person's images of the self (Bhugra, 2004b). This could mean that a person's sense of self could be constructed by disruptive events such as migration, SUP and/or MHP.

Further, Davidson and Strauss argue that sense of self appears to be a major component in the everyday experience of MHP, often described as a core factor in illness and change (Davidson & Strauss, 1992). Sense of self is a dynamic concept and involves rediscovery and reconstruction at different points in the course of the illness and in change. Davidson and Strauss further describe how a person with severe mental illness may enhance the sense of self to provide some degree of refuge from the illness and detrimental elements of the social milieu (such as stress, marginalization and stigma attached to SUP and MHP). This established sense of self may be utilized by a person as a resource in coping with symptoms and impacts of the illness.

2.4 Immigrants living with co-occurring problems and treatment engagement

2.4.1 Treatment engagement

Engagement is understood as the process of establishing a mutually collaborative, trusting and respectful helping relationship (Miller & Rollnick, 2012). Staudt argues that engagement is an ongoing dynamic process and does not remain static throughout treatment (Staudt, 2007). Further, the process of engagement focuses on making contact with the person rather than the diagnosis, a long-term trustful relationship, meeting individual needs and providing various services in addition to clinical care (Tondora & Davidson, 2006). Stewart theorizes that the success of engagement can be determined by the quality of the care and relationship built between service users and health professionals during the treatment process (Stewart, 2013). Additionally, the feeling of being valued by health professionals when in treatment may enhance the engagement process (Ness, Borg, & Davidson, 2014; Pettersen, Ruud, Ravndal, Havnes, & Landheim, 2014).

Historically persons with co-occurring problems are “difficult to engage” in treatment, with high dropout rates (Dixon et al., 2016). Lower engagement by these persons may lead to inferior clinical outcomes, relapses and often rehospitalization. Various factors influence engagement in treatment settings, such as the therapeutic alliance, issues of utility (whether the person feels that the treatment is working or not), accessibility of care (difficult to access treatment, difficult to schedule), users’ trust that their needs will be met, and/or a feeling of being coerced during treatment (Dixon et al., 2016). Additionally, if users have a different cultural and migration background, engagement will be even more difficult, with the presence of numerous systemic, social and cultural barriers (Abdullah & Brown, 2011; Interian, Lewis-Fernández, & Dixon, 2013).

2.4.2 Person-centred theory

Providing person-centred and culturally competent care in mental health treatment settings has shown favourable outcomes due to engagement in the treatment (Saha et al., 2008).

A person-centred approach applies to both research and clinical settings in healthcare. In 2015, the World Health Organization launched a new strategy focusing on person-centred and integrated health services (WHO, 2015). Person-centred healthcare (PCH) is understood as healthcare services that respect the uniqueness of individuals by focusing on their values, beliefs, desires and wishes, regardless of their age, gender, social status, faith, financial situation, ethnicity and cultural background (McCormack, van Dulmen, Eide, Skovdahl, & Eide, 2017).

The concept of person-centredness is often associated with Carl Rogers’ humanism (Rogers, 1961). According to Rogers, the goal for a person-centred approach is “becoming a person” (Borg & Karlsson, 2017; O’Hara, 2006), while highlighting the value of authenticity. The philosophical roots of person-centredness also include the ideas of person and personhood. It involves valuing the individual as having "personhood" with objective, absolute and intrinsic worth, regardless of how others happen to treat them (McCormack & McCance, 2011). Also important are the person's life history and relationships, both in illness and health (McWhinney, 1989). Further, "person" is conceptualized as defined by Cassell, "*as an embodied, purposeful, thinking, feeling, emotional, reflective, relational, human individual always in action, responsive to meaning and whose life in all spheres points both outward and inward. Virtually all of a person's actions – volitional, habitual, instinctual or automatic – are based on meanings*" (Cassell, 2010).

The person-centred approach also has some influence from emancipatory theory (Proctor, Cooper, Sanders, & Malcome, 2006), which involves emancipating and empowering people. From an emancipatory perspective, the focus has been directed towards seeing a person with the person's experiences of health and the meaning which the person gives to these experiences, in the light of aspects of person-centredness (Lyckhage, Brink, & Lindahl, 2018). Further, emancipatory theory suggests the need for actions to enable liberation of both oppressed and oppressors, which can be achieved by mutual cooperation and dialogue between them leading to shared decision making (Freire, 2005).

In research, person-centredness is supported by values such as respect, self-determination, reciprocity, mutuality and transparency, along with building trust and understanding, in order to enter into a collaborative relationship between researchers and participants (McCormack et al., 2017). My research focus included the theory of person-centredness, as this allowed participants that might have been considered as "hard to reach" to share their experience and perspectives on their COP, and their treatment experiences as an immigrant in Norway. Further, I regard substance use and mental health problems and immigration as disruptive events in life that may have a serious impact on individual personhood, such as low self-esteem, isolation, insecurity, hopelessness, which most of the participants reported during the interviews. These experiences can be described in a way that their voices can be heard while they are in treatment settings.

Considering the fact that “meaning” and “personhood” are mutually constituted, understanding about persons involves understanding about values and social phenomena (Mjølstad, Kirkengen, Getz, & Hetlevik, 2013). This may imply that treatment engagement will be improved by the development, coordination and provision of healthcare services that respect the uniqueness of individuals by focusing on their values, beliefs, desires and wishes, regardless of their age, gender, social status, faith, financial situation, ethnicity and cultural background (McCormack et al., 2017). In my experience, this holds true for immigrants living with co-occurring problems, who often feel discriminated against, stigmatized, left alone, and lack a sense of belonging.

Integration of principles of PCH in mental health and addiction services have been shown to enhance the engagement process and lead to improved outcomes (Dixon et al., 2016). PCH has emerged as a cornerstone of effective SUP treatment (Friedmann, Hendrickson, Gerstein, & Zhang, 2004; Hser, Polinsky, Maglione, & Anglin, 1999) and has been highlighted in the Norwegian national guidelines for SUP treatment (Helsedirektoratet, 2017). Person-centred healthcare focuses on the unique goals and life circumstances of an individual in MHP and SUP treatment models (Dixon et al., 2016) by not only managing and overcoming the health conditions, but also rebuilding the lives of persons living with SUP and MHP (Davidson et al., 2007). In addition, to my understanding, culturally tailored healthcare services are part of a person-centred “culture”, which may lead to higher treatment engagement. This implies that PCH may improve the treatment engagement of immigrants.

2.4.3 A cultural competence approach

Racial/ethnic disparities in health and access to healthcare in the provision of general health, mental health and substance use treatment have been well documented (Debesay, Harsløf, Rechel, & Vike, 2014; Hjörleifsson, Hammer, & Díaz, 2018; Saloner &

Cook, 2013; WHO, 2010). Various causes of disparities such as variation in patients' health beliefs, values, preferences and behaviours have been discussed in the literature. The variations may include the patient's recognition of symptoms, ability to communicate symptoms with a health professional who can understand their meaning, when to seek care, understanding of the disease management strategy, expectation of care and staying engaged in treatment. As a result of these disparities, the concept of cultural competence has emerged within healthcare.

In addition to PCH, a cultural competence approach in healthcare has been seen to reduce racial/ethnic disparities (such as the threshold for seeking care, ability to communicate symptoms comprehensibly to health professionals, expectations for care, and adherence to treatment), while also improving the quality of care for immigrants (Betancourt et al., 2003; Govere & Govere, 2016). A culturally competent healthcare system is understood as one that "acknowledges and incorporates - at all levels - the importance of culture, the assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (Betancourt et al., 2003).

Cultural competence further aims to make healthcare more acceptable, accessible and effective for persons with diverse cultural backgrounds (Kirmayer, 2012). In this regard, Betancourt et al. have proposed a practical framework that entails organizational, structural and clinical interventions to achieve the goal of cultural competence. The organizational level includes interventions that ensure that the workforce and leadership of healthcare are diverse and representative of the patient population. Structural level interventions include providing access to quality healthcare for all patients, which may contain interpreter services and linguistically and culturally appropriate health education materials. At the clinical level, it involves interventions that enhance cross-cultural training of healthcare professionals and provide knowledge about sociocultural factors and health beliefs and behaviours of the diverse population, in order to deliver quality care (Betancourt et al., 2003).

Cultural competence among mental health professionals working in diverse multicultural environments is increasingly recognized as an essential skillset. Various approaches have been developed to enhance the cultural competence of mental health professionals, such as ethnic matching of user and provider, providers modifying their mode of interaction with users, the development of culturally adapted interventions or interventions drawn from the user's own cultural traditions (Kirmayer, 2012). Training materials and resources have been made available for these professionals, such as textbooks and a specific curriculum and guidelines for training in cultural psychiatry (Kirmayer et al., 2012).

Additionally, PCH and cultural competence approaches are believed to have the same core features, and hold promise for improving the quality of healthcare for individuals of immigrant background at both interpersonal and systemic levels (Saha et al., 2008) and may therefore also enhance immigrants' treatment engagement.

3 Review of relevant literature

In this chapter, the relevant literature is presented with regard to the aim of the thesis, and the main purpose is to contextualize this thesis. The literature is presented in four sections, first about migration trends in Norway, followed by three sections on relevant literature in accordance with the three articles, in an international and Norwegian context. I have called these “Being an immigrant and living with co-occurring problems”, “Treatment engagement through the eyes of immigrants living with co-occurring problems: Users’ views”, and “Treatment engagement through the eyes of health professionals: Providers’ views”. Here I highlight the sparse literature on co-occurring problems, while the research is even more limited on immigrants in relation to COP.

Studies from European countries and the USA have found that 30-40% of persons with mental health problems also have alcohol-related problems, rising to 40-50% with regard to other types of substance use problems (Alonso et al., 2004; Grant et al., 2004; Hasin et al., 2007; Jane-Llopis & Matytsina, 2006; Kessler, Chiu, Demler, & Walters, 2005). In the USA it has been reported that 1.4% of all adolescents have co-occurring problems, with major depressive syndrome being the most common mental health problem (Sheidow, McCart, Zajac, & Davis, 2012). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has reported that the prevalence of MHP and concurrent SUP has become a matter of great concern and has increased over the last 10 years, especially among the young population. According to EMCDDA, the prevalence of co-occurring problems in Europe is very heterogeneous, but MHP are more prevalent among those with problematic substance use than in the general population (Torrens et al., 2015). The same report found that the prevalence of COP in Norway in 2010 was 23% among those who were receiving psychiatric treatment (Torrens et al., 2015). In a Norwegian study among patients with MHP, lifetime illicit drug use was 44% higher than in the general population, and lifetime use of amphetamines and cocaine was reported to be 160% higher (Ringen et al., 2008). Studies from different counties in Norway showed high prevalence of SUP among persons admitted to psychiatric treatment with MHP (Helseth, Lykke-Enger, Aamo, & Johnsen, 2005; Landheim et al., 2006; Mordal et al., 2008).

Since there is a high degree of co-occurrence of SUP and MHP, the separate literature on substance use problems and mental health problems in the context of migration is also considered in the following sections.

3.1 Migration to Norway

As in other European countries, migration is not a new phenomenon in Norway. Norway has seen a steady increase in the immigrant population, especially during the past four decades (SSB, 2021a). It gained momentum in the 1960s when Norway discovered oil in the North Sea. The first wave of immigration began with workers from Pakistan, Turkey and Morocco in the late 1960s. However, new immigration policies were introduced in 1975 to put a halt to work-related immigration. After that, during the period 1980-2000, humanitarian-based immigration dominated in Norway, involving refugees and asylum seekers. Those immigrants were mainly from Sri Lanka, Iraq, Iran, Somalia, Chile, Vietnam, and the war-torn Eastern European countries of former Yugoslavia. After the expansion of the European Union (EU) in 2004-2007, work-related immigration increased from the new EU countries, when Norway became part of the European Economic Area (EEA) agreement in 1994. Those immigrants were mainly from Poland and the Balkan countries (Myhre & Tønnessen, 2022).

The increase in immigration to Norway has also increased the ethnic diversity in the population. The relocation of large groups of people has transformed Norway from a perceived homogenous and monocultural society to a heterogeneous and multicultural society (Oppedal, Røysamb, & Heyerdahl, 2005). Today, immigrants in Norway are by no means a homogenous group; in fact they vary according to their cultural, social, ethnic, religious and migration background (Attanapola, 2013). This demonstrates that researching and studying the experiences of this population is crucial to identify the comprehensive picture of Norwegian societal health.

The total population of Norway is 5.4 million (as of 24 February 2022), out of which 18.5% are persons of immigrant background (immigrants: 15.1% and NBIP: 3.4%), who come from 221 different countries and self-autonomous regions. Immigrants from low- and middle-income countries comprise 10.8% of the immigrant population (SSB, 2022). The largest groups of immigrants living in Norway today are from Poland, Lithuania, Sweden, Syria and Somalia. Figure 1 shows immigration to Norway by continent. Further, the main reasons for immigration to Norway today are employment, family reunion, humanitarian-based (refugees and asylum seekers), and education (SSB, 2021a).

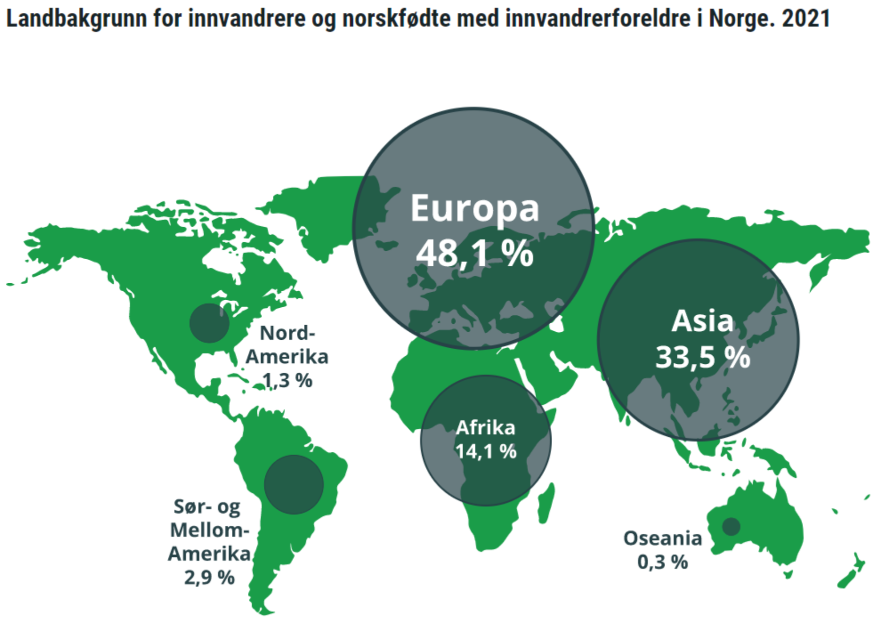


Figure 1: Percentage of immigrants in Norway from different parts of the world.

Source: (SSB, 2021a)

Immigrants are on average much younger than the general population, half of them being aged from 20 to 40 years (SSB, 2022). Immigrants live in different parts of Norway, but they are mostly concentrated in and around big cities like Oslo, Drammen, Bergen and Trondheim (SSB, 2022). SSB conducted a survey on the general living conditions of immigrants and reported a lower educational level, lower employment rate and lower income among immigrants than in the general population. However, there were disparities according to country of origin. The survey also indicated that immigrants more often feel lonely than the general population, with various outcomes of mental health problems (Vrålstad & Wiggen, 2017).

The most common foreign language spoken by immigrants is English, while other important immigrant languages are Urdu, Somali and Persian. Most health professionals speak English, but all patients in Norway have the right to an interpreter paid by the government, not by the patient (Helsenorge, 2019).

3.2 Being an immigrant and living with co-occurring problems

3.2.1 The international context

Migration to Western countries is a growing phenomenon (Lindert, Schouler-Ocak, Heinz, & Priebe, 2008) and is an established determinant of health (Marmot et al., 2012), including mental health. Migration in itself can be a stress-inducing phenomenon which may trigger mental health problems (Bhugra, 2004a), and is regarded as a disruptive event in one's life in this thesis. Kirmayer and colleagues demonstrated that immigrants who have experienced conflict, loss, insecurity, or other traumas have a higher risk of mental health problems. However, the nature of the experience and the person's vulnerability and resilience will differ between individuals (Kirmayer et al., 2011). Further, immigrants who had faced severe childhood trauma had a 12-fold higher risk of co-occurring substance use and mental health problems (Cano & Takeuchi, 2020). Such problems are exacerbated when the native population has negative attitudes toward immigrants, creating challenging situations and integration barriers. These negative attitudes are often associated with racism and discriminatory practices that prevent immigrants from accessing help and social inclusion (Constant, Kahanec, & Zimmermann, 2009). Further, existing ethnic attitudes in the institutional system, including legislation and organizational policies or practices, may lead to unequal opportunities for immigrants (Reitz, 2002), resulting in higher MHP.

Studies have shown that immigrants experience heavier burdens of mental health problems than the general population (Fazel, Wheeler, & Danesh, 2005; Lindert, von Ehrenstein, Priebe, Mielck, & Brähler, 2009). The prevalence of post-traumatic stress disorder (PTSD) in Western counties is reported to be higher, with a ten-fold greater risk among immigrants (Bogic, Njoku, & Priebe, 2015; Fazel et al., 2005). Further, studies have reported higher risk of various other mental health problems such as psychotic disorders (Brandt et al., 2019) and affective and anxiety disorders among immigrants (Bogic et al., 2015; Lindert et al., 2009).

The epidemiology of MHP may differ due to reasons of migration, ethnic origin, generational status and length of residence. In some studies, earlier age at migration has been associated with a higher risk of mental health problems, suggesting that cultural adaptation may influence mental health (Kirkbride et al., 2017; Veling, Hoek, Selten, & Susser, 2011). In first-generation immigrants, a greater risk of mental health problems has been reported, including depression, psychotic disorders, mood disorders, anxiety disorders and PTSD, regardless of the reason for migration (Bourque, van der Ven, & Malla, 2011; Cantor-Graae & Pedersen, 2013; Close et al., 2016; Dykxhoorn et al., 2019; Levecque & Van Rossem, 2015; Markkula, Lehti, Gissler, & Suvisaari, 2017; Mindlis & Boffetta, 2017). Among second-generation immigrants, an increased risk of psychotic disorders, depression and PTSD has been reported in comparison to the general population. (Bourque et al., 2011; Cantor-Graae & Pedersen, 2013; Dykxhoorn et al., 2019; Guardia, Salleron, Roelandt, & Vaiva, 2016; Ruiz-Castell et al., 2017). Further, some studies have revealed ethnic origin to be associated with mental health problems. Studies conducted in the Netherlands suggested that Moroccan and Turkish immigrants have a high risk for affective disorders (de Wit et al., 2008), while for immigrants from Somalia and Afghanistan a lower risk for depression, anxiety and PTSD was reported, as compared to Iranian immigrants (Gerritsen et al., 2006). Studies conducted in the UK (Halvorsrud, Nazroo, Otis, Brown Hajdukova, & Bhui, 2019) and the USA (Kroll, Yusuf, & Fujiwara, 2011) have also reported high risk and prevalence of psychosis in black ethnic groups in comparison with the general population.

As for substance use problems, research varies between lower, higher and no difference between immigrants and the general population. Some studies have shown that immigrants have lower substance use problems than the average in the population (Harris, Dykxhoorn, Hollander, Dalman, & Kirkbride, 2019; Qureshi et al., 2014; Salas-Wright, Vaughn, Clark, Terzis, & Córdova, 2014; Salas-Wright, Vaughn, Goings, Córdova, & Schwartz, 2018); however, those immigrants who do consume substances have higher levels of both substance use problems and mental problems, and a high degree of COP. This was suggested to be associated with immigrant culture, such as extreme stigmatization of substance use, and may lead to high social marginalization and reduced access to treatment (Qureshi et al., 2014). Additionally, there is limited evidence and there could be other and greater hidden problems among immigrants since they tend not to access treatment due to stress, loneliness or self-medication (Lundgren et al., 2012; Mladovsky, 2007).

Nevertheless, some studies have reported more SUP among some immigrant groups. A Swedish survey reported that immigrants were more likely to use illicit drugs than the general population, with most substance use among non-European immigrants (Svensson & Hagquist, 2010). Another Swedish register-based study reported that second generation immigrants are at particular risk for substance use problems, especially for illicit drugs. The high risk was associated with adverse socioeconomic living conditions (Hjern, 2004). Further, socioeconomic exclusion and living in poor and segregated neighbourhoods was also associated with high risk of substance use behaviour among immigrants (Sellström, O'Campo, Muntaner, Arnoldsson, & Hjern, 2011). However, a Finnish study reported that immigrants are less likely to binge drink than the general population, but Somali, Kurdish and Russian immigrants have higher prevalence of smoking than the Finnish population. Socioeconomic disadvantage increased the odds of smoking and migration-related factors such as age at migration and language proficiency were related to substance use (Salama et al., 2018). Further, a UK based study reported more frequent use of opiates among immigrants from Asia than the average in the population (Moselhy & Telfer, 2002). However, immigrants from Somalia, Ethiopia, Yemen, and Arab countries have higher khat use (Fountain et al., 2004).

Research among Turkish immigrants living in Germany found that substance use problems are significantly associated with acculturative stress and mental distress (Haasen et al., 2004). Another study demonstrated that immigrants from East Africa and Arab countries use khat to cope with stressful events, to forget bad memories and to improve concentration (Bongard & Nakajima, 2015). Somali immigrants in Sweden perceived khat as a kind of food that had no negative impact on health (Osman & Söderbäck, 2011). Further, a qualitative study among young immigrant men in Scandinavia suggested that immigration and SUP put them at greater risk of suicide due to a sense of being marginalized in an unfamiliar environment. This study also indicated that immigrants with SUP are a vulnerable group with multiple treatment needs (Biong & Ravndal, 2009). A recent Swedish study demonstrates that post-migration stress due to perceived discrimination, separation from family, integration difficulties, financial difficulties, unemployment, social isolation, and interfamilial conflicts are associated with high risk of mental health problems (Malm, Tinghög, Narusyte, & Saboonchi, 2020).

3.2.2 The Norwegian context

Mental health problems among immigrants have been reported by various studies in Norway. A longitudinal study (Sagatun, Lien, Søgaard, Bjertness, & Heyerdahl, 2008) and two systematic reviews (Abebe, Lien, & Hjelde, 2014; Kale & Hjelde, 2017) found that immigrants experienced more MHP than native Norwegians. One of these reviews further highlighted that immigrants from low- and middle-income countries have a higher degree of mental health problems than the population at large (Abebe et al., 2014). It has also been reported in other studies that immigrants from low-income countries with a war and conflict background suffer from more MHP than the general population and immigrants from high-income countries (Dalgard, Thapa, Hauff, McCubbin, & Syed, 2006; Thapa, Dalgard, Claussen, Sandvik, & Hauff, 2007). Similarly, MHP were reported to be higher among immigrants than in the general population in various surveys conducted by SSB (Blom & Henriksen, 2008; Vrålstad & Wiggen, 2017). For example, the latest survey revealed that 6% of participants reported MHP, but 12% of immigrant participants

(Vrålstad & Wiggen, 2017). A recent Norwegian report also reported a higher proportion of MHP among all immigrant groups than in the general population. However, there were considerable differences among immigrant groups; for instance, immigrants from Iran, Iraq, Turkey, Afghanistan and Pakistan reported higher MHP than those from Poland and Somalia (Kjøllesdal et al., 2019).

The review by Abebe, Lien and Hjelde further reported that a high risk of MHP among immigrants was associated with poor social support, deprived socioeconomic conditions, multiple negative life events, experiences of discrimination and traumatic pre-migration experiences and higher risk for acculturative stress (Abebe et al., 2014). A few studies also identified feelings of powerlessness, social marginalization and economic deprivation as reasons for high prevalence of MHP in the post-migration phase regardless of the reasons for migration (Dalgard et al., 2006; Thapa et al., 2007). Further, young immigrants who were subjected to acculturative pressure, identity crisis, discrimination, and trauma faced by their parents have higher MHP (Lien, Rikard Haavet, Thoresen, Heyerdahl, & Bjertness, 2007; Oppedal et al., 2005). It was also found that perceived discrimination among young immigrants was a consistent predictor of MHP (Oppedal, 2011) and they also reported higher experiences of bullying and victimization (Fandrem, Strohmeier, & Jonsdottir, 2012). Furthermore, Brekke and colleagues recently wrote that discriminatory and unequal policies such as the practice of residence permit or citizenship revocation in Norway has led to disintegrating effects among immigrants, including social exclusion, stigmatization, social withdrawal, and lack of a sense of belonging (Brekke, Birkvad, & Erdal, 2019), resulting in a higher risk for MHP.

Studies conducted in Norway on SUP have demonstrated that the extent of SUP is lower among immigrants than the average in the population(Abebe, Hafstad, Brunborg, Kumar, & Lien, 2015; Amundsen, 2012). The Oslo Health Study (HUBRO) conducted among immigrants from Iran, Pakistan and Turkey and ethnic Norwegians found that alcohol use was higher in ethnic Norwegians than in these groups of immigrants. However, there were differences in immigrant use, where immigrants from Iran drank more alcohol than those from Turkey and Pakistan. Further, the level of alcohol use was higher with increased host culture competence and social integration (Amundsen, 2012). Another study also reported lower prevalence of binge drinking and cannabis and tobacco use in young immigrants of Asian background born in Norway than in native Norwegians. High levels of cannabis and tobacco use were reported among second generation immigrants from Europe and the United States, while the highest level of binge drinking was among native Norwegians. This study also highlighted that higher tobacco and cannabis use is associated with greater symptoms of depression (Abebe et al., 2015). Further, the use of traditional substances such as khat among immigrant men has become an important concern, especially from Somalia and Ethiopia (Ali & Kaur, 2013).

An official Norwegian report stated that mental healthcare and addiction facilities encounter an increasing proportion of persons of immigrant background. Several have stories of being child soldiers, language challenges and PTSD. Many of them have a different understanding of perceived suffering in living with SUP, and a life characterized by continuous stress based on their migration process. This report also pointed out that immigrants who were interviewed held the view that consuming substances is a similar phenomenon for everyone, while what happens before and after consumption is different for persons of immigrant background (Freng & Lund, 2015).

In addition, many immigrants have reported being treated unfairly or disrespectfully, due to racism and prejudices (Midtbøen, 2015). Another ethnographic study highlighted that immigrants who experience poor integration into mainstream society may find solidarity and a sense of community in street drug scenes. The study suggested that immigrants who use substances may experience double marginalization (Sandøy, 2015).

3.3 Treatment engagement through the eyes of immigrants living with co-occurring problems: Users' views

3.3.1 The international context

Research has documented that immigrant groups with SUP and MHP are at a high risk of neglect even in developed healthcare systems; possible reasons include lack of existing healthcare policies for these groups and insufficient funding to target specific areas of immigrants' mental healthcare (Mladovsky, Rechel, Ingleby, & McKee, 2012). A recent Swedish cohort study reported increased rates of SUP among immigrants who migrated at an early age or had lived for a long time in the host country (Harris et al., 2019). Another cross-sectional study that investigated the relationship between immigrant status and the history of compulsory treatment for SUP showed that second generation immigrants were 41% more likely to have had compulsory treatment than the general population, which made them an at-risk population (Lundgren et al., 2012).

Despite this, research has shown higher MHP among immigrants, which would suggest higher mental health and addiction services utilization. However, various studies conducted in the UK (Bhui et al., 2003; Boydell et al., 2012), the USA (Chen & Vargas-Bustamante, 2011; Vaeth, Wang-Schweig, & Caetano, 2017), Canada (Kirmayer et al., 2007; Thomson, Chaze, George, & Guruge, 2015), Sweden (Ivert, Merlo, Svensson, & Levander, 2013), Finland (Castaneda et al., 2020), and the Netherlands (Mulder, Koopmans, & Selten, 2006) have reported lower utilization of mental health services in immigrants than in the population in general. Further, it has been indicated that immigrants have higher hospital admission rates, more frequent compulsory admissions, higher non-adherence to treatment, and less satisfaction with services (McCabe & Priebe, 2004). Immigrants are further disadvantaged by poor access to healthcare (Lundgren et al., 2012; Mladovsky, 2007). In addition, the distinctive challenges that led to poor mental healthcare access were reluctance to seek help because of stigma attached to MHP and concerns related to confidentiality (Giacco, Matanov, & Priebe, 2014).

There is strong evidence that completion of SUP treatment is one of the most consistent factors associated with favourable treatment outcome (Brorson et al., 2013). Persons living with SUP and MHP are often difficult to engage in treatment, leading to frequent relapses and rehospitalizations (Dixon et al., 2016). Lower treatment engagement has also been documented among immigrants (De Kock et al., 2017; Vandevelde, Vanderplasschen, & Broekaert, 2003; Verdurmen et al., 2004), resulting in challenges in providing them with targeted help (Sandøy, 2015). Further, the literature has suggested that persons living with co-occurring substance use and mental health problems access treatment at a lower rate than those without COP (Harris & Edlund, 2005), even though integrated treatment is among the most effective interventions for COP (Drake, Mueser, Brunette, & McHugo, 2004). A clinical trial was conducted among Latino immigrants living in the United States and Spain on perceived barriers to COP treatment engagement. Treatment included ten sessions of cognitive behavioural therapy, psychoeducation and mindfulness (Integrated Intervention for Dual Problems and Early Action). The study reported that mistrust in previous treatment was a significant barrier to treatment engagement (Falgas-Bague et al., 2019). Various other barriers to treatment engagement have been reported among immigrants living with co-occurring problems. These included structural barriers, such as difficulties with transportation and an inflexible schedule of appointments, and attitudinal barriers, such as dealing with one's problems oneself, not seeking help and lacking motivation. Although immigrants were aware of the severity of their symptoms, they were less likely to access treatment due to their belief that they would not benefit from the services (Falgas et al., 2017). In a qualitative study, immigrants reported barriers such as stigma and lack of support from family, perceived treatment needs, and barriers stemming from cultural factors leading to lower treatment engagement (Pinedo, Zemore, & Rogers, 2018). Some studies have also suggested that immigrants seldom use mental healthcare services due to fear of discrimination, which results in ignoring the symptoms and deterioration of their mental health over time (Corrigan, 2004; Hines-Martin, Malone, Kim, & Brown-Piper, 2003).

A recent scoping review on the role of cultural beliefs, religion and spirituality in mental health service utilization pointed out the need for linguistically and culturally appropriate mental health services. This may be due to various reasons, ranging from the influence of cultural beliefs and practices on treatment engagement to lack of awareness of available services (Chaze, Thomson, George, & Guruge, 2015). Another study also emphasized immigrants' perception of the importance of cultural contexts in mental health treatment. The notion of culturally specific stigma around mental health problems render various forms of treatment ineffective and threatening (Yorke, Voisin, Berringer, & Alexander, 2016).

3.3.2 The Norwegian context

Research shows that immigrants have lower than average rates of utilization of specialist mental healthcare services in Norway (Abebe et al., 2017; Elstad, Finnvold, & Texmon, 2015; Kale & Hjelde, 2017). However, a longitudinal study conducted over eight years reported that the use of emergency psychiatric care was higher among immigrants from LMIC than in the general population (Berg, 2009). In addition, forced admission to psychiatric hospitals was also reported to be higher in immigrants from LMIC and was related to socio-economic problems, lack of knowledge of available care and lack of ability to communicate with healthcare professionals. This led to an increase in aggressive or violent behaviour by these immigrants (Iversen, Berg, Småvik, & Vaaler, 2011).

In a monologue, Berg studied the interactions between immigrant patients and health professionals in Norwegian addiction services. The author stated that the immigrants in treatment tended to have a lack of connection with working life and Norwegian society in general, unstable housing conditions, weak social networks and hence appeared to be marginalized. The study also found that immigrant patients had a different understanding from health professionals of the problems and treatment. This led to challenging interactions, which were based mostly on conversations. These conversations were known as a "talking cure" in the treatment settings. The immigrant patients rejected the "talking cure" as a legitimate form of treatment, since they felt that they did not benefit from it, thus resulting in lower engagement in the treatment. Berg also found that immigrant patients who had a strong family connection associated treatment with familial obligations. They further requested help to cast their problems into an “ocean of oblivion”, that is to forget their problems, so that they could restore their own and their families’ dignity. Another important finding in this monologue was that immigrant patients were not a homogenous group and had different impressions of the health professionals. For example, some found it difficult to receive counselling from female health professionals, while others encountered difficulties in accepting young and inexperienced counsellors (Berg, 2003).

Further, the Norwegian Directorate of Health has stated that immigrants who have poor Norwegian proficiency are unable to receive important communication from health professionals and as a result are dissatisfied with treatment (Forland, 2009). In addition, fragmented services for COP may be perceived as irrelevant by persons living with COP, leading to lack of trust (Landheim, Hoxmark, Aakerholt, & Aasbrenn, 2017) and this may especially hold true for immigrants.

Further, some immigrants highlighted experiences of shame associated with using substances, especially those that were not culturally acceptable, which limited their possibilities of accessing treatment (Freng & Lund, 2015). In addition, immigrants who have connections to a closely-knit drug scene or group may be hampered from seeking mental health treatment. This could be due to the feeling of social solidarity that they want to display within the group. Further, these closely-knit scenes may provide a community for immigrants who experience a low degree of inclusion elsewhere. The study recommended targeted help for this group to encourage them to seek treatment (Sandøy, 2015).

While the above information may lead to a negative view of treatment and recovery in COP, first-person experiences of recovery in COP among Norwegians suggest that a better life can be achieved in various ways (Landheim, Wiig, Brendbekken, Brodahl, & Biong, 2016). Becoming part of the community enhances recovery in persons with COP and requires the continuous support of the environment and the efforts of the persons involved in this process (Biong, 2016). This would also mean that the person is involved in the process of decision making about treatment and recovery, implying a person-centred healthcare approach. I would argue that this holds true not only for Norwegians living with COP but also for immigrants living with COP.

3.4 Treatment engagement through the eyes of health professionals: Providers' views

3.4.1 The international context

Barriers to accessing mental health services among immigrants are well documented in the literature; these include lack of information about available services, transport and language difficulties, difficulties in navigating the healthcare system, lack of trust, perceived stigma, different understandings of mental health, and thus different perceived needs for care (Ahmed et al., 2016; Franks, Gawn, & Bowden, 2007; Saechao et al., 2012). A systematic review reported that barriers to treatment or to maintaining care included communication difficulties with healthcare providers, lack of culturally adapted services, and inability of the provider to understand different cultural meanings of mental health problems (Aggarwal et al., 2016). In addition to these barriers, mental health professionals' stereotyping and biased or discriminatory treatment when dealing with immigrants have also been reported (Mladovsky, 2007; Mladovsky et al., 2012). This situation may be aggravated by health professionals' limited knowledge of immigrants' backgrounds, leading to immigrants' dissatisfaction with services (Spilker, Indseth, & Aambø, 2009).

A qualitative study was conducted in Canada on the perspectives of immigrant health professionals on the access and use of mental health services for immigrants. HPs stated that immigrant patients faced barriers, including language barriers, cultural interpretation of mental health, stigma attached to mental health problems and fear of negative repercussions when living with MHP. They also mentioned their lack of relevant training and feeling of inadequacy while working with immigrant patients that required mental health support (Salami, Salma, & Hegadoren, 2019). Feelings of hopelessness among HPs when meeting immigrant patients was also reported in a Danish study (Jensen, Norredam, Priebe, & Krasnik, 2013). Further, HPs mentioned strategies to improve mental health delivery, such as addressing financial barriers, training immigrant health professionals, developing community-based services and collaboration across different sectors in mental health service delivery, increasing use of interpreters and cultural brokers, and awareness of possible histories of trauma (Jensen et al., 2013; Salami et al., 2019).

Similarly, another qualitative study conducted among health professionals across 16 European countries highlighted the challenges faced by HPs while treating immigrant patients, such as difficulty in developing trust, complications related to diagnosis and higher risk of marginalization. Complications related to diagnosis were associated with language barriers and cultural expectations, while lack of knowledge of the patient's cultural background was related to misunderstandings of what was considered socially accepted behaviour and often led to challenges in differentiating between a normal cultural response and an indication of problems (Sandhu et al., 2013). A similar finding has been reported in another study, in addition to negative attitudes among HPs and immigrant patients being a potential barrier. The authors also suggested components to overcome the barriers such as working with families and social services, positive and stable relationships with HPs along with cultural awareness, organizational flexibility with sufficient time and resources, educational programmes and information material for different immigrant groups and guidelines to access mental healthcare services (Priebe et al., 2011).

Poor mutual understanding and cultural differences were reported to be factors in unsuccessful consultations with immigrant patients at the Schengen border by HPs. The authors underlined the importance of respecting human dignity as a crucial factor for providing mental healthcare (Žagar et al., 2019).

3.4.2 The Norwegian context

A study conducted among nurses in the medical and psychiatric units of a hospital in Oslo found that their knowledge about illness and treatment philosophies other than Western biomedicine was inadequate. Assessment of symptoms in terms of cultural and linguistic understanding of immigrant patients was reported as challenging. The nurses also mentioned that they were offered little to no help in terms of in-service training and they wanted more knowledge about intercultural symptom assessment and culturally competent treatment and care (Alpers & Hanssen, 2014). The need for culturally adapted mental health services in Norway was also pointed out in another qualitative study conducted with HPs, where the authors felt that mental health services were unsatisfactory or inadequately tailored to immigrant patients (Dabo, 2015).

A survey conducted among Norwegian health professionals who were treating immigrant patients reported that most felt that they had middle-level competence in treating these patients, while 29% considered their competence to be low. Seventy percent of regular GPs and 55% of psychiatrists reported that it was difficult or sometimes impossible to get experts' advice and guidance, and 51% reported having bad experiences of referring these patients to psychiatric hospitals. The HPs also mentioned the language barrier, where patients could not provide information about their pre-migration experiences, which could potentially be important to identify the cause of their problems. As a result, HPs often did not know whether the patients had a history of trauma or not (Varvin & Aasland, 2009).

Similarly, a qualitative study among nine HPs working in different addiction services in Bergen reported barriers to access services, such as language, organization of services, co-existing health or social issues and lack of provision of information for immigrant patients and for themselves. Further, HPs mentioned that immigrant patients with SUP are doubly marginalized due to being an immigrant and having SUP, which may increase their difficulty of accessing care. As a consequence these groups were at risk of neglect by the healthcare system, in addition to cultural differences and trust problems between immigrant patients and HPs (Malone, 2015).

A Norwegian report on HPs associated this group with a greater feeling of shame regarding substance use. Many HPs also connected the use of substances with a cultural context, as in the case of khat and cannabis. The report also pointed out that discrimination occurs in addiction treatment centres in Norway. This is expressed through racist comments, rejection, condescending attitudes, and low tolerance. Furthermore, lack of competence in terms of cultural background, linguistic competence and commitment were mentioned, along with little use of professional interpreters (Freng & Lund, 2015).

3.5 Summary

There are no indications that the numbers of immigrants from different parts of the world will decline in the near future (UNCHR, 2016). Immigrants settle down in a new country for various reasons. They originate from a range of countries with diverse backgrounds and experiences, and several have faced numerous challenges during the pre-migration, migration and post-migration phases. In the country of arrival, they face various difficulties such as language barriers, low social status, and the lack of a social network, which affect their integration within mainstream society. Their lack of integration, combined with other environmental and social factors, can influence their ability to seek help, which may affect their mental health.

Several studies have reported that persons of immigrant background have a greater risk of mental health problems than the general population. It has been suggested that issues related to immigration and previous individual experiences cause an accumulation of risk factors for mental health problems, sometimes also leading to problems with substance use, especially of illicit drugs. It is unclear whether these groups have higher rates of substance use problems than the general population, or whether these rates vary with length of residence in a new country or due to co-occurring mental health problems. The literature outlined above clearly reveals several knowledge gaps regarding co-occurring substance use and mental health problems among immigrants, internationally as well as in the Norwegian context.

It is worrying that despite the clearly increasing immigrant population in Norwegian society there is still a lack of research on immigrants’ substance use and mental health problems and how this population is accessing mental health and addiction services. There are some surveys of substance use among immigrants in Norway, but I find no studies of the prevalence and incidence of substance use problems in immigrants in Norway. There are studies that report research separately on substance use and mental health problems but have not considered these elements together. Moreover, there is a knowledge gap in the literature on co-occurring problems among the immigrant population. To my best knowledge, no study has been conducted in Norway on immigrants’ experiences of living with co-occurring problems and how they have experienced treatment in Norwegian mental health and addiction services, which makes the present study an important step to explore the group in question.

Additionally, research shows that health professionals clearly lack knowledge and skills to relate to patients of immigrant background. Studies in Norway have shown the experiences of HPs in mental health and addiction services separately, but there is a dearth of knowledge of co-occurring problems. This implies a dire need to explore HPs’ experiences in the Norwegian context, to understand what works and what does not, and to make mental health and addiction services more accessible and better tailored to immigrant patients living with co-occurring problems.

4 Aims and research questions

This thesis seeks to add scientific knowledge on co-occurring problems among immigrants in Norway and is composed of Sub-study 1 and Sub-study 2. The overall aim of this thesis was to explore the coping and treatment experiences of immigrants living with co-occurring problems in Norway, from the perspectives of immigrants and health professionals. This led to the following research questions and aims:

1. How do persons of immigrant background experience living with co-occurring problems in Norway? (Article 1)

2. What are the coping experiences of persons of immigrant background living with co-occurring problems? (Article 1)

3. What are the treatment experiences of persons of immigrant background living with co-occurring problems? (Article 2)

4. How do health professionals in Norwegian mental health and addiction services find the treatment engagement of immigrants with co-occurring problems? (Article 3)

An overview of the study consisting of the sub-studies and their aims, research questions and methods of data collection and analysis is presented in Table 1.

Table 1: Overview of Sub-study 1 and Sub-study 2 and the overall aim of this thesis

	Aim	Research Question	Data Collection	Data Analysis
Sub-study 1				
Article 1	To explore the lived experiences of being an immigrant and living with co-occurring problems in Norway	1 How do persons of immigrant background experience living with co-occurring problems in Norway? 2 What are the coping experiences of persons of immigrant background living with co-occurring problems?	In-depth interviews with 10 persons (men) of immigrant background and living with co-occurring problems	Systematic text condensation
Article 2	To explore the treatment experiences of immigrant men living with co-occurring problems in Norwegian mental health and addiction services	3 What are the treatment experiences of persons of immigrant background living with co-occurring problems?		
Sub-study 2				
Article 3	To explore health professionals' experiences with treatment engagement among immigrants with co-occurring problems	4 How do health professionals in Norwegian mental health and addiction services find the treatment engagement of immigrants with co-occurring problems?	Three focus group interviews with health professionals	Systematic text condensation
Overall aim of this thesis	To explore the coping and treatment experiences of immigrant men living with co-occurring problems in Norway, from the perspectives of immigrants and health professionals			

5 Theory of science, methodology and methods

5.1 A qualitative approach to scientific knowledge

Studying and generating knowledge from human experiences (i.e. subjective ontological phenomena) implies a qualitative approach in research (Malterud, 2001a). Qualitative research is defined as *"the systematic collection, organization, and interpretation of textual material derived from talk or observation. It is used in the exploration of meanings of social phenomena as experienced by individuals themselves, in their natural context."* "*Qualitative inquiry could contribute to a broader understanding of medical science*" (Malterud, 2001b). The foundation of qualitative research is to be systematic and reflective throughout the process in order to develop knowledge that can be shared and contested, with the ambition of transferring it beyond the study setting (Malterud, 2001b). The qualitative method I have used in this study enables me to capture different kinds of knowledge: ideographic knowledge about the individual participant's subjective meaning and the interaction between the participant and society, and scientific knowledge from evaluation by the research community. Further, a key question was to choose the methodology that could be most suitable to give a voice to those who are considered marginalized, and qualitative research holds that potential (Moree, 2018).

As described in Chapter 2, substance use problems, mental health problems and migration are considered as disruptive events in life and therefore an attempt to understand the meaning and explore the lived experience was considered the right approach to this study. Qualitative research uses different theoretical foundations that inform the study of research problems while addressing the meanings individuals or groups ascribe to social or human problems and in this way helps to generate knowledge (Creswell & Poth, 2016). In this study, the other is recognized as the experiencing subject. This points out that subjective experiences exist in a way that they can be accessed through language, even though they may not be exact (Giorgi, 2009). This leads to realistic ontology, while acknowledging that different interpretations of subjective experiences are possible with language as a communicative medium.

The study is underpinned by emancipatory theory at the axiological level, with the aim of making each participant feel acknowledged and valued as a distinct person and able to provide a valuable contribution to knowledge generation (with the interpretations of the researchers). Efforts were thus made to acknowledge the intrinsic humanness (Giorgi, 2009) and personhood (McCormack et al., 2017) of the participants throughout the process. A further aim is to inform decision makers about the lived experiences of immigrants living with COP.

In order to gain a deeper understanding of the meaning of coping and treatment experiences of immigrants living with co-occurring problems in Norway, from the perspectives of immigrants and health professionals, I adopted a qualitative research approach, inspired by phenomenological philosophy, mainly at the methodological level and with different interpretations at the level of methods used (Creswell & Poth, 2016; Finlay, 2009; Giorgi, 2009), in addition to a collaborative approach (Beresford, 2003, 2013; Pettersen, Brodahl, Rundgren, Davidson, & Havnes, 2019; Trivedi & Wykes, 2002; Veseth, Binder, Borg, & Davidson, 2017). A flexible approach to methodology was adopted and hence this study has a pragmatic standpoint (Kvale & Brinkmann, 2009). Further, the study design was exploratory and descriptive.

In this chapter, I will also discuss the phenomenological inspirations and collaborative influences used in this study, followed by a description of how the methods were employed.

5.2 Phenomenological inspirations

This study is influenced by phenomenology at a methodological level and has different inspirations at different levels of employing methods.

Phenomenological philosophers have been *"extraordinarily diverse in their interests, in their interpretation of the central issues of phenomenology, in their application of what they understood to be the phenomenological method, and in their development of what* *they took to be the phenomenological programme for the future of philosophy*" (Moran, 2002). There have been debates about how best to conduct phenomenological research where six questions were posed: *(1) How tightly or loosely should we define what counts as "phenomenology"? (2) Should we always aim to produce a general (normative) description of the phenomenon, or is idiographic analysis a legitimate aim? (3) To what extent should interpretation be involved in our descriptions? (4) Should we set aside or bring to the foreground researcher subjectivity? (5) Should phenomenology be more science than art? (6) Is phenomenology a modernist or postmodernist project, or neither?* (Finlay, 2009)

I will use these six questions to describe the phenomenological inspirations applied to this project. The first question about what counts as "phenomenology" appears difficult to answer within the scope of this study. However, I can state that the phenomenological inspirations of this study involve rich descriptions of lived experiences and adopting a special open attitude, without external frameworks and judgements on the realness of the phenomenon being studied. This is similar to the position of Finlay in this question, where she considers the description of lived experience, i.e. "the things in their appearing", to be the core of phenomenological research (Finlay, 2009).

The second question asks whether the aim of phenomenological research should be to produce a general description of the phenomenon or whether idiographic analysis could also be legitimate. Giorgi states that the aim should be to shed light on the general and essential structures of the phenomenon, thus the phenomenon should be considered as a whole regardless of the individual concerned. He further clarifies that the purpose is to study the phenomenon in a more traditional, normative and scientific sense (Giorgi, 2008). In response to this, Malterud argues for adding examples from life worlds of individuals (Malterud, 2012). Moreover, the person-centred approach considers the context just as important as the individual (McCormack et al., 2017). In this study, the aim was to describe and explore the lived experiences of persons of immigrant background living with co-occurring problems, along with the lived experiences of health professionals. Therefore, the aim was mainly focused on producing rich descriptions of the phenomenon by categorical analysis.

The third question Finlay asks is about the extent of interpretation in our descriptions, that is the distinction between descriptive and interpretive (hermeneutic) phenomenology. While all phenomenological research begins with concrete descriptions of lived experiences, aiming to describe rather than explain, scholars have made divisions between two types of phenomenological approach. In a descriptive approach, the aim is to reveal the meanings of a phenomenon by staying close to the data in all its complexity and richness (Giorgi, 2009). This has been stated in a similar way by Malterud, when describing systematic text condensation as a descriptive approach where lived experiences are studied as they are described by the participants, without finding any underlying meanings of what was said (Malterud, 2012), which is a method of data analysis that has been used in this study. The participants' descriptions have formed the basis of the analysis in my study. However, I also agree with Finlay when she states that there are no hard and fast boundaries between description and interpretation in practice, because "such boundaries would be antithetical to the spirit of the phenomenological tradition that prizes individuality and creativity" (Finlay, 2009). However, my analysis was grounded in the participants' descriptions. To elaborate the meaning that lay within the data, there were some interpretations of it; Malterud states that knowledge is generated from experiences by interpreting and summarizing the organized data (Malterud, 2012).

The fourth question assesses researcher subjectivity, whether it should be set aside or brought to the foreground. Phenomenologists argue that researcher subjectivity is implicated inevitably in research and that researchers need to adopt the "phenomenological attitude", which involves striving to be open to the "other" and to see the world in a fresh and different way. While some phenomenologists agree on the need for an open attitude, others argue for bringing their own experience to the foreground and reflexively exploring their own embodied subjectivity (Finlay, 2009). Giorgi emphasizes the researcher's reduction or bracketing, i.e. to put aside past knowledge, previous understandings, and assumptions about the phenomenon, in order to focus on the phenomenon in its appearing. He states that bracketing is where "one simply refrains from positing altogether; one looks at the data with the attitude of relative openness" (Giorgi, 2009). During the process of analysis, I made constant and deliberate efforts to bracket my preunderstandings, by only focusing on what was presented in the data, and not adding or subtracting anything. However, Malterud argues that complete bracketing is seen as impossible (Malterud, 2012); in this context I therefore considered reflexivity to be important. I tried to continually reflect upon my interpretations of both the experience and phenomenon under study throughout the process, in order to move beyond my previous understandings (Finlay, 2002).

I now move on to the fifth question, which asks whether phenomenology is more science or art. While Giorgi emphasizes "certain openness and flexibility", he also insists on completely respecting scientific rigour when phenomenology is used as a method. He also advocates for phenomenology to be systematic, methodological, general and critical (Giorgi, 2009). Further, qualitative research is understood as being reflexive, systematic, and sufficiently transparent to undergo critical scrutiny. It involves the systematic collection, organization and interpretation of textual material derived from interviews or observations. Moreover, the aim is to generate knowledge that is transferable beyond the study setting (Malterud, 2001b). This is the foundation of my project and hence I consider phenomenological inspirations in this project as scientific, with the aim of adding scientific knowledge to the field of study.

The sixth and final question which Finlay discusses is whether phenomenology is a modernist or postmodernist project or neither. The epistemological stance underpinning this study is that knowledge is situated, and temporary and multiple interpretations of reality can exist based on how it is interpreted (Malterud, 2012). Along with this, as mentioned in the initial section, subjective experiences exist to an extent that they can be shared through language, although with different interpretations. Studying and generating knowledge through the subject's experience is considered a valid focus of research. Therefore, this study can be considered as both or neither modernism nor postmodernism. This is supported by Finlay who argues while discussing phenomenology:

"We need to go beyond the lines drawn by both modernism and postmodernism embracing both and neither" (Finlay, 2009).

5.3 A collaborative approach

Traditional research into the treatment of mental health and substance use problems is considered by an increasing number of service users as disempowering, and poorly reflective of their priorities (Faulkner, 2004; Trivedi & Wykes, 2002). Previous studies have shown that users were not satisfied with the medical model that forms the evidence base for mental health research and services. This was due to the lack of consideration of contextual and social factors in users' everyday lives, resulting in unmet needs (Rose, 2009). Collaborative approaches in mental healthcare contexts with user involvement in qualitative research have gained particular importance over recent years (Beresford, 2003, 2013; Pettersen, Brodahl, et al., 2019; Veseth et al., 2017).

User involvement in research can extend to include: *identifying the focus of research and research questions; commissioning or buying research; seeking, obtaining and controlling research funding; undertaking the research; collating and analysing data; producing findings; writing up and producing publications and other outputs; developing and carrying out dissemination policies; deciding and undertaking follow-up action* (Beresford, 2013). The involvement of service users ranges from none to full involvement. Further, involvement in research has been identified at three different levels: 1) involvement in which the input from service users is added into the already existing projects, 2) collaborative research, in which service users and researchers jointly develop and undertake the project, and 3) service user-controlled research in which service users initiate and control the research (Beresford, 2013). My study is placed under collaborative research. Collaboration in mental health research with users, relatives and healthcare professionals who have first-hand experience and knowledge of the phenomenon under study arguably hold the potential of making studies more appropriate and more responsive to user needs (Pettersen, Brodahl, et al., 2019; Veseth et al., 2017). Further, it has been argued that research becomes more rigorous and relevant when it is informed by the lived experiences and first-hand knowledge of persons who themselves have lived with mental health problems (Rose, 2009).

Collaborative research is invaluable in bringing a different perspective to the research process, highly relevant to clinical practice and helps to improve the evidence base used to inform how services are provided (Beresford, 2003). The kind of collaborative approach used in this study is “mainstream interest in user involvement in research”, where the focus was on seeking and including the views of service users in the research process (Beresford, 2003), such as drawing up the interview guide, the recruitment process and the data analysis, while service users also had an important role in the dissemination of results. The theoretical grounds for collaborative research in this study are rooted in a person-centred approach. This is related to an increased recognition of service users’ experiences and information as an evidence source (Beresford, 2003), in addition to increasing the empowerment of the involved person (Beresford, 2013), and can strengthen the validity of the research. Thus a competency group was created and its contribution regarding the issues mentioned above is described in Section 5.4.2.

5.4 Procedure

This thesis is based on two studies. Study 1 sought to answer research questions 1, 2 and 3, while Study 2 sought to answer research question 4. In this section, the methods used in Study 1 and 2 will be presented in detail, along with ethical considerations. Methodological considerations will be presented in Chapter 7, the discussion chapter.

5.4.1 Setting and recruitment

The setting of this project was the two Norwegian cities with the highest proportion of immigrants in the population, namely Oslo and Drammen. The setting was considered appropriate because SSB Norway has provided data showing that although immigrants live throughout Norway, the greatest proportions are found in Oslo (22.4%) and Drammen (20.1%) (SSB, 2022). For Study 1, a diverse sample of immigrant men from low- and middle-income countries was recruited from these two cities. Further, for Study 2, health professionals were also recruited from these cities, since it was assumed that health professionals there had most contact with immigrants and experience of working with them.

5.4.2 The competency group

Collaborative research was considered of great importance in this study. Drawing on the theory of collaborative research mentioned in Section 5.3, a competency group of three was established. The initial aim was to recruit different groups affected by the study (Ness, Borg, Semb, et al., 2014), i.e. two users of immigrant background with experience of living with COP and of treatment in Norwegian mental health and addiction services, two relatives of users and two service providers with relevant experience. However, due to recruiting challenges and time constraints, only three members were included in this group. No service providers could be recruited into the group even after many attempts. It was therefore suggested by the research team to waste no more time on that, due to the limited time frame of the study.

Two members were previous service users with lived experience of COP, while one was a relative of a service user who was not part of my study. All three members were of immigrant background and had experiences, views and understandings of both their original local context as well as the Norwegian context (Ness, Borg, Semb, et al., 2014). The group advised me throughout the process. They participated in developing the research project in detail throughout the study, including the design of the interview guide and the data analysis, and they played an important role in the dissemination of results in their local context.

The group meetings were conducted four times in person in 2018 and 2019. In 2020, we had to conduct the three meetings online due to COVID-19 infection control restrictions. Eleven meetings were held in all. Face-to-face meetings lasted from two to three hours at a location chosen by the group members. The three online meetings lasted for approximately two hours. The meetings were held as reflective sessions and the interactions in the group were open and flexible. I made a deliberate effort to ensure that the process was guided by shared and supported decision making through regular dialogue with the group members (Ness, Borg, Semb, et al., 2014). This was also related to the development of commitment and trust in collaborative research (Barber, Beresford, Boote, Cooper, & Faulkner, 2011). I prepared the topics for discussion before every meeting, but the group members were also asked for their suggestions. I took notes during meetings and wrote summaries after each meeting, which were shared with the research team with the permission of the competency group.

Having a competency group as a form of user involvement is a way to empower the population of immigrants. Since the members themselves have experienced the disruptive events of migration, substance use and mental health problems, involving this group in research conducted on a similar can enhance empowerment. Moreover, I kept in mind that when person's decisions are valued, they feel a sense of autonomy and the essence of personhood (Pathare & Shields, 2012). This increases the possibility to live with self-respect and control over their lives and their engagement with society at large, and is especially true for persons with COP, who have to cope with varying degrees of life challenges (Davidson, Tondora, & Ridgway, 2010). This collaborative process thus forms the basis for respect, compassion and a sense of belonging (Anderson, 2012), especially when those involved are diverse and live differently, as is the case of persons of immigrant background.

Further, the idea of involving a competency group was also based on the value that the voices of the persons affected should be given power in the research. I made efforts to maintain power dynamics in the group by avoiding informal power structures (Toseland, Jones, & Gellis, 2004). After the first meeting, we had some informal conversations over coffee and dinner, which eased communication and trust among the group members and with me. The mutual trust became stronger when the group members shared their lived experiences with me of their own accord. They wanted me to gain an understanding of the context they came from, which they thought would be valuable in this research. However, there was a power imbalance within the group, as the process of collaborating within the group was guided by me as a researcher.

Further, in line with a person-centred approach (Rogers, 1961), I made a deliberate effort to communicate with an accepting attitude and to value their opinions and suggestions as much as my own. Moreover, I made efforts to keep my mind open and be reflective in the discussions in the group; I was thus mindful of my background and preunderstandings of the topics, while also being open to the understanding of the group members (Pettersen, Brodahl, et al., 2019; Veseth et al., 2017).

The suggestions from the group directly influenced the decision-making in several instances, such as the recruitment of participants (where this group played a key role as described in the recruitment section, 5.4.4.1), inclusion criteria, and the design of the interview guide. A few suggestions were not included in the study due to lack of feasibility within the study framework. One suggestion was to include an interview with a female participant, but this was not considered by the research team due to the lack of implications of the study because of a single female participant. However, the research team has decided to write a case study on a single interview held with a female participant on a later occasion as it was difficult to place in the time frame of the PhD project. Moreover, it was a highly informative interview and thus worthy of consideration for a case study.

The group was also involved in the data analysis process in order to bring multiple perspectives into the analysis, which created a wider analytical space (Malterud, 2012; Mjøsund et al., 2017). The group members were presented with the main themes and sub-themes and supporting text. They read this material and made notes prior to our meetings. During the meetings, the group members and I had reflexive discussions on the data. Each team member presented their perspective, which concurred with their own life experiences. I made notes of these discussions, including disagreements within the group. These notes (including the disagreements) were then discussed among the research team to arrive at common conclusions. Each group member provided insightful feedback during the analysis due to their unique life experiences and interests, enhancing it with multiple perspectives (Mjøsund et al., 2017), and thus helped to ensure the credibility of the study (Houghton, Casey, Shaw, & Murphy, 2013). After publication, they assisted in disseminating the results in their local contexts.

5.4.3 The use of interpreters

High-quality health research needs good communication between participants and researchers. Communication is challenging when the participants are not native speakers of the language of the researcher (Plumridge et al., 2012). Moreover, it is important to include non-native speakers (the participants in my study) in health research to address health inequalities and promote social justice. One of the approaches suggested in the literature is the use of interpreters, especially in qualitative research interviews (Plumridge et al., 2012). Since in-depth information is required, especially in phenomenology, active interpretation and reporting back to the researcher at certain stages are also needed. This is of particular importance in order to aim at giving participants as full a voice as possible by representing their views as accurately as possible (Kapborg & Berterö, 2002).

In this study, neither the participants nor I were native Norwegian speakers, although nine of ten interviews were conducted in Norwegian. The reason was that all the participants had good proficiency in the language as they had been living in Norway for many years. The participants were asked which language they preferred to use prior to the interviews and they were comfortable in speaking Norwegian, except for one participant who chose to speak in Punjabi, his native language. I conducted this interview in Punjabi since it was also my native language.

Although I had a good understanding of the Norwegian language, I did not want to lose any important information from the participants, and using an interpreter was therefore a linguistic necessity. Two different interpreters were recruited with the help of my research network at NK-ROP and NIPH. The initial plan was to use one interpreter for all the interviews but the first interpreter had to leave for personal reasons during the study, which further delayed the proposed plan of conducting interviews. It took some time to recruit a new interpreter and hence some important time was lost between these two recruitments. The first interpreter was involved in six individual interviews and the second interpreter in four individual and three focus group interviews. Both interpreters were also of immigrant background. The first interpreter, a male, was born in Norway and was fluent in both Norwegian and English. The second interpreter, a female, migrated to Norway 15 years prior to the interviews and was also fluent in Norwegian and English. Surprisingly, I did not find it very difficult to have two interpreters, other than the time lost to finding the second interpreter, as both interpreters were interested in the research topic and had good communication skills. Further, two different interpreters were not a challenge for the participants because each participant was interviewed only once.

However, involving interpreters also involved some challenges. I inevitably lost some control over the interviews. I had to rely on the interpreter to keep questions neutral and non-leading, in addition to having a conversation that was disjointed, less spontaneous, and difficult to use prompting. It was also difficult to identify misunderstandings between me and the interpreter or between the interpreter and the participants (Kapborg & Berterö, 2002; Murray & Wynne, 2001). Further, the issue of accuracy could not be guaranteed and it was expected that translation would limit the trans-lingual research (Squires, 2008). Therefore, decisions were made within the research team to balance the needs for in-depth data and valid data (Squires, 2008). Many discussions took place between myself and the interpreter on the style of active interviewing and asking open-ended questions to allow participants to express their experiences. The issue of confidentiality was particularly addressed, and both the interpreters signed a declaration of confidentiality before being recruited to the study.

Further, we discussed the context, aims and research questions of the study in detail, in addition to establishing a trustful relationship between the three of us (myself, the interpreter and the participant) during interviews. I discussed with the interpreter about how he/she saw his/her role and it was important that the interpreter made the environment as comfortable as possible by smiling and using appropriate body language to make sure that participants were relaxed and reassured. This was helpful because both the interpreters had an understanding of the community and culture of most participants (Plumridge et al., 2012). After the interviews, the interpreters provided reflections on the interviews and suggestions for dissemination of results after publication.

5.4.4 Sub-study 1

Study 1 consisted of two aims (Articles 1 and 2). The first was to explore the lived experiences of being an immigrant and living with co-occurring substance use and mental health problems in Norway. The second aim was to explore the experiences of immigrant men living with COP of treatment in Norwegian mental health and addiction services.

5.4.4.1 Recruitment

In view of the aims of this study, persons with lived experience of being an immigrant and treatment experiences from mental health and addiction services were to be recruited. This was in addition to diversity in gender, length of stay in Norway, length of contact with the services, and length of period of living with co-occurring conditions. The decisions on how to recruit the participants were discussed and taken with the competency group, and then agreed upon by the research team. A purposive, criterion-based sampling method (Patton, 2014), followed by snowballing, was employed to recruit participants from two cities in Norway. The inclusion criteria agreed upon were (a) persons of immigrant background from low- and middle-income countries, (b) having experience of living with co-occurring conditions, and (c) having experience of treatment in Norwegian mental health and addiction services. Further, it was decided by the members of the competency group not to consider the objective diagnosis, but rather how the participants understood their own mental health condition.

We initiated the recruitment by phoning and sending emails to leaders of various treatment and rehabilitation centres in these two cities. The treatment facilities were carefully chosen to ensure access to potential participants meeting the inclusion criteria. These leaders received detailed information about the project. Recruitment of participants meeting the inclusion criteria was more challenging than expected. We do not know exactly how many persons the team leaders invited to participate, but most of them refused to take part in the study. A few reasons for refusal mentioned by the leaders were lack of trust in the system including any research project, unwillingness to talk about their lived experiences with unknown researchers, fear of being detected in their small immigrant communities in Norway, and fear of stigma attached to SUP and MHP and seeking treatment for these problems. Only one participant who met the inclusion criteria was recruited via these leaders. I then phoned him to provide information about the project. Subsequently, by snowballing, he helped to recruit three more participants with whom he had contact. The competency group played a key role in recruiting further participants. Since the members of the competency group had contacts in their local communities, they helped in recruiting six participants. Potential participants were able to show interest by contacting me by telephone or text message.

5.4.4.2 Challenges during the recruitment process, and how these shaped this project

The recruitment of immigrants took longer than expected and planned, and there were several challenges involved that delayed the further plans of the project. The study recruited ten participants between June 2018 and March 2019.

The initial plan was to recruit three groups of participants: (1) young males and females (18-24 years), (2) relatives of these young immigrants, and (3) service providers working in specialist or primary mental health services or SUP treatment centres. However, there were challenges in the field and the recruitment strategy was changed accordingly.

Despite my plan to recruit young immigrants aged 18-24 years, this turned out to be impossible due to the difficulty of reaching to this “hard to reach” group. Therefore, the upper age limit was increased to allow for any participants aged 18 years or above.

In addition, I planned to recruit both men and women who met the inclusion criteria. However, recruitment was extremely challenging, even with men, probably due to the stigma attached to SUP and/or MHP. The participants stated that they knew there were many men and women with a similar diagnosis, but they did not want to come forward due to fear of being detected in their small communities in Norway. I argue that this holds true, especially for immigrant women with SUP and/or MHP, because of their different cultural norms and their perceived potential risk of greater harm if they were detected and identified. Moreover, due to their more hidden nature and fear of discrimination, immigrant women are less likely to report their SUP and/or MHP and thus remain camouflaged. I recruited only one female participant for interview who met the inclusion criteria, but found it impossible to recruit any more. Therefore, this study included only men (see also Section 7.2.1).

Further, in agreement with the research team, I decided not to continue with recruitment of relatives in this study, as this was not feasible in the limited time frame. I had tried hard by asking various organizations and even asked participants if their relatives would like to be interviewed, but without success. I was able to recruit only one relative, who was Norwegian but had adopted an immigrant boy who had COP. That interview was extremely informative and in consultation with the team I have decided to write a case study based on the interview, which will not be included in this thesis.

5.4.4.3 Participants

Ten participants who met the inclusion criteria were included in the study (Table 2). All were male, with an age range of 25 to 53 years. All of them had been diagnosed with COP and had experienced treatment in Norwegian mental health and addiction services. All of them were poly-substance users and the most common substances were cannabis, alcohol and heroin. Five of the ten reported not using substances at the time of interview, while the remaining five were using substances. The participants also reported having experienced MHP, most commonly affective disorder, post-traumatic stress disorder, personality disorder and anxiety. Eight participants reported having had suicidal thoughts and having attempted suicide.

Participants mentioned various reasons for initiating substance use including feeling a loss of identity between their native and Norwegian culture, being bullied and discriminated against at school and work and the feeling of being a victim. Further reasons were a traumatized childhood and an unstable family, feeling like an outsider at school, lack of motivation, peer pressure, physical abuse during childhood, familial expectations and rejections, war trauma and ready availability of substances.

Five participants were from the Middle East, while the others were from South Asia, and East and West Africa. Two participants were born in Norway, others migrated at a very early age, while two had arrived aged 21 and 24. All the participants had been using substances at an early age, eight after arriving in Norway, while the two participants who migrated at age 21 and 24 started at a young age in their countries of origin. All the participants had dropped out of treatment at least once and most had dropped out several times during their stay in Norway. All participants had treatment-seeking experiences in various mental health and/or addiction services, such as generic specialist service units, specialized units that collaborate closely with primary level services, residential addiction treatment based on AA or NA principles and detoxification units. Further, participants had both inpatient and outpatient treatment experiences, where the length of the treatment programme ranged from nine to twelve months, and some of the participants were still in treatment.

Table 2: Description of Participants

Participant	Age in years	Region of origin	Age at migration to Norway	Reason for migration	Age of substance use debut	Drop-out from treatment
1	33	Middle East	1.5 years	War/political refugee	12	Several times
2	42	West Africa	7 years	Family reunion	14	Twice
3	32	Middle East	5 months	War/political refugee	12	Several times
4	25	East Africa	16 years	War/political refugee	17	Once
5	30	African descent	12 years	Family reunion	17	Several times
6	38	South Asia	Born in Norway	Family reunion	12	Several times
7	29	South Asia	Born in Norway	Family reunion	19	Once
8	42	Middle East	11 years	War/political refugee	15	Several times
9	53	Middle East	21 years	War/political refugee	8	Several times
10	39	Middle East	24 years	War/political refugee	16	Several times

5.4.4.4 Data collection

An interview guide was created following a literature review and was then further developed in collaboration with the members of the competency group, in order to ensure that the questions were comprehensible and relevant to the participants' lived experiences. The final version of the interview guide was agreed upon by the research team and the competency group. It consisted of open-ended questions (for research questions 1 and 2) (appendix) about what it meant to live in Norway as a person of immigrant background living with co-occurring conditions, and (for research question 3) (appendix) what it means to be treated in Norwegian mental health and addiction services. Participants were asked to describe their own specific personal experiences in relation to these topics.

Ten semi-structured, in-depth interviews (Kvale & Brinkmann, 2009) were conducted between June 2018 and March 2019. After the tenth interview, the data were considered to be sufficient by the research team to fulfil the aim of the study. This was done using the concept of “information power”, which implies that the more relevant information the sample has, the smaller the number of participants needed (Malterud, Siersma, & Guassora, 2016). This can be justified in our study as the aim of the study was narrow and concerns specific experiences among a population with specific characteristics that is also a “hard-to-reach” group, which would in itself limit the number of eligible participants (diverse immigrant background, living with COP, treatment experience from Norwegian mental health and addiction services). Further, we believe that the participants have previously undescribed experiences, which has also enhanced the information power. In additions, there was strong and clear communication between myself and the participants, partly due to my being introduced by members of the competency group and partly because I have prior experience of conducting qualitative interviews. Moreover, after the tenth interview, the research team considered that data saturation had been achieved to enable the study aim to be reached. All the interviews were audio taped and lasted from 40 to 90 minutes. I conducted nine of the ten interviews in Norwegian with the help of the interpreter, while I carried out one interview in Punjabi and English alone. Interviews conducted in Norwegian were transcribed by the interpreter, while I transcribed the one conducted in English and Punjabi.

Immediately after each interview, the participants were asked to reflect on the interview and state whether there was anything they wanted to share beyond the context of the interview. Participants were then asked about the possibility of a second interview, which all of them refused due to reasons such as fear of being detected and stigma. Even though most participants described the interview as a positive experience, a few talked about recalling unpleasant memories, which they did not like to remember, but they were still pleased to have participated. The interviews were thus only conducted once. Participants were given my contact details to get in touch if they had any concerns, but none of them did. At the end of each interview, the interpreter and I sat down for a debriefing session to reflect on the interview and wrote notes about it. This enabled us to recall all the important information from the interview, some of which could have been missed otherwise due to recall bias (Liamputtong & Ezzy, 2005).

5.4.4.5 Data analysis

Within the aim of the study, the analysis had a combined inductive-deductive approach; PCH and cultural competence were used as theoretical background and inspiration, while the analysis was inductive in being based on the participants' descriptions. The transcripts were analysed using systematic text condensation (Malterud, 2012), which is a phenomenological approach inspired by Giorgi (Giorgi, 2009). This is an exploratory and descriptive method aimed at cross-case analysis, which enables a process of reflexivity, feasibility and intersubjectivity, while maintaining methodological rigour. Systematic text condensation is a stepwise procedure that involves the identification of recurring initial codes and themes relevant to the purpose of the study. In the first step, an overall impression was gained by reading all the transcripts, which resulted in initial themes. In the second step, meaning units were identified and sorted into code groups by systematically reviewing the transcripts. In the third step, the code groups with the meaning units were classified into subgroups. The fourth step involved the formation of artificial quotations by reducing the meaning units under each subgroup. An artificial quotation containing the participants' original wording was identified for each subgroup. The final step was to develop the analytic text and descriptions from the artificial quotations. The analytic text was reconceptualized by returning to the complete transcripts and reflecting on whether each illustrative quotation still reflected the original context. This process validated the analytic texts. At the end, the supporting quotes were added to the analytic texts.

5.4.5 Sub-study 2

Study 2 addressed aim 3, which was to explore health professionals' experiences of treatment engagement among immigrants with co-occurring conditions.

5.4.5.1 Setting and recruitment

The study was conducted in the two Norwegian cities previously mentioned. As these two cities have the highest proportion of immigrants, it was assumed that health professionals there had most contact with immigrants and experience of working with them. In order to obtain information-rich data, the study included health professionals working in three different types of service within Norwegian mental health and addiction services. These were a specialized MHP/SUP treatment centre, primary (municipal) healthcare, and a flexible assertive community treatment (FACT) team. Specialized MHP/SUP treatment centres provide diagnosis and treatment, including medication therapy and psychiatric and family therapy, with the aim of helping individuals to desist from substance use and improve their functioning in relation to health, work and family. Primary (municipal) healthcare services in Norway adhere to many of the recommendations for locally based healthcare. These include the provision of comprehensive healthcare, covering e.g. harm-reduction strategies such as needle exchange, opioid maintenance treatment and low-threshold services. Further measures are a recovery-oriented approach with a focus on activities, talk therapy for individuals and groups, while cooperation between specialist and primary healthcare is emphasized, as stated in the guideline of the Norwegian Directorate of Health (Helsedirektoratet, 2014). In addition, introduction programmes for new immigrants form part of primary healthcare services. Moreover, the municipalities in question offer mental health services based on recovery-oriented principles and feedback-informed treatment, as also stated in the guideline of the Norwegian Directorate of Health (Helsedirektoratet, 2014). FACT uses an assertive outreach approach to assist persons with mental health and substance use problems and their local communities, and is a specialist healthcare service that cooperates with primary healthcare (Van Veldhuizen, 2007).

Recruitment was initiated by emailing and calling the leaders of a number of teams working at various levels in Norwegian mental health and addiction services. These leaders received detailed information about the research project. They then sent the information to their team members and only those health professionals who were willing to participate in the study were included. The recruitment was strategic, aiming to recruit health professionals with experience of working with immigrants with co-occurring conditions in Norway. We were only able to recruit health professionals from the above-mentioned three different treatment services, as other teams contacted did not prioritize participation in the study due to lack of time and opportunity.

5.4.5.2 Participants

Study 2 included 19 participants. Twelve were females, seven were males and they were divided into three focus groups. Their ages ranged from 28 to 65 years and their experience of working with persons of immigrant background with COP ranged from one to 25 years. The participants had different professional backgrounds (Table 3), namely one psychiatrist, three psychologists, four specialist nurses, six general nurses, and five social workers. Sixteen of the 19 participants were ethnic Norwegians and three were of immigrant origin. FG 1 consisted of seven health professionals from the specialized MHP/SUP treatment team. FG 2 was composed of eight health professionals from primary healthcare, and FG 3 comprised four health professionals working in a FACT team.

Table 3: Participants' profession and distribution in the focus groups

Professional background	**Focus Group 1:** Specialized MHP/SUP treatment centre	**Focus Group 2:** Primary healthcare services	**Focus Group 3** FACT team	Total
Psychiatrist			1	1
Psychologist	2		1	3
Specialist nurse	1	2	1	4
General nurse	4	1	1	6
Social worker		5		5
Total	7	8	4	19

5.4.5.3 Data collection

Prior to data collection, an interview guide was created following a literature review and was then further developed in collaboration with members of the competency group, in order to ensure that the questions were comprehensible and relevant to the participants' lived experiences (appendix). The final version was agreed upon by all authors and the members of the competency group and consisted of open-ended thematic questions about experiences of providing mental health and addiction services to immigrants with COP. The data were collected through FG interviews, as that method was considered to be well suited to enquire about the participants' experiences, perceptions, desired goals and difficulties, and could provide a deeper understanding of their attitudes (Kitzinger, 1995). In addition, FG interviews assist in exploring phenomena and experiences that are incompletely understood and sensitive issues that may not be captured by the prevailing literature or by expert opinion (McLafferty, 2004).

Three FG interviews were conducted with health professionals between November 2019 and February 2020. The interviews took place at the participants' workplaces, at their convenience and during working hours. The interviews lasted between 60 and 80 minutes and were audio recorded. A moderator, who led the discussion, conducted the interviews in Norwegian. Two moderators were used to conduct these three FG interviews. The first one conducted the first interview and the second one, due to prior commitments of the first one, conducted the remaining two. The second moderator was also the interpreter, who transcribed all three FG interviews and translated them into English. I acted as an observer at all three interviews, concentrating on group dynamics and noting down thoughts that arose when following the dialogue. At the end of each interview, the moderator and I shared our reflections and later discussed them with the research team and the competency group. Data collection was considered complete, after several discussions in the research team, when it was considered sufficient to answer the aim of the study.

5.4.5.4 Data analysis

The approach to data analysis was combined inductive-deductive; PCH and cultural competence were applied as a theoretical background and inspiration, while the analysis was inductive in being based on the participants' descriptions. Systematic text condensation (Malterud, 2012) was used to analyse the interview transcripts. The process of data analysis was similar to that described for Sub-study 1 in Section 5.4.4.5. The analytic texts that resulted from the process of systematic text condensation were supported by quotes, which are presented in the "Results" section. In each step, all the co-authors were consulted, and discussions took place. In the final step, the competency group of experts by experience was consulted to provide an understanding of the results within the local context they represented.

5.4.6 Ethical considerations

The Declaration of Helsinki of the World Medical Association states that any medical research involving human participants is subject to ethical standards to protect the rights and health of the human beings involved in the research study and promote the utmost respect to the individual participant (WMA, 2001). The Declaration of Helsinki makes it very clear that any research conducted on human participants should primarily benefit the participant rather than the researcher and society as a whole. These guidelines, together with an understanding of the importance of ethical considerations for medical and social sciences research, were taken into account during the entire period of this study. Thus, ethical approval was sought prior to study start, participants and their experiences were respected, participation was possible for a group that is underrepresented in research, informed consent was taken, and risks and benefits were assessed prior to interviews. The research procedure was further designed based on the ethical standards of the Norwegian National Committee for Research Ethics in the Social Sciences and the Humanities (NESH, 2016).

5.4.6.1 Ethical approval

Prior to the beginning of the project, ethical approval was sought from the Regional Ethics Committee, which concluded that the project did not require approval from the committee (Case No. 2018/89) as it was not covered by the Health Research Act (Helseforskningsloven) (appendix). The study then received ethical approval from the Norwegian Centre for Research Data (Case No. 59707) (appendix).

5.4.6.2 Informed consent

During the recruitment and individual and focus group interviews, all participants gave their consent and were informed that they could withdraw from study at any time, without giving any reasons and without incurring any repercussions. Both oral and written informed consent were taken prior to the beginning of interviews. According to research ethics guidelines, persons of immigrant background and/or with substance use and/or mental health problems are considered as “vulnerable groups” (CIOMS, 2002). As a politically and often socially and economically marginalized group, they may not consider their participation voluntary (Barsdorf & Wassenaar, 2005). However, exclusion of immigrants from participation based on such factors may constitute a paternalistic overemphasis on the principle of autonomy, which allows for individual decision-making, and the principle of justice, which weighs the benefits against the burden of research across populations. In addition, not including these persons in research would be discriminatory as health services would not be informed of their treatment needs.

I also ensured that each individual participating in the study was genuinely informed about the research process by providing them with oral information about the project prior to the interviews. In addition, an information sheet containing information about the project was given to the participants before the interviews started. This information sheet was first developed by myself and my main supervisor, and was then shared with the competency group members to make sure that the information was simple to read and understand. The information sheet also contained my contact details and those of my main supervisor to enable participants to contact the researchers at any point in time. Permission to audio record the interviews was sought from each participant orally before the beginning of the interview. They were further informed about how the data would be stored and reported in the form of scientific publications.

5.4.6.3 Confidentiality

I ensured that the research did not jeopardize the anonymity and confidentiality of the participants. No information on names, addresses or locations of the interviews was mentioned in the publications, to safeguard confidentiality and make it impossible to trace the participants. Confidential information about the participants was not disclosed to anyone outside the research group, interpreters and the competency group. Both interpreters and the competency group members signed the confidentiality agreement. Further, the data were stored in a secure location provided by NK-ROP, Sykehuset Innlandet.

5.4.6.4 Risks and benefits

When conducting research on sensitive topics such as SUP, MHP and immigrant background, the risks of the research had to be considered in relation to potential benefits. The risks of studying these phenomena may be great and could cause unforeseen harm. Participants may have become distressed by recalling painful and life-threatening past experiences. This was also expressed by one participant. I tried to stop that interview to prevent him re-living the painful experience, but he wanted people to know his story and "why he did what he did" and that he was not solely responsible for his condition. My experience as a medical doctor is that talking about painful experiences is not necessarily risky and can be beneficial. In my clinical practice, I encountered patients who felt relieved after sharing their problems and painful experiences and this also improved our relationship. Moreover, debriefing at the end of the interviews enabled harm reduction. Further, participants expressed some sense of contribution and positivity, as their experiences could improve the situation of the group in question. I had also provided the participants with my telephone number and email address for any follow-up questions or reactions they may have had after the interviews. Another benefit of phenomenologically-oriented research is the ethical contribution; it may generate empathy and engagement for the persons who have had disruptive experiences in their lives (Natvik & Moltu, 2016).

5.4.6.5 Ethical considerations in the competency group

From the formation of the competency group to the end of this project, the group complied with procedural and person-centred ethics. This included signing the confidentiality agreement regarding discussion of sensitive information and data, in addition to sharing their personal experiences within the group.

However, certain ethical dilemmas emerged during collaboration with the competency group. They may be seen as vulnerable due to their prior lived experiences of SUP and MHP, and they may have had difficulty in understanding the informed consent and project information (Hem, 2015). Despite this, two of the group members who were previous users of substances described themselves as recovered from their problems and hence were at low risk of misunderstanding. Additionally, I tried to be as careful as possible to follow the principle of "process consent" during the whole process of collaboration with them (Braun & Clarke, 2006). The first half of the first meeting with the group was devoted to discussing the various ethical aspects such as confidentiality, risks and benefits and understanding the informed consent. Here, confidentiality applied to the participants and the members of the competency group. However, the group members were not concerned about their identity being anonymized and wanted to participate in any presentations of the results of the study. They even wanted me to share their photos if I presented my project in any scientific forums. By this they implied that they felt positive about being in a setting where they could help others with similar experiences. This could be related to the ethical principle of vulnerability stated by Hem, which is that if vulnerable voices are over-protected, it can lead to silencing these important voices in research (Hem, 2015).

6 Summary of articles

This thesis contains three qualitative research articles that answer research questions 1-4. Results from Study 1 are presented in Articles 1 and 2. Article 1 answers RQ 1 and 2, while RQ 3 has been answered in Article 2. Further, results from Study 2 are presented in Article 3, which answers RQ 4. Results from the three articles are presented sequentially, where I outline the aims, methodology, findings, and conclusion of each article, followed by a summary of all three articles together.

6.1 Article 1

Kour, P., Lien, L., Kumar, B., Biong, S., & Pettersen, H. (2019). Coping and Negotiating a Sense of Self: Immigrant Men's Experiences of Living with Co-Occurring Substance Use and Mental Health Disorders in Norway. American Journal of Psychiatric Rehabilitation, 22(1), 43-63.

This article is based on Study 1. The aim of this article was to explore the lived experiences of being an immigrant and living with co-occurring substance use and mental health problems. In-depth interviews with ten men were conducted and data were analysed using systematic text condensation. Three main categories, each with two sub-categories, of participants' experiences were elicited, with an overarching theme of how they coped and negotiated a sense of self. The three main categories where participants had to cope and negotiate their sense of self were (1) within the self, (2) within the surrounding culture, and (3) within the structures of society. Under the main categories were the sub-categories that revealed their experiences that necessitated coping and negotiating sense of self at each level. Further, the significant findings of "living a double life" and "cultural clash", along with a sense of belonging to a marginalized group but not to mainstream society, were described by the participants. In addition, participants described their experiences of racism at different levels and cultural stigma that led to a lack of trust in the context in which they were living. These findings were discussed in relation to previous studies on immigrant health, substance use and mental health problems and in light of mechanisms of coping and negotiating sense of self. This study highlighted understanding of how it is to be an immigrant living with co-occurring problems. Further, this study implies a need for immigrant-friendly policies that may reduce racism and stigma and may increase sense of belonging in the Norwegian context.

6.2 Article 2

Kour, P., Lien, L., Kumar, B., Biong, S., & Pettersen, H. (2020). Treatment Experiences with Norwegian Health Care among Immigrant Men Living with Co-Occurring Substance Use- and Mental Health Disorders. Substance Abuse: Research and Treatment, 14, DOI: *1178221820970929.*

This article is also based on Study 1. The aim of this article was to explore the treatment experiences of immigrant men living with co-occurring substance use and mental health problems. This article was based on the same data as Article 1, namely qualitative interviews with ten men. The interviews were analysed using systematic text condensation. The analysis resulted in six categories of participants' experiences with treatment in Norwegian mental health and addiction services: (1) lack of connection, (2) lack of individually tailored treatment, (3) stigma and discrimination preventing access to treatment, (4) health professionals with multi-cultural competence, (5) care during and after treatment, and (6) raising awareness and reducing stigma. Further, a significant finding that may increase treatment engagement was the value of being seen and treated as a "person" rather than as their diagnosis in treatment settings, followed by aftercare to prevent relapses. These findings were then classified and discussed as barriers (negative experiences) and facilitators (positive experiences) of treatment engagement in the light of previous literature on immigrant health, COP and person-centred theory. By analysing and presenting the experiences of the immigrants, this study adds to the existing literature on factors that can act as barriers or facilitators to treatment engagement. These experiences may increase the knowledge needed to improve treatment engagement in this group. The importance of immigrant men being seen as persons in a treatment context calls for policies focusing on more culturally tailored services.

6.3 Article 3

Kour, P., Lien, L., Kumar, B., Nordaunet, O. M., Biong, S., & Pettersen, H. (2021). Health Professionals' Experiences with Treatment Engagement Among Immigrants with Co-occurring Substance Use-and Mental Health Disorders in Norway. Substance Abuse: Research and Treatment, 15, DOI*: 11782218211028667.*

This article is based on Study 2. Its aim was to explore and describe health professionals' experiences with treatment engagement among immigrants with co-occurring substance use and mental health problems. Three focus group interviews were conducted with health professionals who had considerable contact with immigrants and experience of providing various mental health and addiction services. The data were analysed using systematic text condensation. Based on participants' experiences, five categories were presented in this article: (1) difficulties due to language barriers, (2) difficulties due to lack of a culturally sensitive approach and resources, (3) difficulties due to social factors, (4) being curious and flexible improves relationships, and (5) making mental health and addiction services available. The findings were then categorized and discussed as barriers and facilitators to treatment engagement, in the light of previous literature on immigrants' experiences with treatment settings, COP, person-centred theory and cultural competence in treatment. Thus, this article provides insights into health professionals' experiences with treatment engagement among immigrants with co-occurring problems. The article calls for resources to improve healthcare professionals' cultural competence, competent and professional interpreters and with policies focusing on more culturally tailored services.

6.4 Summary of the results

The above-mentioned three articles illuminate the experiences of immigrant men living with co-occurring problems and health professionals' experiences of providing treatment to this group. Articles 1 and 2 explore the coping and treatment experiences of immigrant men living with COP, while Article 3 explores the experiences of health professionals with considerable contact with immigrants living with COP and thus experience of providing services to them.

The participants described how it is to be an immigrant and live with co-occurring problems in the Norwegian context. Migration was a challenging process for them and settling in a new country had difficult consequences that caused their COP, where they had to cope and negotiate their sense of self at the three different levels of self, the surrounding culture and society. Experiences of cultural clash, stigma and racism had further exacerbated their substance use and they had to live with a burden of a double life within their families. Gaining a sense of belonging in a similar group to themselves helped them to forget the pain and fear they were facing as immigrants using substances. However, they lacked a sense of belonging in mainstream Norwegian society.

These experiences also shaped their treatment engagement in Norwegian mental health and addiction services. Further, they recounted both negative and positive experiences of receiving treatment. Poor connection with health professionals leading to a lack of tailored services, along with discriminatory experiences, acted as a barrier to engaging in treatment. The value of being seen as a person, not merely as a diagnosis, was described as a facilitator for engaging in and completing treatment. Aftercare was described as an important factor to prevent relapses.

With regard to health professionals' experiences, cultural competence was clearly lacking in treatment strategies. They described their helplessness at being unable to engage patients of immigrant background due to language barriers and lack of expertise in culturally tailored services. Further, the lack of available resources such as official courses, training or guidelines on cultural sensitivity in treatment programmes acted as a barrier when approaching patients with immigrant backgrounds. There were also insufficient competent and professional interpreters, which affected building trustful relationships with these patients. However, individual differences of being curious about the patient and finding flexible ambulatory treatment approaches could be a facilitating factor in increasing the treatment engagement of immigrant patients.

The findings of the studies suggested a need for joint efforts by both persons of immigrant background and health professionals in order to facilitate treatment engagement and completion. There is a need for a shift in health policy towards more culturally competent and person-centred healthcare in Norway.

7 Discussion

The overall aim of this thesis was to explore the coping and treatment experiences of immigrants living with co-occurring substance use and mental health problems in Norway, from the perspective of immigrants and health professionals. This study adds to the existing literature on the lived experiences of persons of immigrant background living with COP, and may provide a deeper understanding of COP among immigrants and form evidence for improving the services for this group, especially in the Norwegian context.

To achieve the overall aim, four specific research questions were constructed and answered across three articles. The findings in the sub-studies have been discussed in detail in each article. Therefore, in this chapter, I will only focus on discussion of the significant findings of both sub-studies in the light of existing literature and theory, in three subsections. Finally, the last part of the discussion will focus on the methodological considerations.

7.1 Discussion of results

7.1.1 Immigrants' coping and negotiating sense of self when living with COP

While exploring the lived experiences of being an immigrant and living with co-occurring problems, new insights into the experiences of this group were revealed. The participants described their experiences of coping and ways in which their sense of self was negotiated within their own selves, the surrounding culture, and society. They experienced fluctuating feelings of being an immigrant and living with COP. I will discuss their descriptions in terms of individual (7.1.1.1), cultural (7.1.1.2), and structural (7.1.1.3) factors.

Further, participants' descriptions point out the need for health promotion in this group. "*Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment"* (WHO, 1986). I will therefore shed some light on the individual, cultural and structural factors with regard to three of the five principles of WHO's Ottawa Charter for Health Promotion, 1986, namely development of personal skills, creating supportive environments and reorientation of health services (WHO, 1986).

7.1.1.1 Individual factors

The participants highlighted experiencing a clash between their own and Norwegian culture, which led to their inner conflict with themselves. The challenges of assimilating into the dominant culture, especially when the dominant culture does not welcome diversity, can lead to substance use among immigrants (Dalla et al., 2009). This hypothesis is in line with participants' experiences of a clash as living at the juncture of two cultures, using substances to cope, and finding ways to negotiate their sense of self between two cultures. This is further associated with negative consequences such as family conflicts, intergenerational conflicts and societal pressures (Torres & Rollock, 2009), which can be even more difficult for immigrants who are refugees from conflict-prone areas and thus likely to be dealing with their own trauma. This clash among individuals can be understood via cultural conflict theory, which states that conduct norms vary among cultures, where an action may be a violation of norms in one culture, but not in another. This poses a potential for cultural conflict when the dominant culture sets the standards for acceptable behaviour and considers those who do not comply with these norms to be deviant (Henderson, Greene, & Gabbidon, 2009), which is in line with participants' descriptions in our study, often leading to inner conflicts.

Dalla and colleagues argue that assimilation into a new culture may create family conflicts due to different rates of acculturation between parents and children. This can lead to significant tensions between them including personal distress, delinquent behaviour, and substance use (Dalla et al., 2009), which also agrees with the participants' descriptions. Participants described how experiences of family conflicts, including a sense of a lack of love, support and communication led to substance use and problematic behaviour as early as adolescence. This finding is similar to that of a study of immigrant Latino families (Marsiglia, Kulis, Parsai, Villar, & Garcia, 2009) that showed how family conflicts and low family cohesion predicted lifetime use of substances. The study found that binge drinking was problematic among adolescent immigrants who were trying to navigate between two different cultural worlds. Further, it demonstrated that when these adolescents did not have any positive coping strategies to reduce mental distress caused by family conflicts and tensions, they resorted to substance use and problematic behaviour, including rejecting family values in the form of rebellion, as experienced by our participants. A similar relationship to MHP as in our study was reported among Latin Americans where they blamed family dynamics for their mental health problems (Barrera, Gonzalez, & Jordan, 2013).

Furthermore, the culture clash experienced by the participants resulted in feelings of guilt, shame and harmful thoughts. They described struggling with these negative emotions due to their self-perceived inability to fit in with the norms of society. They described taboos attached to the use of substances and having mental health problems, which together with their immigrant background made it difficult for them to share their feelings about the problems they were facing. They described this as keeping these negative emotions inside even though they were suffering, which led to inner conflicts. Such experiences are associated with low self-esteem, which often results in social devaluation and rejection. Low self-esteem is also shown to be strongly related to a variety of psychological difficulties and substance abuse (Leary, 1999), which also concurs with our findings. Furthermore, a study on harm reduction and tensions in trust and distrust in mental health settings reported that distrust was more prevalent than trust in the participants' reports (Lago, Peter, & Bógus, 2017), which is consistent with the findings of our study in which participants struggled to trust anyone. Dalla and colleagues noted that when such negative emotions become unbearable, using substances becomes the coping mechanism and also a way of expressing frustration, anger and distrust (Dalla et al., 2009).

Because of the culture clash, experiences of racism (discussed in 7.1.1.3) and lack of acceptance in either of the two cultures where they lived, participants struggled with a poor sense of belonging. However, they felt accepted and found a sense of belonging within groups of substance users with similar problems. In these groups they found inclusion and were seen as being of value, in line with the study by Dalla and colleagues, who further suggested that these groups function at the periphery of society and adopt substance use as a method of socialization within the new culture (Dalla et al., 2009). Moreover, they are less likely to seek the mental health treatment they need due to the feeling of solidarity they want to display in these groups, while they feel a lack of inclusion elsewhere (Sandøy, 2015).

The above-mentioned experiences of the participants, such as inner conflicts, a feeling of shame, and negative and harmful thoughts call for the development of personal skills in the individual, in order to support health promotion (WHO, 1986) among such individuals. Personal and social development could be supported by making relevant information easily available, educating persons about health, and improving their life skills. In this way, these persons would have more options to exercise control over their health and the environments they live in, and would thus be able to make choices conducive to better health. Further, the Ottawa Charter states that it is essential to enable persons to develop personal skillsets to cope with chronic problems, which I argue holds true for COP among immigrants too. Enabling immigrant-friendly environments and collaboration between various institutions in the health, education and commercial sectors (WHO, 1986) may improve the health outcomes of immigrants living with COP. Furthermore, I argue that health promotion among those living with COP can be attained through recovery processes which may aid in developing personal skills and improving quality of life regardless of the cure (Davidson et al., 2007). A recent study found that persons with COP described recovery as mastering life and emerging as a person, coming to love oneself and feeling useful and accepted (Brekke et al., 2017).

7.1.1.2 Cultural factors

Participants described their experiences of the surrounding cultural context that made it difficult for them to access sorely needed help. One of the significant findings of the study was when participants described the experiences of “living a double life”, in which they behaved soberly in front of their family and relatives but continued to use substances or seek treatment that they concealed from others. This expression was used in relation to the cultural stigma associated with having substance use and/or mental health problems within their communities. It was further described as stressful to be constantly wearing a mask of sobriety in front of their families and small communities in Norway. They coped and negotiated their sense of self by keeping their substance use secret, and when they were seeking treatment, they were forced to lie about leaving home and going to work outside Norway for a period of time, so that nobody would know that they were in treatment centres.

Substance use problems and mental health problems consistently rank among the most stigmatized conditions (Room, 2005; WHO, 2003). Cultural beliefs have a great impact on perceptions of substance use and mental health problems. In most places, the culture determines how persons understand and deal with these conditions. Chen and Farruggia documented that persons with conservative thinking often view these conditions as stigmatizing and avoid those living with them (Chen & Farruggia, 2002). This is similar to our finding of cultural stigma as experienced by the participants, who described the fear of being discovered by their communities and expelled from families that attach stigma to substance use and mental health problems.

Culture significantly contributes to the practices, meaning and outcome of stigma; examples are viewing a person with MHP as violent or dangerous or perceiving psychiatric medicines as harmful and addictive (Yang, Thornicroft, Alvarado, Vega, & Link, 2014). In a recent systematic review on the cultural aspects of stigma and mental health problems among different immigrant groups in the USA, Misra and colleagues reported that stigma tended to be higher in all immigrant groups than in the white American population. They also found that cultural stigma may lead to concealment of MHP for the sake of one's family, with a fear of being a burden and negative emotional responses leading to self-stigma and service barriers including access to and quality of treatment (Misra et al., 2021).

Further, lack of family support not only contributed to substance use but also prevented the participants from accessing treatment, in addition to the cultural stigma they had experienced. The participants grew up in communities where substance use and MHP were highly stigmatized and were kept hidden. The concealment of MHP and treatment have been reported in previous studies of immigrants, where failure to do so led to worsening of stigma (Chen, Lai, & Yang, 2013; Jones, Hopson, Warner, Hardiman, & James, 2015). Families collectively experienced stigma as one family member having MHP may be perceived as a failure of the entire family in their communities, which led to social isolation and reduced support from community members (Lin, 2013; Yamada, Vaivao, & Subica, 2019). Therefore, family members often discouraged treatment for MHP, which delayed seeking of help, hindered treatment adherence, and meant that the individual had to cope alone even though he/she was willing to seek help (Martinez, 2017; Pinedo et al., 2018). Further, immigrants living with MHP often feel a burden to their families when they do not receive care from family members and feel rejected due to their inability to meet the expectations of their family (Han, Cha, Lee, & Lee, 2017; Lin, 2013; Martinez Tyson, Arriola, & Corvin, 2016), which is in line with our findings.

Jones and colleagues reported that cultural beliefs among African American women lowered access to treatment as taking psychiatric medications was perceived as unsafe and having MHP was not congruent with their cultural role of a "strong black woman" (Jones et al., 2015). This may be exacerbated even more in the case of men in most cultures, where they are expected to have a strong image which becomes distorted by having SUP and MHP. Further, stigmatizing attitudes towards antidepressants have also been reported among Latin Americans and perceived as not culturally acceptable along with implications of personal failure (Vargas et al., 2015).

Furthermore, cultural stigma is often associated with negative emotions or leads to such feelings among immigrants living with MHP, such as the fear of being perceived as “crazy” or “dangerous”, or labelled as “mentally ill” and rejected or discredited (Carpenter-Song et al., 2010; Yamada et al., 2019). This often leads to lower self-confidence, frustration and self-perception as a useless or weak person, a failure or a person of poor moral character (Fancher, Ton, Le Meyer, Ho, & Paterniti, 2010; Martinez Tyson et al., 2016). African immigrants described this as “double discrimination” of being an immigrant and having MHP (Alang, 2019), which is similar to our findings. In order to cope with these negative feelings, immigrants conceal their MHP, deny and isolate themselves, and use substances (Fancher et al., 2010; Jones et al., 2015; Martinez, 2017; Yamada et al., 2019). Another coping response was refusing to receive mental health treatment with the knowledge of their families and communities to avoid negative stereotyping (Jones et al., 2015), which has also been described by our participants.

Stigma has been identified as a major barrier to accessing treatment for SUP and MHP among immigrant communities (Douglass et al., 2022). Experiences of stigma prevented the participants from accessing treatment when living in small communities in Norway, which has been reported in previous studies stating that stigma regarding seeking treatment for SUP and MHP was a significant barrier to joining treatment programmes. Among immigrants, these problems are often viewed as a sign of weakness, shame, or a lack of willpower, which often results in ambivalence about seeking timely help; either the person delays or does not seek treatment at all (Derr, 2016; Fong & Tsuang, 2007; Salami et al., 2019; Yorke et al., 2016).

To counter these cultural factors such as cultural stigma, I argue that it is essential to create support environments for these persons, which can lead to health promotion. The (mental) health of a person is directly linked to the environment he/she is living in, and there is thus a need for “reciprocal maintenance”, i.e. taking care of each other, communities and the environment (WHO, 1986). Creating a supportive environment by maintaining positive social relationships with one's family, peers and HPs has been described as helpful for engaging in the SUP treatment and recovery process, and thus in health promotion (Pettersen, Landheim, Skeie, Biong, Brodahl, Oute et al., 2019). Further, having positive family support and identification of mental health treatment as essential for the person with MHP along with positive experiences with services have been reported to reduce cultural stigma, thus also reducing social isolation (Hines-Martin et al., 2003; Lindsey, Joe, & Nebbitt, 2010). Additionally, those who have more positive feelings towards their families have also been reported to engage more in substance use and mental health treatment. Positive feelings about one's family may be a sign that the person living with COP is being given support, especially emotional support, which can be reflected as being accepted, understood and valued by the family. Brown and colleagues argue that these positive feelings are integral to treatment engagement among persons living with COP and connecting supportive family members at the beginning of treatment may help these persons to stay engaged in treatment (Brown, Bennett, Li, & Bellack, 2011). Further, a supportive network of family and peers allows the individual to be open with them, enable help- seeking behaviour and a feeling of inclusion (Derr, 2016; DeSa, Gebremeskel, Omonaiye, & Yaya, 2022; McCann, Mugavin, Renzaho, & Lubman, 2016; Salami et al., 2019), which our participants also found would increase treatment engagement. Another study among Somali immigrants with MHP in Norway found that they emphasized that in their culture it is required to obey and follow the views of elders, including older family members and spiritual leaders, and these authorities thus seemed to be the "gatekeepers" for accessing mental health services. Hence, the study inferred that involving the ethnic community including spiritual leaders in treatment programmes would increase treatment engagement in addition to reaching immigrant patients in need (Markova & Sandal, 2016).

7.1.1.3 Structural factors

Experiences of racism and being labelled due to immigrant background, substance use history and mental health problems have been documented in the literature (Abdullah & Brown, 2011; Dalla et al., 2009; Flores et al., 2008; Pascoe & Smart Richman, 2009; Sandberg, Saasa, & Yirenya-Tawiah, 2022; Visser, Ikram, Derks, Snijder, & Kunst, 2017). The study participants also described similar experiences in different societal structures, such as schools, workplaces, state welfare services and the healthcare system. Immigrants with mental health problems often face few or no opportunities and decreased access to resources because of racism practised by employers who tend not to give them jobs and by landlords who are less inclined to rent them accommodation. Such racist attitudes deprive them of the chances to fully integrate and participate in mainstream society (Abdullah & Brown, 2011). Their coping response to such experiences is often leaving their ethnic group, and a feeling of embarrassment with their cultural background, including parents (Dalla et al., 2009), which was described by the study participants as coping with racism by hating their family and culture and using substances more than before.

Experiences of racism based on immigrant status have been reported previously, causing stress (Flores et al., 2008; Swim & Stangor, 1998), that may lead to mental health problems and/or even exacerbate existing mental health problems (Pascoe & Smart Richman, 2009). The use of substances then often becomes the coping response in such stressful experiences (Wills & Hirky, 1996), in line with the participants' descriptions. Over time, substance use becomes a problem and may increase mental health problems. Racism was significantly associated with increased risk of SUP among immigrants in several studies (Otiniano Verissimo, Gee, Ford, & Iguchi, 2014; Sandberg et al., 2022; Visser et al., 2017).

Further, participants described experiences of racism as being looked down upon and facing difficulty in finding jobs, which may be an indirect form of social exclusion. A racialized identity and immigrant status pose a high risk for social exclusion, which is further increased by social and economic disadvantage, leading to greater SUP. A recent study among African Americans showed that higher social exclusion significantly increased substance use through a perceived racial discrimination pathway (Sandberg et al., 2022). The consequences of employment concerns, social isolation, stress, racism (based on immigrant status and negative stereotyping of the person's origin) and mental health problems place immigrants at greater risk for severe substance use problems (Akinsulure-Smith, 2017; Assari, Lankarani, & Caldwell, 2018; Meyer, McKenny, Liddell-Quintyn, Nicolas, & St Louis, 2021).

This relationship is further expounded upon in terms of stress-coping mechanisms, where it is stated that these negative social events and chronic exposure to minority stress can increase the risk of maladaptive coping strategies and poorer health behaviour, resulting in adverse health outcomes (Lazarus & Folkman, 1984). These assumptions have been documented in studies among immigrants of African origin in the USA (Assari et al., 2018; Gerrard et al., 2012) and immigrants in the Netherlands (Visser et al., 2017), which found that racism predicts higher SUP and is a significant predictor of social exclusion. These experiences of minority stress, aided by racism, persistent life problems and social exclusion, suggest that SUP are situated within social processes and structural forces and not solely in the person (Sandberg et al., 2022).

Experiences of racism often lead to distrust of the system among immigrants, as described by the participants. Straiton and colleagues, in a study of the role of moderating factors such as trust in perceived racism and mental health in Norway, reported that immigrants with low levels of trust have increased odds of mental health problems when experiencing racism in the system (Straiton, Aambø, & Johansen, 2019). It is not surprising that immigrants have often endured racism and tend to have little trust in various institutions in the country of arrival (De Vroome, Hooghe, & Marien, 2013). Racism is likely to be one of the salient predictors of trust because it is external events and experiences that shape a person's ability to navigate life in broader society. Therefore, due to these previous experiences, immigrants can never be sure of when or where such experiences will occur again, and those who have experienced racism must always be on their guard as a protective mechanism and thus cannot afford to trust others (Rothstein & Uslaner, 2005). Studies that have considered the relationship between racism and trust among immigrants have found that racism affects trust in various institutions, such as lack of trust in Finnish authorities in seven immigrant groups (Liebkind & Jasinskaja-Lahti, 2000), and lack of trust in the police among Somali immigrants in Finland (Kääriäinen & Niemi, 2014). Another study on immigration, trust and racism reported that racism explains the trust gap between immigrants and native-born persons and is a complex relationship (Wilkes & Wu, 2019). This is similarly described by the participants as their inability to trust anyone because of living in a context quite unlike their country of origin, being bullied due to their immigrant background and having experienced war. Carrying this baggage of doubts and suspicions was described by the participants as burdensome and exhausting. This may imply that racism can add to their existing baggage and may become one of the reasons for using substances to cope and negotiate their sense of self.

Further, participants also described experiences of racism in healthcare settings. Diop and colleagues have called racism in healthcare an ongoing public health crisis and a fundamental determinant of health and illness (Diop et al., 2021). Hence, there is a need to reorient health services in order to achieve health promotion. Health services have to work beyond providing clinical and curative services. This involves implementation of a mandate that respects and is sensitive to cultural needs. Further, reorienting health services requires changes in professional education and training, which can reinforce a change of attitude and organization of healthcare, ultimately focusing on the needs of the individual as a whole person (WHO, 1986). It can be argued that such training and educational programmes for HPs should also focus on how racism can affect the health of an individual and what measures can be taken to avoid intentional and unintentional racism in healthcare settings.

Furthermore, Diop et al. argue that the healthcare system has a crucial role in dismantling racism by implementing innovative solutions that can promote diversity and health equity and address social determinants of health. HPs can be aware of their own behaviour and can support immigrant patients by discussing their previous experiences of racism, which in turn will promote PCH by valuing patients and engaging them in meaningful dialogue around racism (Diop et al., 2021). However, discussing experiences of racism can be traumatizing for some patients; training HPs in how to discuss racism would therefore provide them with knowledge and skills to protect patients and converse on this topic with respect (Dueweke, Hanson, Wallis, Fanguy, & Newman, 2019). I would further argue that it is important for HPs to be aware of racism in treatment settings because racism is a violation of HPs' code of ethics that aims at equitable care provision as a form of social solidarity.

7.1.2 Barriers and facilitators of engagement in COP treatment through immigrants' eyes

In this part of Sub-study 1, the treatment experiences of immigrant men living with COP in Norwegian mental health and addiction services were explored. The experiences described by the participants were classified into two major insights, as negative and positive experiences. Negative experiences acted as barriers and reduced treatment engagement, while positive experiences functioned as facilitators and enhanced treatment engagement. I will discuss these findings as barriers and facilitators below.

7.1.2.1 Barriers

The participants described experiences of not being treated as a person in treatment settings and felt discouraged to continue the treatment, implying lower treatment engagement. Being seen as a person was described as being valued and respected for who they were, which included their immigrant background and life history. Having been through a series of disruptive events in life (e.g. immigration, living with SUP and MHP), their coping and sense of self were shaped accordingly. They described how topics that were important to them had not been discussed in treatment, such as their migration process, initiation of substance use and coping with stigma and discrimination in community and treatment settings. They also emphasized that they felt of little worth as a person when the talk in treatment only focused on their diagnosis and symptoms, resulting in lower treatment engagement. This could be understood in terms of Cassell's definition of "person" in medicine, which involves understanding an individual as a person in clinical settings, based on the meanings of the person's actions (Cassell, 2010), through an understanding of the values and beliefs of that person in a particular social context (Mjølstad et al., 2013). Furthermore, relating to a patient with COP as a person may help the patient to feel valued, which may enhance treatment engagement (Ness, Borg, & Davidson, 2014).

In addition, participants described their experiences of lack of connection with health professionals, such as negative past encounters where the HPs demonstrated little interest and attention in the treatment sessions, which decreased treatment engagement. This is similar to the findings of a literature review that found that immigrant status and having COP were associated with lower treatment engagement. It was further found that patients dropped out of treatment as they felt they were not being listened to and did not participate in treatment decisions, again leading to lower or no treatment engagement (O'Brien et al., 2009). Furthermore, previous studies have reported that many immigrants are reluctant to seek treatment for SUP and MHP, often resulting in poor health outcomes and longer duration of untreated problems (Fong & Tsuang, 2007; McCann et al., 2016). This reluctance could be explained by an inability to develop trust in services because of unfamiliarity with how these services work (Sandhu et al., 2013), in addition to past negative experiences in treatment settings (Falgas-Bague et al., 2019). Moreover, the participants revealed that the situation worsened when they had to wait longer to start treatment, leading to more substance use and relapses, which is also reported by Pinedo and colleagues as a logistical barrier to treatment (Pinedo et al., 2018).

Another barrier that overwhelmingly shaped participants' decisions not to receive, or be less engaged in, treatment was the lack of culturally competent services tailored to their specific needs in relation to language and cultural beliefs values, as also reported in previous studies (Fante-Coleman & Jackson-Best, 2020; Fong & Tsuang, 2007; Pinedo et al., 2018; Yorke et al., 2016). Miscommunication and misunderstandings of patients' typical and acceptable behaviour occur when health professionals lack the skills of cultural competence (Sandhu et al., 2013). This often leads to neglect of discussions on important contextual factors, such as immigration and discrimination in previous treatment settings that failed to incorporate the person's culture and belief system, resulting in lower treatment engagement (DeSa et al., 2022; Pinedo et al., 2018) and further isolation of these populations (Donnelly et al., 2011). Previous research has documented that some immigrant patients may mistrust Western medicine and hesitate to adopt this form of treatment because of its cultural significance (Donnelly et al., 2011). In addition, immigrant patients have had lower engagement due to the westernized medical model and the failure to incorporate their culture and belief system (Smith et al., 2019). Furthermore, a treatment programme of 12-step support group therapy did not function well with the participants as they felt that the group members were mismatched with regard to age, language and duration of using substances. They also described difficulty in expressing emotions and sharing private information within such groups and therefore showed lower treatment engagement, similar to the findings in a study on Asian immigrants in the USA (Fong & Tsuang, 2007). An associated factor is the lack of individually tailored services for immigrants, which decreases their treatment engagement. This might be due to the manual-based and standard trend of knowledge-based practice currently followed in mental health and addiction services, which may lack individualization and cultural sensitivity in treatment approaches.

In addition, the participants mentioned experiences of discrimination and unfair treatment from HPs, which reduced their treatment engagement. This resulted in a higher risk of relapses and of severe mental health problems (Gee, Delva, & Takeuchi, 2007; Salami et al., 2019). Such experiences of discrimination at structural level could be explained by Foucault's biopolitics and state racism, where biopolitics refers to the social control and power disseminated through social structures such as healthcare, which is regarded as the norm. This gives rise to state racism, which becomes one of the basic dimensions of social normalization (Foucault, 1977), focusing on the superiority of the dominant culture over others who are culturally different from the majority. Such types of racism at structural level that prevail in European healthcare are normalized and often enacted through invisible, subtle practices by HPs (consciously or unconsciously) that lead to unequal access to treatment (Hamed, Thapar-Björkert, Bradby, & Ahlberg, 2020). This further results in perceived racism, as mentioned by the participants in the form of different treatment from ethnic Norwegians, and is associated with a lack of trust in healthcare, which prevents immigrants from seeking necessary and timely treatment.

7.1.2.2 Facilitators

The UCL-Lancet Commission on Migration and Health has called for universal and equitable access to healthcare for all, including immigrants (Abubakar et al., 2018). This infers that knowledge of the health of immigrant groups is needed to identify unmet needs and reasons for not receiving adequate mental health treatment (Alang, 2015), in addition to developing and facilitating existing healthcare (Bhopal, 2013). This knowledge could perhaps be gained from the positive experiences of immigrants themselves, such as in this study, in order to improve treatment engagement. The participants mentioned that receiving treatment from HPs who were culturally competent facilitated their treatment engagement as their needs were understood during the counselling and healing process. Previous studies (Masson et al., 2013; McCann et al., 2016), including review studies (Abebe, 2010; Fante-Coleman & Jackson-Best, 2020) have similar findings, namely that HPs who were sensitive to cultural nuances were able to engage immigrant patients in treatment. This could be seen in the light of an approach called interculturalization of mental health services, which includes adopting treatment in accordance with the patient’s cultural contexts and needs (De Jong & Van Ommeren, 2005). Furthermore, a recent systematic review has also highlighted the need for culturally sensitive resources in mental health services (DeSa et al., 2022).

The participants described having positive experiences with HPs of immigrant background, which is in line with previous research (Salami et al., 2019), especially if the

HPs also had an understanding of Norwegian culture. HPs familiar with both the participants' culture and Norwegian culture gave the participants a feeling of being understood and heard in treatment. Similarly, a recent review found that ethnic matching between immigrant patient and HP was a facilitator since immigrants were more likely to engage in mental health treatment when their HPs were of similar ethnic/cultural background (Lu et al., 2021). Additionally, some of the participants had experienced trauma in a war zone and stated that HPs with experience of war trauma motivated them to complete treatment along with giving them a sense of belonging. This therefore also facilitated treatment engagement.

Further, several participants found it positive to be seen as a person, not a diagnosis, when in treatment. In addition, their treatment engagement increased when their needs were understood based on their culture, values and beliefs. This is similar to the approach of person-centeredness and individualization of SUP treatment services (Friedmann et al., 2004; Hser et al., 1999), which is now part of the national guidelines for SUP treatment (Helsedirektoratet, 2017; NIDA, 2018). In a Norwegian study, participants' narratives revealed that HPs who used "personal connection" and viewed them as persons beyond their substance use problems were considered facilitators of treatment engagement (Pettersen, Landheim, Skeie, Biong, Brodahl, Benson, et al., 2019). Similar findings have also been suggested in a review study, which found that a good therapeutic relationship between immigrant patients and HPs enhanced treatment engagement (Lu et al., 2021).

Furthermore, participants acknowledged aftercare as an important factor that can prevent relapses and improve treatment outcomes. Aftercare could be understood as long-term monitoring and support in treatment of SUP (Pettersen, Landheim, Skeie, Biong, Brodahl, Benson, et al., 2019) and could be individually tailored to the needs of persons of immigrant background. Additionally, aftercare could be seen as follow-up care in treatment models which allows individuals to cope and regain a meaningful life when they are no longer in treatment settings, along with having a sense of being a contributing member of their community (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). This process can also help to overcome stigma by developing resilience toward stigma and/or actively fighting against it and can provide persons with SUP and/or MHP with a sense of empowerment and control over their lives by enabling them to exercise their rights and duties like other citizens (Davidson et al., 2007).

Participants' descriptions also revealed that awareness about the consequences of COP can enhance treatment engagement. They reported that they knew many users of substances who were unaware of the availability of care and treatment and thus could not start treatment. One recent systematic review highlights that awareness of available treatment among immigrants living in high-income countries was identified as a facilitator for engagement (DeSa et al., 2022). Further, Fong and colleagues suggested an alternative 12-step group programme focusing primarily on support and education and less on confrontation, which would thus facilitate treatment (Fong & Tsuang, 2007), and is in line with the participants' experiences. In addition, immigrants' perceptions of the need for treatment were dependent on social embeddedness (McCann et al., 2016), hence strategies that may help in reducing stigma in their social context and raising awareness may help immigrant patients to engage in treatment. In a qualitative study among immigrant women, the participants indicated that having written resources in their own language and making them available at places such as community centres was a facilitating factor for mental health treatment (Donnelly et al., 2011).

7.1.3 Barriers and facilitators of engagement in COP treatment through health professionals' eyes

In this section, I will discuss the findings of Sub-study 2, in which health professionals' experiences with treatment engagement among immigrants with COP were explored. The HPs described their experiences as both challenging and positive. I will discuss these experiences as barriers and facilitators of treatment engagement below.

7.1.3.1 Barriers

Difficulties arising due to language barriers were described by participants as challenging, often leading to problems in understanding immigrant patients, miscommunication, inadequate diagnosis and treatment, and problems in group therapy sessions, resulting in lower treatment engagement. Diagnosis in mental healthcare is often based on verbal communication rather than an objective physical examination, which makes effective communication between HPs and immigrant patients a key factor (Giacco et al., 2014). Sandhu and colleagues conducted a qualitative study in 16 cities in Europe and found that language difficulties were major barriers in assessing symptoms, diagnosing conditions, and developing trust among immigrant patients (Sandhu et al., 2013), which is in line with our findings. Further, poor language skills among immigrants acted as a barrier to accessing specific mental health treatment, including psychotherapy (Jensen et al., 2013; Salami et al., 2019). This was also reported by participants in our study; they mentioned that immigrant patients find it difficult to join group therapy sessions conducted in Norwegian, which are one of the standard treatments in national guidelines for patients with SUP and/or MHP. In a recent Norwegian study, HPs faced challenges relating to language barriers, which led to mismatched expectations and a feeling of unpreparedness to provide help to immigrant patients. Hence, language barriers prevented the provision of effective care, while also preventing immigrant patients from receiving help (Harris, Binder, & Sandal, 2020). Language barriers also meant time-consuming consultations and the inability to obtain consent from patients when collecting sensitive information (Richard, Richardson, Jaye, & Stokes, 2019). This may be viewed as a lack of cultural competence and PCH in treatment, where services seem less accessible for immigrant patients with COP, and hence a barrier to treatment engagement.

The participants described difficulties with interpreters who did not understand contexts of migration and issues related to COP, leading to miscommunication between themselves and immigrant patients and lower treatment engagement. Similar findings have also been reported in previous studies of HPs providing treatment to immigrant patients (Betancourt et al., 2003; Jensen et al., 2013; Kaltman, Hurtado de Mendoza, Gonzales, & Serrano, 2014; Mirdal, Ryding, & Essendrop Sondej, 2012). Further, unskilled interpreters have been described as frustrating for both HPs and immigrant patients, resulting in negative effects on establishing trust and treatment engagement (Kaltman et al., 2014; Mirdal et al., 2012), which resonates with our findings. Additionally, issues of confidentiality and privacy, together with concerns about the accuracy of translation and interpretation with the use of unskilled interpreters, have proved to be a key barrier to accessing and engaging immigrant patients (DeSa et al., 2022). In addition to this, the participants described that using different interpreters during counselling sessions with the same immigrant patient led to worries about confidentiality and their inability to form a trustful relationship, resulting in lower engagement and even dropping out of treatment. Moreover, a study conducted among psychotherapists reported that 43% of them refused to treat immigrant patients due to language disparities (Mösko, Gil-Martinez, & Schulz, 2013), which concurs with our findings, where some participants perceived treating immigrants as involving extra effort and extra hours. The narrative of extra efforts and extra work can be seen as a discriminatory element in the treatment process, where immigrant patients did not receive the attention and care they needed, which can be linked to the findings of our Sub-study 1.

Additionally, some participants stated that the use of interpreter services was neither cost-effective nor commonly used or recommended in their experience. This finding contrasts with the guidelines of the Norwegian Directorate of Health, which state that patients with limited knowledge of Norwegian are entitled to an interpreter in their preferred language (Helsedirektoratet, 2010). However, lack of funding for and availability of interpreter services has been reported previously (Smith et al., 2019). All these findings indicate the lack of PCH and a cultural competence approach, which ultimately leads to a lack of individually tailored services for immigrants with COP and thus acts as a barrier to treatment engagement. Bhugra and colleagues argue that communicating distress when HPs and patients have no language in common may lead to increased levels of dissatisfaction and lower treatment engagement. Therefore, the good use of professional interpreter services is critical in providing mental healthcare to immigrant patients. The authors further argue that failure to provide appropriate interpreting when needed by immigrant patients is an indirect form of discrimination (Bhugra et al., 2014).

Another barrier that shaped the treatment engagement of immigrants with COP, as reflected in the comments of participants, was difficulties faced due to lack of cultural competence in treatment programmes. Participants described that poor cultural competence caused misunderstandings of what was culturally and socially acceptable behaviour for immigrant patients, thus resulting in lower treatment engagement, which concurs with previous studies (Giacco et al., 2014; Harris et al., 2020; Salami et al., 2019; Sandhu et al., 2013). These narratives of misunderstanding could also be linked to the findings of Sub-study 1, where immigrants themselves described feeling a lack of connection with HPs and a lack of individually tailored services when in treatment. Further, there were no official courses or relevant resources for HPs to learn about cultural competence in mental healthcare. In other studies, HPs felt ill-equipped to deal with comprehensive needs arising during interactions with immigrant patients who had different understandings of MHP and treatment (Salami et al., 2019; Žagar et al., 2019), which is in line with our findings.

Furthermore, a lack of diversity and a need for HPs of immigrant background in mental health and addiction services has been well documented (Giacco et al., 2014; Jensen et al., 2013; Salami et al., 2019). This relates to our findings and was seen in our sample of 19 HPs, where only three were of immigrant background. In addition, Betancourt and colleagues argue that lack of diversity in the leadership and staff of healthcare organizations may result in poorly designed structural policies, procedures and delivery systems to meet the needs of immigrant patients, thus representing a barrier to their treatment engagement (Betancourt et al., 2003).

In addition, some participants mentioned difficulties due to social factors that reduced treatment engagement by immigrant patients. Cultural interpretation of mental health needs, stigma attached to SUP and MHP and experiences of discrimination and social exclusion often cause difficulties in engaging in treatment (Giacco et al., 2014; Salami et al., 2019). This is exacerbated by poor knowledge of available help in mental health and addiction services (Kaltman et al., 2014), as reflected in our findings, where participants mentioned lower treatment engagement by immigrants because of poor integration and living in parallel societies with few contacts in mainstream Norwegian society. Some studies have also reported that socioeconomic factors such as poor living conditions, low income levels and unemployment act as barriers to utilizing mental health and substance use treatment (Harpelund, Nielsen, & Krasnik, 2012; Kaltman et al., 2014), in line with our participants' experiences.

7.1.3.2 Facilitators

It is important to understand the barriers involved (including those mentioned in 7.1.3.1) in order to facilitate adequate use of available treatment and improve the engagement of immigrants living with COP (Falgas-Bague et al., 2019). PCH (Dixon et al., 2016) and a cultural competence approach (Betancourt et al., 2003) have been shown to facilitate treatment engagement. According to the framework proposed by Saha and colleagues, PCH and cultural competence have overlapping core values that work at the interpersonal level (between health professionals and users) and the health system level (Saha et al., 2008). At the interpersonal level, both PCH and cultural competence hold value that includes HPs' ability to view the patient as a unique person, to have an unconditional positive attitude, to effectively build rapport, and to explore the patient's values, beliefs and meaning of illness and cure. In this way, HPs and patients can reach common ground for the treatment, which will also be aided by effective use of interpreters and an understanding of the importance and meaning of culture (Saha et al., 2008). Participants described similar experiences of how being curious to learn about different cultural contexts, being flexible to provide individually tailored services, and being creative to find solutions for miscommunication have improved their relationship with immigrant patients and thus the patients' treatment engagement. Some of the previous studies have also highlighted the importance of cultural competence in mental health treatment for immigrants living with COP (Giacco et al., 2014; Sandhu et al., 2013). Moreover, owning to increasing cultural diversity and a growing multi-ethnic population in Norway, it is becoming ever more important to teach HPs the skills of cultural competence, especially those working in mental health and addiction services.

At a systemic level, both PCH and cultural competence emphasize improved accessibility of HPs, a diverse workforce that reflects minority populations and partnerships with communities in setting priorities and planning, which have been associated with improved treatment outcomes (Saha et al., 2008). Further, these core values promote equity for immigrant groups that are greatly disadvantaged in terms of seeking care and engaging in treatment (Saha et al., 2008). The systemic level could be understood through our participants' statements that making mental health and addiction services accessible to immigrant patients facilitates treatment engagement. Relevant factors here are increased accessibility of mental health professionals, HPs of immigrant background, the use of skilled professional interpreters and the integration of mental health and addiction services in primary healthcare, as also stated in previous research (Giacco et al., 2014; Salami et al., 2019). Further, participants from the FACT team mentioned that having ambulatory services tailored to individual immigrant patients' needs has improved their treatment engagement, which aligns with the principles of PCH and cultural competence at the systemic level. These interventions may help to reduce racial/ethnic disparities in mental healthcare (Betancourt et al., 2003) and may provide quality healthcare for immigrants living with COP, who are overshadowed by the majority population in treatment engagement.

Further, PCH and a cultural competence approach both have importance from a service delivery and policy perspective. It has been seen as vital to adapt services to meet the needs and preferences of immigrant patients, in order to improve accessibility, including outreach and home visits, and to ensure that the information provided is tailored to their needs in their preferred language, and that it improves their health literacy (Allin & Masseria, 2009; Saha et al., 2008). From a health policy perspective it is crucial to identify the reasons for unmet needs (Allin & Masseria, 2009). Here the focus would be on the need to understand factors that may be responsible for the unmet needs of immigrants and the barriers preventing HPs from providing tailored treatment. The participants pointed out some of these factors as the language barrier, limited cultural sensitivity, and a lack of resources to enable professionals to acquire cultural competence. Some such factors were also described by immigrants themselves in Sub-study 1, including lack of individually tailored services, lack of connection between HPs and immigrants, stigma and discriminatory experiences with healthcare, and distrust of the system. Previous studies have suggested some strategies to address these issues and to improve mental health and addiction service delivery, such as highlighting the importance of culturally appropriate services by acknowledging users' needs and preferences, and encouraging them to voice their own explanations of health, worries and treatment expectations (Mölsä, Kuittinen, Tiilikainen, Honkasalo, & Punamäki, 2017; Pavlish, Noor, & Brandt, 2010).

Moreover, the need for cultural competence training has been voiced by HPs themselves for improving treatment engagement in immigrant patients (Hjörleifsson et al., 2018; Richard et al., 2019). Bhugra and colleagues have developed a manual on cultural competency for mental health and addiction services. This manual also emphasizes the need for training and other provision for culturally competent services, which imply that immigrant patients are made welcome by providing skilled interpreters, food, opportunities to practise their religion, and a culturally appropriate structure (Bhugra et al., 2014). Bhugra and colleagues also conducted a randomized controlled trial in the UK among immigrants with severe mental health problems to ascertain the effects of a culturally competent approach. A comparison between standard treatment and culturally competent treatment was made, and the results showed that the latter was found to be more appropriate and was better appreciated by the patients and their families (Bhugra, Ayonrinde, Butler, Leese, & Thornicroft, 2011). Furthermore, Chu et al. defined the theoretical basis of cultural competence to guide mental health treatment and provided three theoretical principles of why cultural competence works: it creates (1) a contextual match with patients' external realities, (2) an experiential match in the microsystem of the therapeutic relationship, and (3) an interpersonal feeling of being valued, understood and empowered with the patient (Chu, Leino, Pflum, & Sue, 2016). This empowerment can be related to the emancipatory stance of this study, which is to place the emphasis on the needs of immigrants living with COP and to give them a voice in treatment settings.

7.2 Methodological considerations

Qualitative research should be conducted and valued for its explicit qualitative value. Trustworthiness is a key term, divided by Lincoln and Guba into four criteria: credibility, transferability, dependability, and confirmability. Trustworthiness thus consists of quality criteria and ensures the worth of qualitative research. The authors define the term as the true reflection of the findings of the research, such as lived experiences of the phenomenon under study. They have developed techniques for each criterion (Lincoln & Guba, 1985). I will discuss in this section how these criteria have been applied to this study, followed by a discussion on reflexivity. Before describing these four criteria, I will discuss why only males of immigrant background were included and why those who were included wanted to participate in this study.

7.2.1 Why were only men included in this study?

SUP are said to be gendered globally in that twice as many men as women have SUP; however, women have more severe health and social consequences (Meyer, Isaacs, El-Shahawy, Burlew, & Wechsberg, 2019; SAMHSA, 2018). In addition, women are generally underrepresented in SUP treatment and when they do seek treatment, their condition is often worse. This implies gender-specific barriers to treatment access and engagement (Meyer et al., 2019; UNODC, 2020). Hence recruiting women may be a question of availability, and it may be assumed to be more difficult when the women are of immigrant background. The study could thus only include male immigrants due to challenges in recruiting immigrant women living with COP. The original aim was not to recruit only men; the plan was to recruit both genders if they met the inclusion criteria. However, the recruitment of both genders was extremely difficult because of the stigma and hidden nature of SUP and/or MHP. According to the participants, there were many men and women with similar problems, but they did not want to come forward and participate in research studies owing to the fear of being detected in their small communities in Norway. The stigma and fear are probably even more prevalent among immigrant women living with COP, because of their different cultural norms, failure to live up to the roles and expectations of their communities, and their perceived potential risk of greater harm if they are identified and detected. Similar findings were also stated by HPs in addiction services for immigrants in a study conducted in Bergen. According to these HPs, a potentially very large and hidden group is immigrant women, who only seek treatment in cases of acute intoxication (Malone, 2015). Additionally, due to their more hidden nature and fear of discrimination, feelings of shame and marginalization, immigrant women are less likely to report their SUP and/or MHP, and are even less likely to access available treatment and care (Derr, 2016; Gueta, 2017), and have far fewer hospital admissions (Ayazi & Bøgwald, 2008). Further, in a recent Norwegian study, it was reported that immigrant women are generally underrepresented in outpatient mental healthcare services, and they experience barriers in accessing and seeking care, in addition to maintaining access to care (Straiton, Corbett, Hollander, & Hauge, 2019). Female substance users lack support from their family, including their husband/partner, more often than males with SUP. It has been documented that women are more likely to have a substance using sexual partner or family member, and because relationships play a major role in women's lives, they tend not to seek treatment due to fear of losing these relationships. They are even forbidden to seek the help they need because of family pressure (UNODC, 2004).

7.2.2 Why did the participants want to participate in this study?

Although there were challenges in recruiting participants in this study, as described in Section 5.4.4.2, those who were included stated their reasons for participation. Most of the participants said that they appreciated the opportunity to be of help to others who are in similar situations as theirs. They wanted to share their lived experiences in relation to their immigrant status, their co-occurring problems and treatment settings in Norway.

Several participants mentioned that participating in this study made them feel valued and heard, as they lacked this feeling in most settings. Participants described being doubly marginalized due to their immigrant status and COP, and the combination of these factors could isolate them in social and working life. They wanted to talk and be heard, based on their previous experiences of not being listened to, especially in treatment settings. They therefore felt that their experiences were considered important in this study and might help in shaping treatment approaches to the needs of this group. Furthermore, some of the participants expressed a positive attitude to being able to share their worries and concerns with me as an immigrant researcher and with the immigrant interpreter; they could not express their concerns with their families due to problematic relationships. Experiences of stigma and racism had limited their chances of contributing to society, and they therefore felt that this study could provide them with a platform for sharing their experiences for the greater good of society.

For the reasons mentioned above, it could be sensed that participants were able to experience a feeling of emancipation through their participation, which was also one of the goals of this study.

7.2.3 Credibility

According to Lincoln and Guba (Lincoln & Guba, 1985), credibility refers to the degree to which the researcher is able to become familiar with the study context, minimize distortions, and build trust. Credibility is similar to the concept of internal validity and includes activities that increase the probability that credible findings were generated. This also means that the findings generated are trustworthy from the participants' perspective.

This study may be criticized for not following a regular phenomenological methodology with clear and consistent rules, but only adopting some phenomenological inspirations. Some qualitative researchers argue for following rigorous, step-by-step approaches, yet there are emerging discussions that criticize such approaches as they tend to quantify qualitative research (Grant, 2016). Hence, this project followed a more pragmatic approach, within which I tried to make my actions, choices, reflections and collaboration with others as transparent as possible throughout the project. These attempts at transparency may be argued to enhance the credibility of this study.

Further, triangulation as a criterion, in the form of data, investigator and theory triangulation, was used to improve the credibility of this study (Denzin & Lincoln, 1994). Krefting defines triangulation as the convergence of multiple perspectives for mutual confirmation of data to ensure that the phenomenon under study is investigated completely (Krefting, 1991). This is done by using different methods of data collection. Triangulation in this study was also ensured by using the literature and individual and focus group interviews. This helped to minimize distortion from a single data source or from a biased researcher. Further, investigator triangulation involved more than one person in data collection, namely myself and the interpreter in Sub-study 1 and myself and the moderator in Sub-study 2. Moreover, an additional investigator was involved in Sub-study 2 (Article 3), in order to access the findings and make a sound basis for forming implications of the study, which can also help to avoid so-called “premature closure”, i.e. reaching conclusions too soon. Rigorous discussions within the research team for all the articles and an additional investigator in the third article thus ensured the credibility of the findings (Lincoln & Guba, 1985) Furthermore, different theoretical perspectives were employed and discussed in each article and in this thesis.

In addition, peer debriefing was used for all three articles; here, a researcher can “explore aspects of the inquiry that might otherwise remain only implicit within the inquirer’s mind” (Lincoln & Guba, 1985). The regular reflective debriefing sessions with the research group guided me at each subsequent step of the analysis and helped to understand the emerging themes and participants’ perspectives. This also enhanced the credibility of this study. In addition, important contributions were made to the study through PhD seminars, workshops, abstract presentations at national and international level, and an extensive peer-review process for the articles.

Prolonged engagement is a criterion of credibility; the researcher should be able to demonstrate that she has spent considerable time on the topic and context and sufficient time to develop the skills needed to successfully implement the chosen research method. In this connection, the analysis and writing phases of all three articles took over one year each. Moreover, I had previous knowledge and professional experience of working with persons with SUP in India, along with experience of working in the field of migration for over three years in Norway, which I consider as forms of prolonged engagement with this study.

Conducting a study with an explorative and descriptive qualitative research design of this kind requires the researcher to avoid approaching the individual and focus group interviews with excessively fixed questions and preunderstandings. Therefore, I focused on letting the participants' voices be heard and refrained from any early interpretations and judgement of the meaning of their experiences. However, my background as a medical doctor and immigrant myself may have influenced the analysis. Selective bracketing of preunderstanding was sought during analysis, even though complete bracketing is seen as impossible. Collaborating with a competency group in all stages of the study, including writing the protocol, preparing the study, analysing the data and compiling the results, has enhanced the credibility of the data and findings.

In addition, in individual interview settings, both the participants and I were non-ethnic Norwegians, which facilitated the interview process; the participants could trust the interviewer and feel connected, which helped to provide meaningful data. This could be understood as "diversity in proximity", meaning that interaction between migrant researcher and migrant participant is effective when both of them can recognize the ties that bind and the social fissure that divides in a host country (Ganga & Scott, 2006). I also believe that "diversity in proximity" enhanced the credibility of this study.

7.2.4 Transferability

The criteria of transferability (Lincoln & Guba, 1985) deals with the extent to which the findings of the study can be applied in other context or to other people in a similar context. The number and characteristics of the participants limits transferability. The findings of qualitative studies are not generalizable, but they may be transferable, whereby the results can be comparable with other studies and further investigations in similar areas, as explained here:

"*…generalizations are impossible since phenomena are neither time – nor context free",* however, *"some transferability of these hypotheses may be possible from situation to situation, depending on the degree of temporal and contextual similarity*" (Guba & Lincoln, 1982).

Thick descriptions and detailed information about the participants (purposive sampling) and context have been provided in the three articles and in this thesis, within the limits of confidentiality, to enable the reader to judge the degree of transferability of the findings to other settings. Our interpretation of the findings should be viewed within the scope of qualitative research and thus is not generalizable in a statistical sense. The findings are based on our participants' lived experiences of a phenomenon, and are considered to hold the potential of achieving a deeper understanding of the phenomenon, while the exploration of subjective experience involves focusing on the meaning of the participants, which may be transferred to other contexts and other people. However, the relevance beyond the local context may be contested. The findings provide rich insights into the experiences of a group of persons who are considered hard to reach, difficult to engage and often stigmatized (Articles 1 and 2), and these insights are thus believed to be of relevance for future research. Furthermore, the theoretical contextualization may allow HPs to reflect on the findings and possibly refine their way of approaching and providing treatment to some men of immigrant background living with COP.

The participants narrated their substance use and mental health problems in the context of migration (Articles 1 and 2), and it can therefore be assumed that the findings will apply to other men of similar background in the other Scandinavian countries (as mentioned in Chapter 3, review of relevant literature). In addition, immigration has increased in these countries in recent decades in an almost similar pattern and the socioeconomic environment is also similar, thus it can be assumed that findings would be transferable to other Scandinavian countries, particularly to immigrant men from low- and middle-income countries.

In Article 3, the participants differed in professional background and length of experience in providing services to immigrant patients with COP, However, their insights and meanings may be transferred to other HPs who treat immigrant patients with substance use and/or mental health problems. Additionally, these insights are believed to be of relevance for future research in the field of migrant healthcare, where there is a paucity of research.

7.2.5 Dependability

Dependability is referred to as the extent to which the replication of the study with similar contexts and similar participants would produce similar findings. According to Lincoln and Guba, it is sufficient to demonstrate credibility in order to establish dependability, since dependability deals with the research process and how the researcher has ensured that the whole process is logical, can be traced in detail and hence can be documented (Lincoln & Guba, 1985). Dependability accounts for changes that occurred in study design and in factors being studied to enhance understanding of the context, together with how decisions during the research process have been handled and possible criticism of those decisions. The research process in this thesis has been presented with optimal transparency. The feedback of the research team throughout the process has been crucial and functioned as an audit of the dependability of the study.

Further, questions can be raised on the trustworthiness of data self-reported by persons living with SUP and/or MHP. I would respond by stating that in my experience the participants in this study provided reliable data and were open and honest about their lived experiences. I could not tell how accurately they described their experiences but most of them were emotional while talking during the interviews. I assume this to be an indication of honesty by the participants; they described what they have really experienced. In a similar vein, previous studies have reported high reliability of self-reported data from persons living with SUP (Johnson et al., 2000; Napper, Fisher, Johnson, & Wood, 2010; Secades-Villa & Fernández-Hermida, 2003) and/or MHP (Goldberg, Seybolt, & Lehman, 2002; Santos et al., 2021). For example, while evaluating the reliability and validity of self-reported amphetamine use among persons with primarily heroin and cocaine use, Napper and colleagues compared urine samples with the self-reported data. They found that both urine samples and self-reported data were 95% accurate, which suggests high validity and reliability of self-reported data (Napper et al., 2010). Further, Santos et al. found similar results when evaluating reliability by comparing the self-reported diagnosis of depression with the psychiatrist's medical diagnosis; they reported 81% agreement between the two diagnoses, which demonstrated high reliability of their self-reported data (Santos et al., 2021).

7.2.6 Confirmability

Confirmability in qualitative research has been described by Lincoln and Guba as the degree to which findings are a result of systematic methodology and analysis, not based on the researcher's personal constructs and biases (Lincoln & Guba, 1985). Within phenomenological influences on research, the researcher may bracket her preunderstandings. Even though complete bracketing is impossible, pre-understandings must be addressed openly to avoid any hidden skewness (Malterud, 2001b). Further, confirmability can be understood as neutrality to the data rather than the neutrality of the researcher in qualitative studies, where the themes and categories resulting from the analysis are developed from the data and not from the researcher's preconceptions and pre-understandings (Dahlgren, Emmelin, & Winkvist, 2007).

Confirmability in this study was enhanced by discussions during the analysis with the research team and competency group, in order to ensure that I was unbiased in obtaining the themes and categories. The three articles based on this study were critically evaluated by reviewers and accepted for publication in respected peer-reviewed journals. In addition, the extensive use of quotations in all the three articles should allow the reader to check whether neutrality of the data has been achieved.

7.2.7 Reflexivity

"As qualitative researchers, we now accept that the researcher is a central figure who actively constructs the collection, selection, and interpretation of data. We appreciate that research is co-constituted - a joint product of the participants, researcher, and their relationship. We realise that meanings are negotiated within particular social contexts so that another researcher will unfold a different story." (Finlay, 2003)

Finlay defines reflexivity as turning a critical gaze towards oneself and "being thoughtfully and critically self-aware of personal/relational dynamics in the research and how these affect the research". She argues that all research occurs in context and is understood differently in different traditions of research (Finlay, 2003). Further, Malterud argues that reflexivity allows the researcher to systematically attend to the context of knowledge co-construction at every step of the research process (Malterud, 2001). Reflexivity is also perceived as a way of ensuring that the research is ethically rigorous (Guillemin & Heggen, 2009). In addition, collaborating with persons with lived experiences of SUP and MHP, i.e. service user involvement in mental health research, has been argued to aid reflexivity (Pettersen, Brodahl, et al., 2019; Veseth et al., 2017).

The background, identities and perspectives of researchers influence their studies in various ways, and their world views and values influence their interpretation of the data collected (Morrow, 2005). Therefore, it is important to have an explicit personal stance through reflexivity, which allows the influence of the researcher to be transparent and act as a strength rather than a weakness (Finlay, 2003). The factors that were considered as having a potential impact on the research process were the following: my experience as a medical doctor and clinician with a biomedical approach to mental health, power issues with participants, the competency group and interpreters, my identity as an immigrant researcher, and my identity as a woman interviewing immigrant men who are not used to expressing themselves in front of women in their communities.

With my professional background as a medical doctor and clinician, I had a biomedical understanding of the concepts of mental health, mental health problems and substance use problems. During my medical studies and clinical practice in India, I had been taught to treat the "disorders", not the "persons". However, I had grown up in a context where I was taught to view "all human beings as equal regardless", and this has shaped my personality in a way that has kept me grounded and I have always approached my patients as individuals. I then took a Master of Philosophy degree in International Community Health at the University of Oslo, which broadened my understanding of public health and social perspectives. Moving from being a clinician to a public health researcher, and to my own PhD study, I found it difficult to define my role. As a medical doctor and clinician, it was extremely challenging for me to position myself and my study within the theory of science. Understanding theory and philosophy was a great challenge, as I had no previous experience of studying with such positioning during my medical studies. In my experience, these terms, concepts and philosophy should be included in the medical curriculum for doctors-to-be, to improve their understanding of the person (first and foremost), the disease, and his/her environment.

At the beginning of this study, while writing the proposal, I aligned with phenomenology and a collaborative approach. I had little knowledge of person-centred theory and healthcare until I took the PCH course at my university, which made me more aware of the social aspects of my research. Throughout my study, I learned more of the social aspects, in addition to the biomedical aspects, of SUP and MHP. I would argue that the approaches of PCH and cultural competence can enhance biomedical treatment of SUP and MHP. This has also been evident in the descriptions of the participants and competency group.

Further, I have often reflected on whether there is any power relationship within the competency group, and between the participants and myself. My role in the competency group was completely different from my role during the interviews. The competency group was included in this study with the purpose of empowering the voice of persons with lived experience who have been affected by the phenomenon (being an immigrant and living with COP in the Norwegian context). The idea was motivated by values such as human rights and the right to live with dignity. However, upon reflection I realized the power difference present within the competency group, since I was the one who arranged the schedule of the meetings, set the agendas, and guided the dynamics during the meetings. In addition, I brought selected descriptions by the participants, which I felt were important to discuss in the group, due to time and financial constraints of this project. Nonetheless, during the meetings I made sure that they expressed their opinions and suggestions in as much detail as possible. I took their reflections into consideration and allowed that to influence my further analysis. This collaborative approach was crucial, since their perspective, based on their lived experience, challenged my preconceptions and preunderstandings of the phenomenon. On the other hand, I could not ignore the power relationship between myself and the participants in Sub-study 1, as the literature describes them as a “difficult to reach” group (Dixon et al., 2016) and interviewing them to gather rich data as ethically challenging. This has been described by Guillemin and Heggen in this way: “*it is a paradox in qualitative research that often the best data come at the expense of participants revealing something deeply personal about themselves*” (Guillemin & Heggen, 2009). Nevertheless, I made efforts to build a trusting and respectful relationship with the participants, and extra precautions were taken to ensure that participants did not feel that their integrity was violated. Further, during the analysis, research typically prioritizes the researcher’s voice over the participants’ voice. I myself analysed and interpreted the data and the findings; although they were based on the participants’ descriptions, it still involves power to present experiences of others (Willig, 2013).

I was an immigrant researcher, whose native language was not Norwegian, conducting research on immigrant participants; how these factors in my research shaped me was a constant concern in my mind throughout the research process. My challenge during the interviews was my imperfect knowledge of the Norwegian language. I gave the participants the choice to conduct the interviews in their preferred language, as I felt that they would be able to describe their lived experiences more precisely in the language they were most comfortable speaking. Nine out of ten participants chose Norwegian in the interviews; although they had different immigrant backgrounds, they had good knowledge of Norwegian, as was evident in the interviews. I invited two Norwegian-speaking interpreters who were both fluent in Norwegian and English, even though they were not native Norwegian speakers. We had discussions prior to each interview to ensure that the language barrier was not an obstacle to effective communication during the interviews. Furthermore, having lived in Norway for eight years, I also have sufficient understanding of the Norwegian language and context. The interpreter and I concluded that even with my imperfect ability in Norwegian, I was able to understand and communicate with the participants during interviews. When I had any doubts, I noted these down during the interview and had reflective discussions with the interpreter after each interview.

Being an immigrant and an outsider may have given me a fresh view of the phenomenon but could have been a disadvantage because I could have misinterpreted the phenomenon in terms of the Norwegian context. However, the participants and I shared some experiences in terms of being an immigrant and the acculturation process in a new culture. During the interviews, this may have helped me to gain the participants’ trust and helped them to feel comfortable when expressing themselves, thus providing richer data. The fact that the interpreters were of immigrant background may also have helped to establish a trusting relationship. I remember one interview when I and the interpreter informed a participant about the study and talked about our experiences of being an immigrant in Norway. This conversation began when the participant was curious to know our backgrounds, and we ended up having one of the most informative interviews.

Furthermore, being an immigrant and having lived in Norway for several years gave me the opportunity to view the research process through two lenses.

In addition, I have also sensed some of the discriminatory expectations felt by my participants and I may have faced something similar myself, being an immigrant researcher. For example, I received few replies to my recruitment requests because of my foreign name; I was thus kept waiting for weeks, which ultimately delayed the recruitment process and affected my mental health. This often makes me think of the researcher's vulnerability (Guillemin & Heggen, 2009). Further, my status as an immigrant researcher researching immigrants may have biased opinions sometimes and meant that I faced some discrimination, but this was worked on through discussions with my supervisors, all three of whom are experts in the field and ethnic Norwegians. My thinking was also challenged by the feedback I received from Dr. Bernadette Kumar, who is an expert in the field of migration and health, and co-author in all three articles. We thus arrived at common ground after our many discussions. Additionally, I had tried to be as honest as possible in the research process and in presenting participants' descriptions. To improve my reflexivity, I was in regular contact with the competency group (Pettersen, Brodahl, et al., 2019; Veseth et al., 2017), which constantly kept me in thinking and reflective mode. These interactions and conversations made me consistently aware of what I was listening to and how I was being reflective about these issues. Above all, they made me think about my duties and responsibilities as a researcher and a person in my own research.

Another concern was my identity as a female researcher interviewing immigrant men who came from a culture where they were perceived as strong and were not supposed to share emotional experiences. The participants of this study were from patriarchal cultures, and I was aware of this challenge because of my previous experience while conducting my master's studies in India, where men often have difficulty in expressing themselves due to societal norms and cultural conditioning in patriarchal societies. Therefore, I made deliberate efforts to work on this challenge with the members of competency group who knew most of the participants on a personal level. I asked the competency group members to have a deep conversation on this concern and convince the participants to describe their lived experiences without viewing me as a woman researcher and this also aided the trust in our relationship. Hence, I assume that participants expressed themselves without allowing my identity as a woman to be a barrier to their statements. However, I can only assume this because I elicited rich descriptions from the participants, although I cannot guarantee that this was never a barrier during the interviews, Moreover, the participants had lived in Norway for many years and may have acquired the sense of gender equality as practised in Norway.

Further, I became aware of my status as an outsider in the focus group interviews, not only as an immigrant with imperfect language skills, but also as researcher with no experience of working in Norwegian mental health and addiction services, in contrast to the participants in the focus groups. Dwyer and Buckle argue that an “insider” shares the “characteristics, role, or experience under study with the participants” in research (Dwyer & Buckle, 2009). However, as I reflected on this, I realized that I was both an outsider and an insider. I was an insider in the sense that I am a medical doctor with previous knowledge and experience of working in psychiatric wards and rehabilitation centres in India. Even with my limited fluency in Norwegian, I could relate to their concerns, although during the analysis I made active efforts to put my past experiences aside and focus entirely on the participants’ descriptions, including those of the HPs in focus groups.

As Finlay has argued, with reflexivity in research subjectivity and problems can be transformed into solutions or opportunities (Finlay, 2002). I agree with this and found that being reflective, in addition to my practical and personal background and my still developing theoretical understanding, enabled me to arrive at reasonable and credible findings. I actively adopted the attitude of bracketing my preunderstandings during interviews and analysis, by not adding to or subtracting from participants’ descriptions, in line with my phenomenological inspirations described in Section 5.2. Further, adopting the principles of person-centredness in research has helped me to become more reflective during the entire study.

7.2.8 General limitations

- In Sub-study 2, in the focus group interviews one of the limitations could have been that the participants were in a particular social context and their comments may have been influenced by the direction of the discussion, the moderator or by what was “politically correct” to say and not to say (Smithson, 2000). Further, my position as an immigrant researcher could have prevented the HPs from making negative statements about immigrants which they might have thought would offend me as an immigrant.
- An important limitation in Sub-study 2 was the lack of an in-depth discussion on how participants described “immigrants”. However, most participants briefly described immigrants as persons who were born or whose parents were born outside Norway. Here, they referred to the standard definition of immigrants used in Norway and provided by the national agency, Statistics Norway (SSB, 2021b). One participant referred to immigrants as persons with a multicultural background in his clinical practice.
- Further, in Sub-study 2, a point of discussion could be the methodological challenge of recruiting from health services with different treatment approaches in the same study. However, few immigrants seek mental health and addiction services in Norway (Abebe et al., 2017), thus it was expected that few health professionals would have had experience of treating immigrants. The study was not focused on context-specific treatment; rather, the goal was to explore the experiences of health professionals working in Norwegian mental health and addiction services, in order to understand immigrants’ treatment engagement. The purpose was to ascertain immigrants’ behaviour in engaging in different services, according to different health professionals such as psychologists, psychiatrists, nurses and social workers. Moreover, this issue could be linked to Sub-study 1, where immigrants voiced their reasons for their lower treatment engagement and lack of satisfaction when their needs remained unmet. Hence, conducting this research on health professionals’

experiences may have helped to provide a multifaceted view of the barriers to treatment engagement among immigrant patients.

8 Concluding remarks and implications

8.1 Conclusion

This study explored the experiences of immigrant men living with co-occurring substance use and mental health problems and those of health professionals working in Norwegian mental health and addiction services. The study examined what it means to be an immigrant living with COP in addition to treatment engagement experiences in Norwegian settings.

Immigrant men living with COP interpreted their experiences of being an immigrant and living with COP in Norway. These experiences described their coping and negotiating a sense of self within themselves, in their cultural communities, and in different structures of society. Cultural clash, lack of family support and cultural stigma worsened their SUP and MHP. Further experiences of racism in different institutions and lack of a sense of belonging in mainstream society discouraged them from integrating, leading to lower awareness of available treatment options. However, these participants described their experiences in Norwegian mental health and addiction services as both negative and positive. Lack of connection with health professionals and lack of individually tailored treatment, in addition to stigma, were the main barriers to accessing treatment and remaining engaged in treatment. By contrast, multicultural competence, aftercare and strategies to reduce stigma and raise awareness were found to be positive and facilitated treatment access and engagement.

Health professionals described their experiences with treatment engagement among immigrants with COP, which provided insight into barriers and facilitators of treatment. Difficulties due to language problems, social factors and lack of culturally competent services were described as important barriers leading to lower treatment engagement. Facilitators were interested and flexible HPs who could connect to individuals and make mental health and addiction services more accessible.

8.2 Implications

- The insights and knowledge gained from participants can broaden the perspectives of health professionals and policy makers towards providing appropriate services to this group.
- Policies and strategies that are immigrant-friendly, and that may reduce cultural stigma, SUP/MHP-related stigma and racism, and increase immigrants' sense of belonging in mainstream society are to be encouraged.
- Strategies that reduce barriers to treatment engagement such as increased prevention and training HPs to tailor treatment to individual needs are called for.
- Culturally competent services are clearly lacking. Greater emphasis on providing more person-centred and culturally competent services may increase treatment engagement. The cultural competence of health professionals must be enhanced by providing education and resources about different cultural backgrounds, which may improve treatment engagement in immigrants living with COP.
- An increased need for competent and professional interpreters who have knowledge of substance use and mental health problems is indicated.
- There is a need of research to better understand the impact of barriers to treatment engagement and immigrants' participation in society. Future research on enhancing understanding of the context of immigration within mental health and addiction services and intervention studies to improve PCH and cultural competence approaches is recommended.

People are more than a single identity and a single story….
Single story creates stereotypes…
And the problem with stereotypes is not that they are untrue but that they are
incomplete, they make one story become the only story…
And the consequence is, it creates critical misunderstanding and
makes our recognition of equal humanity difficult!

Chimamanda Ngozi Adichie
Immigrant writer
“I wasn’t black until I came to America. I became black in America.”

9 References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. Clinical Psychology Review, 31(6), 934-948.

Abebe, D. S., Hafstad, G., Brunborg, G., Kumar, B., & Lien, L. (2015). Binge drinking, cannabis and tobacco use among ethnic Norwegian and ethnic minority adolescents in Oslo, Norway. Journal of Immigrant and Minority Health, 17(4), 992-1001.

Abebe, D. S. (2010). Public health challenges of immigrants in Norway: A research review. NAKMI Report, 2, 2010.

Abebe, D. S., Lien, L., & Elstad, J. I. (2017). Immigrants' utilization of specialist mental healthcare according to age, country of origin, and migration history: A nation-wide register study in Norway. Social Psychiatry and Psychiatric Epidemiology, 52(6), 679-687.

Abebe, D. S., Lien, L., & Hjelde, K. H. (2014). What we know and don't know about mental health problems among immigrants in Norway. Journal of Immigrant and Minority Health, 16(1), 60-67.

Abroms, M., & Sher, L. (2016). Dual disorders and suicide. Journal of Dual Diagnosis, 12(2), 148-149.

Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., . . . Guo, Y. (2018). The UCL–Lancet Commission on Migration and Health: The health of a world on the move. The Lancet, 392(10164), 2606-2654.

Aggarwal, N. K., Pieh, M. C., Dixon, L., Guarnaccia, P., Alegria, M., & Lewis-Fernandez, R. (2016). Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: A systematic review. Patient Education and Counseling, 99(2), 198-209.

Ahmed, S., Shommu, N. S., Rumana, N., Barron, G. R., Wicklum, S., & Turin, T. C. (2016). Barriers to access of primary healthcare by immigrant populations in Canada: A literature review. Journal of Immigrant and Minority Health, 18(6), 1522-1540.

Akinsulure-Smith, A. M. (2017). Resilience in the face of adversity: African immigrants' mental health needs and the American transition. Journal of Immigrant & Refugee Studies, 15(4), 428-448.

Al-Busaidi, Z. Q. (2008). Qualitative research and its uses in health care. Sultan Qaboos University Medical Journal, 8(1), 11.

Alang, S. M. (2015). Sociodemographic disparities associated with perceived causes of unmet need for mental health care. Psychiatric Rehabilitation Journal, 38(4), 293.

Alang, S. M. (2019). Mental health care among blacks in America: Confronting racism and constructing solutions. Health Services Research, 54(2), 346-355.

Ali, W., & Kaur, M. (2013). Khat og helse: en kunnskapsoppsummering. Oslo: Kompetansesenter rus, Velferdsetaten, Oslo kommune.

Allin, S., & Masseria, C. (2009). Unmet need as an indicator of health care access. Eurohealth, 15(3), 7.

Alonso, J., Angermeyer, M., Bernert, S., Bruffaerts, R., Brugha, T., Bryson, H., . . . Demyttenaere, K. (2004). 12-Month comorbidity patterns and associated factors in Europe: Results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. Acta Psychiatrica Scandinavica, 109, 28-37.

Alpers, L.-M., & Hanssen, I. (2014). Caring for ethnic minority patients: A mixed method study of nurses' self-assessment of cultural competency. Nurse Education Today, 34(6), 999-1004.

Amundsen, E. J. (2012). Low level of alcohol drinking among two generations of non-Western immigrants in Oslo: A multi-ethnic comparison. BMC Public Health, 12(1), 1-13.

Anderson, H. (2012). Collaborative relationships and dialogic conversations: Ideas for a relationally responsive practice. Family Process, 51(1), 8-24.

Assari, S., Lankarani, M. M., & Caldwell, C. H. (2018). Does discrimination explain high risk of depression among high-income African American men? Behavioral Sciences, 8(4), 40.

Attanapola, C. T. (2013). Migration and health: A literature review of the health of immigrant populations in Norway. Trondheim: NTNU Social Research.

Avery, J., Dixon, L., Adler, D., Oslin, D., Hackman, A., First, M., . . . Siris, S. (2013). Psychiatrists’ attitudes toward individuals with substance use disorders and serious mental illness. Journal of Dual Diagnosis, 9(4), 322-326.

Ayazi, T., & Bøgwald, K.-P. (2008). Innvandreres bruk av poliklinisk psykiatrisk tjeneste. Tidsskrift for Den norske legeforening, 128.

Ballard, J., Wieling, E., Solheim, C., & Dwanyen, L. (2019). Immigrant and refugee families: Minneapolis, MN: University of Minnesota Libraries Publishing.

Barber, R., Beresford, P., Boote, J., Cooper, C., & Faulkner, A. (2011). Evaluating the impact of service user involvement on research: A prospective case study. International Journal of Consumer Studies, 35(6), 609-615.

Barrera, I., Gonzalez, J., & Jordan, C. (2013). Perceptions of mental illness among Mexican-Americans in the Rio Grande Valley. Journal of Ethnic and Cultural Diversity in Social Work, 22(1), 1-16.

Barsdorf, N. W., & Wassenaar, D. R. (2005). Racial differences in public perceptions of voluntariness of medical research participants in South Africa. Social Science & Medicine, 60(5), 1087-1098.

Bartlett, D. (1998). Stress: Perspectives and processes. Buckingham: Open University Press.

Beresford, P. (2003). User involvement in research: Exploring the challenges. Nursing Times Research, 8(1), 36-46.

Beresford, P. (2013). From 'other' to involved: User involvement in research: An emerging paradigm. Nordic Social Work Research, 3(2), 139-148.

Berg, E. (2003). Samhandlingens monolog. En studie av interaksjon mellom klienter med innvandrerbakgrunn og ansatte i tiltaksapparatet for rusmiddelmisbrukere. SIRUS-rapport nr 1/2003.

Berg, J. E. (2009). The level of non-Western immigrants' use of acute psychiatric care compared with ethnic Norwegians over an 8-year period. Nordic Journal of Psychiatry, 63(3), 217-222.

Berry, J. W. (1997). Immigration, acculturation, and adaptation. Applied Psychology, 46(1), 5-34.

Berry, J. W., & Padilla, A. M. (1980). Acculturation: Theory, models and some new findings. Boulder, CO: Westview.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O., 2nd. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. Public Health Reports, 118(4), 293-302. doi:10.1093/phr/118.4.293

Bhopal, R. (2004). Glossary of terms relating to ethnicity and race: For reflection and debate. Journal of Epidemiology & Community Health, 58(6), 441-445.

Bhopal, R. (2013). Migration, ethnicity, race, and health in multicultural societies. Oxford, UK: Oxford University Press.

Bhugra, D. (2004a). Migration and mental health. Acta Psychiatrica Scandinavica, 109(4), 243-258. doi:10.1046/j.0001-690x.2003.00246.x

Bhugra, D. (2004b). Migration, distress and cultural identity. British Medical Bulletin, 69(1), 129-141.

Bhugra, D. (2005). Cultural identities and cultural congruency: A new model for evaluating mental distress in immigrants. Acta Psychiatrica Scandinavica, 111(2), 84-93.

Bhugra, D., Ayonrinde, O., Butler, G., Leese, M., & Thornicroft, G. (2011). A randomised controlled trial of assertive outreach vs. treatment as usual for black people with severe mental illness. Epidemiology and Psychiatric Sciences, 20(1), 83-89.

Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. World Psychiatry, 4(1), 18.

Bhugra, D., Gupta, S., Schouler-Ocak, M., Graeff-Calliess, I., Deakin, N., Qureshi, A., . . . Tarricone, I. (2014). EPA guidance mental health care of migrants. European Psychiatry, 29(2), 107-115.

Bhugra, D., & Jones, P. (2001). Migration and mental illness. Advances in Psychiatric Treatment, 7(3), 216-222.

Bhugra, D., & Wojcik, W., & Gupta, S. (2011). Cultural bereavement, culture shock and culture conflict: Adjustments and reactions. In D. Bhugra D & S. Gupta (Eds.), Migration and mental health (pp. 139-148). Cambridge: Cambridge University Press.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review. The British Journal of Psychiatry, 182(2), 105-116.

Biong, S. (2008). Between death as escape and the dream of life: Psychosocial dimensions of health in young men living with substance abuse and suicidal behaviour. Gothenburg, Sweden: Nordic School of Public Health NHV Göteborg.

Biong, S. (2016). Å bli en del av fellesskapet-En analyse av recovery som personlige og sosiale prosesser ved ROP-lidelser. In A. Landheim, F. Wiig, M. Brendbekken, M. Brodahl, & S. Biong (Eds.), Et bedre liv. historier, erfaringer og forskning om bedring ved rusproblemer og psykiske helseproblemer (pp. 134-145). Oslo: Gyldendal Akademisk.

Biong, S., & Ravndal, E. (2009). Living in a maze: Health, well-being and coping in young non-western men in Scandinavia experiencing substance abuse and suicidal behaviour. International Journal of Qualitative Studies on Health and Well-being, 4(1), 4-16.

Blank, A., Finlay, L., & Prior, S. (2016). The lived experience of people with mental health and substance misuse problems: Dimensions of belonging. British Journal of Occupational Therapy, 79(7), 434-441.

Blom, S., & Henriksen, K. (2008). Levekår blant innvandrere i Norge 2005/2006. Oslo: Statistisk sentralbyrå.

Boghean, C. (2016). The phenomenon of migration. Opportunities and challenges. The USV Annals of Economics and Public Administration, 16(3), 14-20.

Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. BMC International Health and Human Rights, 15(1), 1-41.

Bongard, S., & Nakajima, M. (2015). Khat chewing and acculturation in East-African migrants living in Frankfurt am Main/Germany. Journal of Ethnopharmacology, 164, 223-228.

Bourque, F., van der Ven, E., & Malla, A. (2011). A meta-analysis of the risk for psychotic disorders among first-and second-generation immigrants. Psychological Medicine, 41(5), 897-910.

Boydell, J., Morgan, C., Dutta, R., Jones, B., Alemseged, F., Dazzan, P., . . . Leff, J. (2012). Satisfaction with inpatient treatment for first-episode psychosis among different ethnic groups: A report from the UK AeSOP study. International Journal of Social Psychiatry, 58(1), 98-105.

Brandt, L., Henssler, J., Müller, M., Wall, S., Gabel, D., & Heinz, A. (2019). Risk of psychosis among refugees: A systematic review and meta-analysis. JAMA Psychiatry, 76(11), 1133-1140.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101.

Brekke, E., Lien, L., Davidson, L., & Biong, S. (2017). First-person experiences of recovery in co-occurring mental health and substance use conditions. Advances in Dual Diagnosis, 10(1), 13-24.

Brekke, J., Birkvad, S., & Erdal, M. (2019). Losing the right to stay: Revocation of immigrant residence permits and citizenship in Norway—Experiences and effects. Report. Oslo: Institutt for samfunnsforskning.

Brorson, H. H., Arnevik, E. A., Rand-Hendriksen, K., & Duckert, F. (2013). Drop-out from addiction treatment: A systematic review of risk factors. Clinical Psychology Review, 33(8), 1010-1024.

Brown, C. H., Bennett, M. E., Li, L., & Bellack, A. S. (2011). Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. Addictive Behaviors, 36(5), 439-447.

Cano, M., & Takeuchi, D. T. (2020). Recent/childhood adversities and mental disorders among US immigrants. Frontiers in Psychiatry, 11, 573410.

Cantor-Graae, E., & Pedersen, C. B. (2013). Full spectrum of psychiatric disorders related to foreign migration: A Danish population-based cohort study. JAMA Psychiatry, 70(4), 427-435.

Carpenter-Song, E., Chu, E., Drake, R. E., Ritsema, M., Smith, B., & Alverson, H. (2010). Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization. Transcultural Psychiatry, 47(2), 224-251.

Cassell, E. J. (2010). The person in medicine. International Journal of Integrated Care, 10(5), 50-52.

Castaneda, A. E., Çilenti, K., Rask, S., Lilja, E., Skogberg, N., Kuusio, H., . . . Suvisaari, J. (2020). Migrants Are underrepresented in mental health and rehabilitation services—survey and register-based findings of Russian, Somali, and Kurdish origin adults in Finland. International Journal of Environmental Research and Public Health, 17(17), 6223.

Chaze, F., Thomson, M. S., George, U., & Guruge, S. (2015). Role of cultural beliefs, religion, and spirituality in mental health and/or service utilization among immigrants in Canada: A scoping review. Canadian Journal of Community Mental Health, 34(3), 87-101.

Chen, C., & Farruggia, S. (2002). Culture and adolescent development. Online Readings in Psychology and Culture, 6(1), 1-12.

Chen, F.-P., Lai, G. Y.-C., & Yang, L. (2013). Mental illness disclosure in Chinese immigrant communities. Journal of Counseling Psychology, 60(3), 379.

Chen, J., & Vargas-Bustamante, A. (2011). Estimating the effects of immigration status on mental health care utilizations in the United States. Journal of Immigrant and Minority Health, 13(4), 671-680.

Chen, W., Hall, B. J., Ling, L., & Renzaho, A. M. (2017). Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: Findings from the first wave data of the BNLA cohort study. The Lancet Psychiatry, 4(3), 218-229.

Chu, J., Leino, A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. Professional Psychology: Research and Practice, 47(1), 18.

CIOMS. (2002). International ethical guidelines for biomedical research involving human subjects. Council for International Organizations of Medical Sciences: Bulletin of Medical Ethics (182), 17-23.

Close, C., Kouvonen, A., Bosqui, T., Patel, K., O'Reilly, D., & Donnelly, M. (2016). The mental health and wellbeing of first generation migrants: A systematic-narrative review of reviews. Globalization and Health, 12(1), 1-13.

Cochrane, R., & Bal, S. S. (1987). Migration and schizophrenia: An examination of five hypotheses. Social Psychiatry, 22(4), 181-191.

Constant, A. F., Kahanec, M., & Zimmermann, K. F. (2009). Attitudes towards immigrants, other integration barriers, and their veracity. International Journal of Manpower, 30(1-2), 5-14.

Corrigan, P. (2004). How stigma interferes with mental health care. American Psychologist, 59(7), 614.

Creswell, J. W., & Poth, C. N. (2016). Qualitative inquiry and research design: Choosing among five approaches: Thousand Oaks, CA: Sage publications.

Dabo, F. J. (2015). Rethinking access to mental health services for refugees in Norway: A fundamental human right. Ås: Norwegian University of Life Sciences.

Dahlgren, L., Emmelin, M., & Winkvist, A. (2007). Qualitative methodology for international public health. Umeå: Umeå University.

Dalgard, O. S., Thapa, S. B., Hauff, E., McCubbin, M., & Syed, H. R. (2006). Immigration, lack of control and psychological distress: Findings from the Oslo Health Study. Scandinavian Journal of Psychology, 47(6), 551-558.

Dalla, M., Antoniou, A.-S., & Matsa, K. (2009). Immigration, acculturation and drug abuse: Multicultural aspects of treatment. In A.-S. Antoniou, C. L. Cooper, G. P. Chrousos, C. D. Spielberger & M. W. Eysenck (Eds.), Handbook of managerial behavior and occupational health (pp. 326-377). Cheltenham: Edward Elgar.

Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. Psychiatric Services, 57(5), 640-645.

Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. British Journal of Medical Psychology, 65(2), 131-145.

Davidson, L., Tondora, J., O'Connell, M. J., Kirk Jr, T., Rockholz, P., & Evans, A. C. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. Psychiatric Rehabilitation Journal, 31(1), 23.

Davidson, L., Tondora, J., & Ridgway, P. (2010). Life is not an “outcome”: Reflections on recovery as an outcome and as a process. American Journal of Psychiatric Rehabilitation, 13(1), 1-8.

De Jong, J. T., & Van Ommeren, M. (2005). Mental health services in a multicultural society: Interculturalization and its quality surveillance. Transcultural Psychiatry, 42(3), 437-456.

De Kock, C., Decorte, T., Vanderplasschen, W., Derluyn, I., & Sacco, M. (2017). Studying ethnicity, problem substance use and treatment: From epidemiology to social change. Drugs: Education, Prevention and Policy, 24(3), 230-239.

De Vroome, T., Hooghe, M., & Marien, S. (2013). The origins of generalized and political trust among immigrant minorities and the majority population in the Netherlands. European Sociological Review, 29(6), 1336-1350.

de Wit, M. A., Tuinebreijer, W. C., Dekker, J., Beekman, A.-J. T., Gorissen, W. H., Schrier, A. C., . . . Verhoeff, A. P. (2008). Depressive and anxiety disorders in different ethnic groups. Social Psychiatry and Psychiatric Epidemiology, 43(11), 905-912.

Debesay, J., Harsløf, I., Rechel, B., & Vike, H. (2014). Facing diversity under institutional constraints: Challenging situations for community nurses when providing care to ethnic minority patients. Journal of Advanced Nursing, 70(9), 2107-2116.

Denzin, N., & Lincoln, Y. (1994). Handbook of qualitative research. London: Sage.

Derr, A. S. (2016). Mental health service use among immigrants in the United States: A systematic review. Psychiatric Services, 67(3), 265-274.

DeSa, S., Gebremeskel, A. T., Omonaiye, O., & Yaya, S. (2022). Barriers and facilitators to access mental health services among refugee women in high-income countries: A systematic review. Systematic Reviews, 11(1), 1-12.

Dinos, S., Ascoli, M., Owiti, J. A., & Bhui, K. (2017). Assessing explanatory models and health beliefs: An essential but overlooked competency for clinicians. British Journal of Psychiatry (Advances), 23(2), 106-114.

Diop, M. S., Taylor, C. N., Murillo, S. N., Zeidman, J. A., James, A. K., & Burnett-Bowie, S.-A. M. (2021). This is our lane: Talking with patients about racism. Women's Midlife Health, 7(1), 1-8.

Dixon, L. B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: Review and update. World Psychiatry, 15(1), 13-20.

Dom, G., & Moggi, F. (2016). Co-occurring addictive and psychiatric disorders. Berlin: Springer.

Donnelly, T. T., Hwang, J. J., Este, D., Ewashen, C., Adair, C., & Clinton, M. (2011). If I was going to kill myself, I wouldn't be calling you. I am asking for help: Challenges influencing immigrant and refugee women's mental health. Issues in Mental Health Nursing, 32(5), 279-290.

Douglass, C. H., Lim, M. S., Block, K., Onsando, G., Hellard, M., Higgs, P., . . . Horyniak, D. (2022). Exploring stigma associated with mental health conditions and alcohol and other drug use among people from migrant and ethnic minority backgrounds: A protocol for a systematic review of qualitative studies. Systematic Reviews, 11(1), 1-11.

Drake, R. E., Mueser, K. T., Brunette, M. F., & McHugo, G. J. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. Psychiatric Rehabilitation Journal, 27(4), 360.

Dressler, W. W., Oths, K. S., & Gravlee, C. C. (2005). Race and ethnicity in public health research: Models to explain health disparities. Annual Review of Anthropology, 34, 231-252.

Dueweke, A. R., Hanson, R. F., Wallis, E., Fanguy, E., & Newman, C. (2019). Training pediatric primary care residents in trauma-informed care: A feasibility trial. Clinical Pediatrics, 58(11-12), 1239-1249.

Dwyer, S., & Buckle, J. (2009). The space between: On being an insider outsider in qualitative research. International Journal of Qualitative Methods, 8(1), 54-63.

Dykxhoorn, J., Hollander, A.-C., Lewis, G., Magnusson, C., Dalman, C., & Kirkbride, J. B. (2019). Risk of schizophrenia, schizoaffective, and bipolar disorders by migrant status, region of origin, and age-at-migration: A national cohort study of 1.8 million people. Psychological Medicine, 49(14), 2354-2363.

Elstad, J. I., Finnvold, J. E., & Texmon, I. (2015). Bruk av sykehus og spesialisthelsetjenester blant innbyggere med norsk og utenlandsk bakgrunn (Vol 10/2015). Oslo: Norsk institutt for forskning om oppvekst, velferd og aldring.

Erdal, K., Singh, N., & Tardif, A. (2011). Attitudes about depression and its treatment among mental health professionals, lay persons and immigrants and refugees in Norway. Journal of Affective Disorders, 133(3), 481-488.

Falgas-Bague, I., Wang, Y., Banerjee, S., Ali, N., DiMarzo, K., Palao Vidal, D. J., & Alegria, M. (2019). Predictors of adherence to treatment in behavioral health therapy for Latino immigrants: The importance of trust. Frontiers in Psychiatry, 10, 817.

Falgas, I., Ramos, Z., Herrera, L., Qureshi, A., Chavez, L., Bonal, C., . . . Alegría, M. (2017). Barriers to and correlates of retention in behavioral health treatment among Latinos in two different host countries: US and Spain. Journal of Public Health Management and Practice, 23(1), e20.

Fancher, T. L., Ton, H., Le Meyer, O., Ho, T., & Paterniti, D. A. (2010). Discussing depression with Vietnamese American patients. Journal of Immigrant and Minority Health, 12(2), 263-266.

Fandrem, H., Strohmeier, D., & Jonsdottir, K. A. (2012). Peer groups and victimisation among native and immigrant adolescents in Norway. Emotional and Behavioural Difficulties, 17(3-4), 273-285.

Fante-Coleman, T., & Jackson-Best, F. (2020). Barriers and facilitators to accessing mental healthcare in Canada for Black youth: A scoping review. Adolescent Research Review, 5(2), 115-136.

Faulkner, A. (2004). The ethics of survivor research: Guidelines for the ethical conduct of research carried out by mental health service users and survivors. Bristol: Policy Press.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. The Lancet, 365(9467), 1309-1314.

Feely, M., & Long, A. (2009). Depression: A psychiatric nursing theory of connectivity. Journal of Psychiatric and Mental Health Nursing, 16(8), 725-737.

Feely, M., Sines, D., & Long, A. (2007). Naming of depression: Nursing, social and personal descriptors. Journal of Psychiatric and Mental Health Nursing, 14(1), 21-32.

Finlay, L. (2002). “Outing” the researcher: The provenance, process, and practice of reflexivity. Qualitative Health Research, 12(4), 531-545.

Finlay, L. (2003). The reflexive journey: Mapping multiple routes. In L. Finlay & B. Gough (Eds.), Reflexivity: A practical guide for researchers in health and social sciences (pp. 3-20). Oxford: Wiley-Blackwell.

Finlay, L. (2009). Debating phenomenological research methods. Phenomenology & Practice, 3(1), 6-25.

Flores, E., Tschann, J. M., Dimas, J. M., Bachen, E. A., Pasch, L. A., & de Groat, C. L. (2008). Perceived discrimination, perceived stress, and mental and physical health among Mexican-origin adults. Hispanic Journal of Behavioral Sciences, 30(4), 401-424.

Fong, T. W., & Tsuang, J. (2007). Asian-Americans, addictions, and barriers to treatment. Psychiatry (Edgmont), 4(11), 51.

Forland, F. (2009). Migrasjon og helse. Utfordringer og utviklingstrekk. Oslo: Helsedirektoratet.

Foucault, M. (1977). Discipline and punish: The birth of the prison (A. Sheridan, trans.) New York: Vintage.

Fountain, J., Bashford, J., Underwood, S., Khurana, J., Winters, M., Carpentier, C., & Patel, K. (2004). Drug use amongst Black and minority ethnic communities in the European Union and Norway. Probation Journal, 51(4), 362-378.

Franks, W., Gawn, N., & Bowden, G. (2007). Barriers to access to mental health services for migrant workers, refugees and asylum seekers. Journal of Public Mental Health, 6(1), 33-41.

Freire, P. (2005). Pedagogy of the oppressed. New York, NY: Continuum.

Freng, E., & Lund, S. (2015). Vi lever i rus: Alt jeg er nå, er det som skjedde meg i hjemlandet: Behandling, migrasjon og asyl. Retrieved from Oslo: https://korusoslo.no/wp-content/uploads/2020/02/Vi-lever-i-rus-rapport.pdf

Friedmann, P. D., Hendrickson, J. C., Gerstein, D. R., & Zhang, Z. (2004). The effect of matching comprehensive services to patients' needs on drug use improvement in addiction treatment. Addiction, 99(8), 962-972.

Friestad, C., & Kjelsberg, E. (2009). Drug use and mental health problems among prison inmates—Results from a nation-wide prison population study. Nordic Journal of Psychiatry, 63(3), 237-245.

Ganga, D., & Scott, S. (2006). Cultural "insiders" and the issue of positionality in qualitative migration research: Moving "across" and moving "along" researcher-participant divides. Paper presented at the Forum Qualitative Sozialforschung/Forum: Qualitative Social Research.

Gee, G. C., Delva, J., & Takeuchi, D. T. (2007). Relationships between self-reported unfair treatment and prescription medication use, illicit drug use, and alcohol dependence among Filipino Americans. American Journal of Public Health, 97(5), 933-940.

Gerrard, M., Stock, M. L., Roberts, M. E., Gibbons, F. X., O'Hara, R. E., Weng, C.-Y., & Wills, T. A. (2012). Coping with racial discrimination: The role of substance use. Psychology of Addictive Behaviors, 26(3), 550.

Gerritsen, A. A., Bramsen, I., Devillé, W., van Willigen, L. H., Hovens, J. E., & Van Der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. Social Psychiatry and Psychiatric Epidemiology, 41(1), 18-26.

Giacco, D., Matanov, A., & Priebe, S. (2014). Providing mental healthcare to immigrants: Current challenges and new strategies. Current Opinion in Psychiatry, 27(4), 282-288.

Giorgi, A. (2008). Concerning a serious misunderstanding of the essence of the phenomenological method in psychology. Journal of Phenomenological Psychology, 39(1), 33-58.

Giorgi, A. (2009). The descriptive phenomenological method in psychology: A modified Husserlian approach. Pittsburgh, PA: Duquesne University Press.

Goffman, E. (1959). The presentation of self in everyday life. New York: Anchor.

Goldberg, R. W., Seybolt, D. C., & Lehman, A. (2002). Reliable self-report of health service use by individuals with serious mental illness. Psychiatric Services, 53(7), 879-881.

Govere, L., & Govere, E. M. (2016). How effective is cultural competence training of healthcare providers on improving patient satisfaction of minority groups? A systematic review of literature. Worldviews on Evidence-Based Nursing, 13(6), 402-410.

Grant, A. (2016). Researching outside the box: Welcoming innovative qualitative inquiry to nurse education today. Nurse Education Today, 45, 55-56.

Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, S. P., Dufour, M. C., Compton, W., . . . Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the national epidemiologic survey on alcohol and related conditions. Archives of General Psychiatry, 61(8), 807-816.

Guardia, D., Salleron, J., Roelandt, J.-L., & Vaiva, G. (2016). Prevalence of psychiatric and substance use disorders among three generations of migrants: Results from French population cohort. L'encephale, 43(5), 435-443.

Guba, E. G., & Lincoln, Y. S. (1982). Epistemological and methodological bases of naturalistic inquiry. Educational Communication & Technology Journal, 30(4), 233-252.

Gueta, K. (2017). A qualitative study of barriers and facilitators in treating drug use among Israeli mothers: An intersectional perspective. Social Science & Medicine, 187, 155-163.

Guillemin, M., & Heggen, K. (2009). Rapport and respect: Negotiating ethical relations between researcher and participant. Medicine, Health Care and Philosophy, 12(3), 291-299.

Haasen, C., Blätter, A., Gharaei, D., Toprak, M. A., Haferkorn, J., & Reimer, J. (2004). Psychosocial aspects of opiate dependence among Turkish migrants in Germany. Journal of Ethnicity in Substance Abuse, 3(1), 1-10.

Hagmayer, Y., & Engelmann, N. (2014). Causal beliefs about depression in different cultural groups—What do cognitive psychological theories of causal learning and reasoning predict? Frontiers in Psychology, 5, 1303.

Halvorsrud, K., Nazroo, J., Otis, M., Brown Hajdukova, E., & Bhui, K. (2019). Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: A systematic review and new meta-analyses for non-affective and affective psychoses. Social Psychiatry and Psychiatric Epidemiology, 54(11), 1311-1323.

Hamed, S., Thapar-Björkert, S., Bradby, H., & Ahlberg, B. M. (2020). Racism in European health care: Structural violence and beyond. Qualitative Health Research, 30(11), 1662-1673.

Hampshire, K. (2003). Health and ethnicity. Edited by H. Macbeth & P. Shetty. Pp. 256. (Taylor & Francis, London, 2001.) £19.99, ISBN 0-415-24167-7, paperback. Journal of Biosocial Science, 35(4), 621-622.

Han, M., Cha, R., Lee, H. A., & Lee, S. E. (2017). Mental-illness stigma among Korean immigrants: Role of culture and destigmatization strategies. Asian American Journal of Psychology, 8(2), 134.

Harpelund, L., Nielsen, S. S., & Krasnik, A. (2012). Self-perceived need for interpreter among immigrants in Denmark. Scandinavian Journal of Public Health, 40(5), 457-465.

Harris, K. M., & Edlund, M. J. (2005). Use of mental health care and substance abuse treatment among adults with co-occurring disorders. Psychiatric Services, 56(8), 954-959.

Harris, S., Dykxhoorn, J., Hollander, A.-C., Dalman, C., & Kirkbride, J. B. (2019). Substance use disorders in refugee and migrant groups in Sweden: A nationwide cohort study of 1.2 million people. PLoS Medicine, 16(11).

Harris, S. M., Binder, P.-E., & Sandal, G. M. (2020). General practitioners' experiences of clinical consultations with refugees suffering from mental health problems. Frontiers in Psychology, 11, 412.

Hasin, D. S., Stinson, F. S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Archives of General Psychiatry, 64(7), 830-842.

Helsedirektoratet. (2010). Patient and interpreter. A brochure about interpretation in the health services. Retrieved from https://www.helsedirektoratet.no/brosjyrer/pasient-og-tolk

Helsedirektoratet. (2011). Nasjonal faglig retningslinje for utredning, behandling og oppfølging av personer med samtidig ruslidelse og psykisk lidelse–ROP-lidelser. Oslo: Helsedirektoratet.

Helsedirektoratet. (2014). Sammen om mestring. Veileder i lokalt psykisk helsearbeid og rusarbeid for voksne. Et verktøy for kommuner og spesialisthelsetjenesten. Oslo: Helsedirektoratet.

Helsedirektoratet. (2017). National guidelines for treatment and rehabilitation of substance use disorders. Oslo: Helsedirektoratet.

Helsenorge. (2019). Interpreter in the health services in Norway. Retrieved from https://www.helsenorge.no/en/health-rights-in-norway/right-to-an-interpreter/

Helseth, V., Lykke-Enger, T., Johnsen, J., & Waal, H. (2009). Substance use disorders among psychotic patients admitted to inpatient psychiatric care. Nordic Journal of Psychiatry, 63(1), 72-77.

Helseth, V., Lykke-Enger, T., Aamo, T. O., & Johnsen, J. (2005). Rusmiddelscreening av pasienter i alderen 17–40 år innlagt med psykose. Tidsskrift for Den norske legeforening, 125, 1178-1180.

Hem, M. (2015). Persons with mental disorders. Retrieved from https://www.forskningsetikk.no/en/resources/the-research-ethics-library/research-on-particular-groups/persons-with-mental-disorders/

Henderson, E., Greene, H., & Gabbidon, S. (2009). Culture conflict theory. In H. Greene & S. Gabbidon (Eds.), The encyclopedia of race and crime (pp. 174-175). Los Angeles, CA: Sage.

Hines-Martin, V., Malone, M., Kim, S., & Brown-Piper, A. (2003). Barriers to mental health care access in an African American population. Issues in Mental Health Nursing, 24(3), 237-256.

Hjern, A. (2004). Illicit drug abuse in second-generation immigrants: A register study in a national cohort of Swedish residents. Scandinavian Journal of Public Health, 32(1), 40-46.

Hjörleifsson, S., Hammer, E., & Díaz, E. (2018). General practitioners' strategies in consultations with immigrants in Norway—Practice-based shared reflections among participants in focus groups. Family Practice, 35(2), 216-221.

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. Nurse Researcher, 20(4).

Hruschka, D. J. (2009). Culture as an explanation in population health. Annals of Human Biology, 36(3), 235-247.

Hser, Y.-I., Polinsky, M. L., Maglione, M., & Anglin, M. D. (1999). Matching clients' needs with drug treatment services. Journal of Substance Abuse Treatment, 16(4), 299-305.

Interian, A., Lewis-Fernández, R., & Dixon, L. B. (2013). Improving treatment engagement of underserved US racial-ethnic groups: A review of recent interventions. Psychiatric Services, 64(3), 212-222.

Iversen, V. C., Berg, J. E., Småvik, R., & Vaaler, A. E. (2011). Clinical differences between immigrants voluntarily and involuntarily admitted to acute psychiatric units: A 3-year prospective study. Journal of Psychiatric and Mental Health Nursing, 18(8), 671-676.

Ivert, A.-K., Merlo, J., Svensson, R., & Levander, M. T. (2013). How are immigrant background and gender associated with the utilisation of psychiatric care among adolescents? Social Psychiatry and Psychiatric Epidemiology, 48(5), 693-699.

Jane-Llopis, E., & Matytsina, I. (2006). Mental health and alcohol, drugs and tobacco: A review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs. Drug and Alcohol Review, 25(6), 515-536.

Jensen, N. K., Norredam, M., Priebe, S., & Krasnik, A. (2013). How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark. BMC Family Practice, 14(1), 17.

Johnson, M. E., Fisher, D. G., Montoya, I., Booth, R., Rhodes, F., Andersen, M., . . . Williams, M. (2000). Reliability and validity of not-in-treatment drug users' follow-up self-reports. AIDS and Behavior, 4(4), 373-380.

Jones, L. V., Hopson, L., Warner, L., Hardiman, E. R., & James, T. (2015). A qualitative study of Black women’s experiences in drug abuse and mental health services. Affilia, 30(1), 68-82.

Kääriäinen, J., & Niemi, J. (2014). Distrust of the police in a Nordic welfare state: Victimization, discrimination, and trust in the police by Russian and Somali minorities in Helsinki. Journal of Ethnicity in Criminal Justice, 12(1), 4-24.

Kagawa-Singer, M., Valdez Dadia, A., Yu, M. C., & Surbone, A. (2010). Cancer, culture, and health disparities: Time to chart a new course? CA: A Cancer Journal for Clinicians, 60(1), 12-39.

Kale, E., & Hjelde, K. H. (2017). Mental health challenges of immigrants in Norway, A literature review 2009–17. Health, 370(9590), 859-877.

Kaltman, S., Hurtado de Mendoza, A., Gonzales, F. A., & Serrano, A. (2014). Preferences for trauma-related mental health services among Latina immigrants from Central America, South America, and Mexico. Psychological Trauma: Theory, Research, Practice, and Policy, 6(1), 83.

Kapborg, I., & Berterö, C. (2002). Using an interpreter in qualitative interviews: Does it threaten validity? Nursing Inquiry, 9(1), 52-56.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 617-627.

Kirkbride, J. B., Hameed, Y., Ioannidis, K., Ankireddypalli, G., Crane, C. M., Nasir, M., . . . Espandian, A. (2017). Ethnic minority status, age-at-immigration and psychosis risk in rural environments: Evidence from the SEPEA study. Schizophrenia Bulletin, 43(6), 1251-1261.

Kirmayer, L. J. (2012). Rethinking cultural competence. Transcultural Psychiatry, 49(2), 149-164.

Kirmayer, L. J., Fung, K., Rousseau, C., Lo, H. T., Menzies, P., Guzder, J., . . . McKenzie, K. (2012). Guidelines for training in cultural psychiatry. The Canadian Journal of Psychiatry, 0706743720907505.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., . . . Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. Canadian Medical Association Journal, 183(12), E959-E967.

Kirmayer, L. J., Weinfeld, M., Burgos, G., du Fort, G. G., Lasry, J.-C., & Young, A. (2007). Use of health care services for psychological distress by immigrants in an urban multicultural milieu. The Canadian Journal of Psychiatry, 52(5), 295-304.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. British Medical Journal, 311(7000), 299-302.

Kjøllesdal, M., Straiton, M., Øien-Ødegaard, C., Aambø, A., Holmboe, O., Johansen, R., . . . Indseth, T. (2019). Health among immigrants in Norway: Living conditions survey among immigrants 2016. Retrieved from: https://www.fhi.no/globalassets/dokumenterfiler/rapporter/2019/levekarsundersokelsen-blant-innvandrere-i-norge-2016-rapport-2019-v2.pdf

Knapstad, M., Nordgreen, T., & Smith, O. R. (2018). Prompt mental health care, the Norwegian version of IAPT: Clinical outcomes and predictors of change in a multicenter cohort study. BMC Psychiatry, 18(1), 1-16.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. The American Journal of Occupational Therapy, 45(3), 214-222.

Kreyenbuhl, J., Nossel, I. R., & Dixon, L. B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. Schizophrenia Bulletin, 35(4), 696-703.

Kroll, J., Yusuf, A. I., & Fujiwara, K. (2011). Psychoses, PTSD, and depression in Somali refugees in Minnesota. Social Psychiatry and Psychiatric Epidemiology, 46(6), 481-493.

Kumar, B. (2006). Ethnic differences in obesity and related risk factors for cardiovascular diseases among immigrants in Oslo, Norway (PhD dissertation). Oslo: University of Oslo.

Kumar, B., & Diaz, E. (2019). Migration health theories: Healthy migrant effect and allostatic load. Can both be true? In B. N. Kumar & E. Diaz (Eds.), Migrant health: A primary care perspective (pp. 17-30). Boca Raton, FL: CRC Press.

Kumar, B. N., & Diaz, E. (2019). Migration and migrants: What we know about worldwide mobility and why it matters. In B. N. Kumar & E. Diaz (Eds.), Migrant health: A primary care perspective (pp. 3-16). Boca Raton, FL: CRC Press.

Kvale, S., & Brinkmann, S. (2009). InterViews: Learning the craft of qualitative research interviewing. Thousand Oaks, CA: Sage.

Lafeuille, M.-H., Dean, J., Fastenau, J., Panish, J., Olson, W., Markowitz, M., . . . Lefebvre, P. (2014). Burden of schizophrenia on selected comorbidity costs. Expert Review of Pharmacoeconomics & Outcomes Research, 14(2), 259-267.

Lago, R. R., Peter, E., & Bógus, C. M. (2017). Harm reduction and tensions in trust and distrust in a mental health service: A qualitative approach. Substance Abuse Treatment, Prevention, and Policy, 12(1), 1-9.

Landheim, A., Bakken, K., & Vaglum, P. (2002). Sammensatte problemer og separate systemer. Norsk epidemiologi, 12(3), 309-318.

Landheim, A., Hoxmark, E., Aakerholt, A., & Aasbrenn, K. (2017). Potensialet for Assertive Community Treatment (ACT) og Fleksibel ACT (FACT) i Norge (NAPHA-rapport 3/2017). Retrieved from https://samforsk.brage.unit.no/samforsk-xmlui/bitstream/handle/11250/2599538/Potensialet+for+Assertive+Community+Treatment+ACT+og+Fleksibel+ACT+FACT+i+Norge+WEB.pdf?sequence=2

Landheim, A., Wiig, F., Brendbekken, M., Brodahl, M., & Biong, S. (2016). Et bedre liv: historier, erfaringer og forskning om recovery ved rusmiddelmisbruk og psykiske problemer. Oslo: Gyldendal akademisk.

Landheim, A. S., Bakken, K., & Vaglum, P. (2006). Impact of comorbid psychiatric disorders on the outcome of substance abusers: A six year prospective follow-up in two Norwegian counties. BMC Psychiatry, 6(1), 44.

Lazarus, R. S. (1993). Coping theory and research: Past, present, and future. Psychosomatic Medicine, 55(3), 234-247.

Lazarus, R. S. (2006). Stress and emotion: A new synthesis. New York, NY: Springer.

Lazarus, R. S., & Folkman, S. (1984). Stress, appraisal, and coping. New York, NY: Springer.

Leary, M. R. (1999). Making sense of self-esteem. Current Directions in Psychological Science, 8(1), 32-35.

Levecque, K., & Van Rossem, R. (2015). Depression in Europe: Does migrant integration have mental health payoffs? A cross-national comparison of 20 European countries. Ethnicity & Health, 20(1), 49-65.

Liamputtong, P., & Ezzy, D. (2005). Qualitative research methods (2nd ed.). Melbourne: Oxford University Press.

Liebkind, K., & Jasinskaja-Lahti, I. (2000). The influence of experiences of discrimination on psychological stress: A comparison of seven immigrant groups. Journal of Community & Applied Social Psychology, 10(1), 1-16.

Lien, L., Rikard Haavet, O., Thoresen, M., Heyerdahl, S., & Bjertness, E. (2007). Mental health problems, negative life events, perceived pressure and the frequency of acute infections among adolescents. Results from a cross-sectional, multicultural, population-based study. Acta Paediatrica, 96(2), 301-306.

Lin, S. Y. (2013). Beliefs about causes, symptoms, and stigma associated with severe mental illness among 'highly acculturated' Chinese-American patients. International Journal of Social Psychiatry, 59(8), 745-751.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Lindert, J., Schouler-Ocak, M., Heinz, A., & Priebe, S. (2008). Mental health, health care utilisation of migrants in Europe. European Psychiatry, 23(S1), s114-s120.

Lindert, J., von Ehrenstein, O. S., Priebe, S., Mielck, A., & Brähler, E. (2009). Depression and anxiety in labor migrants and refugees–A systematic review and meta-analysis. Social Science & Medicine, 69(2), 246-257.

Lindsey, M. A., Joe, S., & Nebbitt, V. (2010). Family matters: The role of mental health stigma and social support on depressive symptoms and subsequent help seeking among African American boys. Journal of Black Psychology, 36(4), 458-482.

Long, E., Aggen, S., Neale, M., Knudsen, G., Krueger, R., South, S., . . . Torvik, F. (2017). The association between personality disorders with alcohol use and misuse: A population-based twin study. Drug and Alcohol Dependence, 174, 171-180.

Lovdata. (2020). Lov om kommunale helse- og omsorgstjenester m.m. (helse- og omsorgstjenesteloven). Retrieved from https://lovdata.no/dokument/NL/lov/2011-06-24-30

Lovdata. (2021). Lov om spesialisthelsetjenesten m.m. (spesialisthelsetjenesteloven). Retrieved from https://lovdata.no/dokument/NL/lov/1999-07-02-61

Lu, W., Todhunter-Reid, A., Mitsdarffer, M. L., Muñoz-Laboy, M., Yoon, A. S., & Xu, L. (2021). Barriers and facilitators for mental health service use among racial/ethnic minority adolescents: A systematic review of literature. Frontiers in Public Health, 9, 641605.

Lundgren, L., Brännström, J., Armelius, B.-Å., Chassler, D., Morén, S., & Trocchio, S. (2012). Association between immigrant status and history of compulsory treatment in a national sample of individuals assessed for drug use disorders through the Swedish public welfare system. Substance Use & Misuse, 47(1), 67-77.

Lyckhage, E. D., Brink, E., & Lindahl, B. (2018). A theoretical framework for emancipatory nursing with a focus on environment and persons' own and shared lifeworld. Advances in Nursing Science, 41(4), 340-350.

Malm, A., Tinghög, P., Narusyte, J., & Saboonchi, F. (2020). The refugee post-migration stress scale (RPMS)–Development and validation among refugees from Syria recently resettled in Sweden. Conflict and Health, 14(1), 1-12.

Malone, J. (2015). Slipping through our fingers: A qualitative study into the barriers minority groups, with substance misuse problems, face accessing healthcare. From the perspective of health professionals working in Bergen, Norway (Master's thesis). Bergen: The University of Bergen.

Malterud, K. (2001a). The art and science of clinical knowledge: Evidence beyond measures and numbers. The Lancet, 358(9279), 397-400.

Malterud, K. (2001b). Qualitative research: Standards, challenges, and guidelines. The Lancet, 358(9280), 483-488.

Malterud, K. (2012). Systematic text condensation: A strategy for qualitative analysis. Scandinavian Journal of Public Health, 40(8), 795-805.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. Qualitative Health Research, 26(13), 1753-1760.

Markkula, N., Lehti, V., Gissler, M., & Suvisaari, J. (2017). Incidence and prevalence of mental disorders among immigrants and native Finns: A register-based study. Social Psychiatry and Psychiatric Epidemiology, 52(12), 1523-1540.

Markova, V., & Sandal, G. M. (2016). Lay explanatory models of depression and preferred coping strategies among Somali refugees in Norway. A mixed-method study. Frontiers in Psychology, 7, 1435.

Marmot, M., Allen, J., Bell, R., Bloomer, E., & Goldblatt, P. (2012). WHO European review of social determinants of health and the health divide. The Lancet, 380(9846), 1011-1029.

Marquez-Arrico, J. E., Río-Martínez, L., Navarro, J. F., Prat, G., Forero, D. A., & Adan, A. (2019). Coping strategies in male patients under treatment for substance use disorders and/or severe mental illness: Influence in clinical course at one-year follow-up. Journal of Clinical Medicine, 8(11), 1972.

Marsiglia, F. F., Kulis, S., Parsai, M., Villar, P., & Garcia, C. (2009). Cohesion and conflict: Family influences on adolescent alcohol use in immigrant Latino families. Journal of Ethnicity in Substance Abuse, 8(4), 400-412.

Martinez, A. R. (2017). Intersectionality, voz, and agency: A culture-centered approach to understanding US-born Mexican Americans' depression experiences. Southern Communication Journal, 82(5), 278-297.

Martinez Tyson, D., Arriola, N. B., & Corvin, J. (2016). Perceptions of depression and access to mental health care among Latino immigrants: Looking beyond one size fits all. Qualitative Health Research, 26(9), 1289-1302.

Masson, C. L., Shopshire, M. S., Sen, S., Hoffman, K. A., Hengl, N. S., Bartolome, J., . . . Iguchi, M. Y. (2013). Possible barriers to enrollment in substance abuse treatment among a diverse sample of Asian Americans and Pacific Islanders: Opinions of treatment clients. Journal of Substance Abuse Treatment, 44(3), 309-315.

Mbanya, V. N., Terragni, L., Gele, A. A., Diaz, E., & Kumar, B. N. (2019). Access to Norwegian healthcare system–Challenges for sub-Saharan African immigrants. International Journal for Equity in Health, 18(1), 125.

McCabe, R., & Priebe, S. (2004). Explanatory models of illness in schizophrenia: Comparison of four ethnic groups. The British Journal of Psychiatry, 185(1), 25-30.

McCann, T. V., Mugavin, J., Renzaho, A., & Lubman, D. I. (2016). Sub-Saharan African migrant youths' help-seeking barriers and facilitators for mental health and substance use problems: A qualitative study. BMC Psychiatry, 16(1), 275.

McCormack, B., & McCance, T. (2011). Person-centred nursing: theory and practice. Oxford: John Wiley & Sons.

McCormack, B., van Dulmen, S., Eide, H., Skovdahl, K., & Eide, T. (2017). Person-centred healthcare research. Hoboken, NJ: John Wiley & Sons.

McLafferty, I. (2004). Focus group interviews as a data collecting strategy. Journal of Advanced Nursing, 48(2), 187-194.

McWhinney, I. R. (1989). 'An acquaintance with particulars...'. Family Medicine, 21(4), 296-298.

Meyer, J. P., Isaacs, K., El-Shahawy, O., Burlew, A. K., & Wechsberg, W. (2019). Research on women with substance use disorders: Reviewing progress and developing a research and implementation roadmap. Drug and Alcohol Dependence, 197, 158-163.

Meyer, M. L., McKenny, M. C., Liddell-Quintyn, E., Nicolas, G., & St. Louis, G. (2021). Racial stress and racialized violence among Black immigrants in the United States. In P. Tummala-Narra (Ed.), Trauma and racial minority immigrants: Turmoil, uncertainty, and resistance (pp. 147-163). Washington, DC: American Psychological Association.

Midtbøen, A. H. (2015). Diskriminering av samer, nasjonale minoriteter og innvandrere i Norge: En kunnskapsgjennomgang. Oslo: Institutt for samfunnsforskning.

Miele, G. M., Tilly, S. M., First, M., & Frances, A. (1990). The definition of dependence and behavioural addictions. British Journal of Addiction, 85(11), 1421-1423.

Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Helping people change. New York, NY: Guilford Press.

Mindlis, I., & Boffetta, P. (2017). Mood disorders in first- and second-generation immigrants: Systematic review and meta-analysis. The British Journal of Psychiatry, 210(3), 182-189.

Mirdal, G. M., Ryding, E., & Essendrop Sondej, M. (2012). Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment. Psychology and Psychotherapy: Theory, Research and Practice, 85(4), 436-455.

Misra, S., Jackson, V. W., Chong, J., Choe, K., Tay, C., Wong, J., & Yang, L. H. (2021). Systematic review of cultural aspects of stigma and mental illness among racial and ethnic minority groups in the United States: Implications for interventions. American Journal of Community Psychology, 68(3-4), 486-512.

Mjølstad, B. P., Kirkengen, A. L., Getz, L., & Hetlevik, I. (2013). What do GPs actually know about their patients as persons? European Journal for Person Centered Healthcare, 1(1), 149-160.

Mjøsund, N. H., Eriksson, M., Espnes, G. A., Haaland-Øverby, M., Jensen, S. L., Norheim, I., . . . Vinje, H. F. (2017). Service user involvement enhanced the research quality in a study using interpretative phenomenological analysis–The power of multiple perspectives. Journal of Advanced Nursing, 73(1), 265-278.

Mladovsky, P. (2007). Migrant health in the EU. Eurohealth, 13(1), 9-11.

Mladovsky, P., Rechel, B., Ingleby, D., & McKee, M. (2012). Responding to diversity: An exploratory study of migrant health policies in Europe. Health Policy, 105(1), 1-9.

Mölsä, M., Kuittinen, S., Tiilikainen, M., Honkasalo, M.-L., & Punamäki, R.-L. (2017). Mental health among older refugees: the role of trauma, discrimination, and religiousness. Aging & Mental Health, 21(8), 829-837.

Moran, D. (2002). Introduction to phenomenology. London: Routledge.

Mordal, J., Bramness, J. G., Holm, B., & Mørland, J. (2008). Drugs of abuse among acute psychiatric and medical admissions: Laboratory based identification of prevalence and drug influence. General Hospital Psychiatry, 30(1), 55-60.

Moree, D. (2018). Qualitative approaches to studying marginalized communities. In G. Noblit (Ed.), Oxford Research Encyclopedia of Education. Oxford: Oxford University Press.

Morojele, N. K., Saban, A., & Seedat, S. (2012). Clinical presentations and diagnostic issues in dual diagnosis disorders. Current Opinion in Psychiatry, 25(3), 181-186.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. Journal of Counseling Psychology, 52(2), 250.

Moselhy, H. F., & Telfer, I. (2002). The pattern of substance misuse among ethnic minorities in a community drug setting. The European Journal of Psychiatry, 16(4), 240-247.

Mösko, M. O., Gil-Martinez, F., & Schulz, H. (2013). Cross-cultural opening in German outpatient mental healthcare service: An exploratory study of structural and procedural aspects. Clinical Psychology & Psychotherapy, 20(5), 434-446.Mueser, K., Drake, R., & Wallach, M. (1998). Dual diagnosis: A review of etiological theories. Addictive Behaviors, 23(6), 717-734.

Mueser, K. T. (2003). Integrated treatment for dual disorders: A guide to effective practice. New York, NY: Guilford Press.

Mulder, C. L., Koopmans, G. T., & Selten, J.-P. (2006). Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to the Netherlands. The British Journal of Psychiatry, 188(4), 386-391.

Murray, C. D., & Wynne, J. (2001). Researching community, work and family with an interpreter. Community, Work & Family, 4(2), 157-171.

Myhre, J., & Tønnessen, M. (2022). Innvandring til Norge. Retrieved from https://snl.no/innvandring

Najt, P., Fusar-Poli, P., & Brambilla, P. (2011). Co-occurring mental and substance abuse disorders: A review on the potential predictors and clinical outcomes. Psychiatry Research, 186(2-3), 159-164.

Napper, L. E., Fisher, D. G., Johnson, M. E., & Wood, M. M. (2010). The reliability and validity of drug users' self reports of amphetamine use among primarily heroin and cocaine users. Addictive Behaviors, 35(4), 350-354.

Natvik, E., & Moltu, C. (2016). Just experiences? Ethical contributions of phenomenologically-oriented research. Scandinavian Psychologist, 3, e17.

NESH. (2016). Guidelines for Research Ethics in the Social Sciences, Humanities, Law and Theology. Retrieved from https://www.forskningsetikk.no/en/about-us/our-committees-and-commission/nesh/

Ness, O., Borg, M., & Davidson, L. (2014). Facilitators and barriers in dual recovery: A literature review of first-person perspectives. Advances in Dual Diagnosis, 7(3), 107-117.

Ness, O., Borg, M., Semb, R., & Karlsson, B. (2014). "Walking alongside:" Collaborative practices in mental health and substance use care. International Journal of Mental Health Systems, 8(1), 1-8.

NIDA. (2018). Principles of drug addiction treatment: A research-based guide (3rd ed.). Rockville, MD: National Institute on Drug Abuse.

NIPH. (2019). Substance use disorders in Norway. Retrieved from https://www.fhi.no/en/op/hin/mental-health/intoxicants-and-substance-use/

O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. Social Psychiatry and Psychiatric Epidemiology, 44(7), 558-568.

Odegaard, O. (1932). Emigration and insanity. Acta Psychiatrica et Neurologica Scandinavica, Suppl.(4), 1-206.

Oppedal, B. (2011). The role of social support in the association between perceived discrimination and mental health among young immigrants in Norway. International Journal of Developmental Science, 5(1-2), 85-99.

Oppedal, B., Røysamb, E., & Heyerdahl, S. (2005). Ethnic group, acculturation, and psychiatric problems in young immigrants. Journal of Child Psychology and Psychiatry, 46(6), 646-660.

Osman, F. A., & Söderbäck, M. (2011). Perceptions of the use of khat among Somali immigrants living in Swedish society. Scandinavian Journal of Public Health, 39(2), 212-219.

Otiniano Verissimo, A. D., Gee, G. C., Ford, C. L., & Iguchi, M. Y. (2014). Racial discrimination, gender discrimination, and substance abuse among Latina/os nationwide. Cultural Diversity and Ethnic Minority Psychology, 20(1), 43.

Padgett, D. K., Smith, B. T., Henwood, B. F., & Tiderington, E. (2012). Life course adversity in the lives of formerly homeless persons with serious mental illness: Context and meaning. American Journal of Orthopsychiatry, 82(3), 421.

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. Psychological Bulletin, 135(4), 531.

Pathare, S., & Shields, L. S. (2012). Supported decision-making for persons with mental illness: A review. Public Health Reviews, 34(2), 1-40.

Patton, M. Q. (2014). Qualitative research & evaluation methods: Integrating theory and practice. Los Angeles, CA: Sage.

Pavlish, C. L., Noor, S., & Brandt, J. (2010). Somali immigrant women and the American health care system: Discordant beliefs, divergent expectations, and silent worries. Social Science & Medicine, 71(2), 353-361.

Pettersen, H., Brodahl, M., Rundgren, J., Davidson, L., & Havnes, I. A. (2019). Partnering with persons in long-term recovery from substance use disorder: Experiences from a collaborative research project. Harm Reduction Journal, 16(1), 1-14.

Pettersen, H., Landheim, A., Skeie, I., Biong, S., Brodahl, M., Benson, V., & Davidson, L. (2019). Helpful ingredients in the treatment of long-term substance use disorders: a collaborative narrative study. Substance Abuse: Research and Treatment, 13, 1178221819844996.

Pettersen, H., Landheim, A., Skeie, I., Biong, S., Brodahl, M., Oute, J., & Davidson, L. (2019). How social relationships influence substance use disorder recovery: A collaborative narrative study. Substance Abuse: Research and Treatment, 13, 1178221819833379.

Pettersen, H., Ruud, T., Ravndal, E., Havnes, I., & Landheim, A. (2014). Engagement in assertive community treatment as experienced by recovering clients with severe mental illness and concurrent substance use. International Journal of Mental Health Systems, 8(1), 1-12.

Pinedo, M., Zemore, S., & Rogers, S. (2018). Understanding barriers to specialty substance abuse treatment among Latinos. Journal of Substance Abuse Treatment, 94, 1-8.

Plumridge, G., Redwood, S., Greenfield, S., Akhter, N., Chowdhury, R., Khalade, A., & Gill, P. (2012). Involving interpreters in research studies. Journal of Health Services Research & Policy, 17(3), 190-192.

Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., . . . Lorant, V. (2011). Good practice in health care for migrants: Views and experiences of care professionals in 16 European countries. BMC Public Health, 11(1), 1-12.

Proctor, G., Cooper, M., Sanders, P., & Malcome, B. (2006). Politicizing the person-centred approach: An agenda for social change. Monmouth, UK: PCCS books.

Qureshi, A., Garcia Campayo, J., Eiroa-Orosa, F. J., Sobradiel, N., Collazos, F., Febrel Bordeje, M., . . . Casas, M. (2014). Epidemiology of substance abuse among migrants compared to native born population in primary care. The American Journal on Addictions, 23(4), 337-342.

Reitz, J. G. (2002). Host societies and the reception of immigrants: Research themes, emerging theories and methodological issues. International Migration Review, 36(4), 1005-1019.

Richard, L., Richardson, G., Jaye, C., & Stokes, T. (2019). Providing care to refugees through mainstream general practice in the southern health region of New Zealand: A qualitative study of primary healthcare professionals' perspectives. BMJ Open, 9(12), e034323.

Ringen, P., Melle, I., Birkenaes, A., Engh, J., Faerden, A., Jonsdottir, H., . . . Larsen, F. (2008). Illicit drug use in patients with psychotic disorders compared with that in the general population: A cross-sectional study. Acta Psychiatrica Scandinavica, 117(2), 133-138.

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships: As developed in the client-centered framework. In S. Koch (Ed.), Psychology: A study of a science. Formulations of the person and the social context (Vol. 3, pp. 184-256). New York, NY: McGraw-Hill.

Rogers, C. R. (1961). On becoming a person: A therapist's view of psychotherapy. London: Constable.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. Drug and Alcohol Review, 24(2), 143-155.

Rose, D. (2009). Is collaborative research possible? In J. Wallcraft, B. Schrank & M. Amering (Eds.), Handbook of service user involvement in mental health research (pp. 169-180). Chichester: Wiley-Blackwell.

Rothstein, B., & Uslaner, E. M. (2005). All for all: Equality, corruption, and social trust. World Politics, 58(1), 41-72.

Ruiz-Castell, M., Kandala, N.-B., Perquin, M., Bocquet, V., Kuemmerle, A., Vögele, C., & Stranges, S. (2017). Depression burden in Luxembourg: Individual risk factors, geographic variations and the role of migration, 2013–2015 European Health Examination Survey. Journal of Affective Disorders, 222, 41-48.

Saechao, F., Sharrock, S., Reicherter, D., Livingston, J. D., Aylward, A., Whisnant, J., . . . Kohli, S. (2012). Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States. Community Mental Health Journal, 48(1), 98-106.

Sagatun, Å., Lien, L., Søgaard, A. J., Bjertness, E., & Heyerdahl, S. (2008). Ethnic Norwegian and ethnic minority adolescents in Oslo, Norway. Social Psychiatry and Psychiatric Epidemiology, 43(2), 87-95.

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. Journal of the National Medical Association, 100(11), 1275-1285.

Salama, E., Niemelä, S., Suvisaari, J., Laatikainen, T., Koponen, P., & Castaneda, A. E. (2018). The prevalence of substance use among Russian, Somali and Kurdish migrants in Finland: A population-based study. BMC Public Health, 18(1), 1-13.

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. International Journal of Mental Health Nursing, 28(1), 152-161.

Salas-Wright, C. P., & Schwartz, S. J. (2019). The study and prevention of alcohol and other drug misuse among migrants: Toward a transnational theory of cultural stress. International Journal of Mental Health and Addiction, 17(2), 346-369.

Salas-Wright, C. P., Vaughn, M. G., Clark, T. T., Terzis, L. D., & Córdova, D. (2014). Substance use disorders among first- and second-generation immigrant adults in the United States: Evidence of an immigrant paradox? Journal of Studies on Alcohol and Drugs, 75(6), 958-967.

Salas-Wright, C. P., Vaughn, M. G., Goings, T. T. C., Córdova, D., & Schwartz, S. J. (2018). Substance use disorders among immigrants in the United States: A research update. Addictive Behaviors, 76, 169-173.

Saloner, B., & Cook, B. L. (2013). Blacks and Hispanics are less likely than whites to complete addiction treatment, largely due to socioeconomic factors. Health Affairs, 32(1), 135-145.

SAMHSA. (2018). Age- and gender-based populations. Retrieved from https://www.samhsa.gov/specific-populations/age-gender-based

Sandberg, S., Saasa, S., & Yirenya-Tawiah, A. (2022). Social exclusion and substance use among African immigrants: The role of discrimination. Journal of Human Behavior in the Social Environment. DOI: 10.1080/10911359.2022.2072039.

Sandhu, S., Bjerre, N. V., Dauvrin, M., Dias, S., Gaddini, A., Greacen, T., . . . Lamkaddem, M. (2013). Experiences with treating immigrants: A qualitative study in mental health services across 16 European countries. Social Psychiatry and Psychiatric Epidemiology, 48(1), 105-116.

Sandøy, T. A. (2015). Group solidarity in a hostile milieu: Immigrant experiences in a street-based drug scene. Drugs: Education, Prevention and Policy, 22(3), 232-238.

Santos, B., Oliveira, H., Miranda, A., Hermsdorff, H., Bressan, J., Vieira, J., . . . Pimenta, A. (2021). Research quality assessment: Reliability and validation of the self-reported diagnosis of depression for participants of the Cohort of Universities of Minas Gerais (CUME project). Journal of Affective Disorders Reports, 6, 100238.

Secades-Villa, R., & Fernández-Hermida, J. R. (2003). The validity of self-reports in a follow-up study with drug addicts. Addictive Behaviors, 28(6), 1175-1182.

Sellström, E., O'Campo, P., Muntaner, C., Arnoldsson, G., & Hjern, A. (2011). Hospital admissions of young persons for illicit drug use or abuse: Does neighborhood of residence matter? Health & Place, 17(2), 551-557.

Sheidow, A. J., McCart, M., Zajac, K., & Davis, M. (2012). Prevalence and impact of substance use among emerging adults with serious mental health conditions. Psychiatric Rehabilitation Journal, 35(3), 235.

Singer, M. K., Dressler, W., George, S., Baquet, C. R., Bell, R. A., Burhansstipanov, L., . . . Garro, L. (2016). Culture: The missing link in health research. Social Science & Medicine, 170, 237-246.

Smith, L. A., Reynish, T., Hoang, H., Mond, J., Hannah, C., McLeod, K., . . . Slewa-Younan, S. (2019). The mental health of former refugees in regional Australia: A qualitative study. Australian Journal of Rural Health, 27(5), 459-462.

Smithson, J. (2000). Using and analysing focus groups: limitations and possibilities. International Journal of Social Research Methodology, 3(2), 103-119.

Spilker, R., Indseth, T., & Aambø, A. (2009). Tilstandsrapport: minoritetshelsefeltet i Norge. Oslo: Nasjonal kompetanseenhet for minoritetshelse (NAKMI).

Squires, A. (2008). Language barriers and qualitative nursing research: Methodological considerations. International Nursing Review, 55(3), 265-273.

SSB. (2021a). Fakta om innvandring. Retrieved from https://www.ssb.no/innvandring-og-innvandrere/faktaside/innvandring

SSB. (2021b). Immigrants and Norwegian-born to immigrant parents. Retrieved from https://www.ssb.no/en/befolkning/innvandrere/statistikk/innvandrere-og-norskfodte-med-innvandrerforeldre

SSB. (2022). Immigrants and Norwegain-born to immigrant parents. Retrieved from https://www.ssb.no/en/befolkning/statistikker/innvbef

Staudt, M. (2007). Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. Journal of Child and Family Studies, 16(2), 183-196.

Stewart, K. D. (2013). Factors contributing to engagement during the initial stages of treatment for psychosis. Qualitative Health Research, 23(3), 336-347.

Straiton, M., Corbett, K., Hollander, A.-C., & Hauge, L. J. (2019). Outpatient mental healthcare service use among women with migrant background in Norway: A national register study. BMC Health Services Research, 19(1), 1-11.

Straiton, M. L., Blystad, H. H., & Reneflot, A. (2018a). Helse i innvandrerbefolkningen. Oslo: Folkehelseinstituttet.

Straiton, M. L., Ledesma, H. M. L., & Donnelly, T. T. (2018b). “It has not occurred to me to see a doctor for that kind of feeling”: A qualitative study of Filipina immigrants’ perceptions of help seeking for mental health problems. BMC Women's Health, 18(1), 1-11.

Straiton, M. L., Reneflot, A., & Diaz, E. (2017). Mental health of refugees and non-refugees from war-conflict countries: Data from primary healthcare services and the Norwegian prescription database. Journal of Immigrant and Minority Health, 19(3), 582-589.

Straiton, M. L., Aambø, A. K., & Johansen, R. (2019). Perceived discrimination, health and mental health among immigrants in Norway: The role of moderating factors. BMC Public Health, 19(1), 1-13.

Svensson, M., & Hagquist, C. (2010). Adolescent alcohol and illicit drug use among first- and second-generation immigrants in Sweden. Scandinavian Journal of Public Health, 38(2), 184-191.

Swim, J. K., & Stangor, C. (1998). Prejudice: The target's perspective. San Diego, CA: Elsevier.

Thapa, S. B., Dalgard, O. S., Claussen, B., Sandvik, L., & Hauff, E. (2007). Psychological distress among immigrants from high-and low-income countries: Findings from the Oslo Health Study. Nordic Journal of Psychiatry, 61(6), 459-465.

Thomson, M. S., Chaze, F., George, U., & Guruge, S. (2015). Improving immigrant populations’ access to mental health services in Canada: A review of barriers and recommendations. Journal of Immigrant and Minority Health, 17(6), 1895-1905.

Tondora, J., & Davidson, L. (2006). Practice guidelines for recovery-oriented behavioral health care. Retrieved from https://portal.ct.gov/-/media/DMHAS/Publications/practiceguidelinespdf.pdf

Torrens M, Mestre-Pinto J, & Domingo-Salvany, A. (2015). Co-morbidity of substance use and mental disorders in Europe. Luxembourg: Publication Office of the European Union.

Torres, L., & Rollock, D. (2009). Psychological impact of negotiating two cultures: Latino coping and self-esteem. Journal of Multicultural Counseling and Development, 37(4), 219-228.

Torvik, F. A., Rosenström, T. H., Ystrom, E., Tambs, K., Røysamb, E., Czajkowski, N., . . . Reichborn-Kjennerud, T. (2017). Stability and change in etiological factors for alcohol use disorder and major depression. Journal of Abnormal Psychology, 126(6), 812.

Toseland, R. W., Jones, L. V., & Gellis, Z. D. (2004). Group dynamics. In C. D. Garvin, L. M. Gutiérrez, & M. J. Galinsky (Eds.), Handbook of social work with groups (pp. 13-31). New York, NY: Guilford Press.

Trivedi, P., & Wykes, T. (2002). From passive subjects to equal partners: Qualitative review of user involvement in research. British Journal of Psychiatry, 181, 468-472. doi:10.1192/bjp.181.6.468

Turner, V. (1973). The forest of symbols: Aspects of Ndembu ritual. London: Cornell University Press.

Ujhelyi, K., Carson, J., & Holland, M. (2016). Positive psychology in dual diagnosis: A preliminary investigation. Advances in Dual Diagnosis 9(4), 139-153.

UNHCR. (2016). Refugees/Migrants Emergency Response–Mediterranean. Geneva: UNHCR.

UNODC. (2004). Substance abuse treatment and care for women: Case studies and lessons learned. New York, NY: United Nations Office on Drugs and Crime.

UNODC. (2020). World Drug Report. New York, NY: United Nations Office on Drugs and Crime.

Vaeth, P. A., Wang-Schweig, M., & Caetano, R. (2017). Drinking, alcohol use disorder, and treatment access and utilization among US racial/ethnic groups. Alcoholism: Clinical and Experimental Research, 41(1), 6-19.

Van Manen, M. (2017). Phenomenology in its original sense. Qualitative Health Research, 27(6), 810-825.

Van Veldhuizen, J. R. (2007). FACT: a Dutch version of ACT. Community Mental Health Journal, 43(4), 421-433.

Vandevelde, S., Vanderplasschen, W., & Broekaert, E. (2003). Cultural responsiveness in substance-abuse treatment: A qualitative study using professionals' and clients' perspectives. International Journal of Social Welfare, 12(3), 221-228.

Vargas, S. M., Cabassa, L. J., Nicasio, A., De La Cruz, A. A., Jackson, E., Rosario, M., . . . Lewis-Fernández, R. (2015). Toward a cultural adaptation of pharmacotherapy: Latino views of depression and antidepressant therapy. Transcultural Psychiatry, 52(2), 244-273.

Varvin, S., & Aasland, O. G. (2009). Physicians' attitude towards treating refugee patients. Tidsskrift for den Norske laegeforening, 129(15), 1488-1490.

Veling, W., Hoek, H. W., Selten, J.-P., & Susser, E. (2011). Age at migration and future risk of psychotic disorders among immigrants in the Netherlands: A 7-year incidence study. American Journal of Psychiatry, 168(12), 1278-1285.

Verdurmen, J. E., Smit, F., Toet, J., Van Driel, H. F., & Van Ameijden, E. J. (2004). Under-utilisation of addiction treatment services by heroin users from ethnic minorities: Results from a cohort study over four years. Addiction Research & Theory, 12(3), 285-298.

Veseth, M., Binder, P.-E., Borg, M., & Davidson, L. (2017). Collaborating to stay open and aware: Service user involvement in mental health research as an aid in reflexivity. Nordic Psychology, 69(4), 256-263.

Visser, M. J., Ikram, U. Z., Derks, E. M., Snijder, M. B., & Kunst, A. E. (2017). Perceived ethnic discrimination in relation to smoking and alcohol consumption in ethnic minority groups in The Netherlands: The HELIUS study. International Journal of Public Health, 62(8), 879-887.

Vrålstad, S., & Wiggen, K. S. (2017). Living conditions among imigrants in Norway 2016. Oslo-Kongsvinger: Statistics Norway.

Werneke, U., & Bhugra, D. (2018). Culture makes a person. Nordic Journal of Psychiatry, 72(sup1), S1-S2.

WHO. (1986). Ottawa charter for health promotion, 1986. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/349652/WHO-EURO-1986-4044-43803-61677-eng.pdf?sequence=1

WHO. (2003). Investing in mental health. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/42823/9241562579.pdf?sequence=1&isAllowed=y

WHO. (2010). How health systems can address health inequities linked to migration and ethnicity (9289002042). Retrieved from https://www.euro.who.int/__data/assets/pdf_file/0005/127526/e94497.pdf

WHO. (2015). WHO global strategy on people-centred and integrated health services: Interim report. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/155002/WHO_HIS_SDS_2015.6_eng.pdf

WHO. (2019a). Facts and figures on substance abuse. Retrieved from https://www.who.int/substance_abuse/facts/en/

WHO. (2019b). Mental disorders. Retrieved from https://www.who.int/en/news-room/fact-sheets/detail/mental-disorders

Wilkes, R., & Wu, C. (2019). Immigration, discrimination, and trust: A simply complex relationship. Frontiers in Sociology, 4, 32.

Willig, C. (2013). Interpretation and analysis. In U. Flick (Ed.), The SAGE handbook of qualitative data analysis (pp. 136-149). Los Angeles, CA: Sage.

Wills, T. A., & Hirky, A. E. (1996). Coping and substance abuse: A theoretical model and review of the evidence.

World Bank. (2022). New World Bank country classifications by income level: 2022-2023. Retrieved from https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023

WMA. (2001). World Medical Association Declaration of Helsinki. Ethical principles for medical research involving human subjects. Bulletin of the World Health Organization, 79(4), 373.

Xu, H., Vorderstrasse, A. A., McConnell, E. S., Dupre, M. E., Østbye, T., & Wu, B. (2018). Migration and cognitive function: A conceptual framework for Global Health Research. Global Health Research and Policy, 3(1), 1-12.

Yamada, A.-M., Vaivao, D. E. S., & Subica, A. M. (2019). Addressing mental health challenges of Samoan Americans in Southern California: Perspectives of Samoan community providers. Asian American Journal of Psychology, 10(3), 227.

Yang, L. H., Thornicroft, G., Alvarado, R., Vega, E., & Link, B. G. (2014). Recent advances in cross-cultural measurement in psychiatric epidemiology: Utilizing 'what matters most' to identify culture-specific aspects of stigma. International Journal of Epidemiology, 43(2), 494-510.

Yorke, C. B., Voisin, D. R., Berringer, K. R., & Alexander, L. S. (2016). Cultural factors influencing mental health help-seeking attitudes among Black English-Speaking Caribbean immigrants in the United States and Britain. Social Work in Mental Health, 14(2), 174-194.

Žagar, M., Pavlič, D. R., Švab, I., Maksuti, A., Ilić, B., Smrekar, M., & Kovačević, I. (2019). Through health workers' eyes: A qualitative study of health service provision for migrants at Schengen border. International Journal for Equity in Health, 18(1), 117.

Zhang, X., Martinez-Donate, A. P., Nobles, J., Hovell, M. F., Rangel, M. G., & Rhoads, N. M. (2015). Substance use across different phases of the migration process: A survey of Mexican migrants flows. Journal of Immigrant and Minority Health, 17(6), 1746-1757.

Zimmerman, C., Kiss, L., & Hossain, M. (2011). Migration and health: A framework for 21st century policy-making. PLoS Medicine, 8(5), e1001034.

Articles

Article 1

Kour, P., Lien, L., Kumar, B., Biong, S., & Pettersen, H. (2019). Coping and Negotiating a Sense of Self: Immigrant Men's Experiences of Living with Co-Occurring Substance Use and Mental Health Disorders in Norway. *American Journal of Psychiatric Rehabilitation*, *22*(1), 43-63.

Coping and Negotiating a Sense of Self: Immigrant Men's Experiences of Living with Co-Occurring Substance Use and Mental Health Diso....

Article *in* American Journal of Psychiatric Rehabilitation · December 2019

5 authors, including:

Prabhjot Kour
Innlandet Hospital Trust
16 PUBLICATIONS 104 CITATIONS
SEE PROFILE

Lars Lien
Innlandet Hospital Trust
235 PUBLICATIONS 5,086 CITATIONS
SEE PROFILE

Stian Biong
University of South-Eastern Norway
39 PUBLICATIONS 499 CITATIONS
SEE PROFILE

Henning Pettersen
University of Oslo
12 PUBLICATIONS 194 CITATIONS
SEE PROFILE

Coping and Negotiating a Sense of Self

Immigrant Men's Experiences of Living with Co-Occurring Substance Use and Mental Health Disorders in Norway

PRABHJOT KOUR, LARS LIEN, BERNADETTE KUMAR,
STIAN BIONG, AND HENNING PETTERSEN

ABSTRACT

Recent years have seen an increase in the immigrant population in Norway, and within this population, a considerable rise in substance use disorders (SUDs) and elevated odds of developing mental health disorders (MHDs). Immigrants are thus regarded as an at-risk group for both situations. No studies have been conducted on the subjective understanding of co-occurring SUDs and MHDs among this immigrant population; thus, there is limited knowledge of the field. This qualitative study aims to explore the lived experiences of being an immigrant and living with co-occurring SUDs and MHDs. Individual interviews with 10 persons of immigrant background with co-occurring SUDs and MHDs, and treatment experience in Norway, were conducted. Data were analyzed using a phenomenological approach and systematic text condensation. Analysis yielded three categories, each with two subcategories, of the immigrants' experiences of living with co-occurring SUDs and MHDs. The overarching theme was how they coped and negotiated a sense of self within the self, within the surrounding culture, and within the structures of society. Subcategories revealed their experiences that necessitated coping and negotiating sense of self within each level. Participants experienced "living a double life" and a "culture clash" along with a sense of belonging to a marginalized group, thus, lacking a sense of belonging in mainstream society. This study provides enhanced understanding of how immigrants with co-occurring SUDs and MHDs experience being an immigrant and having the concurrent disorders.

KEYWORDS

co-occurring disorders, substance use disorder, mental health disorder, immigrants, lived experiences

Introduction

Immigrants constitute 17.7% of Norway's population, 10.4% of whom are from low- and middle-income countries (SSB, 2019). Immigrants are vulnerable due to their different cultural and ethnic backgrounds, and those diagnosed with co-occurring substance use disorder (SUD) and mental health disorder (MHD) are often referred to as "difficult to help" and "complex" due to a variety of factors and lack of tailored services (Davidson et al., 2008). This becomes even more difficult when native populations have negative attitudes toward immigrants, creating challenging situations and integration barriers. The negative attitudes are often associated with racism and discriminatory practices that prevent immigrants from accessing help and social inclusion (Constant et al., 2009). Further, preexisting ethnic attitudes in the institutional arrangements, including law and organizational policies or practices, may make opportunities for immigrants unequal (Reitz, 2002). Brekke and colleagues recently wrote that the practice of residence-permit or citizenship revocation in Norway has led to disintegrating effects among immigrants, including social exclusion, stigmatization, social withdrawal, and lack of a sense of belonging (Brekke et al., 2019). Also, recent studies have revealed underutilization of mental health services (Abebe et al., 2017) and less frequent hospitalizations among immigrants, despite a prevalence of mental problems three times higher than in the general population (Spilker et al., 2009). In addition, immigrants' mental health is affected by acculturative pressure that causes stressors while they balance between two cultures and adapt to the dominant culture of the society (e.g., identity crisis, discrimination, and trauma faced by their parents during different phases of migration), which increases their risk of developing SUDs and MHDs (Lien et al., 2007).

A Swedish survey among adolescents reported that immigrants were more likely to use illicit drugs than the native population (Svensson & Hagquist, 2010). Another cross-sectional study that explored the relationship between immigrant status and the history of compulsory treatment for SUD showed that second-generation immigrants were 41% more likely than the general population to have had compulsory treatment, making them an at-risk group (Lundgren et al., 2012). A longitudinal study (Sagatun et al., 2008) and a review study (Abebe et al., 2014) from Norway also found that the immigrant population experienced more

MHD than native Norwegians. The immigrants in Abebe et al.'s study had a high risk of developing acculturative stress, suffered from poor social support, socioeconomic deprivation, multiple negative life events, and experiences of discrimination and traumatic premigration experiences. A qualitative study (Biong & Ravndal, 2009) among young immigrant men in Scandinavia suggested that immigration and SUDs put them at greater risk of suicide due to a sense of being marginalized in an unknown environment. This study also indicated that immigrants with SUDs are a vulnerable group with multiple treatment needs.

Understanding the processes of coping and sense of self in persons with prolonged MHDs can provide a basis for them to manage, compensate for, and help them to recover from their disorders. Coping is understood as the process in which individuals take actions to handle stressful situations (Bartlett, 1998). We regard migration, SUD, and MHD as stressful events in one's life. Lazarus (1993) argued that stressful situations are associated with harm, loss, threat, or challenge, and that if these situations are significant for the person, then the person will engage in coping to deal with the perceived harm, loss, threat, or challenge. Sense of self is understood as the organized, consistent set of perceptions and beliefs about oneself (Rogers, 1959), and it appears to be a major component in the everyday experience of MHDs, often described as a core factor in illness and change (Davidson & Strauss, 1992). Furthermore, in a novel framework for sense of self, Prebble and colleagues described the phenomenological experience of selfhood as a subjective sense of self, which provides a crucial precondition for phenomenological continuity in episodic memory (Prebble et al., 2013), and we argue that it may also provide insights into the experiences of persons living with SUDs and/or MHDs.

Increased immigration to Norway in the last 20 years has led to greater ethnic diversity among the population (Abebe et al., 2015). This relocation of large groups of persons has transformed Norway from a perceived homogeneous and monocultural society to a heterogeneous and multicultural society (Oppedal et al., 2005). Research has shown that poor integration has led to higher rates of MHDs in immigrant groups (Roberts et al., 1997; Virta & Westin, 1999). This makes it important to study both cross-cultural and within-culture perspectives in multicultural society (Oppedal et al., 2005). Culture must be understood as mental representation of the meaning of systems, symbols, and practices through which persons interpret experiences, and culture and individual psychological functioning are mutually constitutive (Mistry & Saraswathi, 2003). We therefore need more knowledge about cultural perceptions, possible ethnic differences, and risk factors for lifestyle behaviors. This knowledge is important for generally reducing social inequality in health (Abebe et al., 2015).

The aim of this study is to explore the lived experiences of being an immigrant and living with co-occurring substance use and mental health disorders in Norway.

Method

Design and Collaborative Research

The study design is qualitative and exploratory, with a phenomenological approach to data analysis.

Collaborative research is invaluable in bringing a fresh perspective to the research process, is highly relevant to clinical practice, and helps to improve the evidence base used to inform how services are provided (Beresford, 2003). Therefore, a competency group of three persons was established to work with the research team in all stages of the study. Two members were previous users of psychiatric treatment with lived experiences of co-occurring MHD and SUD, and one was a relative of one user. All three members had immigrant backgrounds and understanding of their local community as well as the greater Norwegian community.

Recruitment

A purposive, criterion-based sampling method (Patton, 2002) was used to recruit the participants from two large Norwegian cities, Oslo and Drammen. To achieve information-rich data, the study included a diverse sample of immigrants from low- and middle-income countries with experience of living with co-occurring disorders and of treatment in Norwegian health care. *Immigrants* in this project are understood as persons who were born or whose parents were born in low- and middle-income countries. In addition, we included immigrants (persons born abroad of two foreign-born parents and four foreign-born grandparents) and persons who were Norwegian born to immigrant parents (persons born in Norway of two parents born abroad who also have four grandparents born abroad) in our study (SSB, 2019). Note also that *immigrants* is not a homogeneous category; they differ in multiple ways, including culture, ethnicity, the reason for migration, and historical migration patterns. So this study considers them heterogeneous versus homogeneous.

We initiated contact by emailing and calling the leaders of various treatment and rehabilitation centers in these two cities who had access to participants with the inclusion criteria. These leaders received detailed information about the research project. Recruitment of participants was extremely challenging. We do not know exactly how many persons the team leaders asked to participate, but most of them refused to take part in the study. Only one participant was recruited through these leaders. This participant was contacted by telephone by the first author and informed about the study. Subsequently, by snowballing, this participant helped to recruit three more participants with whom he had contact. The competency group played a key role in recruiting further participants: Six participants were recruited with the help of this group, whose members had contacts in their local community. Potential participants were able to show interest by contacting the first author by telephone or text.

Participants

Ten participants who met the inclusion criteria were included in this study (Appendix A, Table-1). All were males, with an age range of 25 to 53 years. They had been diagnosed with co-occurring SUDs and MHDs and had experience of treatment in the Norwegian health care system. All of them were polysubstance users and the most common substances used were cannabis, alcohol, and heroin. Five persons reported not using substances at the time of interview, while the other five were using substances. The participants also reported having experienced MHDs, most commonly affective disorder, posttraumatic stress disorder, personality disorder, and anxiety. Eight participants reported having experienced suicidal thoughts and attempting suicide. The objective diagnosis was not considered, but rather how the participants understood their own mental health condition.

Five participants were from Iran, and the remainder were from Sierra Leone, Eritrea, India, and Pakistan. Two participants were born in Norway, and most others migrated at a very early age, while two had arrived at ages 21 and 24 years. Eight participants started using substances at a young age after arriving in Norway, while the two adult migrants started at a young age in their countries of origin.

Data Collection

Ten semistructured, in-depth individual interviews (Kvale & Brinkmann, 2009) were conducted between June 2018 and March 2019. After 10 interviews, the research team considered the data to be sufficiently saturated to fulfill the aim of the study. The interviews lasted between 40 and 90 minutes and all were audio recorded. Nine of the interviews were conducted in Norwegian with the first author and an interpreter, while one interview was carried out in English and Punjabi only with the first author, and transcribed in English. An interview guide, consisting of open-ended questions about what it means to live in Norway as a person with immigrant background living with co-occurring SUD and MHD, was created and agreed upon by all authors and the competency group.

Data Analysis

Interviews conducted in Norwegian were transcribed by the interpreter, and the one conducted in English and Punjabi was transcribed by the first author. The transcripts were analyzed using systematic text condensation (Malterud, 2012), which is a pragmatic phenomenological approach inspired by Giorgi (2009). This is an exploratory and descriptive method aimed at thematic cross-case analysis, which enables a process of reflexivity, feasibility, and intersubjectivity, while maintaining methodological rigor. Systematic text condensation is a stepwise procedure that involves the identification of recurring initial codes and themes relevant to the purpose of the study. In the first step, a total impression was gained by reading all the transcripts, which resulted in initial themes. In the second step, meaning units were identified and sorted into code groups by systematically reviewing the transcripts. In the third step, the code groups with the meaning units were classified into subgroups. The fourth step involved the formation of artificial quotations by reducing the meaning units under each subgroup. The artificial quotation containing the participants' original terminology was identified for each subgroup. The final step was to develop the analytic text and descriptions from the artificial quotations. The analytic text was reconceptualized by returning to the complete transcripts and reflecting on whether each illustrative quotation still reflected the original context. This process validated the analytic texts. At the end, the supporting quotes were added to the analytic texts, which are presented in the Results section. In each step, the research team was consulted, and in the final step, the competency group was consulted to provide an understanding of the results within the local context they represented.

Ethical Considerations

This study was approved by the Norwegian Centre for Research Data (Project No. 59707). The participants signed the informed consent form and received an information letter and debriefing about the project prior to the interviews. All confidential details were deleted from the data to preserve participant anonymity. The interpreter and the members of the competency group signed a confidentiality declaration. The contact details of the first author were made available to the participants in case they had any postinterview concerns or questions.

Results

The analysis yielded three categories, each containing two subcategories, of the immigrants' experiences of living with co-occurring substance use and mental health disorders. The main theme overarching these categories and subcategories was coping and negotiating a sense of self. The analysis conceptualized how participants coped and negotiated their sense of self (a) within the self, (b) within the surrounding culture, and (c) within the structures of society (Appendix B, Figure 1).

Coping and Negotiating a Sense of Self Within the Self

Inner conflict. A "culture clash" between their own culture and Norwegian culture emerged as one of the major inner conflicts of the participants. The cultural differences and understanding of Norwegian culture were described as a big problem, and ultimately, the participants did not know how to fit into both cultures. This led to the conflict of recognizing oneself in both cultures and losing one's sense of self with no sense of belonging (participant ID numbers follow each interview excerpt):

> . . . culture clash between Iran and Norway. It was a big clash and I didn't know who I was. . . . I started seeing both sides and lost myself completely. I became a person with a completely blocked mind and I did not know where I belonged. (P-8)

A majority of the participants described the inner conflict of struggling to trust anyone. Their immigrant background, living in a context quite unlike their country of origin and having experienced war and bullying, had ruined their ability to trust anyone, and resulted in their carrying a baggage of doubts and suspicions, which they found tiresome and exhausting.

> Trust, which is zero. I don't trust anyone and nothing in this world. . . . We sat with many Norwegian drug abusers but I still could not see myself in them. There was more to this, I had suffered, I had another background, I had war, bullying, refugee. All of this was also baggage I was carrying. It wasn't just drugs and alcohol for me, I had much more. So I struggled with trust and trusting anyone with my words. (P-5)

Participants experienced guilt, shame, and hurtful thoughts. They described struggling with these negative emotions due to their self-perceived inability to fit in with the norms of society. They described taboos attached to the use of substances and having a mental health disorder, which together with their immigrant background made it difficult for them to share their feelings about the problems they were facing. They described this as keeping these negative emotions inside even though they were suffering, which led to the inner conflict. As one participant explained, "It's a lot of taboo and difficult to talk about. I don't talk much either and keep things inside me even though I'm suffering" (P-4).

The participants described how they coped by running away when things became difficult and using substances; this became the way to escape from who they were and a medicine for all the negative emotions. Using substances made them feel invulnerable and confident, and reduced their pain of not recognizing their sense of self. Some of the participants described coping by developing selective mutism, becoming introverted and passive-aggressive. Furthermore, they negotiated their sense of self by being affected by past experiences that helped to carry them forward.

Lack of family support. Participants experienced a lack of family support, which also contributed to their substance use. Having abusive family relationships in which they were beaten by their family members led to a feeling of being pressured over time. They experienced a serious lack of communication within the family, which meant that they did not confront their family members with their struggles. Many described the divorce of their parents as a disruptive event and the beginning of destructive relationships between their parents and themselves. They also reported that their inability to live up to their family's expectations and demands led to the fear of family rejecting them. In addition, some pointed out that their family had broken their trust by placing them in child care.

Participants described how, in order to cope with destructive family relationships, they found substances to be a kind of survival strategy and defense mechanism to anesthetize themselves. Some of them described having to negotiate their sense of self by becoming bitter, hateful, and angry about their family situation. Some developed the rebellious attitude of smoking in front of their family to cope with the lack of familial love and support:

> I smoked, I was in opposition to my family. When I was 15, my father had had enough and told me to pack my things and go to hell. The substances helped me get through everything actually. The pain, everything about my family, about not having seen them, having been thrown out. . . . We came from a well-established family . . . I did not manage to fulfill my family's high demands and expectations. And that led to more and more substances, in fact. (P-9)

Coping and Negotiating a Sense of Self Within the Surrounding Culture

Cultural stigma. The participants' experiences illustrated that having substance use and mental health disorders was associated with stigma, especially within their communities. It was considered disgraceful by their families, and discovery as an "addict" within their community was associated with shame and everyone around them looking down on them. Since participants' communities in Norway are small, they constantly faced the fear of being detected.

To cope with the cultural stigma, participants described the experiences of wearing a mask and using substances even more. They coped and negotiated their sense of self by keeping their substance use secret, and when they were seeking treatment, they were forced to lie about leaving home and going to work outside Norway for some period of time, so that nobody would know that they were in treatment centers. They described this as "living a double life," in which they behaved soberly in front of their family and relatives, but continued to use substances or seek treatment that they concealed from others:

> I know people who don't dare to start the treatment. Or they've been in treatment, and tell their mum and dad, "I'm going on a trip around the globe for one year. And I don't want to take my phone with me, because I don't want to be a part of this digital world," when they are going to treatment centers. And if you have to do that with your close ones, I can imagine how many masks you must be wearing. If you can't manage to be this open with your family, and the people closest to you, then how on earth are you going to get help? (P-3)

Belonging. Being accepted for who they were in a group of substance users was experienced as positive by the participants and gave them a sense of belonging. They described having struggled to find a place where they were not judged based on their immigrant background and their diagnosis of co-occurring SUD and MHD. It was therefore easier for them to be with other substance users than with persons in general due to a feeling of acceptance and belonging. They experienced being recognized as a person and not as a "junkie" or "addict" or based on their ethnicity. Moreover, they did not feel victimized in these groups, as they used to feel with their family and relatives:

> It was hard for me to find a place anywhere, but I met a gang of people who used drugs and they accepted me for who I was. I didn't really feel like I had a place before, but with that gang of people I was just me and had the place where I belong. (P-1)

Participants coped and negotiated their sense of self by using substances with others and protecting each other at all times. They even reported fighting together against racial remarks. They also joined training activities like taekwondo and gym together and coped by supporting each other within the group. This also helped them to forget the pain and fear they were facing by being substance users and immigrants.

Coping and Negotiating a Sense of Self Within the Structures of Society

Experiences of racism. Most participants reported having experienced racism and being labeled at various institutions due to their immigrant background, substance use history, and mental health disorder. Many stated that, even though they had lived most of their lives in Norway, they were still considered as "black" and not Norwegian. They also described being given an ethnic label if there were any crime situation. Some participants described their experiences of being bullied in school due to their different skin and hair color and lack of fluency in Norwegian. They mentioned being beaten and given bad grades by teachers, even though they believed they were doing well at school. They had also experienced racial remarks from persons in their community.

Several participants mentioned being looked down on and facing difficulties in getting jobs. They felt that they were stigmatized when applying for jobs at the Norwegian Labour and Welfare Administration (NAV) due to their history of substance use and crime:

> When I apply for something I can feel that I'm being looked down upon by the system, because of my past with drugs and crime. They push us down. . . . With the system and with jobs, with people at work. That's where I feel stigmatized . . . yes, that's something I've noticed. Like with NAV, or if I'm applying for a job. (P-2)

These racial experiences led participants to try to cope by using substances even more than before. They also coped by hating their own immigrant background and culture. This hatred resulted in a lack of communication with their families and relatives. The participants negotiated their sense of self by getting involved in fights to defend themselves from racism.

Distrust of the system. Several participants said that they had very little or no trust in the system. They reported being unable to rely on health care services when seeking treatment. Being prescribed antidepressants or anti-anxiety pills without anyone inquiring about the problems they were dealing with made them reluctant to receive the treatment. Their dissatisfaction with treatment added to their lack of trust in the health care system. Some participants mentioned that they felt worse after treatment ended, which led to relapses and self-medication. Participants described their experience of treatment while in Child Welfare Services (CWS) as astonishing because their personal information, which they had shared with their psychiatrist, was reported to the child care services. This led them to feel cheated and initiated their fundamental distrust in the system.

Participants also experienced fear of CWS because they could lose their parental rights. Many stated that having a child was a ray of hope for them in their struggle with SUD and MHD. The fear of losing their child to CWS was thus a threatening experience, which led them to distrust the services:

> It's a very difficult situation, I have to stay alert and cautious whenever I'm out with my kid. I feel I'm being watched all the time. I don't like this thing at all. I feel constantly scared of losing my child to the child care services. So yes, this is one thing that scares me. (P-6)

Participants reported coping by seeking compulsory treatment, as they did not want to lose their children to CWS. Some described coping and negotiating their sense of self by being manipulative in treatment and counseling. These painful early experiences led to an inability to regain trust in the system later in life.

Discussion

This study provides new insights into the experiences of immigrant men living with co-occurring SUDs and MHDs. The participants described their experiences of coping and ways in which their sense of self was negotiated within their own selves, with the surrounding culture, and with society. One significant finding is participants' experiences of "living a double life" and a "culture clash" due to conflicts between their family culture and the culture of the host country. Another is the participants' experiences of racism at different levels and cultural stigma that leads to lack of trust and no sense of belonging within the context they are living. This was in addition to fluctuating feelings of being an immigrant and living with co-occurring disorders.

Migration is a profound, nonnormative transitional event with long-term effects on life. The challenges of assimilating into the dominant culture, and those faced when the dominant culture does not welcome diversity, can lead to increased substance use among immigrants (Dalla et al., 2009). This hypothesis is in line with participants' experiences of culture clash as living at the juncture of two cultures, using substances to cope, and finding ways to negotiate their sense of self between two cultures. Further, this is associated with negative consequences such as intergenerational conflicts, family conflicts, and societal pressures (Torres & Rollock, 2009); also, immigrants who are refugees from conflict-prone areas are likely to be dealing with their own trauma. Culture clash can also be understood in terms of culture conflict theory, which states that conduct norms vary among cultures, where an action may be a violation of norms in one culture, but not in another culture. This poses a potential for cultural conflict when the dominant culture sets the standards for acceptable behavior and considers those who do not comply with these norms deviant (Henderson, 2009), which concurs with the participants' experiences.

Experiences of guilt, shame, negative thoughts, and difficulty in trusting anyone created a feeling of inner conflict for participants. These experiences are associated with low self-esteem, which often results in social devaluation and rejection. Low self-esteem is also shown to be strongly related to a variety of psychological difficulties and substance abuse (Leary, 1999), which likewise is in line with our findings. Furthermore, a study on harm reduction and tensions in trust and distrust in mental health settings reported that distrust was more prevalent than trust in the participants' reports (Lago et al., 2017), consistent with the findings of our study in which participants struggled to trust anyone. Dalla et al. (2009) noted that when such negative emotions become unbearable, using substances becomes the coping mechanism and also a way of expressing frustration and anger.

Participants described how experiences of family conflicts, including a sense of a lack of love, support, and communication, led to substance use and problematic behavior as early as adolescence. This finding is similar to a study of immigrant Latino families (Marsiglia et al., 2009) that showed how family conflicts and low family cohesion predicted lifetime use of substances. The study found that binge drinking was problematic among adolescent immigrants who were trying to navigate between two different cultural worlds. Further, it demonstrated that when these adolescents did not have any positive coping strategies to reduce mental distress caused by family conflicts and tensions, they resorted to substance use and problematic behavior, including rejecting family values in the form of rebellion, as experienced by the participants of the present study. Furthermore, Dalla and colleagues (2009) reported that assimilation into a new culture may create family conflicts due to different rates of acculturation between parents and children. This can lead to significant tensions between them including personal distress, delinquent behavior, and substance use, which is also in line with the findings of the present study.

Substance use disorders and mental health disorders consistently rank among the most stigmatized conditions (Room, 2005; WHO, 2003). Personal cultural beliefs have a great impact on perceptions of mental disorders and substance use. In most places, the culture determines how persons understand and deal with these conditions. Chen and Farruggia (2002) documented that persons with conservative thinking often view these conditions as stigmatizing and avoid those living with them. This is similar to our finding of cultural stigma as experienced by the participants, who described fear of being discovered by their communities and expelled from families that attach stigma to MHD and SUD. Participants also described this cultural stigma as one of the reasons for "living a double life," which is stressful as they constantly have to wear a mask of sobriety in front of their families and community.

The participants had a positive view of their sense of belonging and feeling of acceptance when in a group of substance users with a similar diagnosis. Within these groups they found inclusion and were seen as being of value, in line with the study by Dalla and colleagues (2009), who further suggested that these groups function at the periphery of society and adopt substance use as a method of socialization within the new culture. Because of their lack of acceptance in the two cultures where they lived, participants struggled with their lack of a sense of belonging elsewhere. Further, it has been documented that it is not only a cultural barrier, but a community-level barrier, that leads to lack of acceptance and no sense of belonging within the community. A study done in Norway among persons admitted to psychiatric hospitals stated that participants experienced a sense of loneliness, struggled for equality, and felt neglected, and hence lacked a sense of belonging within the community (Granerud & Severinsson, 2006). Such a sense of belonging is validated by one's fellow citizens (Ponce & Rowe, 2018). This includes persons with co-occurring disorders who are marginalized, hard to reach, and often face difficulties in achieving inclusion within communities.

A sense of belonging is both supported by and supports a person's relation to the citizenship framework, with the 5 Rs of rights, responsibilities, roles, resources, and relationships that society offers (Rowe, 2015). Moreover, the citizenship framework offers a connection via social and public institutions, supportive social networks, closely tied relationships, and associational life in their community (Rowe & Pelletier, 2012). This in turn would be valuable for the participants of our study, who have experienced disruptive life events, stigma and racism, no sense of belonging, and social marginalization. Giving the participants a possibility of community integration and inclusion by allowing them to participate in society and valuing their participation would provide them a sense of personal ownership of their roles and responsibilities (Ponce et al., 2012). Further, to experience a sense of belonging, it is important to value dignity, diversity, and difference for all persons, which would reduce psychiatric symptoms and substance use (Rowe, 2015). This would in turn provide a sense of belonging and acceptance not only within a particular group of users, but also at a societal level.

Participants described experiences of racism related to their immigrant background and their co-occurring disorders from different societal structures, including school, workplace, state welfare services, and the health care system. In a recent integrative review, it was stated that persons of immigrant background with MHD often face few or no opportunities and decreased access to resources because of racism practiced by employers who tend not to give them jobs, and by landlords less inclined to rent them houses. Such racist attitudes deprive them of the chance to fully integrate and participate in society (Abdullah & Brown, 2011). Immigrants often cope with these experiences of racism by leaving their ethnic group, feeling embarrassed by their parents and culture (Dalla et al., 2009), which is similar to our findings that participants described coping with racism by hating their family and culture.

Last, this study included only men due to the challenges in recruiting immigrant women with co-occurring disorders. We had planned to recruit both men and women with the inclusion criteria. The recruitment of participants, however, was extremely challenging, even with men, due to the stigma attached to SUD and/or MHD. According to the participants, there were many men and women with a similar diagnosis, but they did not want to come forward owing to fear of being detected in their small communities in Norway. We argue that this holds true, especially for immigrant women with SUDs and/or MHDs, because of their different cultural norms and their perceived potential risk of greater harm if they are detected and identified. Moreover, due to their more hidden nature and fear of being discriminated against, immigrant women are less likely to report their SUDs and/or MHDs and instead remain camouflaged.

Limitations and Strengths

This study provides insights into immigrants' experiences of living with SUDs and MHDs in Norway, which to our knowledge has not been explored previously. The results are based on these participants' experiences and do not allow for generalization; however, the insights may be of relevance to future research. Further, our interpretation of the results should be viewed within the scope of qualitative research and is thus not generalizable in a statistical sense. However, even with these challenges, we argue that our results provide insights into the experiences of a group of persons who are considered hard to reach and often stigmatized. Furthermore, we enhanced the internal validity of our data by collaborating with a competency group in all stages of the study, including writing the protocol, preparing the study, analyzing the data, and compiling the results. Last, this study included only men due to the challenges in recruiting immigrant women with co-occurring disorders.

Conclusion

Immigrant men living with substance use and mental health disorders interpreted their experiences within themselves, within the surrounding culture, and within the structures of society, in order to cope and negotiate their sense of self. Norway and other countries would greatly benefit by improving the health of immigrants. Hence, we believe that the insights from the participants are timely and that the knowledge gained can broaden the perspectives of practitioners and policy makers to provide more appropriate services. Further, we suggest that policies that are immigrant-friendly, that may reduce stigma and racism, and that increase a sense of belonging should be implemented within the Norwegian context at a community level, thus enabling immigrants to achieve full citizenship. Further research is suggested for comparative studies between native and immigrant persons living with co-occurring SUDs and MHDs.

PRABHJOT KOUR, Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP), Innlandet Hospital Trust and University of South-Eastern Norway

LARS LIEN, Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP), Innlandet Hospital Trust and Faculty of Health and Social Sciences, Inland Norway University of Applied Sciences

BERNADETTE KUMAR, Norwegian Institute of Public Health

STIAN BIONG, University of South-Eastern Norway

HENNING PETTERSEN, Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP), Innlandet Hospital Trust and Faculty of Health and Social Sciences, Inland Norway University of Applied Sciences

REFERENCES

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, *31*(6), 934–948. https://doi.org/10. 1016/j.cpr.2011.05.003

Abebe, D. S., Hafstad, G. S., Brunborg, G. S., Kumar, B. N., & Lien, L. (2015). Binge drinking, cannabis and tobacco use among ethnic Norwegian and ethnic minority adolescents in Oslo, Norway. *Journal of Immigrant & Minority Health*, *17*(4), 992–1001. https://doi.org/10.1007/s10903-014-0077-9

Abebe, D. S., Lien, L., & Elstad, J. I. (2017). Immigrants' utilization of specialist mental healthcare according to age, country of origin, and migration history: A nation-wide register study in Norway. *Social Psychiatry & Psychiatric Epidemiology*, *52*(6), 679–687. https://doi.org/10.1007/s00127-017-1381-1

Abebe, D. S., Lien, L., & Hjelde, K. H. (2014). What we know and don't know about mental health problems among immigrants in Norway. *Journal of Immigrant & Minority Health*, *16*(1), 60–67. https://doi.org/10.1007/s10903-012-9745-9

Bartlett, D. (1998). *Stress: Perspectives and processes*. McGraw-Hill Education.

Beresford, P. (2003). User involvement in research: Exploring the challenges. *NT Research*, *8*(1), 36–46. https://doi.org/10.1177/136140960300800106

Biong, S., & Ravndal, E. (2009). Living in a maze: Health, well-being and coping in young non-Western men in Scandinavia experiencing substance abuse and suicidal behaviour. *International Journal of Qualitative Studies on Health & Well-being*, *4*(1), 4–16. https://doi.org/10.1080/17482620802239869

Brekke, J.-P., Birkvad, S. R., & Erdal, M. B. (2019). *Losing the right to stay: Revocation of immigrant residence permits and citizenship in Norway—Experiences and effects* (Report 2019:9). Institute for Social Research. https://www.udi.no/globalassets/global/forskning-fou_i/utlendingsforvaltningen/rapport-9-19-losing-the-right-to-stay-web.pdf

Chen, C. S., & Farruggia, S. (2002). Culture and adolescent development. *Online Readings in Psychology & Culture*, *6*(1). https://doi.org/10.9707/2307-0919.1113

Constant, A. F., Kahanec, M., & Zimmermann, K. F. (2009). Attitudes towards immigrants, other integration barriers, and their veracity. *International Journal of Manpower*, *30*(1/2), 5–14. https://doi.org/10.1108/01437720910948357

Dalla, M., Antoniou, A.-S., & Matsa, K. (2009). Immigration, acculturation and drug abuse: Multicultural aspects of treatment. In A.-S. Antoniou, C. L. Cooper, G. P. Chrousos, C. D. Spielberger, & M. W. Eysenck (Eds.), *Handbook of managerial behavior and occupational health* (pp. 362–380). Edward Elgar.

Davidson, L., Andres-Hyman, R., Bedregal, L., Tondora, J., Frey, J., & Kirk, T. A., Jr. (2008). From "double trouble" to "dual recovery": Integrating models of recovery in addiction and mental health. *Journal of Dual Diagnosis*, *4*(3), 273–290. https://doi.org/10.1080/15504260802072396

Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, *65*(2), 131–145. https://doi.org/10.1111/j.2044-8341.1992.tb01693.x

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Duquesne University Press.

Granerud, A., & Severinsson, E. (2006). The struggle for social integration in the community—The experiences of people with mental health problems. *Journal of Psychiatric & Mental Health Nursing, 13*(3), 288–293. https://doi.org/10.1111/j.1365-2850.2006.00950.x

Henderson, E. (2009). Culture conflict theory. In H. T. Greene & S. L. Gabbidon (Eds.), *Encyclopedia of race and crime* (pp. 175–176). SAGE Publications.

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. SAGE Publications.

Lago, R. R., Peter, E., & Bógus, C. M. (2017). Harm reduction and tensions in trust and distrust in a mental health service: A qualitative approach. *Substance Abuse Treatment, Prevention, & Policy, 12*(1), 12. https://doi.org/10.1186/s13011-017-0098-1

Lazarus, R. S. (1993). Coping theory and research: Past, present, and future. In R. S. Lazarus (Ed.), *Fifty years of the research and theory of RS Lazarus: An analysis of historical and perennial issues* (pp. 366–388). Lawrence Erlbaum.

Leary, M. R. (1999). Making sense of self-esteem. *Current Directions in Psychological Science, 8*(1), 32–35. https://doi.org/10.1111/1467-8721.00008

Lien, L., Rikard Haavet, O., Thoresen, M., Heyerdahl, S., & Bjertness, E. (2007). Mental health problems, negative life events, perceived pressure and the frequency of acute infections among adolescents: Results from a cross-sectional, multicultural, population-based study. *Acta Paediatrica, 96*(2), 301–306. https://doi.org/10.1111/j.1651-2227.2007.00084.x

Lundgren, L., Brännström, J., Armelius, B.-Å., Chassler, D., Morén, S., & Trocchio, S. (2012). Association between immigrant status and history of compulsory treatment in a national sample of individuals assessed for drug use disorders through the Swedish public welfare system. *Substance Use & Misuse, 47*(1), 67–77. https://doi.org/10.3109/10826084.2011.628736

Malterud, K. (2012). Systematic text condensation: A strategy for qualitative analysis. *Scandinavian Journal of Public Health, 40*(8), 795–805. https://doi.org/10.1177/1403494812465030

Marsiglia, F. F., Kulis, S., Parsai, M., Villar, P., & Garcia, C. (2009). Cohesion and conflict: Family influences on adolescent alcohol use in immigrant Latino families. *Journal of Ethnicity in Substance Abuse, 8*(4), 400–412. https://doi.org/10.1080/15332640903327526

Mistry, J., & Saraswathi, T. S. (2003). The cultural context of child development. In R. L. Lerner, A. Easterbrooks, & J. Mistry (Eds.), *Handbook of psychology: Vol. 6. Developmental psychology* (pp. 267–291). Wiley.

Oppedal, B., Røysamb, E., & Heyerdahl, S. (2005). Ethnic group, acculturation, and psychiatric problems in young immigrants. *Journal of Child Psychology & Psychiatry, 46*(6), 646–660. https://doi.org/10.1111/j.1469-7610.2004.00381.x

Patton, M. Q. (2002). *Qualitative research & evaluation methods*. SAGE Publications.

Ponce, A. N., Clayton, A., Noia, J., Rowe, M., & O'Connell, M. J. (2012). Making meaning of citizenship: Mental illness, forensic involvement, and homelessness. *Journal of*

Forensic Psychology Practice, 12(4), 349–365. https://doi.org/10.1080/15228932.2012.69566

Ponce, A. N., & Rowe, M. (2018). Citizenship and community mental health care. *American Journal of Community Psychology, 61*(1–2), 22–31. https://doi.org/10.1002/ajcp.12218

Prebble, S. C., Addis, D. R., & Tippett, L. J. (2013). Autobiographical memory and sense of self. *Psychological Bulletin, 139*(4), 815. https://doi.org/10.1037/a0030146

Reitz, J. G. (2002). Host societies and the reception of immigrants: Research themes, emerging theories and methodological issues. *International Migration Review, 36*(4), 1005–1019. https://doi.org/10.1111/j.1747-7379.2002.tb00115.x

Roberts, R. E., Roberts, C. R., & Chen, Y. R. (1997). Ethnocultural differences in prevalence of adolescent depression. *American Journal of Community Psychology, 25*(1), 95–110. https://doi.org/10.1023/A:1024649925737

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships: As developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science: Vol. 3. Formulations of the person and the social context* (pp. 184–256). McGraw-Hill.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug & Alcohol Review, 24*(2), 143–155. https://doi.org/10.1080/09595230500102434

Rowe, M. (2015). *Citizenship and mental health.* Oxford University Press.

Rowe, M., & Pelletier, J.-F. (2012). Citizenship: A response to the marginalization of people with mental illnesses. *Journal of Forensic Psychology Practice, 12*(4), 366–381. https://doi.org/10.1080/15228932.2012.697423

Sagatun, Å., Lien, L., Søgaard, A. J., Bjertness, E., & Heyerdahl, S. (2008). Ethnic Norwegian and ethnic minority adolescents in Oslo, Norway. *Social Psychiatry & Psychiatric Epidemiology, 43*(2), 87–95. https://doi.org/10.1007/s00127-007-0275-z

Spilker, R. S., Indseth, T., & Aambø, A. (2009). *Tilstandsrapport: Minoritetshelsefeltet i Norge. Mighealthnet, Norge.* NAKMI.

Statistics Norway. (2019). Key figures for the population. Retrieved from https://www.ssb.no/innvandring-og-innvandrere/faktaside/innvandring

Svensson, M., & Hagquist, C. (2010). Adolescent alcohol and illicit drug use among first- and second-generation immigrants in Sweden. *Scandinavian Journal of Public Health, 38*(2), 184–191. https://doi.org/10.1177/1403494809353822

Torres, L., & Rollock, D. (2009). Psychological impact of negotiating two cultures: Latino coping and self-esteem. *Journal of Multicultural Counseling & Development, 37*(4), 219–228. https://doi.org/10.1002/j.2161-1912.2009.tb00104.x

Virta, E., & Westin, C. (1999). *Psychosocial adjustment of adolescents with immigrant background in Sweden.* Centre for Research in International Migration and Ethnic Relations, Stockholm University.

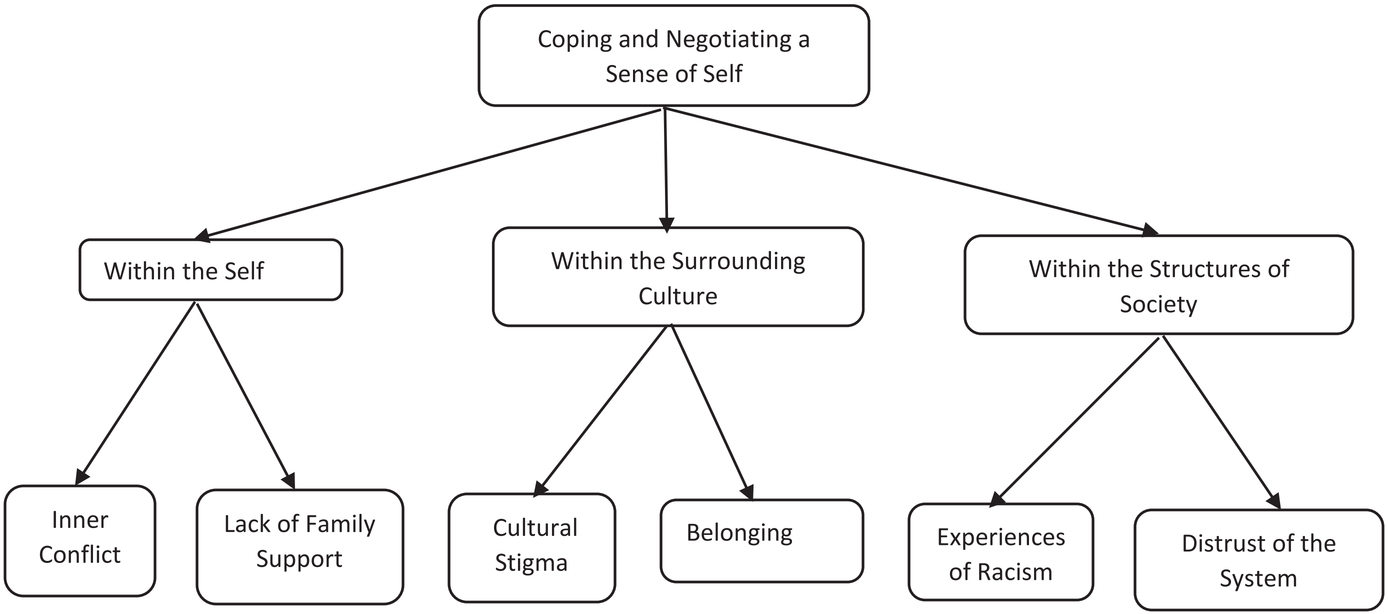
World Health Organization. (2003). Investing in mental health. *World Health Organization.* https://apps.who.int/iris/bitstream/handle/10665/42823/9241562579.pdf?sequence=1&isAllowed=y

Appendix A

Table 1. Description of Participants

PARTICIPANT	*Age in Years*	*Country of Origin*	*Age at Migration to Norway*	*Reason for Migration*	*Age When Starting to Use Substances*
1	33	Iran	1.5 years	War/political refugees	12
2	42	Sierra Leone	7 years	Family reunion	14
3	32	Iran	5 months	War/political refugees	12
4	25	Eritrea	16 years	War/political refugees	17
5	Around 30 (not confirmed)	African descent (unknown country)	12 years	Family reunion	17
6	38	India	Born in Norway	Family reunion	12
7	29	Pakistan	Born in Norway	Family reunion	19
8	42	Iran	11 years	War/political refugees	15
9	53	Iran	21 years	War/political refugees	8
10	39	Iran	24 years	War/political refugees	16

Appendix B


Coping and Negotiating a Sense of Self
Within the Self
Within the Surrounding Culture
Within the Structures of Society
Inner Conflict
Lack of Family Support
Cultural Stigma
Belonging
Experiences of Racism
Distrust of the System

Article 2

Kour, P., Lien, L., Kumar, B., Biong, S., & Pettersen, H. (2020). Treatment Experiences with Norwegian Health Care among Immigrant Men Living with Co-Occurring Substance Use- and Mental Health Disorders. *Substance Abuse: Research and Treatment*, *14*, DOI: 1178221820970929.

Treatment Experiences with Norwegian Health Care among Immigrant Men Living with Co-Occurring Substance Use- and Mental Health Disorders

Substance Abuse: Research and Treatment
Volume 14: 1–10
© The Author(s) 2020
DOI: 10.1177/1178221820970929
SAGE

Prabhjot Kour[1], Lars Lien[2], Bernadette Kumar[3], Stian Biong[4] and Henning Pettersen[2]

[1]Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP), Innlandet Hospital Trust and University of South-Eastern Norway, Norway. [2]Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP) Innlandet Hospital Trust; and Faculty of Health and Social Sciences, Inland Norway University of Applied Sciences, Norway. [3]Norwegian Institute of Public Health, Norway. [4]University of South-Eastern Norway, Kongsberg, Norway.

ABSTRACT: Immigrants are considered at risk of psychological distress and therefore involvement in substance abuse, due to a variety of pre- and post-migration factors. Further, there is lower treatment engagement, a higher dropout rate, and less frequent hospitalizations among this group compared to the general population. There are few studies on the subjective understanding of co-occurring substance use disorder (SUD) and mental health disorder (MHD) among immigrants in Norway. This qualitative study aims to explore the treatment experiences of immigrant men living with co-occurring SUD and MHD. Within a collaborative approach, individual interviews were conducted with 10 men of immigrant background, living with co-occurring SUD and MHD, who had treatment experiences from the Norwegian mental health and addiction services. Data were analyzed using a systematic text condensation. The analysis yielded 6 categories where participants described their treatment experiences in mental health and addiction services in Norway as: lack of connection, lack of individually tailored treatment, stigma and discrimination preventing access to treatment, health professionals with multi-cultural competence, care during and after treatment, and raising awareness and reducing stigma. A significant finding was the mention by participants of the value of being seen and treated as a "person" rather than their diagnosis, which may increase treatment engagement. They further mentioned aftercare as an important factor to prevent relapse. This study provides an enhanced understanding of how immigrant men living with co-occurring SUD and MHD experienced being treated in Norwegian healthcare settings. These experiences may add to the knowledge required to improve treatment engagement.

KEYWORDS: Co-occurring disorders, mental health disorder, substance use disorder, immigrants, qualitative methods, treatment experiences, lived experiences

RECEIVED: May 20, 2020. **ACCEPTED:** October 6, 2020.

TYPE: Original Research

FUNDING: The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was funded by Inlanndet Hospital Trust, Norway

DECLARATION OF CONFLICTING INTERESTS: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

CORRESPONDING AUTHOR: Prabhjot Kour, Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP), Innlandet Hospital Trust, Kjonerud kompetansesenter, Løvstadvegen 7, Ottestad, 2312, Norway. Email: prabhjot.kour@usn.no

Introduction

Over the past 2 decades Norway has become a multicultural and ethnically diverse society due to a substantial increase in migration.[1] Immigrants account for 18.2% of Norway's population, and 10.8% are from middle- and lower-income countries.[2] Previous studies show that immigrants may be at risk for developing mental health problems due to a variety of pre- and post-migration factors.[1,3] Mental health problems and substance use often present with a high degree of co-occurrence[4-6] with poor life quality[7] and those diagnosed with co-occurring substance use disorder (SUD) and mental health disorder (MHD) are often referred to as "complex" and "difficult to help" due to lack of tailored services.[8] SUD is understood as a term that includes harmful use of, and dependency on, drugs and alcohol[9] and MHD as range of problems characterized by some combination of abnormal thought, emotions, behaviors and relationships, for example, depression, schizophrenia, intellectual disabilities, post-traumatic stress disorder etc.[10] Further, co-occurring disorder is understood as the co-existing of SUD and any combination of MHD in an individual with a strong impact on everyday life.

Further, research has documented that immigrant groups with SUD and MHD are at a high risk of neglect even in developed healthcare systems; possible reasons include lack of existing healthcare policies for these groups and insufficient funding to target specific areas of immigrants' mental health care.[11] A recent Swedish cohort study reported increased rates of SUDs among immigrants who migrated at an early age or had lived for a long time in the host country[12]; they were further disadvantaged by poor access to healthcare.[13,14] In addition, immigrants who have connections to a closely-knit drug scene or group may be hampered from seeking mental health treatment. This could be due to the feeling of social solidarity that they want to display within the group. Further, these closely-knit scenes may provide a community for immigrants who experience a low degree of inclusion elsewhere.[15] Moreover, it has also been documented that immigrants have lower rates of utilization of specialist mental health care services in

Norway,[16] compared to the general population. This has also been documented among immigrants in Sweden,[17] and among non-Western immigrants in the Netherlands.[18]

There is strong evidence that completion of SUD treatment is one of the most consistent factors associated with favorable treatment outcome.[19] Persons living with SUD and MHD are often difficult to engage in treatment, leading to frequent relapses and rehospitalizations.[20] Lower treatment engagement has also been documented among immigrants,[21-23] resulting in challenges in providing them with targeted help.[15] Engagement is understood as the process of establishing a mutually collaborative, trusting, and respectful helping relationship.[24] Integration of principles of person-centered healthcare (PCH) in mental health and addiction services have been shown to enhance the engagement process and lead to improved outcomes.[20] Person-centered healthcare focuses on the unique goals and life circumstances of an individual in MHD and SUD treatment models[20] by not only managing and overcoming the health conditions, but also rebuilding the lives of persons living with SUD and MHD.[25]

Further, PCH involves valuing the individual as a "person" with objective, absolute and intrinsic worth,[26] along with the person's life history and relationships, both in illness and health.[27] We conceptualize "person" as defined by Cassell, "as an embodied, purposeful, thinking, feeling, emotional, reflective, relational, human individual always in action, responsive to meaning and whose life in all spheres points both outward and inward. Virtually all of a person's actions – volitional, habitual, instinctual or automatic – are based on meanings".[28] Considering the fact that "meaning" and "personhood" are mutually constituted, understanding about persons involves understanding about values and social phenomena.[29] This may imply that treatment engagement will be improved by the development, coordination and provision of healthcare services that respect the uniqueness of individuals by focusing on their values, beliefs, desires and wishes, regardless of their age, gender, social status, faith, financial situation, ethnicity, and cultural background.[30] We believe that this holds true for immigrants living with co-occurring MHD and SUD, who often feel discriminated against, stigmatized, left alone, and lack a sense of belonging.[31] PCH has emerged as a cornerstone of effective SUD treatment[32,33] and has been highlighted in the Norwegian national guidelines for SUD treatment.[34] In addition, we believe that culturally tailored healthcare services are a part of person-centered "cultures", which may lead to higher treatment engagement.

Various studies have shown that immigrants are less likely to use the available mental health and addiction services,[16,35,36] which may be due to lower treatment engagement and unsatisfied treatment needs. There have been a few quantitative studies, but no qualitative research, that has studied treatment experiences from the perspectives of immigrants. Thus, there is a knowledge gap concerning immigrants' subjective experiences of MHD and SUD treatment.

This descriptive and exploratory study aims to examine the treatment experiences of immigrant men living with co-occurring MHD and SUD in Norwegian mental health and addiction services.

Methods

Collaborative study design

The study follows a qualitative and exploratory design with a collaborative approach. Traditional research into mental health and substance use disorder treatment is considered by an increasing number of service users as disempowering, and poorly reflective of their priorities.[37,38] To remedy this, the present study has adopted a collaborative research approach. Collaborative research brings a different perspective to the research process, which is highly relevant to clinical practice and helps to improve the evidence base used to inform how services are provided.[39] Thus, a competency group of 3 persons was established to work with the research team in all stages of the study. Two members were previous users with lived experience of having co-occurring MHD and SUD, and one was a relative of one of the users. All 3 members were of immigrant background and had an understanding of both their original local context as well as the Norwegian context.

Recruitment

A criterion-based, purposive sampling method[40] followed by snowballing was employed to recruit the participants from 2 cities in Norway. The inclusion criteria were persons with immigrant background, from low- and middle-income countries, having experienced living with co-occurring SUD and MHD and treatment in Norwegian healthcare. A diverse sample was included in order to obtain information-rich data for the study. "Immigrants" in this project are understood as persons who were born or whose parents were born in low- and middle-income countries. In addition, we include as immigrants persons born abroad or in Norway of 2 foreign-born parents and 4 foreign-born grandparents in our study.[2] We would also like to point out that "immigrants" are not a homogenous group; they differ in various ways, including culture, ethnicity, reason for migration, historical migration patterns, etc.

Recruitment began by phoning and sending emails to leaders of various rehabilitation and treatment centers in these 2 cities. The facilities chosen were those with access to potential participants with the inclusion criteria. Detailed information about the research project was given to these leaders. The recruitment of participants meeting the inclusion criteria was more challenging than expected. We do not know exactly how many persons were asked by team leaders to participate, but most of them refused to take part in the study. A few reasons mentioned were, person's unwillingness to talk about their lived experiences, lack of trust in system, including any research project, fear of being detected in their small immigrant communities in Norway and fear of stigma attached to SUDs and MHDs and seeking it's treatment. Further, through these leaders only one participant was recruited. This participant was contacted by telephone by the first author and given information about the study. Subsequently, by snowballing, this participant helped to recruit 3 more participants with whom he had contact. The competency group played a key role in recruiting further participants. Six participants were recruited with the help of the competency group, whose members had contacts in their local community. Potential participants were able to show interest by contacting the first author by telephone or SMS.

Study participants

The study included 10 participants who met the inclusion criteria (Appendix A, Table 1). All the participants were males, aged from 25 to 53 years. All of them had been diagnosed with co-occurring SUD and MHD and had experience of treatment in the Norwegian mental health and addiction services. All participants were polysubstance users and the most common substances used were alcohol, heroin, and cannabis. Five participants reported not using substances at the time of the interview. The participants also stated having experienced MHDs, most commonly anxiety, affective disorder, personality disorder and post-traumatic stress disorder. Eight of 10 participants reported having experienced suicidal thoughts and suicide attempts. The objective diagnosis was not considered, but rather how the participants understood their own mental health condition. Five participants were from the Middle East, while others were from South Asia and East and West Africa. Two participants were born in Norway, and most others migrated at a very early age, while 2 had arrived at age 21 and 24. All the participants started using substances at an early age: 8 after arriving in Norway, while the 2 who migrated at age 21 and 24 started at a young age in their countries of origin. All the participants had dropped out of treatment in Norway at least once and most had dropped out several times. All participants had the treatment seeking experience in one or the other mental health or/and addiction services, such as generic specialist service units, special units that collaborate closely with primary level services, residential addiction treatment based on AA- or NA-principles and detoxification units. Further, participants have both in-patient and out-patient treatment experience, where the length of treatment program ranged from 9 to 12 months, and some of the participants were still continuing the treatment.

Data collection

Data were collected through in-depth, semi-structured individual interviews[41] between June 2018 and March 2019. The data were considered be sufficient to fulfill the aim of the study after the tenth interview. This was done using the concept of "information power", which implies that the more relevant information the sample has, the smaller the number of participants needed.[42] This could be justified in our study as the aim of the study was narrow, and concerns a specific experience among a population that hold specific characteristics and which are "hard-to-get" group, which would in itself limit the number of eligible participants (diverse immigrant background, living with co-occurring SUDs and MHDs, with having treatment experience in Norwegian mental health and addiction services). Further, we believe that participants hold the experiences that have previously not been described, has also enhanced the information power. Also, there was strong and clear communication between the first author and the participants, partly due to being introduced by the members of competency group and partly because the first author has previous experience with qualitative interviews. Moreover, the after the tenth interview, assessment was made by all the authors that these data made it possible to answer the aim of the study. All the interviews were audio taped and lasted from 40 to 90 minutes. Nine of the 10 interviews were conducted in Norwegian by the first author and an interpreter, while one interview was carried out in Punjabi and English by the first author only. All the interviews were transcribed in English. An interview guide, consisting of open-ended questions about what it means to be treated in Norwegian healthcare settings when living with co-occurring disorders as a person of immigrant background, was created and agreed upon by all authors and the competency group. The main questions included were (all these questions had the follow up and probing questions): Can you please describe your experiences with treatment within Norwegian mental health and addiction services as a person with immigrant background? Can you please tell us why according to you persons with immigrant background do not take the complete treatment? Can you please describe your experiences with treatment when it comes to your needs as a person with immigrant background? What kind of treatment do you wish for as a person with immigrant background in Norway?

Data analysis

The interview conducted in English and Punjabi was transcribed by the first author and the remaining 9 conducted in Norwegian were transcribed by the interpreter. These interview transcripts were analyzed using systematic text condensation (STC),[43] which is a descriptive and explorative method which aims at thematic cross-case analysis, and which maintains methodological rigor and enables feasibility, intersubjectivity, and reflexivity. STC is a stepwise procedure that includes the identification of recurring initial codes and themes relevant to the aim of the study. Step one involves the formulation of a total impression gained by reading all the transcripts, leading to initial themes. In step two, after systematically reviewing the transcripts, meaning units were identified and sorted into code groups. The third step involved the formation of subgroups from code groups with meaning units. The next step was to form artificial quotations by the reduction of meaning units under each subgroup. In the final step, analytic text and descriptions were developed from artificial quotations. The analytic text was reconceptualized by returning to the complete transcripts and reflecting on whether each illustrative quotation still reflected the original content. This was done in order to validate the analytic texts. Lastly, the analytic texts were supported by quotes, which are presented in the "Results" section. In each step, all the co-authors were consulted and discussions took place. In the final step, the competency group was consulted to provide an understanding of the results within the local context they represented.

Ethical aspects

The study was ethically approved by the Norwegian Centre for Research Data (Project No. 59707). The research procedure was designed and followed in accordance with the Declaration of Helsinki. The participants agreed to take part in the study voluntarily and signed the informed consent, which ensured their confidentiality and anonymity. They received an information letter and an oral explanation about the project prior to the interviews. The members of the competency group and the interpreter signed a confidentiality declaration. The participants were given the contact details of the first author in case they had any concerns or questions after the interviews.

Results

The analysis yielded 6 categories where participants described their treatment experiences in mental health and addiction services in Norway as: lack of connection, lack of individually tailored treatment, stigma and discrimination preventing access to treatment, health professionals with multi-cultural competence, care during and after treatment, and raising awareness and reducing stigma. A significant finding was the mention by participants of the value of being seen and treated as a "person" rather than their diagnosis, which may increase treatment engagement. They further mentioned aftercare as an important factor to prevent relapse.

Lack of connection

A majority of participants experienced a lack of connection between themselves and health professionals (HPs) while they were in treatment, such as a lack of interest from HPs. The feeling of lack of connection was interpreted as not being listened to and having unsatisfactory communication. They further mentioned that the lack of connection was stronger when the HP only talked about their diagnosis and said nothing about contexts that were important for them, like their process of migration, living as an immigrant in Norway, reasons why they started using substances and discrimination in treatment settings. They experienced not being seen as a person in treatment settings, leading to a more pronounced feeling of lack of connection, which discouraged them from continuing the treatment.

> *They did not understand my needs. It was only written in papers, about me, that my mother is divorced and about events of my life but there were actually no conversations about it with me, nothing about what it's like to be an immigrant. . . (P-6)*

The participants also stated that there was no aftercare once they were out of the treatment centers. They had no contact with service providers after the standard treatment was over. They had to follow a schedule while they were in treatment and they felt lost once they had no schedule, leading to a higher chance of relapse.

> *We didn't have any aftercare. When people are done, what happens to them afterwards? It's called aftercare, in the medical terminology. And that's the part we are bad at. The time when you are inside, you know that 12 o'clock you go and eat, 6 o'clock the food comes on the table, 9 o'clock is dinner time. You have a routine. But when you come out, nobody tells you to go and eat at 12 o'clock, do they? And if you're hungry, or thirsty, all that, it can have almost the same effect as the drugs, you see?. . .But when you wake up in the morning, look around, see the same apartment, the same place, the same things, you know? They can't take it. And then you go and you take drugs. . .(P-8)*

Participants also described how HPs did not have any understanding of their cultural context, which meant that their needs were not met in treatment, further leading to a lack of connection between them and the HP.

> *If you talk about immigrant background, there is actually a lack of cultural identification topics in every treatment I have been to in Norway, both in psychiatric and drug abuse treatment. They do not have this in their protocol. I will give you an example, I know so many people from Iceland who have addiction problems, it is a big issue with them, they are alcoholics. I have many friends who are from Iceland and we talk about this topic many times among ourselves and they also say they want more culturally specific treatment, that we do not have in Norway. (P-3)*

Lack of individually tailored treatment

The participants described experiencing a conventional and standard approach to treatment with no cultural sensitivity. There were no new strategies brought up in the treatment protocol that could satisfy their needs of being culturally different from the majority. They mentioned having few daily activities and a monotonous routine while in treatment, which discouraged continuity of treatment. Further, they mentioned conventional group therapy where the participants felt mismatched in the group. This led to discomfort and lack of satisfaction in the group therapy. Some participants also mentioned that even though they had the same sickness and diagnosis as Norwegians, their needs were different. They further added that even though group therapy was important, individual therapy was equally important, because of their different needs and levels of understanding, and they had not experienced that as part of the treatment.

> *I felt bad, I felt like shit. The others were old, in their 40s and had been shooting needles for years. I was only 20 so I felt very small, I felt dirty, small, low. It wasn't a good place to be. You just sat there and ate and watched TV. I thought to myself "Is this the place to be for treatment?"(P-1)*

Furthermore, participants narrated their experiences of not being understood specifically in relation to their cultural beliefs, values and language. Only being prescribed the standard anti-depressant and sleeping pills when they asked for help, without the HP understanding their social and cultural context led to their discontinuing the treatment. Some participants expressed worries as they felt vulnerable being an addict and might be very likely to become dependent on sleeping pills.

Stigma and discrimination preventing access to treatment

Living with SUD and MHD, all the participants described experiencing stigma and discrimination in one form or another. They were aware of the fact that using substances and having MHD was associated with stigma and discrimination, which had restrained them from accessing help and adhering to treatment. If they sought help, they felt they would become even more stigmatized in their small communities.

> *I see so many Norwegians in the treatment, of course they are in the majority here but very few immigrants. They feel that they will be stigmatized if they take such treatments, they want to be identified beyond their skin color, beyond their social and cultural background. That is one of the main reasons they don't take treatment. . .. That makes me feel inferior, especially with such closed and cold behavior. That's the biggest stigma and this stigma is also incorporated in the Norwegian health care system. (P-6)*

Many participants revealed a cultural stigma in acknowledging the problems of SUD and MHD, and this prevented them from seeking treatment and help. They described that seeking psychiatric help was associated with a stigma in their culture where they were labeled "mad". They also stated that they had to drop out of treatment because of family pressure and the stigma that the family faced, which led to relapses and continued use of substances.

In addition, participants recounted experiences of discrimination that they faced while they were in the treatment centers, due to their immigrant background, which also prevented them from getting the help they needed in treatment. They mentioned incidents of being looked down upon by the HPs, which led to them dropping out of treatment and further relapses.

> *So I went to the meeting there and there was a psychiatrist there and she was going to talk to me and I shared a bit about my life and such, about how I had been treated here in terms of racism. I was so vulnerable and then she only asked me "Are you violent?", and I thought "What. . . are you going to start judging me?", that's what I thought at least. I said I can't work with you. You are already judging me when I am so vulnerable and then asking me if I'm violent. I've had enough of that violent thing. Every time I have been seen in the streets they asked if I was violent. What does that have to do with anything? I also want to live like a person in this country, I don't want to have these labels on me all the time. That's what hurts, right? (P-8)*

Health professionals with multi-cultural competence

Several participants experienced that having health professionals who had expertise in understanding different cultural backgrounds was helpful in completing treatment. They further mentioned that HPs who recognized the special needs of immigrants led to a higher level of satisfaction with treatment. In addition, participants stated that it could lead to better treatment outcomes if HPs learned more about different cultures via seminars and shared results of different studies and experiences from treatment centers in Norway and abroad that have successful rates in treating persons with different cultural backgrounds. Moreover, participants reported receiving the most help from HPs who had an understanding of both foreign and Norwegian culture. Experiences of having being understood and accepted as who they were without judgments in the treatment centers were facilitators for their treatment.

> *He (HP with immigrant background) is quite well-known in the psychologist circles, and he works as chief psychologist, here, which is the oldest place offering treatment in Norway. It was really great. I just met him and I felt it was positive. .. He had experience with people who had seen war, and that helped, yes. (P-10)*

Some participants also stated that having an HP with an immigrant background was a motivating experience, as it became easier to connect with them. They experienced a sense of being better understood by HPs with a similar background, which helped in building trust. Further, a few participants mentioned that having an HP with experience of war traumas was beneficial for them, as they could open up about their own trauma experiences. This provided participants with motivation to complete treatment and a sense of belonging.

> *Member of staff or doctor with a similar background. . . That would be perfect. . .definitely because there was one health professional from Chile at the treatment center where I was admitted to. I could identify with him, much better than with other health workers. . . I opened up a little bit with health workers from different cultural backgrounds, on the sole basis of identification, that I could identify with them. (P-2)*

Care during and after treatment

Experiences of being valued as a person in treatment centers, and not being looked down upon based on their diagnosis and their immigrant background, were regarded as meaningful. One participant described the feeling of being well attended to by one of the HPs and not seen as an "addict" who does not look like most people in that treatment center, and has different cultural background. The participant experienced the positive feeling of being welcomed and thus completed treatment in the same center twice. A few participants said that conversations about their past related to migration and settling in Norway and understanding their needs in relation to their past in the treatment process had a positive impact on them. Another participant also mentioned that the use of prayers in treatment gave him the experience that life is meaningful and worth living, which helped him to adhere to treatment.

> *Well, if someone would sit there alone, or looked a bit depressed, he (HP) would try and involve the person a bit more. He would say "Come here", and he would walk into their rooms and bring us out and things like that. He kind of involved us, he tried to pull us out of those thoughts, feeling included was a good thing. (P-3)*

For a few participants, the experience of being treated with love and respect regardless of their cultural background was encouraging and this created an open and healthy relationship between them and the HP. Moreover, positive attitudes of HPs with expressions of gratitude toward the participants, like shaking hands and hugging, contributed to a higher level of satisfaction with treatment. This further led to the building of trust between the participants and HPs.

> *Luckily the people (HPs) that worked there said "Try telling us a little, you have the same rights as us here in Norway." And I thought "Oh, do I? Can I also take a little space here?", And I started thinking, oh maybe I can. Maybe the woods outside are also for me, and not only for Norwegians. Maybe it's not just Norwegian nature for Norwegians. Maybe I can actually enjoy the green leaves as well. That's how I began, step by step. (P-8)*

Most of the participants mentioned the importance of aftercare. They described being lost after they left the treatment centers, they had no schedule and no one to look after them, which ultimately led to frustration and relapses. Further, they mentioned that aftercare was as important as in-treatment care. This was because they did not spend a long time in treatment or detoxification centers and were thus on their own most of the time and were more likely to have relapses when they were not followed up, especially because they had different cultural background and lack the feeling of social inclusion elsewhere. A few participants mentioned that aftercare from HPs was crucial in their treatment process, as they often remained hidden and could not ask for help in their small communities due to fear of stigmatization.

Raising awareness and reducing stigma

Several participants stated that it would have been easier for them to access treatment if there was less stigma attached to SUDs and MHDs among acquaintances and in their communities. One participant mentioned that it would be his dream treatment if he could be seen and treated beyond the wall of the stigma in healthcare and his community. Others mentioned that it would be better not to have stigmatizing names of treatment centers, like 'acute addiction ward', but to have nicer names, as they felt that such traditional names were associated with stigma within their community and prevented their access to the services needed for emergency treatment.

> *Take away some of that shame. . . To talk more about it in the media, maybe? To remove that taboo that is there. We have to be a bit realistic and admit that a drug/alcohol problem is seen as a taboo still, and a moral problem, not a sickness, actually. . . That barrier can also be removed just by seeing it as a sickness, you know what I mean. I think that many people, me included, have way too much prejudice when it comes to drugs and alcohol. (P-1)*

Obtaining information and awareness about the consequences, diagnosis and treatment strategies from the HP was described as a positive experience by a few participants. They described how having insight into their diagnosis and the harmful effects of using substances motivated them to adhere to and complete treatment. Further, some participants mentioned that raising awareness about the harmful effects of substances and available treatment options, and reducing stigma via the media, would allow their co-users to access treatment. In addition, they stated that raising early awareness in primary and secondary schools was important, as most of them had started using substances at that time.

> *and at the same time, a treatment where you get information. Information about your sickness, what are the drugs doing to you, how are they making you react, why do you, despite being sick the day before, go out and buy the same stuff and become as sick as before, again. What is that insanity? Those places where they can give you information and take care of you, at the same time as you yourself have to create a network. These are the places I go for. . ..(P-3)*

Additionally, having a supportive network of family, peers and role models was mentioned as particularly helpful, both during and after treatment. A few participants mentioned that this supportive network was key to giving them hope, motivation and a positive approach toward accessing and completing treatment. This further gave them a feeling of inclusion which was a driving force to get out of their "dark side of life" and change their self.

> *Encouragement. Because I had psychologists that encouraged me and I had those who think negatively themselves and it was contagious. So, it is important, very important for the patients, to understand that it is possible to get well. It is the most important thing. I would say that it is to try to build trust in the patient. (P-9)*

Discussion

In this study, we explored the treatment experiences of men of immigrant background living with co-occurring SUD and MHD in Norwegian mental health and addiction services. Six main categories of experiences were revealed, which we classified into 2 major insights. First, negative experiences that acted as barriers and reduced treatment engagement. These negative experiences posed significant challenges for the participants prevented them from seeking treatment and encouraged drop-out. Emphasis was placed on the connection between them and the HPs, individually tailored treatment and stigma and discrimination. Secondly, positive experiences that functioned as facilitators and enhanced treatment engagement. HPs with multicultural competence, being cared for well during and after treatment, along with strategies to reduce stigma and raise awareness for treatment completion were supportive experiences for the participants' well-being. Further, a significant finding of being treated as a "person" in treatment settings, not as a disease or diagnosis, was reflected in both types of experiences. Being regarded as a "person" was experienced as positive and valued, while not being seen as a "person" was perceived as negative and led to lower treatment engagement.

Participants' experiences of not being treated as a "person" in the treatment setting resulted in lower treatment engagement. They described the notion of "person" as being valued and respected for who they were, which was dependent on their immigrant background and their life history. They had been through a series of disruptive events (immigration, living with SUD and MHD) which had shaped their coping and negotiating of their sense of self.[31] They experienced a lack of discussions around events such as their migration process, initiation of substance use and coping with stigma and discrimination in community and treatment settings, which were vital for them. They felt of little worth when conversations only focused on their diagnosis and symptoms, which made it impossible to feel like a "person" while they were in treatment. This could be understood in terms of Cassell's definition of "person", which involves understanding an individual as a person in medicine, based on the meanings of the person's actions[28] through an understanding of values and beliefs of that person in a particular social context.[29]

Further, participants' experiences of lack of connection with HPs in view of negative past encounters with lack of interest and little attention in treatment sessions resulted in lower treatment engagement. Other studies have found that many immigrants are reluctant to seek treatment for mental health and substance use problems, which results in poor health outcomes with longer duration of untreated problems.[44,45] This could be attributed to difficulty in developing trust in mental health and addiction services due to unfamiliarity with how these services work[31,46] and previous negative experiences with treatment.[35] Moreover, participants revealed that the situation worsened when they had to wait longer to start treatment, leading to more substance use and relapses, which is reported by Pinedo et al.[36] as a logistical barrier to treatment.

Another barrier that overwhelmingly shaped participants' decisions not to enter treatment or to be less engaged in treatment was the lack of culturally competent services tailored to their specific needs in relation to cultural beliefs, values and language, which is in line with previous studies.[36,45] Misunderstandings arise regarding patients' acceptable and typical behavior when HPs lack cultural competence.[46] This often leads to a lack of discussions on important social contexts, such as immigration and discrimination within treatment settings, resulting in low adherence rates,[36] which concurs with the participants' experiences. Furthermore, the treatment program of 12-step support group therapy did not function well with the participants as they felt the groups were mismatched with regard to age, language and duration of using substances. They further mentioned that they had difficulty expressing emotions and sharing private information within such groups and hence showed lower treatment engagement, as in a study on Asian immigrants in the US.[45] Connected to this is the lack of individually tailored services for immigrants, which reduces their engagement to treatment. This could be due to the manual-based and standard trend of knowledge-based practice that is followed in mental health and addiction services, which may lack individualization and cultural sensitivity within treatment.

Further, experiences of stigma prevented participants from accessing treatment when living in small communities in Norway. This is in line with previous studies stating that stigma regarding seeking treatment for SUDs and MHDs was a significant barrier to enroll in treatment programs. These disorders among immigrants are often viewed as a sign of weakness, shame or a lack of willpower, which often results in ambivalence about seeking timely help; either the person delays or does not seek treatment at all.[45,47,48] Further, in recent studies on immigrants, fear of being negatively perceived within their community, especially family resistance, discouraged them from seeking treatment even though they were willing to get help,[31,36] which concurs with the participants' experiences in our study. In addition to stigma, our participants mentioned experiences of discrimination and unfair treatment from HPs which lowered their treatment engagement. This further resulted in a higher risk of relapses and severe mental health disorders.[47,49] These experiences of discrimination at structural level could be understood by Foucault's biopolitics and state racism, where biopolitics refers to the social control and power disseminated through social body, such as healthcare and is regarded as the norm. This gives rise to the state racism which becomes one of basic dimensions of social normalization,[50] focusing on the superiority of dominant culture over the another who are culturally different from majority. Such type of structural racism that prevails in European health care, is normalized and is enacted through invisible, subtle practices by HPs (consciously or unconsciously) that leads to unequal access to treatment.[51] This further leads to perceived racism, as stated by participants to be treated differently from the ethnic Norwegians and is associated with lack of trust in healthcare and refrain from seeking treatment.

Understanding barriers is critical to ensure lower drop-out rates and facilitate adequate use of treatment.[35] The participants stated that receiving treatment from culturally competent HPs facilitated their treatment process, as their needs were understood during the counseling and healing process. This finding is consistent with previous studies[44,52] and a review,[53] where having HPs that were sensitive to cultural nuances was seen as more effective. This could be correlated with an approach of interculturalization of mental health services, which entails adopting treatment according to the patient's cultural contexts and needs.[54] Further, our participants had positive experiences with HPs of immigrant background, in line with a study by Salami et al.,[47] especially if the HPs also had an understanding of Norwegian culture. In addition, HPs with war trauma experiences were considered as facilitators that motivated the participants to complete the treatment and gave them a sense of belonging.

Furthermore, the positive experience of being seen as a person and not as a diagnosis and of having one's needs understood based on one's culture, values and beliefs were appreciated by the participants and increased treatment engagement. This is similar to the approach of person-centeredness and individualization of SUD treatment services,[32,33] which is now part of the national guidelines for SUD treatment.[34,55] In a recent Norwegian study, participants' narratives suggested that HPs who used "personal connection" and saw them as persons beyond their substance use problems were considered facilitators for treatment.[56] In addition, participants acknowledged aftercare as an important factor to prevent relapses and improve treatment outcomes. Aftercare could be seen as long-term monitoring and support in SUD treatment[56] and could be individualized to meet the needs of persons of immigrant background. Also, aftercare could be understood as follow-up care in treatment models which allows individuals to cope and regain a meaningful life when they are no longer in treatment settings, along with having a sense of being a contributing member of their community.[57] This process can also aid in overcoming stigma by developing resilience toward stigma and/or actively fighting against it and can provide people with MHD/SUD with a sense of empowerment and control over their lives by exercising their rights and responsibilities as other citizens.[25]

Further, participants' experiences revealed that the greater their awareness about the consequences of SUD and MHD, the higher was their engagement to treatment. It was also reported that many of their co-users were unaware that care was available and hence did not initiate treatment. Fong et al. suggested that creating alternative 12-step groups focusing primarily on support and education and less on confrontation would facilitate treatment,[45] which is in line with participants' experiences in our study. In addition, immigrants' perceptions of the need for treatment were dependent on social embeddedness,[44] hence strategies for reducing stigma within the social context may facilitate treatment among immigrants. Another treatment facilitator is the supportive network of peers and family.[48] Being open with family and friends harnesses help-seeking enablers,[44] along with raising the family's mental health literacy,[47] which is in agreement with the participants' experiences. Further, having a supportive network gave the participants a feeling of inclusion.

Lastly, our study was able to include only men due to the challenges in recruiting immigrant women with co-occurring SUD and MHD. We had initially planned to recruit both women and men who met the inclusion criteria. We argue that the recruitment of immigrant men was extremely challenging due to the hidden nature and stigma attached to SUDs and/or MHDs. Our participants reported that there were many men and women with a similar diagnosis but they were not willing to participate in the study because of fear of being recognized and detected within their small communities in Norway. We believe that this fear and stigma are probably even more prevalent among immigrant women with co-occurring SUD and MHD, due to their perceived potential risk of greater harm if they are detected and identified and different cultural norms. In addition, due to experiences of shame, discrimination, and marginalization, immigrant women are less likely to report their SUD and/or MHD and are less likely to access the available care and treatment.[58]

Limitations and strengths

This qualitative study provides insights into treatment experiences of immigrant men living with co-occurring SUD and MHD in Norway, which to our knowledge has not been previously explored. The results are based on our participants' experiences and may be argued about the relevance beyond the local context. However, in exploring subjective experience involves focusing on the meaning of the participants, which may be transferred to other contexts and other people. Moreover, these insights are believed to be of relevance for future research. Further, we argue that our results provide insights into the experiences of a group of persons who are considered hard to reach and often stigmatized. Furthermore, the credibility in our study was enhanced by collaborating with a competency group in all stages of the study, starting from writing the protocol, preparing the study, recruiting the participants, analyzing the data, to compiling the results. In addition, in interview settings, both the participants and the first author were non-ethnic Norwegians, which facilitated the interview process, where the participants could trust the interviewer and feel connected, which helped to provide meaningful data. This could be understood as "diversity in proximity", meaning that interaction between migrant researcher and migrant participant is effective when both of them can recognize the ties that bind and the social fissure that divides in a host country.[59] We also believed that "diversity in proximity" enhanced the credibility of our study. Lastly, this study could only recruit immigrant men because of the challenges in recruiting immigrant women living with co-occurring SUD and MHD.

Conclusion and future recommendations

Immigrant men living with co-occurring SUD and MHD interpreted their lived experiences of treatment in mental health and addiction services in Norway as both negative and positive. Lack of connection and individually tailored treatment along with stigma were important ongoing barriers to treatment and hence led to low treatment engagement. However, HPs with multicultural competence, aftercare and strategies for raising awareness and reducing stigma acted as facilitators to treatment, increasing treatment engagement. Improving the health of immigrants would benefit Norway and other countries, as migration is increasing worldwide. Hence, we argue that the insights from the participants are timely and that the knowledge from their treatment experiences can broaden the perspectives of practitioners and policy makers to provide more culturally tailored services. Further, we suggest that strategies that reduce barriers to treatment will require increased prevention and education efforts tailored to individual needs. We also suggest that treatment engagement may increase with a greater emphasis on strategies that provide more person-centered and culturally competent services. We suggest future research on how to better understand the impact of these barriers on the diagnosis of individuals and their participation in the society.

Acknowledgements

The authors wish to express their appreciation to all the participants for generously sharing their time, insights and experiences. We also thank the members of the competency group, who have been vital in recruitment and have provided invaluable insights and reflections throughout the study. Finally, we would like to thank Innlandet Hospital Trust for funding the study.

Author contributions

PK conducted the study and initial data analysis. All the authors contributed in further analysis and drafting the final article.

ORCID iD

Prabhjot Kour https://orcid.org/0000-0001-5716-6683

REFERENCES

1. Abebe DS, Lien L, Hjelde KH. What we know and don't know about mental health problems among immigrants in Norway. *J Immigr Minor Health*. 2014;16:60-67.
2. SSB. Immigrants and Norwegain-born to immigrant parents. Statistics Norway. Published 2020. Accessed March 9, 2020. https://www.ssb.no/en/befolkning/statistikker/innvbef.
3. Chen W, Hall BJ, Ling L, Renzaho AM. Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: findings from the first wave data of the BNLA cohort study. *Lancet Psychiatry*. 2017;4:218-229.
4. Rossow I, Bramness JG. The total sale of prescription drugs with an abuse potential predicts the number of excessive users: a national prescription database study. *BMC Public Health*. 2015;15:288.
5. Long EC, Aggen SH, Neale MC, et al. The association between personality disorders with alcohol use and misuse: a population-based twin study. *Drug Alcohol Depend*. 2017;174:171-180.
6. Torvik FA, Rosenström TH, Ystrom E, et al. Stability and change in etiological factors for alcohol use disorder and major depression. *J Abnorm Psychol*. 2017;126:812-822.
7. Carrà G, Johnson S, Crocamo C, et al. Psychosocial functioning, quality of life and clinical correlates of comorbid alcohol and drug dependence syndromes in people with schizophrenia across Europe. *Psychiatry Res*. 2016;239:301-307.
8. Davidson L, Andres-Hyman R, Bedregal L, Tondora J, Frey J, Kirk TA Jr. From "double trouble" to "dual recovery": integrating models of recovery in addiction and mental health. *J Dual Diagn*. 2008;4:273-290.
9. NIPH. Substance use disorders in Norway. *Norwegian Institute of Public Health*. Published August 8, 2016. Updated December 9, 2019. Accessed April 12, 2020. https://www.fhi.no/en/op/hin/mental-health/intoxicants-and-substance-use/
10. WHO. Mental disorders. *World Health Organization*. Published November 28, 2019. Accessed January 11, 2020. https://www.who.int/en/news-room/fact-sheets/detail/mental-disorders
11. Mladovsky P, Rechel B, Ingleby D, McKee M. Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy*. 2012;105:1-9.
12. Harris S, Dykxhoorn J, Hollander A-C, Dalman C, Kirkbride JB. Substance use disorders in refugee and migrant groups in Sweden: a nationwide cohort study of 1.2 million people. *PLoS Med*. 2019;16:e1002944.
13. Lundgren L, Brännström J, Armelius B-Å, Chassler D, Morén S, Trocchio S. Association between immigrant status and history of compulsory treatment in a national sample of individuals assessed for drug use disorders through the Swedish public welfare system. *Subst Use Misuse*. 2012;47:67-77.
14. Mladovsky P. Migrant health in the EU. *Eurohealth (Lond)*. 2007;13:9.
15. Sandøy TA. Group solidarity in a hostile milieu: immigrant experiences in a street-based drug scene. *Drugs (Abingdon Engl)*. 2015;22:232-238.
16. Abebe DS, Lien L, Elstad JI. Immigrants' utilization of specialist mental healthcare according to age, country of origin, and migration history: a nation-wide register study in Norway. *Soc Psychiatry Psychiatr Epidemiol*. 2017;52:679-687.
17. Ivert A-K, Merlo J, Svensson R, Levander MT. How are immigrant background and gender associated with the utilisation of psychiatric care among adolescents? *Soc Psychiatry Psychiatr Epidemiol*. 2013;48:693-699.
18. Mulder CL, Koopmans GT, Selten J-P. Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to the Netherlands. *Br J Psychiatry*. 2006;188:386-391.
19. Brorson HH, Arnevik EA, Rand-Hendriksen K, Duckert F. Drop-out from addiction treatment: a systematic review of risk factors. *Clin Psychol Rev*. 2013;33:1010-1024.
20. Dixon LB, Holoshitz Y, Nossel I. Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry*. 2016;15:13-20.
21. Vandevelde S, Vanderplasschen W, Broekaert E. Cultural responsiveness in substance-abuse treatment: a qualitative study using professionals' and clients' perspectives. *Int J Soc Welf*. 2003;12:221-228.
22. Verdurmen JE, Smit F, Toet J, Van Driel HF, Van Ameijden EJ. Under-utilisation of addiction treatment services by heroin users from ethnic minorities: results from a cohort study over four years. *Addict Res Theory*. 2004;12:285-298.
23. De Kock C, Decorte T, Vanderplasschen W, Derluyn I, Sacco M. Studying ethnicity, problem substance use and treatment: from epidemiology to social change. *Drugs (Abingdon Engl)*. 2017;24:230-239.
24. Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change*. Guilford Press; 2012.
25. Davidson L, Tondora J, O'Connell MJ, Kirk T Jr, Rockholz P, Evans AC. Creating a recovery-oriented system of behavioral health care: moving from concept to reality. *Psychiatr Rehabil J*. 2007;31:23-31.
26. McCormack B, McCance T. *Person-Centred Nursing: Theory And Practice*. John Wiley & Sons; 2011.
27. McWhinney IR. 'An acquaintance with particulars. . .'. *Fam Med*. 1989;21:296-298.
28. Cassell EJ. The person in medicine. *Int J Integr Care*. 2010;10:5
29. Mjølstad BP, Kirkengen AL, Getz L, Hetlevik I. What do GPs actually know about their patients as persons? *Eur J Pers Cent Healthc*. 2013;1:149.
30. McCormack B, van Dulmen S, Eide H, Skovdahl K, Eide T. *Person-Centred Healthcare Research*. John Wiley & Sons; 2017.
31. Kour P, Lien L, Kumar B, Biong S, Pettersen H. Coping and negotiating a sense of self: immigrant men's experiences of living with co-occurring substance use and mental health disorders in Norway. *Am J Psychiatr Rehabil*. 2020;22:43-63.
32. Friedmann PD, Hendrickson JC, Gerstein DR, Zhang Z. The effect of matching comprehensive services to patients' needs on drug use improvement in addiction treatment. *Addiction*. 2004;99:962-972.
33. Hser Y-I, Polinsky ML, Maglione M, Anglin MD. Matching clients' needs with drug treatment services. *J Subst Abuse Treat*. 1999;16:299-305.
34. NDH. *National Guidelines for Treatment and Rehabilitation of Substance use Disorders*. Norwegian Directorate of Health (NDH); 2017.
35. Falgas-Bague I, Wang Y, Banerjee S, et al. Predictors of adherence to treatment in behavioral health therapy for Latino immigrants: the importance of trust. *Front Psychiatry*. 2019;10:817.
36. Pinedo M, Zemore S, Rogers S. Understanding barriers to specialty substance abuse treatment among Latinos. *J Subst Abuse Treat*. 2018;94:1-8.
37. Trivedi P, Wykes T. From passive subjects to equal partners: qualitative review of user involvement in research. *Br J Psychiatry*. 2002;181:468-472.

38. Faulkner A. *The Ethics of Survivor Research: Guidelines for the Ethical Conduct of Research Carried Out by Mental Health Service Users and Survivors*. Policy Press; 2004.
39. Beresford P. User involvement in research: exploring the challenges. *NT Res*. 2003;8:36-46.
40. Patton MQ. *Qualitative Research & Evaluation Methods: Integrating Theory and Practice*. Sage Publications; 2014.
41. Kvale S, Brinkmann S. *Interviews: Learning the Craft of Qualitative Research Interviewing*. Sage Publications; 2009.
42. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. *Qual Health Res*. 2016;26:1753-1760.
43. Malterud K. Systematic text condensation: a strategy for qualitative analysis. *Scand J Public Health*. 2012;40:795-805.
44. McCann TV, Mugavin J, Renzaho A, Lubman DI. Sub-Saharan African migrant youths' help-seeking barriers and facilitators for mental health and substance use problems: a qualitative study. *BMC Psychiatry*. 2016;16:275.
45. Fong TW, Tsuang J. Asian-Americans, addictions, and barriers to treatment. *Psychiatry (Edgmont)*. 2007;4:51-59.
46. Sandhu S, Bjerre NV, Dauvrin M, et al. Experiences with treating immigrants: a qualitative study in mental health services across 16 European countries. *Soc Psychiatry Psychiatr Epidemiol*. 2013;48:105-116.
47. Salami B, Salma J, Hegadoren K. Access and utilization of mental health services for immigrants and refugees: perspectives of immigrant service providers. *Int J Ment Health Nurs*. 2019;28:152-161.
48. Derr AS. Mental health service use among immigrants in the United States: a systematic review. *Psychiatr Serv*. 2016;67:265-274.
49. Gee GC, Delva J, Takeuchi DT. Relationships between self-reported unfair treatment and prescription medication use, illicit drug use, and alcohol dependence among Filipino Americans. *Am J Public Health*. 2007;97:933-940.
50. Foucault M. *Discipline and Punish: The Birth of the Prison* (Trans. Alan Sheridan). Vintage; 1977: 227.
51. Hamed S, Thapar-Björkert S, Bradby H, Ahlberg BM. Racism in European health care: structural violence and beyond. *Qual Health Res*. 2020;30:1662-1673.
52. Masson CL, Shopshire MS, Sen S, et al. Possible barriers to enrollment in substance abuse treatment among a diverse sample of Asian Americans and Pacific Islanders: opinions of treatment clients. *J Subst Abuse Treat*. 2013;44:309-315.
53. Abebe DS. Public health challenges of immigrants in Norway: a research review. *NAKMI Report*. 2010;2:41-48.
54. De Jong JT, Van Ommeren M. Mental health services in a multicultural society: interculturalization and its quality surveillance. *Transcult Psychiatry*. 2005;42:437-456.
55. NIDA. *Principles of Drug Addiction Treatment: A Research-Based Guide*. 3rd ed. National Institute on Drug Abuse; 2018.
56. Pettersen H, Landheim A, Skeie I, et al. Helpful ingredients in the treatment of long-term substance use disorders: a collaborative narrative study. *Subst Abuse*. 2019;13:1178221819844996.
57. Davidson L, O'Connell M, Tondora J, Styron T, Kangas K. The top ten concerns about recovery encountered in mental health system transformation. *Psychiatr Serv*. 2006;57:640-645.
58. Gueta K. A qualitative study of barriers and facilitators in treating drug use among Israeli mothers: an intersectional perspective. *Soc Sci Med*. 2017;187:155-163.
59. Ganga D, Scott S. Cultural "insiders" and the issue of positionality in qualitative migration research: moving "across" and moving "along" researcher-participant divides. In Forum Qualitative Sozialforschung/Forum: Qualitative Social Research; 2006;7:3.

Appendix A

Table 1. Description of participants.

PARTICIPANT	AGE IN YEARS	REGION OF ORIGIN	AGE AT MIGRATION TO NORWAY	AGE WHEN STARTING TO USE SUBSTANCES	DROP-OUT FROM TREATMENT
1	33	Middle East	1.5 y	12	Several times
2	42	West Africa	7 y	14	Twice
3	32	Middle East	5 mo	12	Several times
4	25	East Africa	16 y	17	Once
5	Around 30 (not confirmed)	African descent	12 y	17	Several times
6	38	South Asia	Born in Norway	12	Several times
7	29	South Asia	Born in Norway	19	Once
8	42	Middle East	11 y	15	Several times
9	53	Middle East	21 y	8	Several times
10	39	Middle East	24 y	16	Several times

Article 3

Kour, P., Lien, L., Kumar, B., Nordaunet, O. M., Biong, S., & Pettersen, H. (2021). Health Professionals' Experiences with Treatment Engagement Among Immigrants with Co-occurring Substance Use-and Mental Health Disorders in Norway. *Substance Abuse: Research and Treatment*, *15*, DOI: 11782218211028667.

Health Professionals' Experiences with Treatment Engagement Among Immigrants with Co-occurring Substance Use- and Mental Health Disorders in Norway

Substance Abuse: Research and Treatment
Volume 15: 1–11
© The Author(s) 2021
DOI: 10.1177/11782218211028667
SAGE

Prabhjot Kour[1], Lars Lien[2], Bernadette Kumar[3], Ole Martin Nordaunet[4], Stian Biong[5] and Henning Pettersen[2]

[1]Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP), Innlandet Hospital Trust, and University of South-Eastern Norway, Norway. [2]Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP), Innlandet Hospital Trust, and Faculty of Health and Social Sciences, Norway University of Applied Sciences, Norway. [3]Norwegian Institute of Public Health, Oslo, Norway. [4]Drammen Municipal Mental Health and Drug Addiction Services, Drammen, Norway. [5]University of South-Eastern Norway, Norway.

ABSTRACT: Immigrants face barriers in seeking and accessing mental health and addiction services. Health professionals are crucial in providing and promoting healthcare and it is important to understand their experiences in order to enhance the access of mental healthcare. The aim of this paper is to explore and describe health professionals' experiences with treatment engagement among immigrants with co-occurring substance use disorders (SUD) and mental health disorders (MHD) in Norwegian mental health and addiction services. Within a collaborative approach, 3 focus group interviews were conducted with health professionals, who had provided various mental health and addiction care services to immigrants with co-occurring SUD and MHD. The focus group interviews were transcribed verbatim and analyzed using systematic text condensation. The analysis resulted in 5 main categories: (1) difficulties due to language barriers, (2) difficulties due to lack of culturally competent services, (3) difficulties due to social factors, (4) being curious and flexible improves the user-provider relationship, and (5) increasing access to mental health and addiction services. This study provides an enhanced understanding of how health professionals' experienced treatment engagement among immigrants with co-occurring SUD and MHD in the Norwegian context. Implications of the findings for clinical practice and future research are discussed.

KEYWORDS: Co-occurring substance use and mental health disorders, immigrants, health professionals, mental health and addiction services, qualitative methods, lived experiences, Norway

RECEIVED: November 4, 2020. **ACCEPTED:** June 7, 2021.

TYPE: Original Research

FUNDING: The author(s) disclosed reciept of the following financial support for the research, authorship, and/or publication of this article: This study was funded by Innlandet Hospital Trust, Norway.

DECLARATION OF CONFLICTING INTERESTS: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

CORRESPONDING AUTHOR: Prabhjot Kour, Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders (NK-ROP), Innlandet Hospital Trust, Kjonerud kompetansesenter, Løvstadvegen 7, Ottestad 2312, Norway. Email: prabhjot.kour@usn.no

Introduction

Various studies have investigated racial/ethnic disparities in immigrants' access to mental health services.[1-3] Research in Norway,[1] Sweden,[4] the Netherlands,[5] and Finland[3] has documented the underutilization of specialist mental health services by immigrants in comparison to the host population. Although the Norwegian healthcare system is grounded in principles of equity and solidarity,[6] and immigrants with a residence permit are entitled to similar health services as the host population,[7] immigrants face barriers in accessing these services.[8] Barriers to accessing mental health services are well documented in the literature; these include lack of information about available services, transport and language difficulties, difficulties in navigating the healthcare system, lack of trust, perceived stigma, different understandings of mental health, and thus different perceived needs for care.[9-11] A systematic review reported that barriers to treatment or to maintaining care included communication difficulties with the healthcare provider, lack of culturally adapted services, and inability of the provider to understand different cultural meanings of mental health disorders (MHDs).[12] In addition to these barriers, mental health professionals' stereotyping and biased or discriminatory treatment when dealing with immigrants have also been reported.[13,14] Further, Mladovsky et al[15] have pointed out that immigrants with substance use disorders (SUDs) and MHDs are at high risk of neglect due to lack of existing healthcare policies and insufficient funding to target specific areas of immigrants' mental healthcare. This situation may be aggravated by health professionals' limited knowledge of immigrants' backgrounds, leading to immigrants' dissatisfaction with the services.[16-18]

The rate of immigration to Norway has considerably increased over recent decades; immigrants form a growing proportion of the Norwegian population,[19,20] which leads to an ethnically diverse society.[21] The share of immigrants in Norway's total population is 18.2%, while 10.8% of the population are immigrants from middle- and lower-income countries.[19] The most common countries of origin of this 10.8% are Somalia, Pakistan, Iraq, Syria, and Eritrea.[19] The most common foreign language spoken is English, among others are Urdu, Somali, and Persian. Most health professionals speak English, but all patients in Norway have the right to an interpreter, who is paid by the government, not by the patient.[22] Studies show that immigrants may be at high risk of developing MHDs due to various pre- and post-migration factors.[21,23] Typically, MHDs and substance use present with a high degree of co-occurrence,[24-26] accompanied by poor quality of life.[27] People diagnosed with co-occurring SUD and MHD often face challenges in getting support for tailored and integrated treatment.[28] Moreover, several factors influence their utilization of health services[20] and may lead to lower treatment engagement.[18,29-31] These factors may include their expectations based on experiences in their home countries, lack of culturally tailored services, and previous negative and discriminatory experiences with health services in the host country.[32]

Understanding the process of treatment engagement among immigrants with co-occurring SUD and MHD through health professionals' experiences can provide a basis for the treatment. Engagement is understood as the process of establishing a mutually collaborative, trustful, and respectful helping relationship.[33] Stewart theorizes that the success of engagement can be determined by the quality of the care and relationship built between service users and health professionals during the treatment process,[34] Integrating the principles of "person-centered healthcare" (PCH) in mental health and addiction services has been shown to enhance the quality of relationships and engagement, with improved outcomes.[35] PCH is understood as health services respecting the uniqueness of individuals by focusing on their values, beliefs, desires, and wishes, regardless of their age, gender, social status, faith, financial situation, ethnicity, and cultural background.[36] PCH has emerged as a cornerstone of effective SUD treatment[37,38] and is highlighted in Norwegian national guidelines for SUD treatment.[39] This implies that PCH may improve treatment engagement among immigrants.

In addition to PCH, a cultural competence approach in healthcare has been seen to reduce racial/ethnic disparities (such as threshold for seeking care, ability to communicate symptoms comprehensibly to health professionals, expectations for care, and adherence to treatment), while also improving the quality of care for immigrants.[40] A culturally competent healthcare system is understood as one that "acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs."[40] Cultural competence among mental health professionals working in diverse environments is increasingly recognized as an essential skillset. Various approaches have been developed to enhance the cultural competence of mental health professionals, such as ethnic matching of user and provider, and providers may modify their mode of interaction with users, develop culturally adapted interventions, or offer interventions drawn from the user's own cultural traditions.[41] Training materials and resources have been made available for these professionals, such as textbooks and a specific curriculum and guidelines for training in cultural psychiatry.[42] Additionally, PCH and cultural competence approaches are believed to have the same core features, and hold promise for improving the quality of healthcare for individuals[43] and thus enhancing immigrants' treatment engagement.

In former research on treatment experiences of immigrants living with co-occurring SUD and MHD, some participants narrated various reasons for their lower treatment engagement in mental health and addiction services in Norway; these included a lack of culturally competent staff.[18] Health professionals are crucial in providing and promoting healthcare and thus there is a need to understand their experiences of treatment engagement among immigrants with co-occurring SUD and MHD, which to best of our knowledge has not been previously studied in Norway.

The aim of this paper is to explore the health professionals' experiences with treatment engagement among immigrants with co-occurring SUD and MHD.

Methods

An explorative and descriptive qualitative research design was implemented, with a collaborative approach. Collaborative research is considered highly relevant to the research process and clinical practice, and can improve the evidence base used to inform how services are provided.[44] The kind of collaborative approach used in this study is "mainstream interest in user involvement in research," where the focus was on seeking and including the views of service users in the research process.[44] Hence, drawing on the literature on collaborative research, a competency group of 3 persons was established. Aiming to include different groups affected by the study,[45] 2 members were previous users with lived experience of having co-occurring SUD and MHD, and 1 was a relative of one of the users included. All 3 were immigrants and had an understanding of both their original local context and the Norwegian context. The group worked as advisors to the research team in all stages of the study: planning the study, developing the focus group (FG) interview guide, recruitment approaches, analysis and understanding the results in a local context, as well as dissemination.

Context

Norwegian mental health and addiction services are mostly divided into 2 levels: primary healthcare[46] (based on social, health and welfare legislation, run by municipalities) and secondary healthcare[47] (based on specialist healthcare legislation, run by the state). The specialist services include various polyclinics and psychiatric centers, including opioid substitute treatment facilities, multidisciplinary specialized addiction treatment centers, district psychiatric centers, and hybrid solutions in partnership with primary healthcare, namely (flexible) assertive community treatment (FACT/ACT) teams.

Specialized MHD/SUD treatment centers provide diagnosis and treatment, including drug therapy, psychiatric and family therapy with the aim of helping individuals to desist from substance use, and improve their functioning in relation to health, work, and family. Primary healthcare services (municipalities) in Norway adhere to many of the recommendations for locally based healthcare. The recommendations emphasize that services aim to deliver a comprehensive healthcare services spanning from harm-reductive strategies that is needle exchange, opioid treatment and low-threshold services, to a strengths based recovery oriented approach with focus on activities, talking therapies and groups, and the need for a cooperative healthcare system between specialist and primary healthcare such as stated in the guideline provided by the Norwegian Directorate of Health.[48] In addition, introduction programs for new immigrants form part of primary healthcare. Introduction programs are designed for newly arrived immigrants; here, they are given basic skills in the Norwegian language, insight into Norwegian culture and society, and preparation for work or education.[49] Moreover, the municipality in question offers mental health services based on recovery-oriented principles and feedback-informed treatment as stated in the guideline provided by the Norwegian Directorate of Health.[48] The FACT team is multidisciplinary, consisting of psychiatrists, nurses, psychologists, social workers, and peer workers with user experiences. FACT uses an assertive outreach approach to assist persons with mental health and substance use problems and their local communities, and cooperates with specialist and primary healthcare, in terms of reducing hospitalizations, and enhancing the person's well-being in the local community with individual follow-up care in the areas of work, family, leisure, and housing.[50]

Recruitment

This study forms part of a larger project with an exploratory and descriptive aim, which examines, on the one hand, the experiences of immigrants with co-occurring SUD and MHD with coping[16] and treatment in Norwegian mental health and addiction services,[18] and on the other hand, health professionals' experiences of these factors. It was decided to conduct the project in the 2 Norwegian cities, Oslo and Drammen, with the highest proportion of immigrants, 33% and 29% respectively.[51] Because of the large immigrant population in these cities,[51] health professionals there were expected to have the most contact with immigrants and experience of providing various mental health and addiction care services.

Recruitment was initiated by emailing and calling the leaders of various primary and secondary mental health and addiction services with access to potential immigrant patients with co-occurring SUD and MHD. These leaders received detailed information about the research project. They then sent the information to their team members and only those health professionals who were willing to participate in the study were included. The recruitment was strategic, being aimed at health professionals with experience of providing a variety of mental health and addiction care services to immigrants with co-occurring SUD and MHD in Norway. These were a specialized MHD/SUD treatment center, primary (municipal) healthcare, and a flexible assertive community treatment (FACT) team.

Participants

The study included 19 participants, 12 females and 7 males, divided into 3 FGs. Their ages ranged from 28 to 65 years, while their experience of treating immigrants with co-occurring SUD and MHD ranged from 1 to 25 years. The participants had different professional backgrounds (Appendix A, Table A1), including 1 psychiatrist, 3 psychologists, 4 specialist nurses, 6 general nurses, and 5 social workers. Sixteen of the 19 participants were ethnic Norwegians and 3 were of immigrant origin. FG 1 consisted of 7 health professionals from the specialized MHD/SUD treatment team. FG 2 was composed of 8 health professionals from primary healthcare, and FG 3 comprised 4 health professionals working in a FACT team.

Data collection

Prior to data collection, an FG interview guide, consisting of open-ended thematic questions about experiences of providing various mental health and addiction care services to immigrants with co-occurring SUD and MHD was created and agreed upon by all authors and the members of the competency group. Table A2 (Appendix B) shows the interview guide with main questions, which all had follow-up and probing questions.

The data were collected through FG interviews, as the method was considered to be well suited to enquire about the participants' experiences, perceptions, desired goals and difficulties, and could provide a deeper understanding of their attitudes.[52] In addition, FG interviews assist in exploring phenomena and experiences that are incompletely understood and sensitive issues that may not be captured by the prevailing literature or expert opinion.[53] Three FG interviews were conducted with health professionals between November 2019 and February 2020. The FG interviews were conducted at the participants' workplaces, as per their convenience and working hours. The FG interviews lasted between 60 and 80 minutes and were audio recorded. They were led by moderators and the first author. Two different moderators were used: FG 1 was conducted by the first moderator, and FGs 2 and 3 by the second moderator. The first moderator could not continue for FGs 2 and 3 because of commitments elsewhere, and a second moderator was therefore used for the remaining FG interviews. The second moderator was also the interpreter, who transcribed all 3 FG interviews and translated them into English. The first author acted as an observer at all 3 FG interviews, concentrating on group dynamics, and noting down thoughts that arose when following the dialog. At the end of each FG interview, the moderator and first author shared their reflections and later discussed them with all authors and the members of the competency group.

Data analysis

Within the aim of the study, the analysis was combined inductive-deductive, that is, PCH and cultural competence were applied as theoretical background and inspiration, while inductive in a sense that the participants' descriptions were the point of departure. The FG interviews were transcribed and translated to English by the interpreter. Systematic text condensation (STC),[54] was employed to analyze these interview transcripts. Further, STC is an explorative and descriptive method which aims at thematic cross-case analysis, and which also maintains methodological rigor and enables intersubjectivity, feasibility, and reflexivity.[54] STC is a stepwise procedure that encompasses identification of recurring initial codes and themes relevant to the study aim. In step 1, a general impression was formed by reading all the transcripts, which led to the formation of initial themes. In the second step, after a systematic review of the transcripts, meaning units were identified and sorted into code groups. In the third step, subgroups were formed from the code groups with their meaning units. The next step was to form artificial quotations by reducing the meaning units under each subgroup. The final step was to develop the analytic text and descriptions from the artificial quotations. The analytic text was reconceptualized by returning to the complete transcripts and reflecting on whether each illustrative quotation still reflected the original content. This was done in order to validate the analytic texts. Lastly, the analytic texts were supported by quotes, which are presented in the "Results" section. In each step, all the co-authors were consulted, and discussions took place. In the final step, the team of experts by experience was consulted to provide an understanding of the results within the local context they represented.

Ethical statement

The study was conducted in accordance with the Declaration of Helsinki and was approved by the Norwegian Centre for Research Data (Project No. 59707). The participation was completely voluntary. All FG participants signed informed consent and received an information letter about the project prior to the group interviews. Confidential details of the participants were deleted from the data in order to maintain their anonymity. The informed consent contained information on the study, including the aim and purpose of the research. It also mentioned the selection of participants, voluntary participation, duration, potential risks and benefits, confidentiality, anonymity, right to withdraw, and dissemination of results. The contact information of the first author was provided in case the participants had concerns or questions after the FG interviews. The moderator and interpreter signed a confidentiality declaration prior to the interviews.

Results

The analysis yielded 5 main categories describing health professionals' experiences of treatment engagement among immigrants with co-occurring SUD and MHD. These categories were: (1) Difficulties due to language barriers, (2) Difficulties due to lack of culturally competent services, (3) Difficulties due to social factors, (4) Being curious and flexible improves the user-provider relationship, and (5) Increasing access to mental health and addiction services. Each category is described below with reference to the empirical data and numbers used to identify the participants follow each excerpt.

Difficulties due to language barriers

When treating immigrants with co-occurring SUD and MHD participants stated that both they and the immigrant patients faced difficulties due to the language barrier. These difficulties were often experienced as frustrations due to miscommunication and were described as a constraining factor in diagnosis and treatment. Further, some participants mentioned that group therapy sessions were among standard treatments for patients with co-occurring SUD and MHD, but that many immigrants were excluded from group therapy because they could not speak and understand Norwegian, and if included, they changed the dynamics of group sessions by disturbing others and reducing spontaneity. Additionally, a few participants highlighted difficulties experienced due to language barriers and miscommunication in one-to-one counseling sessions, where effective communication was considered vital in engaging patients with co-occurring SUD and MHD.

> *And the difficulty has been to understand how good their language skills are, if we need an interpreter or not. It has also been difficult to know if they should get 24-hour treatment and if they understand enough [Norwegian] to participate in group sessions. Because almost all treatment we have here is based on group therapy. . . .And we would not be able to have an interpreter here 24 hours a day so. . . They [non-Norwegian speakers] are in a way excluded from that. . .* (P2, FG-1)

Further, a few participants described difficulties in using interpreters with immigrant service users with a poor command of Norwegian. They mentioned that sometimes the interpreters were not competent enough to understand issues related to co-occurring SUD and MHD, which led to frustrations for both the patients and the participants themselves. Also, sometimes the use of different interpreters in different sessions with the same patient led to unsuccessful communication. Seeing a new interpreter at every new session was described as inconvenient and often created miscommunication between the parties. Moreover, a few participants mentioned difficulty in obtaining interpretation services since these were not cost-effective in Norway, resulting in lower use of interpreters, and often only in crucial situations.

> *So I have had patients that went through 5-6 different interpreters, or at least five different interpreters. And that is not appropriate because there is the confidentiality and the trust that are necessary if they are to share things. I see that as a difficulty. . ..* (P5, FG-1)

Having to work with immigrants with poor Norwegian language skills was perceived as difficult as it required extra effort and extra hours of work in their busy schedule. One participant described it in the following way:

> *And the other thing that you realize about patients from other cultures or with bad Norwegian. . . it is a busy working day and to understand that someone doesn't speak Norwegian is almost extra work and we find it difficult. An extra. . .extra work. . ..* (P4, FG-3)

Difficulties due to lack of culturally competent services

Most of the participants described difficulties due to the lack of culturally competent services in treatment. Further, it was stated that not knowing the person's cultural background often caused misunderstandings of what was socially and culturally acceptable behavior. Some participants also linked this to their feeling of helplessness in not knowing on how to approach these patients in treatment. This led to difficulty in developing a trusting relationship and when the cultural expectations of these patients were not met, they tended to discontinue the treatment. Further, participants talked about the lack of available resources such as official courses, training or guidelines on cultural sensitivity in treatment programs. This gave them limited opportunity to acquire knowledge and skills in cultural competence.

> *We have very few resources, knowledge and skills about cultural competence . . . Also, I think, when it comes to how. . . what do we do? I mean, how, what do I do? What should I do if I meet an immigrant patient, how do I get things started?* (P1, FG-3)

Some participants also mentioned that there are very few immigrant health professionals in Norwegian mental health and addiction services. One participant said that immigrant patients often ask for health professionals of immigrant origin and it causes difficulties when they do not get access to these.

> *I have been working with this for over 20 years at many different places. I have met one. . . one psychologist who was from a non-Western country. And. . . two or three nurses. . . I don't know why, but there are too few non-Western immigrants working in the Norwegian mental healthcare and addiction services. . .* (P5, FG-1)

In addition, a few participants who work in introduction programs mentioned that there is little focus on mental health and substance use in the programs. This means that such problems continue undetected and develop in severity before the program counselor notices them. In such cases, the problems can lead to new problems and require more effort to address and treat.

Difficulties due to social factors

Participants mentioned various social factors that discourage immigrants from seeking and engaging in treatment. Predominant factors were poor integration, isolation, and marginalization. Some participants also mentioned that immigrants often live in parallel societies, where they have very little contact with mainstream society, in addition to the stigma attached to SUDs and MHDs.

> *I think that immigrants have problems with participating. They do not come out of their contexts. Not very willing to be integrated. Living in parallel worlds. Like, they are not well integrated and it seems like many cultures live in parallel societies.* (P4, FG-2)

Further, participants highlighted immigrants' poor financial and living conditions. They described how the combination of co-occurring SUD and MHD, stigma attached to them, and poor coping with the transition from their home country to Norway with few supportive contacts is a potential barrier to the treatment engagement process. In addition, there is no local immigrant network that can help to improve treatment engagement.

> *. . ..I mean, my experience is that when you take, typical areas of immigrant housing. And you see a kindergarten where all the children are dark skinned. . . And then there is housing for addicts, where there is a lot of substance use, just next door. And the heroin addicts or khat-chewing old people are sitting there, and there is the mosque right next door, and there is a place where a lot of garbage gets thrown.. . . and stuff like that. I mean, that proximity of non-existing maintenance, drugs, crime. . . That would not be tolerated in areas where Norwegians live. . . So. . . I think it plays a part. That immigrants feel like they can't demand the same. . . That it is in a way a double standard. That you don't have the right to be treated the same way or have the same attention. . .* (P2, FG-3)

Some of the participants mentioned that having poor Norwegian language skills also leads to social exclusion. The participants further experienced that this hampers the possibility to seek knowledge about the available treatment options and leads to a poor understanding of how the Norwegian mental health and addiction services work.

> *And it was very challenging, as I recall, when it came to the. . . immigrants who were badly integrated, did not speak Norwegian and didn't have any formal knowledge or understanding of the society. . .. it was very challenging. . ..* (P3, FG-2)

Being curious and flexible improves the user-provider relationship

Some participants described how being curious and flexible while treating immigrants with co-occurring SUD and MHD had improved their relationships with them. They also mentioned that when they had met their expectations based on the cultural context and acknowledged that cultural differences existed when tailoring individual treatment, this had engaged immigrants and enabled them to complete treatment.

> *Being open-minded and curious,. . .. I have a patient who has some difficulties and I go and I read about that, you see? When they grew up in a country that I don't entirely understand. So then I go and read up on that a bit. . .. It's possible to read. . . read a book about that but it's because they grew up in a country, take up the topic. . .* (P1, FG-3)

A few participants mentioned that allowing immigrant patients to practice their faith while they are in treatment enhanced the engagement process.

> *We try to accommodate. . . all the religions and. . .When we want to build up [a relationship], we could have a diversity room, a place where they can pray or. . . or do what they want.* (P6, FG-1)

A few participants found that their relationship improved by having a welcoming attitude with an interest in how persons of immigrant origin function, coupled with communicative skills of being creative, and using non-verbal communication. One participant mentioned that the ability to find flexible solutions to address communication problems, along with frequent and close follow-up, has improved their relationships.

> *Being aware that they can have, not necessarily, but they can have a different understanding of the sickness, another understanding of why I am sick and what is the sickness. . . to be a fellow human being, to be curious, be interested. . ..* (P1, FG-1)

Increasing access to mental health and addiction services

A few participants showed a general concern about the possible lack of primary mental healthcare accessible to immigrants with co-occurring SUD and MHD. Further, 1 participant mentioned that providing practical help to immigrants, such as a mental health nurse who already has a relationship with them accompanying them to their doctor, has facilitated the participation and engagement process. Moreover, some participants stated that using professional and competent interpreters who have cultural competence can aid in building trust in therapy sessions.

> *We had a psychiatric nurse that worked with us who had a very important influence. She worked hard to: I mean, when I sit there as program consultant and counselor and. . . and I see that there is something here, something that doesn't. . . fit. So. . . I have to come in. . . in a position where the participant I want to talk to talks to our psychiatric nurse. And then she would carefully assess their health, mental and physical health and then she would also accompany us to the person's doctor, and we started there to see if there is a need for, what kind of needs there are. . .* (P5, FG-2)

Additionally, a few participants also stated that increasing the accessibility of mental health and addiction services by making them ambulatory has improved treatment engagement. Addressing the complex challenges faced by immigrants, such as service providers going to their homes when they cannot come to the treatment centers, or meeting in parks, as per their convenience, with close follow-up, helping them with their everyday work and providing injections, has helped to build a trusting relationship.

> *I think, when it comes to what we can do; for us working in FACT, I think we are very ambulatory, go home to people, follow them up closely, we help them with everything from hanging up the curtains to giving them injections. To be able to get, to get trust, a relationship, that's what keeps our work going.* (P3, FG-3)

Discussion

This study illuminates health professionals' experiences with treatment engagement among immigrants with co-occurring SUD and MHD in Norway. Five main categories were identified which we classified into 2 major sections as barriers and facilitators to treatment engagement and have discussed the results in these 2 sections. The first section consisted of barriers that reduced treatment engagement, which were difficulties due to language barriers, difficulties due to a lack of culturally competent services, and difficulties due to social factors. The second section consisted of facilitators that enhanced treatment engagement, which were being curious and flexible to improve the user-provider relationship, and increasing accessibility of mental health and addiction services.

Barriers to treatment engagement

Participants described how difficulties due to language barriers led to miscommunication, limiting diagnosis and treatment, and problems in group therapy sessions, which lowered treatment engagement among immigrants with co-occurring SUD and MHD. Effective communication between health professionals and users is a key factor in mental healthcare, as diagnosis is based on verbal communication rather than on objective physical examinations.[55] A study conducted in 16 major European cities reported that language difficulties were a major barrier in assessing symptoms, making a diagnosis, and developing a trusting relationship with immigrant patients,[56] which resonates with our findings. In addition, a few studies have reported that insufficient language skills among immigrants act as a barrier to accessing specific mental health treatments such as psychotherapy.[57,58] This is similar to our findings, where participants stated that immigrants faced difficulties in joining group therapy sessions conducted in Norwegian, which were among the standard treatment approaches in their services. This can be seen as a lack of PCH and a cultural competence approach in the treatment, where services seem less accessible for immigrants with co-occurring SUD and MHD, representing a barrier to treatment engagement.

Further, participants experienced using interpreters often led to miscommunication and lower treatment engagement because of incompetent interpreters who did not understand the issues of co-occurring SUD and MHD. This has also been reported in previous studies conducted among mental health professionals providing treatment to immigrants.[40,58-60] In addition, language difficulties and unskilled interpreters have been reported to be frustrating for both health professionals and immigrant patients, with negative effects on treatment alliances and establishing trust,[59,60] as reflected in our participants' experiences, leading to poor treatment engagement. Moreover, a survey conducted among psychotherapists reported that 43% of them refused to treat immigrant patients due to language disparities,[61] which concurs with our findings where some participants perceived treating immigrants as involving extra effort and extra hours. Further, the narrative of extra efforts and extra work can be seen as a discriminatory element in the treatment process, where immigrant patients were not given the attention and care they needed, which can be correlated with our previous findings.[16,18] Furthermore, some of the participants mentioned the use of interpreter services as neither cost-effective nor commonly used in their work experience. This is in contrast to the guidelines of the Norwegian Directorate of Health, which state that patients with limited knowledge of Norwegian are entitled to an interpreter in their preferred language.[62] Additionally, all these findings indicate the lack of PCH and a cultural competence approach, which ultimately leads to a lack of individually tailored services for immigrants with co-occurring SUD and MHD and hence acts as a barrier to treatment engagement.

Another barrier that shaped the treatment engagement of immigrants with co-occurring SUD and MHD, as reflected in the participants' experiences, was difficulties faced due to lack of cultural competence in treatment programs. Participants described how the lack of cultural competence caused misunderstandings of what is socially and culturally acceptable behavior for immigrant patients and hence decreased treatment engagement, in line with previous studies.[18,55-57] These misunderstandings could also be understood in terms of immigrants' narratives of experiencing lack of connection and lack of individually tailored services while in treatment for co-occurring SUD and MHD.[18] This was exacerbated by the lack of official courses and relevant resources for health professionals to learn about cultural competence in mental health settings.[57,63] Moreover, health professionals who feel unequipped to deal with comprehensive needs arising during interactions with immigrant patients have different understandings of mental illness and treatment,[57,63] which resonates with our findings. Further, a lack of diversity among healthcare workers and a need for immigrant professionals in mental health and addiction services are well documented in the literature.[55,57,58] This concurs with our findings and was seen in our sample, where only 3 of 19 health professionals were of immigrant origin. In addition, Betancourt et al[40] argue that lack of diversity in the leadership and staff of healthcare organizations may result in poorly designed structural policies, procedures and delivery systems to meet the needs of immigrant patients, thus representing a barrier to their treatment engagement.

In addition, some participants mentioned difficulties due to social factors that reduced treatment engagement among immigrants with co-occurring SUD and MHD. Cultural interpretation of mental health needs, stigma attached to SUDs and MHDs and experiences of discrimination and social exclusion often cause difficulties in engaging in treatment.[18,55,57] This is exacerbated by poor knowledge of available help in mental health and addiction services,[59] as reflected in our findings, where participants mentioned lower treatment engagement by immigrants because of poor integration and living in parallel societies with few contacts in mainstream Norwegian society. Some studies have also reported that socioeconomic factors including poor living conditions, low income levels, and unemployment act as barriers to utilizing mental health and substance use treatment,[59,64] in line with our participants' experiences. Additionally, in our previous study,[16] the immigrants' narrative of "living a double life," "cultural clash," and "racism and cultural stigma" acted as barriers to seeking or continuing treatment, which concurs with the participants' experiences of facing difficulties due to social factors.

Facilitators to treatment engagement

To facilitate the adequate use of available treatment and to ensure lower drop-out rates, it is critical to understand the barriers.[65] PCH[35] and a cultural competence approach[40] have been shown to facilitate treatment engagement. According to the framework suggested by Saha et al,[43] both PCH and cultural competence have overlapping core values that work at the interpersonal level (between health professionals and users) and the health system level. At the core of PCH and cultural competence at the interpersonal level is health professionals' ability to see the patient as a unique person, to maintain an unconditional positive attitude, to build effective rapport, and to explore the patient's beliefs, values, and meaning of illness, in order to find a common ground for treatment plans, which is also aided by understanding the meaning and importance of culture, and the effective use of interpreters.[43] This is similar to our findings where participants described how being curious to learn about different cultural contexts, being flexible to provide individually tailored treatment, and being creative to find solutions to address communication problems, have all improved their therapeutic relationships and hence facilitated treatment engagement among immigrants with co-occurring SUD and MHD. Previous studies on healthcare professionals' perspectives have also shed light on the importance of cultural competence in mental health treatment for immigrants.[55,56]

Furthermore, at system level, PCH and cultural competence, an emphasis on enhancing health professionals' accessibility, a diverse workforce that reflects the minority population and partnering with communities in setting priorities and planning, are all associated with improved treatment outcomes.[43] This further promotes equity for minority groups, who tend be disadvantaged in terms of seeking care and in treatment engagement.[43] The systemic level could be understood in terms of the participants' experiences where they mentioned that making mental health and addiction services accessible to immigrants with co-occurring SUD and MHD facilitates treatment engagement, including increased accessibility of mental health professionals, immigrant health professionals, the use of professional interpreters, and the integration of mental health and addiction services with primary services, which is consistent with previous studies.[55,57] Further, participants from the FACT team mentioned that having ambulatory services tailored to individual immigrant patients' needs has facilitated their process of treatment engagement, which aligns with the principles of PCH and cultural competence at the systemic level. These interventions may help to reduce racial/ethnic disparities in healthcare and truly provide quality healthcare[40] for immigrants with co-occurring SUD and MHD, who are overshadowed by the majority in treatment engagement.

Lastly, on the one hand, from a PCH and cultural competence perspective, it is important to adapt services to meet the needs and preferences of immigrants with co-occurring SUD and MHD in treatment, to increase the accessibility of health services in immigrant communities, including outreach and home visits, and to ensure that health information material is tailored to immigrants' needs, preferred language and health literacy.[43] On the other hand, from a policy perspective, it is crucial to identify the causes of unmet needs.[66] Here we would point out the need to understand factors that may be responsible for the unmet needs of immigrants and the barriers preventing health professionals from providing tailored treatment. The participants pointed out that some of these factors are the language barrier, limited cultural sensitivity, and a lack of resources to enable professionals to acquire cultural competence. Some such factors were also narrated by immigrants with co-occurring SUD and MHD, including lack of individually tailored services, lack of connection between health professionals and immigrants, stigma and discriminatory experiences with healthcare, and distrust of the system, in our previous studies.[16,18] Previous studies have suggested some strategies to address these issues and to improve mental health and addiction service delivery, such as highlighting the importance of culturally appropriate services by acknowledging users' needs and preferences, and encouraging users to voice their own explanations of health, worries, and expectations.[67,68]

Limitations and strengths

The present study provides an overview of health professionals' experiences with treatment engagement among immigrants with co-occurring SUD and MHD in Norway. The results are based on the experiences of the participants and their relevance beyond the local context may be discussed. Nevertheless, exploring subjective experience involves a focus on the insights and meaning of the participants, which may be transferred[69] to other people and other contexts. Additionally, these insights are believed to be of relevance for future research in the field of migrant healthcare, where there is a paucity of research. Further, the collaboration with the competency group in all stages of the study, from writing the protocol, preparing the study, analyzing the data to compiling the results, has enhanced the credibility[69] of our study.

Conducting a study with an explorative and descriptive qualitative research design of this kind requires the researcher to avoid approaching the FG interviews with too fixed questions and pre-understandings. Therefore, the first author focused on letting the participants' voices be heard and refrained from any early interpretations and judgment of the meaning of their experiences. However, the first author's background as a medical doctor and immigrant herself may have influenced the analysis. Selective bracketing of pre-understanding was sought during analysis, even though complete bracketing is seen as impossible. To this end, the competency group was involved in the process of analysis to offer validation and reflexivity and may have addressed this potential limitation.[70] Additionally, all the co-authors had several discussions about the analysis process.

This study has an important methodological limitation, namely that it was only possible to recruit health professionals from 3 different services and those who were willing to participate. This may be considered as selection bias during recruitment and we may not have reached health professionals with more experience of treating immigrants with co-occurring SUD and MHD. However, with the limited time frame of this study, this was the only feasible approach. A longer-term strategy could have made it easier to reach health professionals from other Norwegian mental health and addiction services. Another limitation was lack of in-depth discussion on how participants described "immigrants." However, most participants briefly described "immigrants," as persons who were born or whose parents were born outside Norway. Here, they referred to the standard definition of immigrants used in Norway and provided by the national agency, Statistics Norway (SSB). One participant referred to "immigrants" as persons with a multicultural background in his clinical practice.

Further, one can discuss the methodological challenge of recruiting from health services with different treatment approaches in the same study. However, few immigrants seek mental health and addiction services in Norway,[1] thus it was expected that few health professionals would have had experience of treating immigrants. As such, we were not focused on context-specific treatment; our goal was to explore the experiences of health professionals working in Norwegian mental health and addiction services, in order to understand immigrants' treatment engagement. Our purpose was to find immigrants' treatment engaging behavior in different services, according to different health professionals, including psychologists, psychiatrists, nurses, and social workers. In addition, this could be linked to our previous study, where immigrants voiced their reasons for their lower treatment engagement and lack of satisfaction when their needs remained unmet.[18] Hence, conducting this research on health professionals' experiences may have helped to provide a multifaceted view of the barriers to treatment engagement among immigrant patients.

Conclusion

Health professionals' experiences with treatment engagement among immigrants with co-occurring SUD and MHD were described and explored, which shed light on both barriers and facilitators to treatment. Difficulties due to language barriers, social factors, and the lack of culturally competent services were described as important ongoing barriers and hence led to lower treatment engagement. However, health professionals' ability to be curious and flexible, and to make mental health and addiction services accessible to immigrant patients, facilitated treatment, and thus improved treatment engagement. The findings of this study indicate an increased need for competent and professional interpreters who have knowledge about mental health and substance use problems, in order to overcome language barriers. A culturally competent approach is clearly lacking; therefore, we suggest placing greater emphasis on strategies that provide person-centered and culturally competent services. The cultural competence of the healthcare professionals providing treatment to immigrants must be enhanced and cannot depend on their personal interest only. Hence, we suggest that providing resources to teach healthcare professionals about diverse cultural backgrounds is paramount to improve treatment engagement among immigrants with co-occurring SUD and MHD. Future research on how to enhance understanding of these barriers in the context of immigration, and intervention studies to enhance PCH and cultural competence in healthcare settings are recommended.

Acknowledgements

The authors would like to thank all the participants of the study for generously sharing their time, perspectives, and experiences. We also would like to express our appreciation to the members of the competency group, who have been valuable in providing their insights and reflections throughout the study. Finally, we would like to thank Innlandet Hospital Trust for providing funding for the study.

Author Contributions

PK conducted the study and initial data analysis. All the authors contributed in further analysis and drafting the final article.

ORCID iDs

Prabhjot Kour https://orcid.org/0000-0001-5716-6683
Ole Martin Nordaunet https://orcid.org/0000-0002-6061-0033

REFERENCES

1. Abebe DS, Lien L, Elstad JI. Immigrants' utilization of specialist mental healthcare according to age, country of origin, and migration history: a nation-wide register study in Norway. *Soc Psychiatry Psychiatr Epidemiol*. 2017;52:679-687.
2. Cook BL, Trinh N-H, Li Z, Hou SS-Y, Progovac AM. Trends in racial-ethnic disparities in access to mental health care, 2004–2012. *Psychiatr Serv*. 2017;68:9-16.
3. Castaneda AE, Çilenti K, Rask S, et al. Migrants are underrepresented in mental health and rehabilitation services—survey and register-based findings of Russian, Somali, and Kurdish origin adults in Finland. *Int J Environ Res Public Health*. 2020;17:6223.
4. Ivert A-K, Merlo J, Svensson R, Levander MT. How are immigrant background and gender associated with the utilisation of psychiatric care among adolescents? *Soc Psychiatry Psychiatr Epidemiol*. 2013;48:693-699.
5. Mulder CL, Koopmans GT, Selten J-P. Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to the Netherlands. *Br J Psychiatry*. 2006;188:386-391.
6. Helse-og-Omsorgsdepartmentet. Likeverdige helse-og omsorgsstjenester-god helse for alle. National strategi om innvandreres helse, 2017. Helse-og-Omsorgsdepartmentet; 2013.
7. Ringard Å, Sagan A, Saunes I, Lindahl A. Norway: health system review. *Health Syst Transit*. 2013;15:1-162.
8. Mbanya VN, Terragni L, Gele AA, Diaz E, Kumar BN. Access to Norwegian healthcare system – challenges for sub-Saharan African immigrants. *Int J Equity Health*. 2019;18:125.
9. Ahmed S, Shommu NS, Rumana N, Barron GR, Wicklum S, Turin TC. Barriers to access of primary healthcare by immigrant populations in Canada: a literature review. *J Immigr Minor Health*. 2016;18:1522-1540.
10. Franks W, Gawn N, Bowden G. Barriers to access to mental health services for migrant workers, refugees and asylum seekers. *J Public Ment Health*. 2007;6:33-41.
11. Saechao F, Sharrock S, Reicherter D, et al. Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States. *Community Ment Health J*. 2012;48:98-106.
12. Aggarwal NK, Pieh MC, Dixon L, Guarnaccia P, Alegria M, Lewis-Fernandez R. Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: a systematic review. *Patient Educ Couns*. 2016;99:198-209.
13. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9:117-125.
14. Kauff M, Asbrock F, Issmer C, Thörner S, Wagner U. When immigrant groups "misbehave": the influence of perceived deviant behavior on increased threat and discriminatory intentions and the moderating role of right-wing authoritarianism. *Eur J Soc Psychol*. 2015;45:641-652.
15. Mladovsky P, Rechel B, Ingleby D, McKee M. Responding to diversity: an exploratory study of migrant health policies in Europe. *Health Policy*. 2012;105:1-9.
16. Kour P, Lien L, Kumar B, Biong S, Pettersen H. Coping and negotiating a sense of self: immigrant men's experiences of living with co-occurring substance use and mental health disorders in Norway. *Am J Psychiatr Rehabil*. 2019;22:43-63.
17. Diaz E, Kumar BN. Health care curricula in multicultural societies. *Int J Med Educ*. 2018;9:42.
18. Kour P, Lien L, Kumar B, Biong S, Pettersen H. Treatment experiences with Norwegian health care among immigrant men living with co-occurring substance use- and mental health disorders. *Subst Abuse*. Published online November 24, 2020. doi:10.1177/1178221820970929
19. SSB. Immigrants and Norwegain-born to immigrant parents. Statistics Norway. Published 2020. Accessed August, 2020. https://www.ssb.no/en/befolkning/statistikker/innvbef
20. Mosdøl A, Vist GE, Straumann GSH, Spilker RACS, Austvoll-Dahlgren A. Adapted health information and patient education for persons with immigrant or minority ethnic background. Report - 2018. Oslo: Norwegian Institute of Public Health. 2018.
21. Abebe DS, Lien L, Hjelde KH. What we know and don't know about mental health problems among immigrants in Norway. *J Immigr Minor Health*. 2014;16:60-67.
22. Helsenorge. Interpreter in the health services in Norway. Helsenorge. Published 2019. Accessed February 23, 2021. https://www.helsenorge.no/en/health-rights-in-norway/right-to-an-interpreter/

23. Chen W, Hall BJ, Ling L, Renzaho AM. Pre-migration and post-migration factors associated with mental health in humanitarian migrants in Australia and the moderation effect of post-migration stressors: findings from the first wave data of the BNLA cohort study. *Lancet Psychiatry*. 2017;4:218-229.
24. Rossow I, Bramness JG. The total sale of prescription drugs with an abuse potential predicts the number of excessive users: a national prescription database study. *BMC Public Health*. 2015;15:288.
25. Long E, Aggen S, Neale M, et al. The association between personality disorders with alcohol use and misuse: a population-based twin study. *Drug Alcohol Depend*. 2017;174:171-180.
26. Torvik FA, Rosenström TH, Ystrom E, et al. Stability and change in etiological factors for alcohol use disorder and major depression. *J Abnorm Psychol*. 2017;126:812.
27. Carrà G, Johnson S, Crocamo C, et al. Psychosocial functioning, quality of life and clinical correlates of comorbid alcohol and drug dependence syndromes in people with schizophrenia across Europe. *Psychiatry Res*. 2016;239:301-307.
28. Drake RE, Mueser KT, Brunette MF, McHugo GJ. A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatr Rehabil J*. 2004;27:360.
29. De Kock C, Decorte T, Vanderplasschen W, Derluyn I, Sacco M. Studying ethnicity, problem substance use and treatment: from epidemiology to social change. *Drugs (Abingdon Engl)*. 2017;24:230-239.
30. Verdurmen JE, Smit F, Toet J, Van Driel HF, Van Ameijden EJ. Under-utilisation of addiction treatment services by heroin users from ethnic minorities: results from a cohort study over four years. *Addict Res Theory*. 2004;12:285-298.
31. Vandevelde S, Vanderplasschen W, Broekaert E. Cultural responsiveness in substance-abuse treatment: a qualitative study using professionals' and clients' perspectives. *Int J Soc Welf*. 2003;12:221-228.
32. Kalich A, Heinemann L, Ghahari S. A scoping review of immigrant experience of health care access barriers in Canada. *J Immigr Minor Health*. 2016;18:697-709.
33. Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change*. Guilford press; 2012.
34. Stewart KD. Factors contributing to engagement during the initial stages of treatment for psychosis. *Qual Health Res*. 2013;23:336-347.
35. Dixon LB, Holoshitz Y, Nossel I. Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry*. 2016;15:13-20.
36. McCormack B, van Dulmen S, Eide H, Skovdahl K, Eide T. *Person-Centred Healthcare Research*. John Wiley & Sons; 2017.
37. Friedmann PD, Hendrickson JC, Gerstein DR, Zhang Z. The effect of matching comprehensive services to patients' needs on drug use improvement in addiction treatment. *Addiction*. 2004;99:962-972.
38. Hser Y-I, Polinsky ML, Maglione M, Anglin MD. Matching clients' needs with drug treatment services. *J Subst Abuse Treat*. 1999;16:299-305.
39. Norwegian Directorate of Health. National Guidelines for Treatment and Rehabilitation of Substance Use Disorders. *NDH;* 2017.
40. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O 2nd. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep*. 2003;118:293-302.
41. Kirmayer LJ. *Rethinking Cultural Competence*. Sage Publications Sage; 2012.
42. Kirmayer LJ, Fung K, Rousseau C, et al. Guidelines for training in cultural psychiatry. *Can J Psychiatry*. 2021;66:195-246.
43. Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. *J Natl Med Assoc*. 2008;100:1275-1285.
44. Beresford P. User involvement in research: exploring the challenges. *J Res Nurs*. 2003;8:36-46.
45. Ness O, Borg M, Semb R, Karlsson B. "Walking alongside:" collaborative practices in mental health and substance use care. *Int J Ment Health Syst*. 2014;8:1-8.
46. Lovdata. Lov om kommunale helse- og omsorgstjenester m.m. (helse- og omsorgstjenesteloven). Lovdata. Published 2011. Accessed February 23, 2021. https://lovdata.no/dokument/NL/lov/2011-06-24-30
47. Lovdata. Lov om spesialisthelsetjenesten m.m. (spesialisthelsetjenesteloven). Lovdata. Published 1999. Accessed February 23, 2021. https://lovdata.no/dokument/NL/lov/1999-07-02-61
48. Helsedirektoratet. Sammen om mestring. Veileder i lokalt psykisk helsearbeid og rusarbeid for voksne. Et verktøy for kommuner og spesialisthelsetjenesten. Helsedirektoratet Oslo; 2014.
49. Government.no. Introduction programme. Ministry of Education and Research. Published 2014. Accessed February 23, 2021. https://www.regjeringen.no/en/topics/immigration-and-integration/kd/Verkemiddel-i-integreringsarbeidet/introduksjonsprogram/id2343472/
50. Van Veldhuizen JR. FACT: a Dutch version of ACT. *Community Ment Health J*. 2007;43:421-433.
51. SSB. 14 prosent av befolkningen er innvandrere. Statistics Norway. Published 2018. Accessed February 23, 2021. https://www.ssb.no/befolkning/artikler-og-publikasjoner/14-prosent-av-befolkningen-er-innvandrere
52. Kitzinger J. Qualitative research: introducing focus groups. *BMJ*. 1995;311:299-302.
53. McLafferty I. Focus group interviews as a data collecting strategy. *J Adv Nurs*. 2004;48:187-194.
54. Malterud K. Systematic text condensation: a strategy for qualitative analysis. *Scand J Public Health*. 2012;40:795-805.
55. Giacco D, Matanov A, Priebe S. Providing mental healthcare to immigrants: current challenges and new strategies. *Curr Opin Psychiatry*. 2014;27:282-288.
56. Sandhu S, Bjerre NV, Dauvrin M, et al. Experiences with treating immigrants: a qualitative study in mental health services across 16 European countries. *Soc Psychiatry Psychiatr Epidemiol*. 2013;48:105-116.
57. Salami B, Salma J, Hegadoren K. Access and utilization of mental health services for immigrants and refugees: perspectives of immigrant service providers. *Int J Ment Health Nurs*. 2019;28:152-161.
58. Jensen NK, Norredam M, Priebe S, Krasnik A. How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark. *BMC Fam Pract*. 2013;14:17.
59. Kaltman S, Hurtado de Mendoza A, Gonzales FA, Serrano A. Preferences for trauma-related mental health services among Latina immigrants from Central America, South America, and Mexico. *Psychol Trauma*. 2014;6:83.
60. Mirdal GM, Ryding E, Essendrop Sondej M. Traumatized refugees, their therapists, and their interpreters: three perspectives on psychological treatment. *Psychol Psychother*. 2012;85:436-455.
61. Mösko MO, Gil-Martinez F, Schulz H. Cross-cultural opening in german outpatient mental healthcare service: an exploratory study of structural and procedural aspects. *Clin Psychol Psychother*. 2013;20:434-446.
62. Norwegian Directorate of Health. Patient and interpreter. A brochure about interpretation in the health services. Norwegian Directorate of Health. Published 2015. Accessed February 2021. https://www.helsedirektoratet.no/brosjyrer/pasient-og-tolk
63. Žagar M, Pavlič DR, Švab I, et al. Through health workers' eyes: a qualitative study of health service provision for migrants at Schengen border. *Int J Equity Health*. 2019;18:117.
64. Harpelund L, Nielsen SS, Krasnik A. Self-perceived need for interpreter among immigrants in Denmark. *Scand J Public Health*. 2012;40:457-465.
65. Falgas-Bague I, Wang Y, Banerjee S, et al. Predictors of adherence to treatment in behavioral health therapy for Latino immigrants: the importance of trust. *Front Psychiatry*. 2019;10:817.
66. Allin S, Masseria C. Unmet need as an indicator of health care access. *Eurohealth*. 2009;15:7.
67. Pavlish CL, Noor S, Brandt J. Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. *Soc Sci Med*. 2010;71:353-361.
68. Mölsä M, Kuittinen S, Tiilikainen M, Honkasalo M-L, Punamäki R-L. Mental health among older refugees: the role of trauma, discrimination, and religiousness. *Aging Ment Health*. 2017;21:829-837.
69. Lincoln YS, Guba EG. But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Dir Program Eval*. 1986;1986:73-84.
70. Ynnesdal Haugen LS, Envy A, Borg M, Ekeland T-J, Anderssen N. Discourses of service user involvement in meeting places in Norwegian community mental health care: a discourse analysis of staff accounts. *Disabil Soc*. 2016;31:192-209.

Appendix A

Table A1. Participants' profession and distribution in the focus groups.

PROFESSIONAL BACKGROUND	FOCUS GROUP 1: SPECIALIZED MHD/SUD TREATMENT CENTER	FOCUS GROUP 2: PRIMARY HEALTHCARE SERVICES	FOCUS GROUP 3 FACT TEAM	TOTAL
Psychiatrist			1	1
Psychologist	2		1	3
Specialist nurse	1	2	1	4
General nurse	4	1	1	6
Social worker		5		5
Total	7	8	4	19

Appendix B

Table A2. Interview guide.

Questions
1. Can you describe your experiences of providing treatment services to immigrant patients with co-occurring SUD and MHD?
2. Can you describe what in your experience promoted treatment in these patients?
3. Can you describe the barriers to treatment in your experience?
4. Can you describe trust building strategies, if you have experience of using any, and how these worked with these patients?
5. Can you describe any experience you have of using culturally competent strategies with these patients?
6. Would you describe your sources of knowledge of culturally competent treatment, if any?
7. Can you describe to what extent treatment needs are adapted to individual immigrant patients in your experience?

Appendices

Appendix 1: Interview guide, Sub-study 1, Research Question 1 and 2.

Appendix 2: Interview guide, Sub-study 1, Research Question 3.

Appendix 3: Interview guide, Sub-study 2, Research Question 4.

Appendix 4: REK/NSD ethical approval

Appendix 1

Interview guide, Sub-study 1, Research Question 1 and 2 (Article 1)

Guiding question: What it means to live in Norway as a person with immigrant background living with co- occurring problems?

1. Do you feel you have problems with substance use and mental health?
2. Can you describe the reasons for started using substances?
3. Does your family know that you have/have had a substance use and/or mental health problems?
4. Can you describe your experiences of living with substance use and/or mental health problems with your family and friends?
5. Do you think that there is any kind of cultural influence associated with using substances?
6. Can you describe your experiences of living with substance use and/or mental health problems as a person with different cultural background within Norwegian society?
7. Is there anything you would like to say that has not been talked about and that you think it can be an important information?

Appendix 2

Interview guide, Sub-study 1, Research Question 3 (Article 2)

1. Can you please describe your experiences with treatment within Norwegian mental health and addiction services as a person with immi- grant background?
2. Can you please tell us why according to you persons with immigrant background do not take the complete treatment?
3. Can you please describe your experiences with treatment when it comes to your needs as a person with immi- grant background?
4. What kind of treatment do you wish for as a person with immigrant background in Norway?
5. Is there anything you would like to say that has not been talked about and that you think it can be an important information?

Appendix 3

Interview guide, Sub-study 2, Research Question 4 (Article 3)

1. Can you describe your experiences of providing treatment services to immigrant patients with co-occurring SUD and MHD?
2. Can you describe what in your experience promoted treatment in these patients?
3. Can you describe the barriers to treatment in your experience?
4. Can you describe trust building strategies, if you have experience of using any, and how these worked with these patients?
5. Can you describe any experience you have of using culturally competent strategies with these patients?
6. Would you describe your sources of knowledge of culturally competent treatment, if any?
7. Can you describe to what extent treatment needs are adapted to individual immigrant patients in your experience?
8. Is there anything you would like to say that has not been talked about and that you think it can be an important information?

Appendix 4

REK/NSD ethical approval

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Silje U. Lauvrak	22845520	05.03.2018	2018/89/REK sør-øst D
			Deres dato:	**Deres referanse:**
			09.01.2018	

Vår referanse må oppgis ved alle henvendelser

Henning Pettersen
Sykehuset Innlandet HF

2018/89 Behandling av rus- og samtidig psykisk lidelse blant unge innvandrere i Norge: en kvalitativ studie

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt, samt til intervjuguide ettersendt 01.02.2018. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst D) i møtet 14.02.2018. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

Forskningsansvarlig: Sykehuset Innlandet HF
Prosjektleder: Henning Pettersen

Prosjektleders prosjektbeskrivelse

De senere år har det vært en markert økning i andelen innvandrere i Norge. Vi har sett en økning i rusrelaterte lidelser i innvandrerbefolkningen og med økt risiko for utvikling av psykiske lidelser, spesielt hos de unge. Denne kvalitative studien har fokus på hva som fremmer og hemmer behandling av samtidig rus- og psykisk lidelse (dobbeltdiagnose) hos unge ikke-vestlige innvandrere i Norge. Forskningspørsmål: 1) Hva fremmer og hemmer behandling av dobbeltdiagnose utfra perspektivet til unge ikke-vestlige innvandrere i Norge? 2) Hvilke perspektiv har behandlere og ungdommens familie på hva som innvirker på at innvandrerungdom med dobbeltdiagnose søker, fullfører eller avbryter behandling. Datainnsamling ved personlige intervjuer med ungdommene og deres familie, samt gruppeintervjuer med behandlere. Studien vil bidra til at behandlere kan utvikle bedre strategier for kartlegging, behandling og oppfølging av unge innvandrere med samtidig rus- og psykisk lidelse.

Vurdering

Formålet med prosjektet er å undersøke hvilke perspektiver unge innvandrere med samtidig rus- og psykisk lidelse har på hva som fremmer og hemmer behandling. Slik komiteen leser søknad og protokoll, skal prosjektet gjennomføres for å kunne utvikle bedre strategier for kartlegging, behandling og oppfølging av denne gruppen. Komiteen vurderer dermed prosjektet som helsetjenesteforskning, og at fokuset ikke er å fremskaffe ny kunnskap om helse og sykdom. Prosjektet faller derfor utenfor REKs mandat etter helseforskningsloven, som forutsetter at formålet med prosjektet er å skaffe til veie "ny kunnskap om helse og sykdom", se lovens § 2 og § 4 bokstav a).

Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet. Det er institusjonens ansvar å sørge for at prosjektet gjennomføres på en forsvarlig måte med hensyn til for eksempel regler for taushetsplikt og personvern samt innhenting av stedlige godkjenninger.

Vurdering

Prosjektet faller utenfor helseforskningslovens virkeområde, jf. § 2 og § 4 bokstav a). Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet.

Komiteens avgjørelse var enstemmig.

Klageadgang
REKs vedtak kan påklages, jf. forvaltningslovens § 28 flg. Klagen sendes til REK sør-øst D. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst D, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Vi ber om at alle henvendelser sendes inn med korrekt skjema via vår saksportal: http://helseforskning.etikkom.no. Dersom det ikke finnes passende skjema kan henvendelsen rettes på e-post til: post@helseforskning.etikkom.no.

Vennligst oppgi vårt referansenummer i korrespondansen.

Med vennlig hilsen

Finn Wisløff
Professor em. dr. med.
Leder

Silje U. Lauvrak
Rådgiver

Kopi til: Ingeborg.Hartz@sykehuset-innlandet.no; kari.lillehaug@sykehuset-innlandet.no

Prabhjot Kour

3603 KONGSBERG

Vår dato: 07.05.2018 Vår ref: 59707 / 3 / HJP Deres dato: Deres ref:

Tilrådning fra NSD Personvernombudet for forskning § 7-27

Personvernombudet for forskning viser til meldeskjema mottatt 08.03.2018 for prosjektet:

59707	*Facilitators and barriers to treatment of 'dual diagnosis' among young immigrants in Norway: A qualitative study.*
Behandlingsansvarlig	*Høgskolen i Sørøst-Norge, ved institusjonens øverste leder*
Daglig ansvarlig	*Prabhjot Kour*

Vurdering

Etter gjennomgang av opplysningene i meldeskjemaet og øvrig dokumentasjon finner vi at prosjektet er unntatt konsesjonsplikt og at personopplysningene som blir samlet inn i dette prosjektet er regulert av § 7-27 i personopplysningsforskriften. På den neste siden er vår vurdering av prosjektopplegget slik det er meldt til oss. Du kan nå gå i gang med å behandle personopplysninger.

Vilkår for vår anbefaling

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:

- opplysningene gitt i meldeskjemaet og øvrig dokumentasjon
- vår prosjektvurdering, se side 2
- eventuell korrespondanse med oss

Meld fra hvis du gjør vesentlige endringer i prosjektet

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke endringer du må melde, samt endringsskjema.

Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i Meldingsarkivet.

Vi tar kontakt om status for behandling av personopplysninger ved prosjektslutt

Ved prosjektslutt 31.12.2020 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

Se våre nettsider eller ta kontakt dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Vennlig hilsen

Marianne Høgetveit Myhren

Hanne Johansen-Pekovic

Kontaktperson: Hanne Johansen-Pekovic tlf: 55 58 31 18 / hanne.johansen-pekovic@nsd.no
Vedlegg: Prosjektvurdering

Prosjektvurdering - Kommentar

Prosjektnr: 59707

NATIONAL COLLABORATIVE STUDY
According to your notification form this project is a national collaborative study. The PhD project is funded by Sykehuset Innlandet HF, but is carried out at Høgskolen i Sørøst-Norge (HSN). HSN is the data controller. The Data Protection Official presupposes that responsibility for the processing of personal data is clarified between the institutions involved. We recommend that an agreement is made; one that indicates which institution has initiated the project, and includes allocation of responsibilities, use of data and eventual ownership. In an email dated 23.04.18 you informed that only anonymized data material will be shared with research groups at HSN and Sykehuset Innlandet.

REK EVALUATION
We received 19.04.18 the decision from REK that the project is not considered to be health research.

PURPOSE
The purpose of the PhD project is to explore facilitators and barriers to treatment of double diagnosis among young immigrants in Norway, from the perspective of service providers, young immigrants and their relatives. Double diagnosis refers to the co-occurrence in the same individual of a psychoactive substance use disorder (SUD) and another mental health disorder.

SAMPLE AND DATA COLLECTION
The sample will consist of three groups of participants. The first group is 15 - 20 immigrants between the age of 18 - 24 years with a double diagnosis, the second group is 5 - 6 relatives of the immigrants, and the thirds is service providers who are working in institutional- or municipality-based mental health services or SUD treatment centres. The data will be collected through personal interviews with the young immigrants and the relatives. There will be arranged focus group interviews with the service group providers.

RECRUITMENT
The service providers will be recruited by personal contact through researchers in the research network, who have co-workers working at the relevant institutions. The young immigrants with a double diagnosis will be recruited through their service providers. The service providers will assess who may be suitable participants, to ensure that participation will not bring unnecessary burden. Relatives will be recruited both through young immigrants and service providers. To ensure the confidentiality of the service provider we recommend that in recruitment of the last two groups the service providers forward information about the study/information letter, and those who want to participate can contact you directly.

COMPETENCY GROUP
In the PhD proposal you have given information that you will establish a competency group to work with the research group in all the stages of the study. The competency group will consist of two service users, two

relatives and two service providers. The members of this group will sign a written confidentially agreement. You have also given information that the procedure of the data collection is formed in a way so that personal information is protected from spreading from patients to relatives, and vice versa.

INFORMATION AND CONSENT

According to your notification form the sample will receive written and oral information and will give their consent to participate. The revised information letter received 23.04.18 is well formulated.

THIRD PARTS - NEXT OF KIN

The interview guide for participants who are next of kin contains questions about their relative who has a double diagnosis. The information letter for the participants with a DD is therefore revised to give information about this. When the participants are next of kin, and their family member with a double diagnosis doesn’t participate, the relative will give information and ask for consent from the young immigrant.
The revised information letters received 30.04.18 are well formulated.

THIRD PART - PARTICIPANTS WITH A DOBULE DIAGNOSIS

In the interview guide for participants with a double diagnosis you have included some questions about family and friends (questions B4 and B5). The information gathered from these questions should be reduced to a minimum and should not be sensitive, and must be made anonymous in the publication. We recommend that you instruct the participant to avoid making their family member/friend identifiable. As long as the disadvantages for third persons are reduced in this way, the project leader can be exempted from the duty to inform third persons of the participant with a double diagnosis.

SENSITIVE DATA

It is indicated that you intend to process sensitive personal data about ethnic origin and health.

INFORMATION SECURITY

The Data Protection Official presupposes that you will process all data according to the internal guidelines and routines for information security at Høgskolen i Sørøst-Norge.

In the report form you have stated that the data material will be stored at Sykehuset Innlandet. We presuppose that this storing of sensitive information outside the institution is clarified with HSN in beforehand. And furthermore that the data storage is in compliance with the routines of HSN.

INTERPRETER

If you plan to use an interpreter we remind you that HSN have to make a data processing agreement with the interpreter.

PROJECT COMPLETION AND ANONYMISATION

The estimated end date of the project is 31.12.2020. According to your notification form you intend to anonymise the collected data by this date.
Making the data anonymous entails processing it in such a way that no individuals can be identified. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable personal data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)
- deleting digital audio

Doctoral dissertation no. 163
2023

—

Through the eyes of immigrants and health professionals
Dissertation for the degree of PhD

—

Prabhjot Kour

—

ISBN: 978-82-7206-778-5 (print)
ISBN: 978-82-7206-796-9 (online)

usn.no