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Group peer support among immigrants and refugees: a scoping review

Fareeda Abo-Rass[a], Ora Nakash[b], Liz Friedman[c], Peggy O'Neill[b] and Maria E. Torres[d]

[a]Takemi Program in International Health, T.H. Chan School of Public Health, Harvard University, Boston, MA, USA; [b]School for Social Work, Smith College, Northampton, MA, USA; [c]GPS Group Peer Support, Northampton, MA, USA; [d]School of Social Welfare, Stonybrook University, Stony Brook, NY, USA

ABSTRACT

This study aims to synthesize and evaluate the evidence on the effectiveness, implementation, and outcomes of group peer support among these immigrants and refugees worldwide. This study adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews. Empirical studies from the past ten years were identified through comprehensive searches of databases, including PubMed, PsycINFO, CINAHL, and Web of Science. Articles included in the final analysis focused on group peer support interventions among immigrants and refugees. Seven studies, primarily conducted in North America and Europe, were identified, showcasing diverse and tailored implementations of group peer support interventions. All included psychoeducational components were conducted in person in the participants' native languages and incorporated various cultural adaptations. These interventions uniformly featured discussions and sharing of experiences, consistently showing improvements in self-reported social support and emotional well-being. Group peer support is a promising intervention model that can be adapted to various settings and needs. It provides critical support and fosters resilience among immigrants and refugees. Further empirical studies are needed to explore the nuanced impacts of these interventions and their adaptability to the unique challenges these populations face.

KEYWORDS

Peer support; group support; mental health; immigrants; refugees

Introduction

Peer support interventions provide emotional, social, and practical support through the engagement of peers with similar experiences or challenges, such as physical or mental health conditions or social difficulties. By creating a non-judgmental space, these interventions foster understanding, acceptance, and empathy, helping to alleviate emotional distress and reduce

CONTACT Fareeda Abo-Rass Abo-Rass@hsph.harvard.edu Takemi Program in International Health, T.H. Chan School of Public Health, Harvard University, 665 Huntington Avenue, Building 1, Room 1210, Boston, MA 02115, USA.

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the sense of isolation often associated with these challenges (Dennis, 2003; Mead et al., 2001; Simoni et al., 2011). The strategies employed in these interventions span a broad spectrum, focusing on empowerment, education, and psychosocial support, and are carefully tailored to address the specific needs and circumstances of the target population (Penney, 2018).

Implementations of peer support interventions vary widely, encompassing one-on-one or group formats, which can be delivered online or in person and can range from structured to more flexible approaches. These interventions can be tailored to offer particular activities to achieve specific goals or develop specific skills or offer more generalized support, effectively meeting the diverse and dynamic needs of those seeking assistance (Cooper et al., 2024; Heisler, 2006; Solomon, 2004; Strand et al., 2020).

Group peer support offers a unique environment through a group setting where individuals can connect, share experiences, and receive support from peers who face similar challenges. This setting not only fosters a sense of community and belonging but also promotes personal growth and well-being (Mead et al., 2001). Unlike one-on-one interactions, group peer support introduces diverse perspectives and strengthens the sense of collective empowerment by cultivating a supportive community (Mead et al., 2001; Repper & Carter, 2011; Solomon, 2004). This approach enhances feelings of belonging while maximizing the potential for exchanging resources and facilitating experiential learning among participants (Repper & Carter, 2011; Solomon, 2004).

Beyond the unique environment it creates, group peer support, like one-to-one interventions, offers numerous benefits, including improved participant well-being, reduced healthcare costs, and enhanced self-management and self-efficacy (Carter et al., 2020; Penney, 2018; Repper & Carter, 2011). Group peer support, in particular, has been a cost-effective modality in promoting behavior change, fostering resilience (Lyons et al., 2021), reducing psychological distress, and addressing post-traumatic stress disorder symptoms (Meredith et al., 2024). Our recent umbrella review, which synthesizes studies across medical and mental health conditions, further underscores these findings. We found that group peer support consistently enhances personal recovery and psychosocial outcomes, while its impact on clinical symptoms remains inconclusive (Abo-Rass et al., Under Review). Also, in line with other studies, it indicates that individuals who commonly participate in group peer support include those with chronic illnesses such as diabetes or cancer, as well as those with mental health conditions like schizophrenia, bipolar disorder, depression, suicidal tendencies, and substance misuse (Abo-Rass et al., Under Review).

One of the most under-researched groups in this field are immigrants and refugees, despite the rapid increase in global migration. The literature frequently emphasizes this growing trend; for instance, in 2015, around

244 million people, or 3.3% of the global population, were living outside their country of birth. This number is expected to double by 2050 (Gou et al., 2020).

Immigrants and refugees represent a diverse demographic. Reasons for migration are numerous, including economic opportunities, escaping conflict or persecution, environmental disasters, and seeking better living conditions (International Organization for Migration (IOM), 2020). Often, the journey of migration holds many risks (Nakash et al., 2015), and the experience in the receiving countries is fraught with a range of complex challenges, such as language barriers, cultural differences, social isolation, discrimination, racism, trauma, and difficulties in securing employment and accessing essential services, particularly in health and mental health care (Nakash et al., 2017, 2016). Moreover, adapting to a new cultural environment, especially in the current political climate in many Western countries, can heighten the risk of developing additional health and mental health problems (IOM, 2020; World Health Organization (WHO), 2022).

Given these complexities, effective support systems that are scalable are critical. It is, therefore, surprising that there remains a significant gap in research specifically focused on how group peer support interventions can address the unique needs of this population. In this scoping review, we aim to collect, synthesize, and summarize the available evidence from published empirical studies focused specifically on group peer support among immigrants and refugees worldwide. It explores the format and setting, facilitation, implementation components, and outcomes of group peer support across various refugee and immigrant groups.

Methods

Search strategy

The current scoping review was conducted following the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews) guidelines as outlined by Tricco et al. (2018), ensuring a structured and standardized methodology. We searched four electronic databases: PubMed, PsycINFO, CINAHL, and Web of Science. The search was conducted across all databases in June 2024, restricting the results to publications from the last ten years. No ethical approval or informed consent was required as this study is a scoping review with no participant involvement.

Titles, abstracts, and keywords were searched using terms and term combinations from two main categories of interest: Group Peer Support (Category #1): ("mutual aid" OR "mutual help" OR "mutual support" OR "peer based" OR "peer support" OR "peer led" OR "peer guided" OR "peer provided" OR "peer run" OR "peer to peer") AND (group OR groups)

OR “support group” OR “help group” OR “group support” And Immigrants and Displaced People (Category #2): Refugees* OR “Asylum Seekers” OR Immigrants* OR Migrants* OR “Displaced People” OR “Displaced Persons” OR “International Migrants” OR “Stateless Persons” OR newcomers*.

In each database, synonymous keywords were applied using Boolean operators, truncation, standard Medical Subject Heading (MeSH) terms, thesaurus, and wildcard features where appropriate. To ensure a comprehensive search, reference lists of all included studies were also manually reviewed to identify any additional relevant studies not captured in the initial database searches.

Study selection

The eligibility criteria for studies were established using the PICOS framework (Population, Intervention, Comparison, Outcome, and Study design) as described by Amir-Behghadami & Janati (2020) and included the following: (a) Original empirical studies (quantitative and/or qualitative); (b) Studies published in peer-reviewed journals, written in English, or with an available published English translation, limited to publications from the last ten years; (c) Studies investigating peer support interventions implemented in group settings; (d) Studies focusing on various health and mental health conditions within immigrant populations, with no restrictions on age, gender, race/ethnicity, or country; (e) Studies reporting any outcomes related to the intervention.

Studies were excluded if they: (a) Were published as grey literature; (b) Examined peer support interventions conducted exclusively in one-to-one settings or facilitated solely by mental health professionals.

During the first stage of the search, results from all databases were imported and combined in Covidence, a systematic review management software by Veritas Health Innovation, resulting in a total of 581 articles. Duplicates were then removed, leaving 400 articles. To ensure consistent application of the eligibility criteria, the two first authors independently screened the same set of ten titles and abstracts, discussing their inclusion and exclusion decisions to reach a consensus.

Subsequently, the first author screened the titles and abstracts of the remaining articles. The reasons for exclusion at this stage were: not researching a group peer support at all, being grey literature, support groups led exclusively by professionals without peer involvement, one-to-one peer support, and not focused on immigrants. After this stage, 17 articles were identified as potentially meeting the inclusion criteria and required a thorough full-text review.

These 17 articles were thoroughly read and evaluated by both lead authors, with any disagreements resolved through discussion. Ten studies

were excluded for the following reasons: focusing exclusively on peer mentors, specifically focusing on the implementation process without referencing measurement of any outcomes, including solely self-help groups, presenting the intervention as part of nontraditional interventions without detailing their outcomes uniquely, and involving peers who were immigrants (i.e., shared identity) but did not share the specific condition that the group targeted (i.e., obesity or parenting). Ultimately, seven papers met the inclusion criteria and were included in this scoping review. The flowchart in Figure 1 illustrates the search and screening process, detailing the number of studies excluded during both the initial and full-text screening stages.

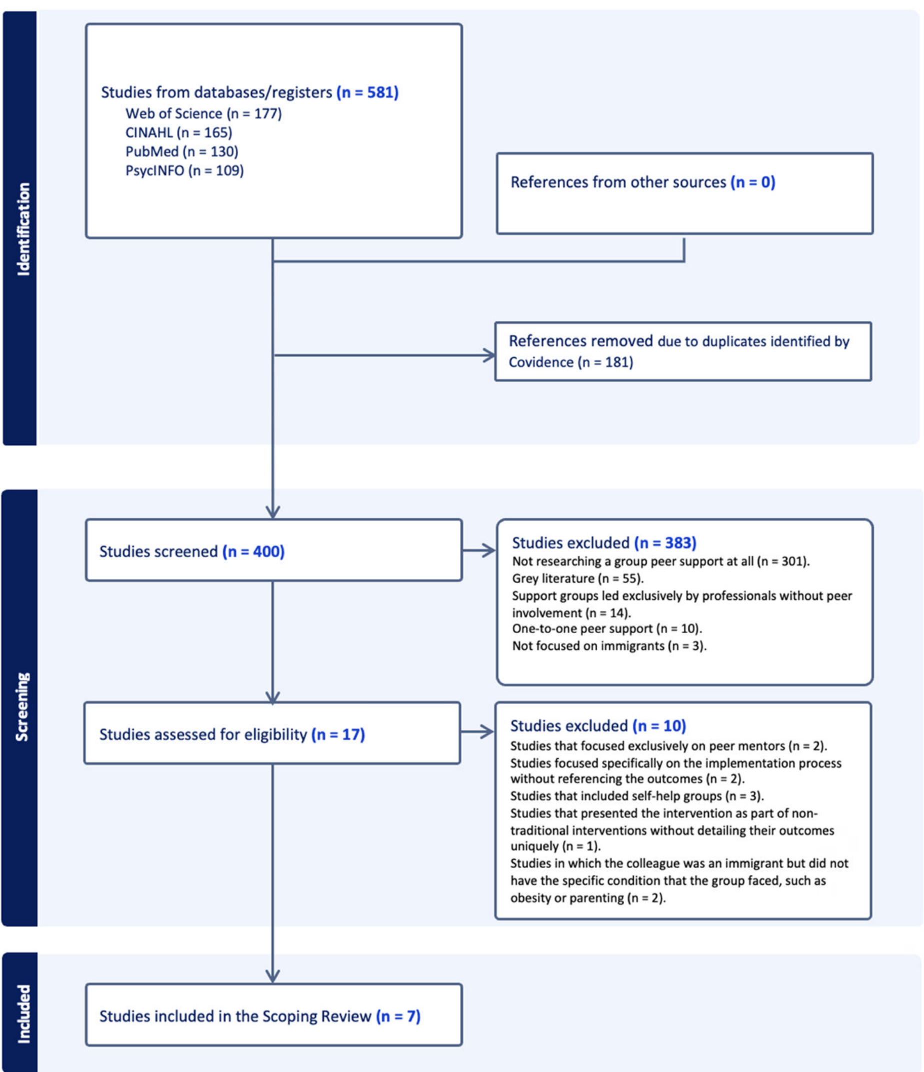

Figure 1. Flow diagram of the publications selection process.

Data analysis and charting

Data extraction was standardized to ensure study consistency. The summary table included general information (first author and year), details about the studies (aim, design, and method), population characteristics (participants and country), and intervention characteristics (formats and settings, facilitators and training, implementation elements). Additionally, we included information on reported outcomes, encompassing any reported physical, mental, or social outcomes.

Results

The search and selection process for this scoping review, guided by our predetermined inclusion and exclusion criteria, resulted in seven studies. Table 1 summarizes these studies.

Characteristics of the studies and participants

The studies included in this scoping review included immigrant and refugee participants from diverse backgrounds and countries of origin. Participants migrated most commonly from the global south, including various African, South Asian and Latin American countries (e.g., Sudan, Zimbabwe, Bhutan, Mexico, Honduras, and Colombia). Receiving countries included mostly Western countries in North America and Europe. Three of the studies were conducted in the United States (Arthur et al., 2024; Im & Rosenberg, 2016; Yang et al., 2014). Two studies took place in Canada (Stewart et al., 2018; Tang et al., 2015), and two were conducted in Spain (Paloma et al., 2020; Soriano-Ayala & Cala, 2019). Participants had been in their new countries for varying lengths of time, ranging from less than six months (Paloma et al., 2020) to an average of 29 years (Tang et al., 2015).

All the studies primarily focused on adults aged between 18 and 67. However, one study focused on adolescents (Soriano-Ayala & Cala, 2019). The gender distribution was generally balanced across the studies, except for Tang et al. (2015) and Im and Rosenberg (2016), where most participants were female, and Arthur et al. (2024), which included only mothers.

Each study focused on a specific condition or issue related to the specific population, such as parenting young children (Stewart et al., 2018) or parenting with chronic conditions or disabilities (Arthur et al., 2024), general health and mental health status (Im & Rosenberg, 2016; Paloma et al., 2020; Soriano-Ayala & Cala, 2019), or specific health and/or mental health condition (Yang et al., 2014; Tang et al., 2015).

Three studies were qualitative, employing various methods such as semi-structured interviews and focus group discussions (Arthur et al., 2024;

Table 1. Characteristics of included studies.

Author and year of publication	Participants and Country	Aims	Design and Method	Formats and settings	Facilitators And training	Implementation elements	Outcomes
1. Stewart et al. (2018)	85 refugee parents of young children (48 Sudanese, 37 Zimbabwean; 47 males, 38 female) who had settled in Canada within the previous five years.	To implement and test a culturally relevant social support intervention for African refugee parents of young children.	Qualitative; semi-structured in-depth interviews with eight groups (n = 67) and individual interviews (n = 37) conducted post-intervention.	Face-to-face meetings were held bi-weekly for over seven months, each lasting one to two hours. Eight Groups were segregated by country of origin and gender (e.g., Sudanese females, Zimbabwean males). Meetings were held in various public places, such as community halls and parks. Sometimes, participants offered their homes as alternative meeting places.	Groups were co-led by a peer mentor (an experienced refugee parent) and a professional mentor (a service provider for refugee populations). Peer and professional mentors participated in a one-day training session covering support needs, intervention preferences, group dynamics, roles, responsibilities, and session documentation. Professional mentors were available for peer mentors, providing ongoing support through individual meetings and telephone calls.	The groups did not follow a predetermined curriculum but included structured format for discussions. Topics were based on challenges identified during the pre-intervention needs assessment and suggestions from group members. Key topics included parenting across cultures, disciplining children in Canada, parental legal responsibilities and rights, and balancing cultural differences with respect to gender roles. Representatives of refugee-serving agencies were invited to present on relevant topics, and online videos and reading materials were used as facilitation aids. Meetings included refreshments, providing an opportunity for socialization and creating a welcoming environment.	The intervention demonstrated significant positive impact on participants, increasing social support by providing essential information, enhancing spousal relationships, and expanding engagement with their ethnic community. Participants experienced a decrease in loneliness and isolation, an enhancement in coping abilities, and an improvement in their capacity to attain education and employment. Parenting competence also increased as a result of the intervention. Additionally, the program's relevance and potential sustainability were highlighted by the fact that some support groups continued to meet after the formal conclusion of the intervention. Peer mentors expressed a desire for more extensive training to better respond to participants' needs and to gain a deeper understanding of the scope of the social support intervention. Factors enhancing retention and group engagement included peer mentors, financial resources, childcare, transportation assistance, and extra one-on-one peer support. Participants developed new friendships, expanded social networks, and connected at social occasions as a strategy for coping with stress

(*Continued*)

Table 1. Continued.

Author and year of publication	Participants and Country	Aims	Design and Method	Formats and settings	Facilitators And training	Implementation elements	Outcomes
2. Arthur et al. (2024)	16 Spanish-speaking immigrant mothers of children with chronic conditions or disabilities in the United States, 88% from Mexico and the rest from other unspecified countries, but all are Spanish-speaking, 94% of whom have lived in the United States for more than 10 years.	To explore how Spanish-speaking immigrant mothers experienced a peer-led mindfulness-based program and identify adaptations to make it culturally relevant.	Qualitative, semi-structured interviews with 13 participants were conducted post-intervention. The data analysis used a theoretical thematic analysis based on the Realist Evaluation Framework.	Weekly meetings were held for six weeks from May to June 2019. Each meeting lasted 2 hours in Spanish, with one 4-hour silent retreat session. No specific information about the location of the meetings was provided.	The group was led by peer facilitators, including three mothers of children with chronic conditions or disabilities (two Mexican and one bilingual white mother who is a mindfulness teacher), who received training through weekly meetings in an 8-week Mindful Self-Compassion (MSC) course, covering meditations, exercises, and theoretical understanding, and a 6-week facilitator training course that included intervention strategies, communication skills, activity design, and a trauma-sensitive approach.	The intervention included a structured curriculum, with each meeting focusing on a specific topic: Mindful Self-Compassion (MSC), mindfulness, compassion for self and others, managing difficult emotions, silent retreat, and gratitude and joy. Each session began with an introduction to the theme and psychoeducation on the concepts of mindfulness and self-compassion. Following the introduction, participants engaged in practice activities related to the session's theme, which were followed by discussions allowing participants to share their experiences and reflections. At the end of each session, participants were given homework tasks to try to practice in their daily lives. The program incorporated culturally relevant elements, such as using culturally syntonic language, Mexican folkloric dance for mindful movement, providing Mexican food, and offering transportation support and childcare.	The analysis identified four prominent contextual factors: self-concept as a woman and a mother, faith, past-trauma, and level of social support. These contextual factors interacted with three mechanisms: having positive experiences when trying practices, engaging in self-reflection, and sharing life experiences and learning in the community. The mechanisms led to four outcomes as reported by the participants: Emotion regulation: Pausing to take breaths in a challenging moment, using self-kindness practices or phrases in a challenging moment. Savoring daily life experiences: Heightened enjoyment of experiences in daily life, heightened enjoyment of moments with child. Empowerment to practice self-care: Allocation of time for a pleasurable activity, incorporating self-kindness and self-affirmation in daily life. Common humanity: Normalizing challenges, feeling less alone, and drawing inspiration from hearing about other mothers' resilience.

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Table 1. Continued.

Author and year of publication	Participants and Country	Aims	Design and Method	Formats and settings	Facilitators And training	Implementation elements	Outcomes
3. Im and Rosenberg (2016)	22 refugees from the Bhutanese community (4 males and 18 females) in the United States, all of whom have lived in the U.S. for one to six years and hold permanent residency status.	To explore the impact of pilot peer-led community health workshop (CHW) in the Bhutanese refugee community.	Qualitative, using focus group discussions (FGDs) embedded in the CHW sessions. Each session began with a check-in related to the intervention and ended with reflective questions, including future suggestions and cultural topics and examples. The final session included a closing ceremony and post-intervention evaluation. A hybrid thematic analysis was used, combining inductive and deductive approaches.	The intervention consisted of eight face-to-face sessions over two months. Sessions were conducted in Nepali and held in locations accessible to the participants, ensuring they could walk or use public transit to attend. Specific locations or session duration were not mentioned .	The CHW was facilitated by six trained Bhutanese refugee leaders (three males and three females) who received a four-day training on mental health and psychosocial support developed and provided by the first author, followed by additional training on health education and group facilitation skills. The facilitation process is not explicitly detailed, but it seems that peers who did not facilitate the pertinent session ran the focus group discussions, with a third person interpreting and translating the evaluation data.	The curriculum was based on the psychoeducation modules by the first author and developed with inputs from the refugee leaders to include culturally relevant examples and activities. Key topics included healthy eating and nutrition, daily stressors of resettlement, healthy coping strategies, and common psychological distress and mental health issues facing the refugee community. Each session focused on one topic, starting with a check-in and ending with reflective questions. Practical activities and structured discussions were included to promote community participation and mutual support, with cultural elements such as Bhutanese proverbs and chanting integrated into the sessions. The final session included a closing ceremony.	The analysis demonstrated that the peer-led CHW was highly beneficial, as the results showed improvement in health promotion outcomes, with participants exhibiting enhanced knowledge about healthy eating, nutrition, and coping with daily stressors. They reported positive changes in health behaviors, such as better dietary practices and stress management techniques, along with increased awareness of mental health issues. Additionally, the intervention proved to be an effective tool for fostering social capital and improving community health. Key outcomes included enhanced community participation, expanded social networks, and strengthened community capacity. Participants reported feeling more supported and connected, with improvements in mutual aid and leadership within the Bhutanese community.

(*Continued*)

Table 1. Continued.

Author and year of publication	Participants and Country	Aims	Design and Method	Formats and settings	Facilitators And training	Implementation elements	Outcomes
4. Soriano-Ayala and Cala (2019)	52 sixth-grade immigrants students living in Spain, divided into two groups. The intervention group consisted of 26 students (11 males and 15 females) from multicultural backgrounds, including Moroccan, Romanian, Senegalese, as well as Spanish. The control group (who did not receive any intervention) also included 26 students (9 males and 17 females) from the same multicultural backgrounds.	To evaluate the effectiveness of a transcultural health intervention led by autochthonous and migrant adolescents elementary-school students from multicultural backgrounds.	Mixed methods: A quasi-experimental study with pre- and post-surveys was performed with intervention and control groups. The study utilized a mixed-methods approach, combining quantitative pre- and post-surveys with qualitative in-depth interviews and focus groups to evaluate the intervention's impact. For the quantitative part, six scales were used to assess attitudes toward eating patterns, physical activity, emotional abilities, empowerment, personal agency, and life satisfaction. A parametric statistic was performed for the analysis, including contrasts of the means, correlations, and bivariate associations. The qualitative analysis used descriptive codes and were organized and examined to identify patterns and themes relevant to the study's objectives.	The intervention consisted of 15 face-to-face formative sessions conducted over six months (January to June 2016). Sessions were led by groups of two to three health peers in elementary school settings. The duration of each session is not specified.	The groups were facilitated by 12 trained immigrant adolescents from Moroccan, Romanian, and Spanish backgrounds (6 males and 6 females, average age 15.3 years). The peer facilitator training was divided into three phases: General Training consisted of six sessions, including 2 on transcultural nutrition, 2 on transcultural physical activity, and 2 on emotional health. Specialization Training included four sessions focusing on intervention keys, intercultural mediation, and communication skills.	The sessions were co-prepared by the peer facilitators and university teachers and included elements such as a transcultural view of foods, dietary patterns, menu elaboration, body empowerment, physical activity, and cultural diversity in emotional expression. No further information regarding the intervention is provided.	The results demonstrate that, in general, the post-test values showed improvement compared with the pretest values across all domains: eating attitudes, physical activity, psycho-emotional health, openness to diversity, empowerment and personal agency, and life satisfaction. This improvement was more pronounced in the intervention group, although it was not always considered high or significant. The qualitative outcomes suggest that the intervention positively influenced the elementary students' knowledge and behaviors across several key areas. The students demonstrated improved understanding and application of healthy dietary practices, better emotional control, and increased engagement in physical activities. Additionally, they showed enhanced environmental health habits, such as better hygiene and cleanliness practices, improved skills in conflict resolution, increased awareness and appreciation of cultural diversity, greater empowerment and personal agency, and enhanced life satisfaction. The participants saw the peer facilitators as a key component of the project, providing cultural and social proximity and communication skills often missing in adult-led health programs.

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Table 1. Continued.

Author and year of publication	Participants and Country	Aims	Design and Method	Formats and settings	Facilitators And training	Implementation elements	Outcomes
5. Paloma et al. (2020)	36 refugees (16 women and 20 men), aged 18 to 63, from Honduras, Venezuela, El Salvador, Cuba, Colombia, Ukraine, Cameroon, Burkina Faso, Guinea-Bissau, Gambia, and Ivory Coast, who had been living in Spain for less than six months and were residing in flats managed by the NGO.	To examine the effectiveness of a community-based approach in enhancing positive mental health, particularly posttraumatic growth, among refugees.	Mixed-methods; using a pretest-posttest evaluation design with the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) in Spanish to measure changes in participants' posttraumatic growth (5 subscales: Appreciation of life, Personal strength, Relating to others, New possibilities, Spiritual change). Quantitative data were analyzed using a t-test. Qualitative data were collected through peer mentors' written assessments, participants' written assessments, and ongoing comments shared in a WhatsApp group. These qualitative data were analyzed using thematic analysis.	There were four groups: two groups led in Spanish by a mentor pair for each group, one group led in Ukrainian by one mentor, and another group led in French by one mentor. Each group consisted of culturally similar participants and included 12 sessions, twice a week, each lasting 2-3 hours. Sessions took place in a room provided by the Department of Psychology at the University of Seville, equipped with a projector, sound system, and collaborative worktable. Participants decorated the room with materials created during the sessions, such as collages, timelines, and drawings, fostering a welcoming and personalized space.	The groups were led by 11 peer facilitators, aged 20-64, including 4 women and 7 men. Their educational backgrounds varied, with 4 having secondary-level education and 7 having university-level education. All mentors were asylum seekers residing in Spain for at least a year and had proven Spanish language proficiency and hailed from diverse countries, including El Salvador, Colombia, Venezuela, Cameroon, Somalia, Western Sahara, Morocco, Palestine, and Ukraine. A lead researcher facilitated the training, which lasted eight weeks and consisted of two weekly sessions, each lasting 2 to 3 hours. Key components of the training included a detailed project introduction in the introductory session; an exploration of individual and sociopolitical reasons for migration in the second session; a focus on "migratory mourning" from the third to ninth sessions, addressing challenges like social networks, language, culture, land, status, ethnic group, and health; and, in the final two weeks, concentrating on skills for group revitalization, creating culturally adapted materials, and discussing items from the PTG assessment tool.	All sessions in the second phase followed a similar structure: guided relaxation, individual reflection, sharing migratory stories, and presenting relevant community resources identified by participants.	The results of the pretest-posttest evaluation indicate significant increases in the total PTG score and in the subscales of Appreciation of Life, Personal Strength, Relating to Others, and New Possibilities. However, there was no significant change in the Spiritual Change subscale. The qualitative data revealed several key outcomes. Participants found the sessions beneficial for appreciating life more, redefining their priorities, and reclaiming their sense of purpose. They reported increased personal strength, feeling more resilient and capable of handling challenges. The value of maintaining close relationships in a supportive environment was emphasized, with participants enjoying peer connections, feeling more liberated and relaxed, and improving their problem-solving abilities. Additionally, they saw new opportunities, set goals, and felt empowered to change their futures.

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Table 1. Continued.

Author and year of publication	Participants and Country	Aims	Design and Method	Formats and settings	Facilitators And training	Implementation elements	Outcomes
6. Yang et al. (2014)	11 Chinese immigrant caregivers of individuals with psychosis (10 parents, 1 spouse; 10 females) in the United States, with a mean age of 59 years. Caregiver participants were primarily Chinese speaking.	To test a brief anti-mental health stigma intervention for Chinese immigrant caregivers of individuals with psychosis.	Mixed methods: using pre-post assessment of changes in internalized stigma with the Self-Stigma of Consumer Families Scale in Chinese (Perlick et al., 2011), analyzed with paired-sample t-tests. The qualitative component involves clinical case illustrations written based on observations and interactions during the sessions and participants' answers to two open-ended questions (*"What did you find most helpful about the intervention?" and "What would you change about the intervention to better address stigma?"*). The analysis was conducted using content analysis.	Three 90-minute sessions held over 3 weeks in Mandarin Chinese. Groups comprised of three to five caregivers from separate families. Sessions were held in community settings, such as the National Alliance on Mental Illness building in New Jersey and a community center in New York's Chinatown.	The groups were co-led by a peer (a family caregiver with previous experiences with internalized stigma) and a clinician. Two peer leaders underwent a comprehensive training program conducted by Mandarin-speaking clinicians. The training involved experiencing the intervention themselves as participants and receiving mini lectures on its principles, including cognitive behavioral principles for countering internalized stigma. Peer leaders prepared real-life examples before co-leading sessions.	Each session from the three-session intervention focused on a specific element: the first was psychoeducation, which focused on the causes and treatment of mental illness; the second was countering experienced stigma, which introduced behavioral skills to cope with discrimination; and the third was countering internalized stigma, which targeted internalized stigma with cognitive behavioral therapy principles, challenging automatic stigmatizing thoughts and encouraging realistic optimism. The intervention encouraged active participation through discussions, sharing of personal experiences, and problem-solving exercises. Peer leaders shared real-life examples to illustrate coping strategies and counter stigma. Each participant received a 15- to 20-minute weekly call from the clinician co-leader to review the session content, address individual concerns, and ensure continued engagement. The intervention incorporated Chinese cultural perspectives to make the content more relatable and acceptable to the participants.	The results of the pretest-posttest evaluation indicate no significant change in internalized stigma for the entire group of caregivers after the intervention. However, for those caregivers who had higher levels of internalized stigma before the intervention, there was a noticeable but not statistically significant reduction in stigma levels after the intervention. The qualitative results highlight the participants' overall satisfaction with the intervention. Participants appreciated the blend of theoretical knowledge provided by the clinician and practical problem-solving strategies shared by the peer leaders, finding the real-life examples from peer leaders particularly helpful. The family-peer format facilitated a better understanding of symptoms and helped reduce caregivers' potential stigmatizing responses. Some participants suggested extending the duration of each session and increasing the total number of sessions to allow more time for discussion and application of the strategies learned, while others recommended follow-up meetings to reinforce the material and support long-term changes.

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Table 1. Continued.

Author and year of publication	Participants and Country	Aims	Design and Method	Formats and settings	Facilitators And training	Implementation elements	Outcomes
7. Tang et al. (2015)	41 South-Asian adults with Type 2 diabetes in Metro Vancouver, Canada (mean age of 67 years, 73% were women, 78% were born in India, and they had lived in Canada for an average of 29 years).	To assess the feasibility and potential health impact of a diabetes self-management education and support intervention that includes peer support.	Mixed methods: pre-post assessment to measure changes in glycaemic control and diabetes distress scales at baseline, 6 weeks, and 24 weeks, analyzed with paired-sample t-tests. The qualitative component involved open-ended questions ("How satisfied were you with the program?," "How helpful were the diabetes education sessions?," "How helpful were the peer-led support sessions?" and "How can we improve the program?") during post-intervention feedback sessions for program evaluation.	a 24-week intervention consisting of two phases. The first phase, Diabetes Self-Management Education, included six weekly group-based education sessions, each lasting 75 minutes, facilitated by a certified diabetes educator and two peer leaders. The second phase, Diabetes Self-Management Support, involved eighteen weekly group-based support sessions, each lasting 60 minutes, facilitated by two peer leaders. The five groups were held in faith-based settings such as Sikh and Hindu temples, with two groups conducted in English and three in Punjabi.	The groups were co-led by certified diabetes educators and two peer leaders facilitated the sessions. The educators underwent a 2-day training session focused on patient empowerment, communication skills, facilitation strategies, and behavior modification techniques. Peer leaders, who were required to either have diabetes or be caregivers for someone with diabetes, were of South-Asian background, resided in Metro Vancouver, were at least 40 years old, proficient in English and/or Punjabi, and had transportation to attend training sessions. They participated in a 20-hour training program that covered active listening, empowerment-based facilitation, behavioral goal setting, and self-efficacy.	During the diabetes self-management education phase, educators were responsible for delivering the educational content. Each session included reviewing activities from the previous week, giving new diabetes education material, and reviewing activities accomplished during the current session. While the educators focused on providing educational content, peer leaders concentrated on behavior modification activities. During the education phase, each peer leader and participant pair was required to schedule a one-on-one meeting to discuss personal motivation for lifestyle changes, set behavioral goals, and develop an action plan. Additionally, they conducted follow-up telephone support calls to assess progress and address any challenges. The following 18 support sessions did not follow a pre-established curriculum; they consistently addressed five core components: reflecting on recent self-management challenges, sharing emotions related to those challenges, engaging in group-based problem-solving, asking self-management questions, and setting new behavioral goals and action plans. Peer leaders were explicitly trained not to respond to medical or clinical questions. If a participant missed three consecutive sessions, peer leaders made a telephone support call to check in on the participant's progress with their goals and offer any needed assistance or support.	The results of the pretest-posttest evaluation indicate that there were no significant changes in HbA1c (glycaemic) levels at the 6-week mark. However, by the end of the 24-week intervention, HbA1c levels had significantly declined. In contrast, scores on the Diabetes Distress Scale improved significantly, decreasing from 2.0 at baseline to 1.7 at 24 weeks. The qualitative results highlight several areas for improvement of the intervention. Participants suggested moving sessions from faith-based locations to neutral venues like community centers to avoid unhealthy food temptations. They also recommended enhancing peer leaders' diabetes knowledge and incorporating more structured, curriculum-based education to accommodate those with lower literacy levels. Additionally, participants suggested adding an active exercise component or providing home-based exercise tools to improve the program's effectiveness.

Im & Rosenberg, 2016; Stewart et al., 2018). Four studies utilized mixed methods, combining qualitative methods like open-ended interviews and focus groups with quantitative approaches, including pre-and post-intervention surveys, to assess effectiveness of intervention (Paloma et al., 2020; Soriano-Ayala & Cala, 2019; Tang et al., 2015; Yang et al., 2014). All studies aimed to evaluate the effectiveness of peer group interventions among immigrant and refugee populations, focusing on outcomes such as increased social support, improved mental health, enhanced coping skills, and overall well-being.

Overview of the peer groups formats, settings, and implementation elements

All peer groups were in-person, in various accessible locations tailored to the participants' needs. For instance, Stewart et al. (2018) held sessions in community halls, parks, and sometimes participants' homes, while Soriano-Ayala and Cala (2019) conducted their sessions in elementary schools, targeting adolescent students. Paloma et al. (2020) utilized a room at the University of Seville, creating a personalized space for the intervention. Yang et al. (2014) chose community settings like the community center in Chinatown for their anti-stigma intervention. Tang et al. (2015) organized their sessions in faith-based settings, such as Sikh and Hindu temples, to cater to South-Asian participants.

The peer group interventions were conducted in various languages to accommodate the linguistic needs of immigrant and refugee participants, ensuring accessibility and cultural relevance. Five studies specifically mentioned the languages used: Arthur et al. (2024) conducted their sessions in Spanish for 16 Spanish-speaking immigrant mothers in the United States. Im and Rosenberg (2016) facilitated their community health workshops in Nepali, catering to the Bhutanese refugee community in the United States. Paloma et al. (2020) conducted sessions in Spanish, Ukrainian, and French, aligning with the diverse backgrounds of the 36 refugees from various countries. Yang et al. (2014) led their groups in Mandarin Chinese for Chinese immigrants. Additionally, Tang et al. (2015) organized their intervention in both English and Punjabi to accommodate the linguistic preferences of the South-Asian participants.

The number of sessions for each intervention varied, ranging from as few as three sessions (Yang et al., 2014) to as many as 24 sessions (Tang et al., 2015). The duration of the sessions also varied, with some lasting 60 to 75 minutes (Tang et al., 2015), others one to two hours (Arthur et al., 2024; Stewart et al., 2018), and one lasting two to three hours (Paloma et al., 2020). The frequency of meetings ranged from once a week (Arthur et al., 2024; Tang et al., 2015) to bi-weekly (Stewart et al., 2018) to up to twice a week (Paloma et al., 2020). The number of participants

in each group also varied, with as few as 11 participants (Yang et al., 2014) or 85 participants divided into eight groups (Stewart et al., 2018). Some studies had multiple smaller groups, such as Tang et al. (2015), which had 41 participants divided into five groups, and Paloma et al. (2020), which involved 36 participants divided into four groups. All groups were closed, meaning that the same participants attended every week.

Regarding the implementation elements of the group peer support interventions, the seven studies reviewed demonstrated various strategies tailored to meet the cultural, clinical and contextual needs of the participants. Most interventions followed a structured curriculum, except for Stewart et al. (2018), which did not follow a predetermined curriculum but included a structured discussion format. All interventions included psychoeducational components related to the topics of the interventions, such as healthy eating habits for a group focusing on obesity (Im & Rosenberg, 2016), mindfulness and self-compassion (Arthur et al., 2024), and psychoeducation on mental health for immigrant caregivers of individuals with psychosis (Yang et al., 2014). Additionally, various activities were incorporated to enhance participant engagement and support. For example, Arthur et al. (2024) integrated Mexican folkloric dance for mindful movement, and Paloma et al. (2020) used guided relaxation and individual reflection exercises.

All interventions included discussions and sharing of experiences, stories, and emotions to enhance participant engagement and non-judgmental support, except for the study by Soriano-Ayala and Cala (2019) among adolescents, which did not include information about this element of peer group support in their report.

The interventions included various additional elements, such as opportunities to come together through shared ceremonies and food. Additionally, to enhance accessibility and engagement some interventions included participant compensation, extra calls, and one-on-one meetings with participants. Stewart et al. (2018) offered refreshments during meetings to create a welcoming atmosphere and encourage socialization. Arthur et al. (2024) incorporated culturally relevant elements like Mexican food in their sessions and provided transportation support and childcare to participants. Im and Rosenberg (2016) concluded their community health workshops with a closing ceremony.

Yang et al. (2014) included weekly 15- to 20-minute follow-up calls from the clinician co-leader to review session content and ensure participants remained engaged. Tang et al. (2015) required each peer leader and participant pair to schedule one-on-one meetings to discuss personal goals and develop action plans. They also conducted follow-up telephone support calls to monitor progress and address any challenges, and if a participant missed three consecutive sessions, peer leaders would reach out to check on their progress and offer assistance.

Overview of the peer facilitators and their training

The interventions were facilitated by either peer mentors alone or a combination of peer mentors and professional mentors, such as experienced service providers for refugee populations, clinicians, or certified diabetes educators. Peer-only facilitated interventions included the studies by Arthur et al. (2024), Im and Rosenberg (2016), Soriano-Ayala and Cala (2019), and Paloma et al. (2020). Interventions facilitated by both peers and professionals included those by Stewart et al. (2018), Yang et al. (2014), and Tang et al. (2015).

The duration of facilitator training varied across the interventions, ranging from a one-day session (Stewart et al., 2018) to an extensive 8-week course followed by a 6-week facilitator training (Arthur et al., 2024). Im and Rosenberg (2016) conducted a four-day training, while Paloma et al. (2020) implemented an eight-week training program. Soriano-Ayala and Cala (2019) offered a phased training program over several months, and Tang et al. (2015) provided a 20-hour training program.

The content of the training programs varied, but common elements included education on mental health and psychosocial support, group facilitation skills, strategies for engaging participants and supporting participants effectively. Specific interventions also included content relevant to the intervention topic. For example, Soriano-Ayala and Cala (2019) included transcultural nutrition, physical activity, emotional health, intercultural mediation, and communication skills. Yang et al. (2014) incorporated mini-lectures and experiential learning on cognitive behavioral therapy principles to counter internalized stigma, which also involved experiencing the intervention themselves as participants.

Only Stewart et al. (2018) mentioned that professional mentors were available for peer mentors, providing ongoing support through individual meetings and telephone calls.

Overview of the outcomes

The interventions documented a range of positive outcomes, notably improved self-reported social support and emotional well-being, as evidenced by both qualitative feedback and pre-post structured surveys.

Qualitatively, participants across multiple studies reported enhanced social support, increased confidence, and improved coping strategies, such as healthy coping with stress. For example, Stewart et al. (2018) noted significant improvements in social support, spousal relationships, and engagement with the ethnic community, along with reduced feelings of loneliness and isolation. Participants in Arthur et al. (2024) expressed heightened enjoyment of daily life, empowerment to practice self-care, and

a sense of common humanity. Similarly, Im and Rosenberg (2016) observed that participants felt more supported and connected, with increased awareness of health issues and better health behaviors. Pre-post-survey results also indicated significant improvements in social and emotional domains. For instance, Paloma et al. (2020) found notable increases in posttraumatic growth, particularly in areas such as appreciation of life, personal strength, relating to others, and new possibilities. Tang et al. (2015) reported a significant decrease in diabetes distress scores, although there was no significant change in glycemic levels. Yang et al. (2014) observed a reduced internalized stigma among participants with higher levels of stigma before the intervention, although this was not statistically significant for the entire group.

Discussion

To the best of our knowledge, this scoping review is the first to specifically focus on group peer support interventions among immigrants and refugees worldwide. We identified only seven papers, underscoring the scarcity of studies employing peer support groups among migrants (IOM, 2020; WHO, 2022). The included studies featured immigrant and refugee participants from diverse backgrounds and countries of origin. However, the receiving countries were limited to the United States, Canada, and Spain. This finding aligns with our umbrella review, where we noted that group peer support studies are geographically concentrated, mainly in the United States, limiting a comprehensive global examination of these interventions (Abo-Rass et al., under review). This concentration is understandable, considering migration patterns typically flow from low- and middle-income countries (LMICs) to high-income countries (Abubakar et al., 2018). Furthermore, the fact that each study focused on a specific condition or issue in addition to addressing the immigrant experience highlights the adaptability of this intervention across various contexts, even among diverse populations of refugees and immigrants. However, consistent with previous conclusions on group peer support, ambiguity around the term persists (Abo-Rass et al., under review; Mead et al., 2001; Penney, 2018; Watson, 2019). This scoping review further underscores this challenge, as only one study explicitly identified the intervention as group peer support in its title and abstract (Tang et al., 2015), while the other studies included all the elements of the intervention without specifically labeling it as such. Furthermore, the considerable variation in structure, duration, and implementation—from three to 24 sessions—complicates both intervention comparison and outcome evaluation.

Regarding facilitation, four studies were facilitated solely by peers, while three were co-led by both peers and professionals. The professional

backgrounds in these co-led interventions varied; one study involved a clinician, and two others included experienced service providers for refugee populations and certified diabetes educators. While the specific professions or educational backgrounds of these professionals were not clearly defined, two of the papers with co-led interventions detailed that the professionals received the same training as the peer facilitators. This finding underscores the importance of having experts explicitly trained in group peer support interventions, emphasizing that simply being a professional or a peer is insufficient without proper training in the unique nature of these interventions.

Expanding on the characteristics of facilitators, all studies in this scoping review featured peer facilitators who were not only refugees and immigrants but also shared the same specific conditions as the group members, such as being parents, caregivers, or living with diabetes. This may suggest the importance of the specific "lived experience" component in peer support interventions (Watson, 2019; Solomon, 2004) that goes beyond identity, highlighting that peers who share both the migration experience and the specific health or social condition can provide more meaningful and relatable support.

The duration of training for peers and professionals varied across studies, but the content consistently covered essential aspects of group peer support, such as psychological support, group facilitation skills, strategies for engaging participants, and content directly relevant to the intervention topic. Our previous umbrella review of group peer support interventions across various conditions and populations highlighted a significant lack of detail regarding the training of peers (Abo-Rass et al., under review). In contrast, this scoping review provides clearer evidence that peers received adequate training, likely due to the vulnerable nature of the immigrant and refugee populations, which necessitates ensuring that peers are well-prepared (Abubakar et al., 2018). We recommend that future studies explicitly state whether peers receive ongoing support from professionals, as only one study in this review addressed this aspect. This is particularly crucial since the peers themselves are often immigrants and refugees, who may also be vulnerable and in need of continuous support.

Interestingly, despite the diverse backgrounds of participants and the recognized need for flexible support options, all seven studies in this review were conducted in person. This is surprising given the growing shift toward digital platforms for group peer support. Previous research indicates that online support groups can achieve outcomes comparable to those of in-person groups, while also enhancing service accessibility and reducing healthcare costs—benefits that are particularly crucial for disadvantaged groups, including immigrants and refugees (Bartlett & Coulson, 2011; Bennett & Glasgow, 2009; Van Uden-Kraan et al., 2008).

However, for immigrants and refugees, direct in-person social contact may be particularly important, as they are often separated from their home communities. This face-to-face interaction can play a crucial role in building trust and fostering a sense of belonging, which might be more difficult to achieve in a digital setting. Additionally, it is notable that the settings for these interventions included various elements designed to ensure accessibility and facilitate participation. These elements encompassed both material and cultural considerations. Material aspects included convenient locations, suitable times, transportation support, childcare provision, and smaller group sizes, all aimed at reducing participation barriers. Cultural elements were also thoughtfully integrated, such as conducting sessions in participants' native languages and incorporating culturally relevant practices like local food, specific ceremonies, dances, and closing social events with families. These efforts were intended to enhance the participants' experience and encourage socialization among group members.

Moreover, additional support, such as follow-up calls and one-on-one meetings with facilitators, was a distinctive feature in the interventions targeting immigrants and refugees. These continued engagement efforts were carefully tailored to address the specific needs and characteristics of these groups (Stewart et al., 2018). The design of these components was intentional, aimed at enhancing accessibility and fostering active participation and deeper involvement. Additionally, all the interventions included in this scoping review, except for one (Stewart et al., 2018), followed a structured curriculum. They all incorporated structured discussions, psychoeducational components, and the sharing of experiences, stories, and emotions. This approach aligns with the core principles of peer support interventions (Penney, 2018) and is consistent with our umbrella review, which highlighted similar implementation elements across various populations and groups. These findings suggest that these core mechanisms are fundamental to group peer support interventions even among vulnerable groups, such as immigrants and refugees.

Lastly, this scoping review underscores the positive outcomes of group peer support interventions, especially in the social and emotional domains. The reported benefits include enhanced social support and emotional well-being, more robust social networks, increased confidence, improved coping strategies, reduced loneliness and isolation, greater enjoyment of daily life, empowerment for self-care, and posttraumatic growth. However, it's important to note that these benefits are primarily limited to social and emotional areas. The only study that assessed clinical outcomes, Tang et al. (2015), did not find significant changes in glycemic levels in a pre-post-assessment of a group peer support intervention among adults with Type 2 diabetes. This suggests that group peer support interventions effectively promote personal recovery and psychosocial well-being among

refugees and immigrants, but their impact on clinical outcomes warrants additional research and remains unclear.

Limitations and future studies

There are several limitations of the current scoping review that should be noted. First, we restricted our review to peer-reviewed papers written in English, which may have introduced publication bias, particularly as grey literature was excluded. Additionally, since the included studies were conducted in only a few countries, this may limit the generalizability of the findings to other cultural and regional contexts. Future reviews should include grey literature and consider articles published in other languages better to capture the diverse experiences of immigrant and refugee populations. Second, while the review highlights positive social and emotional outcomes, there is limited exploration of clinical outcomes. This indicates a gap in understanding the impact of group peer support interventions on clinical health and mental health symptoms. We recommend that future studies prioritize examining these outcomes to provide a more comprehensive evaluation of intervention effectiveness. Third, although our review employed rigorous methods, including searches across four databases and using a broad range of MeSH terms, we observed ambiguity in terminology across the included studies. Additionally, the significant heterogeneity in intervention designs, such as variations in session frequency, duration, and content, may have influenced the comparability of outcomes. Future studies could benefit from expanding search terms and performing manual searches in journals specializing in immigrant and refugee populations to capture a broader range of relevant studies.

We also suggest that future studies examine the long-term impact of group peer support interventions to assess their sustained effectiveness in improving outcomes among refugees and immigrants. Understanding how these effects hold over time can provide valuable insights for designing and implementing effective interventions. In addition, research should explore how peer support interventions can be effectively integrated into existing healthcare systems and other social services. Investigating strategies for collaboration between peer support facilitators, healthcare providers, and social support networks may help improve accessibility, scalability, and sustainability. Identifying ways to embed these interventions into such systems can enhance early intervention efforts, reduce service gaps, and strengthen holistic care approaches.

Implications

Despite the review's limitations, this study has several important implications. First, it is the first to compile all existing studies on group peer

interventions among immigrant populations. This comprehensive review provides valuable information to professionals, policymakers, researchers, and future studies in two important fields: group peer support interventions and immigrant and refugee support—a vulnerable group that requires substantial resources for integration into a new environment. The study demonstrates that group peer support interventions are particularly effective in enhancing social and emotional well-being among immigrants and refugees. Receiving countries can utilize these cost-effective interventions, which are easily adaptable, by integrating them into community-based programs and health services aimed at improving psychosocial outcomes in these populations.

Additionally, the review underscores the importance of maintaining the core mechanisms of group peer support interventions while also adapting them culturally and contextually to specific groups to enhance their effectiveness and encourage greater participation. In the context of immigrants and refugees, the research highlights the need for culturally sensitive adaptations, such as using native languages, incorporating cultural elements like food and rituals, providing financial assistance, childcare support, and facilitator follow-up. These insights can assist organizations and professionals in designing more effective group peer support interventions for immigrant and refugee populations.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Data availability

All data generated or analyzed during this study are included in this article.

ORCID

Fareeda Abo-Rass http://orcid.org/0000-0001-5312-2923
Ora Nakash http://orcid.org/0000-0001-9963-1184
Peggy O'Neill http://orcid.org/0000-0003-3801-6852
Maria E. Torres http://orcid.org/0000-0001-6110-6384

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