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Place-making and its impact on health and wellbeing among recently resettled refugees in high income contexts: A scoping review

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Economic, violence, and climate related conditions are among the reasons for many millions of people to leave their homes and communities. The United Nations High Commissioner for Refugees (UNHCR) defines 26.2 million people displaced worldwide as refugees (United Nations High Commissioner for Refugees, 2021). Large numbers of refugees are being resettled in high-income countries (United Nations High Commissioner for Refugees, 2021). Evidence indicates that social isolation and loneliness is higher among refugees and migrants (Johnson et al., 2019), leading to poorer mental (Fazel et al., 2005; Hynie, 2018; Porter and Haslam, 2005), and physical health (Dharod et al., 2013; Patil et al., 2010). However, a focus on refugee displacement has limited the potential for strengths-based approaches that emphasise 'place--making' to promote health and wellbeing in resettlement.

'Place-making' as a term and concept derives from the fields of urban planning and design. They originally focused on physical places (e.g. buildings), and recently shifted towards centring public space and human activity; including what happens in these spaces, why, how, and with and by whom, and not (Courage et al., 2020). Place-making can be seen as a set of activities that define a place and support its ongoing evolution (Biglin, 2020). It creates the capacity for people to invest in that place with meaning (Mateo-Babiano and Lee, 2020). Place-making activities can be realised through physical initiatives such as community gardens (Turner et al., 2020), public space design and development, and public art (Mateo-Babiano and Lee, 2020); and relations and connections (between people, and between people and places) that unfold through a process of ongoing negotiation of place (Bambra et al., 2019). While the latter conceptualisation of place-making is more abstract, it is no less important, and may include 'activities' (organic or planned) that facilitate relational place attachment such as social cohesion (Mutero and Govender, 2019), and a sense of belonging (Trudeau, 2006) and wellbeing (Biglin, 2020).

Refugee families and diasporic communities are scattered across the globe (Sampson and Gifford, 2010), and resettled refugees are often subject to racism and 'othering' (viewing or treating people as intrinsically different from and alien to oneself) in resettlement countries (Bartlett et al., 2017). Relational place-making aspects are particularly relevant in this regard, as they emphasise agency and active participation, rather than focusing on top-down, structural expressions of place-making which may or may not reflect the sociocultural values or priorities of resettled refugees. Place-making scholarship has discussed the role of refugee 'deterritorialization' (separation of culture, people and place by removing cultural subjects and objects from their place), and the process of re-territorialization including 'spatial strategies that displaced people engage in when being physically present in one place, whilst feeling a sense of belonging to another place' (Biglin, 2020). Refugees are active in their re-emplacement process, and place-making activities, alongside local and transnational community connectedness and cultural identity, are central to this (Biglin, 2020, p.2; Brun, 2001).

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Place-making research has also considered refugee place attachment (Boğaç, 2009), overcoming alienation (Shoeb et al., 2007), gendering of place (Dyck and Dossa, 2007), and the complexities of local neighbourhoods as concentrated resettlement spaces (Mazumdar et al., 2000).

Some studies have explored how illness impacts resettlement (Grønseth, 2001; Lawrence, 2008), yet there is limited evidence about the potential for place-making to promote health and wellbeing within the context of resettlement, including what can be learned from actions taken toward 're-placement' (e.g. creating new roots in a place) among refugees (Magan and Padgett, 2021). This includes understanding the restorative powers of place-making, such as considering 'therapeutic landscapes' (Gesler, 1996). Gesler (1996, p.96) defined therapeutic landscapes as places "where the physical and built environments, social conditions and human perceptions combine to produce an atmosphere which is conducive to healing". A recent scoping review (Bell et al., 2018), identified spiritual, symbolic and cultural dimensions as additional aspects of therapeutic landscapes, and how they connect with the broader discourse on healthy spaces, places and practices.

There are very few studies that have applied the concept of place-making, or considered the therapeutic aspects of place, to refugee resettlement (Biglin, 2020; Sampson and Gifford, 2010). There is also a lack of knowledge on the barriers to making place, and how these might be overcome to better address the unique and complex health needs of resettled refugees. For example, the recently (2022) published 'Handbook of Settings-Based Health Promotion' (Kokko and Baybutt, 2022) only touches upon migrant and refugee health in terms of healthcare service delivery. To address that gap, we conducted a systematic scoping review which aimed to document links between physical and mental health and wellbeing, and aspects of place-making, among recently resettled refugees in high-income contexts.

1. Methods

Our search strategy followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Scoping Reviews (PRISMA-ScR) guidelines (Tricco et al., 2018). The following databases were searched for studies published between January 2000 and July 2021: PubMed, Scopus, Web of Science, and ProQuest Central. A set of search terms was compiled (Table 1) and tested across the different databases to ensure papers of relevance were being captured. The database search results were imported into a single library in EndNote (Clarivate Analytics, USA). Duplicates were removed. The combined library was imported into Covidence systematic review software (Veritas Health Information, Australia) for title/abstract and full text screening.

1.1. Defining place-making

We drew on Courage's (2020) inclusive definition of place-making which encompasses both physical (e.g. connection between people and material or physical places), and psychosocial (e.g. connection between people and place, and between people in relation to place) aspects of place that come about through processual practices, activities, relationships, and experiences that encompass the 'making' (in place-*making*). We also drew on understandings from the therapeutic landscape discourse (Bell et al., 2018) to include spiritual, symbolic, and cultural dimensions of place. We focused on the 'activities' or practices that facilitate connection to place, or act as barriers in the process of re-territorialization among refugees (Biglin, 2020), including those in public (e.g. parks) or private (e.g. homes) places. In considering re-territorialization as a concept specific to refugee place-making (Biglin, 2020), we drew on structuration theory (Giddens, 1984) to explore how the structural aspects of 'resettlement' (e.g. legal and political institutions, support services, amenities), and the agency of refugees to act within the societal values and norms of resettlement countries (as a marginalised population), intertwine to facilitate or inhibit place-making.

'Resettlement' is a broad concept generally referring to the transfer of refugees from an asylum country to another country granting them permanent residence (UNHCR, 2022). Resettlement services may include 'cultural orientation, language and vocational training, as well as programmes to promote access to education and employment' (UNHCR, 2022). We acknowledge that some aspects of 'resettlement' overlap with place-making, and that the two concepts should not be seen as dichotomous, but rather intertwined. These definitions were used as basis for discussions among reviewers during the study selection stage, so that consensus on inclusion or exclusion of papers could be reached. Our process allowed an organic approach to applying a complex and multilayered understanding of place-making to the refugee context and experience, and how it is relative to health and wellbeing. This ensured that we were not restricting the review to papers that explicitly used the term 'place-making', to avoid limiting it to specific discourses (e.g. geography, built environment). Rather, our aim was to take an inclusive interdisciplinary approach to include papers in the fields of public health, sociology, anthropology, and migration studies, and allow for place-making aspects to emerge inductively during the analysis stage.

Table 1
Search term groups using the 'PICO' strategy. Each group were combined with the Boolean operator 'AND'.

Population	"Asylum seekers" OR refugees OR migrants OR immigrants OR migration
AND	
Intervention	place-making OR placemaking OR "therapeutic landscapes" OR "social space*" OR "public space*" OR "greenspace*" OR "green space" OR resettlement OR "social integration" OR "social cohesion" OR "community resilience" OR housing OR "healthy space" OR "therapeutic space" OR "place-related determinants" OR "connection to place" OR "place attachment" OR "people-place relationship" OR "enabling place"
AND	
Outcomes	health OR mental OR well* OR ill* OR disease* OR pain* OR chronic OR "quality of life" OR psychosocial OR recovery OR "healing" OR stress OR "physical activity"
Context	N/A no country limiting terms were used

1.2. Study selection

Articles were included in the review if they: (i) were peer-reviewed; (ii) in a high-income (United Nations, 2014) setting; (iii) included empirical data from the perspectives of refugees settled within ten years of the publication date; (iv) documented a quantitative or qualitative link between aspects of place-making and a physical or mental health outcome from the perspectives of refugees; (v) were published between 2000 and 2021; and (vi) were in English. Reviews, study protocols, commentaries, editorials, books, and theses were excluded. Studies looking at asylum seekers and temporary visa holders were also excluded as our focus was on permanently resettled refugees. Titles and abstracts of all articles retrieved were assessed against the inclusion and exclusion criteria by one of the authors, and a 20% sample by a second author to address risk of selection bias. Where it was unclear whether the selection criteria were met, studies were included for full text review. All full text articles were reviewed by two of the authors independently. Disagreements were resolved by discussion and consensus or independently by a third author.

1.3. Data analysis & synthesis

Based on our conceptually inclusive scoping of place (-making) in a structuration theoretical framework, an inductive analysis (Glaser and Strauss, 2009) was performed on each paper identified for inclusion in the final synthesis. Any empirical data (qualitative or quantitative) that linked aspects of place-making with health or wellbeing outcomes from the perspectives of recently resettled refugees were coded using NVivo

qualitative data analysis software (QSR International Pty Ltd. Version 12, 2018). Only direct quotes or statistical data from included studies were coded. Interpretive or synthesized data within papers were excluded. Where studies included non-refugee perspectives, these were excluded from the analysis. Health and wellbeing outcomes across the identified literature varied depending on methodology, with some articles reporting clinical or self-reported quantitative data, and others reporting experiential or phenomenological qualitative data.

A meta-analysis of quantitative data was not performed. Rather, quantitative data that was relative to both the aspects of place-making and health and wellbeing outcomes, were coded and categorised thematically in NVivo. Qualitative data was similarly coded in NVivo, applying a layer of interpretation to methodically categorise data. All thematic codes were cross-tabulated in NVivo to reveal data coded at the intersection between aspects of place-making (Table 2) and health and wellbeing data among refugees. Intersecting data was subsequently summarised and presented in this paper. Our analysis enabled the organic emergence of a thematic framework which identified three overarching aspects of place-making relative to health and wellbeing among recently resettled refugees in high-income countries. These emergent dimensions included: material/physical, psychosocial, and structural (Table 2).

2. Results

Details of the systematic selection process are outlined in Fig. 1. A total of 65 articles were included for extraction. Characteristics are outlined in Table 3. Most studies were set in Australia (n = 24), the United States (US) (n = 16), and Canada (n = 12), with a smaller number set in the United Kingdom (UK) (n = 3), and various European countries (n = 7). Most studies included participants who were from diverse ethnic or cultural backgrounds (n = 29), however many originated from countries in Western Asia (n = 15) or Sub-Saharan Africa (n = 12). Qualitative methodologies were used in most articles (n = 44), with the remainder using quantitative (n = 14) or mixed methods (n = 6). More than two thirds of the articles (n = 42) were published in the last five years (2017–2021).

Mental health and wellbeing were most reported as linked to factors that shaped refugees' perspectives and experiences of place-making in the reviewed articles, this included general psychological wellbeing (n = 48), anxiety (n = 26), depression (n = 21), trauma (n = 21), and suicidal ideation (n = 2). Physical health was often reported in a general or non-specific way among articles (n = 12), with a smaller number of articles reporting data on insomnia (n = 4), and chronic disease (n = 2). Table 4 provides an outline of the overarching aspects of place-making identified, the sub-themes associated with each, and example quotes from the reviewed articles. The following sections discuss each aspect of place-making and how it is linked to health and wellbeing for our research population.

Table 2
Aspects of place-making and examples relative to refugee health and wellbeing in high-income contexts identified in the reviewed papers.

Aspects of place-making	Examples relevant to refugee health and wellbeing
Material/physical	Housing, neighbourhood (built environment), public places (green spaces, swimming pools, public libraries, sport spaces), schools, places of worship
Psychosocial	*Internal (psychological):* sense of belonging, resilience, assimilation, cultural identity *External (social):* sociocultural connection and support, family, community, language skills, sociocultural capital
Structural	Visa or legal status, laws, rights, policies in resettlement country, resourcing of support services, access to health and support services, education and employment opportunities, racism and discrimination (values and norms in resettlement country)

2.1. Material/physical place-making

This section summarises the relation between the built (housing, neighbourhood, school, leisure spaces and institutional venues of worship) and natural environments as an aspect of place-making, and refugee health and wellbeing.

2.1.1. Home & housing

Safe and suitable housing is central to one's ability to settle in place. The literature raised a number of housing-related barriers that impacted refugees' health and wellbeing. When applying for rental housing, refugees experienced discrimination, based on their visa, employment, and socio-economic status (Hordyk et al., 2015; Oudshoorn et al., 2020; Van der Boor et al., 2020; Ziersch et al., 2020). These experiences led to stress, tension, 'social erosion' and low self-esteem (Oudshoorn et al., 2020; Van der Boor et al., 2020). Due to limited funds, refugees faced fewer housing and neighbourhood options (Barnes, 2001; Due et al., 2020; Hadjiyanni, 2007; Hordyk et al., 2015; Oudshoorn et al., 2020; Ziersch et al., 2017). Spatial restrictions led to acceptance of poor housing conditions, feeling unsafe (Hadjiyanni, 2007; Ziersch et al., 2017), overcrowding (Hadjiyanni, 2007; Oudshoorn et al., 2020; Ziersch et al., 2017), a sense of insecurity (e.g. fear of having to move or homelessness) (Ziersch et al., 2017), and inadequate indoor climate control (Hansen et al., 2014). Poor housing conditions were linked to negative mental health. Quantitative studies identified that refugees' lack of satisfaction with housing was significantly associated with depressive symptoms (Ahmad et al., 2021) and higher odds of poorer emotional wellbeing (Campbell et al., 2018). Inability to find safe, affordable and adequately-sized housing was also associated with stress (Baranik et al., 2018), anxiety (Ziersch et al., 2017) and exacerbation of existing trauma (Due et al., 2020). On the other hand, an ability to exercise agency over a structurally restrictive housing environment saw positive outcomes. Cultural homemaking practices, such as decorating the house in a traditional way (Due et al., 2020), or preparing cultural food (Humam et al., 2017), provided a sense of place, while an inability to make improvements to one's house for structural reasons (e.g. rent conditions or physical integrity of the home) negatively affected health and wellbeing (Due et al., 2020).

2.1.2. Neighbourhood

Safety, poor walkability, physical distance, cold weather and restrictive work schedules limited important social connection (Dharod et al., 2013; Due et al., 2020; van Liempt and Staring, 2021) and access to services (Rees et al., 2009). This was an issue of stress for parents who lack family members to help with childrearing (Ikafa and Hack-Polay, 2018; van Liempt and Staring, 2021). Some study participants could not afford to use public transport, while others did not have the confidence to do so (Oudshoorn et al., 2020; van Liempt and Staring, 2021) limiting ability to create social bonds, which are important to wellbeing. For some, small cities were therapeutic, as they engendered a greater sense of belonging, peace and quiet (Drolet and Moorthi, 2018; van Liempt and Staring, 2021) However, demonstrating that refugees have different experiences of place, some responds reported that small cities heightened the experience of being different, and limited access to religious spaces and grocery stores selling cultural foods (Drolet and Moorthi, 2018). Those who saw their local area as 'diverse' felt safer (Magan and Padgett, 2021) and thus spent more time in their neighbourhood, an activity understood to be a placemaking practice. Places of connection and meaning contribute to refugees' ability to access public space and thus exercise placemaking agency. The following three themes discuss how particular types of places may contribute to positive health and wellbeing.

2.1.3. Places of worship

A crucial aspect of physical place-making, places of worship, and the access to faith-based communities that they provide, largely promoted

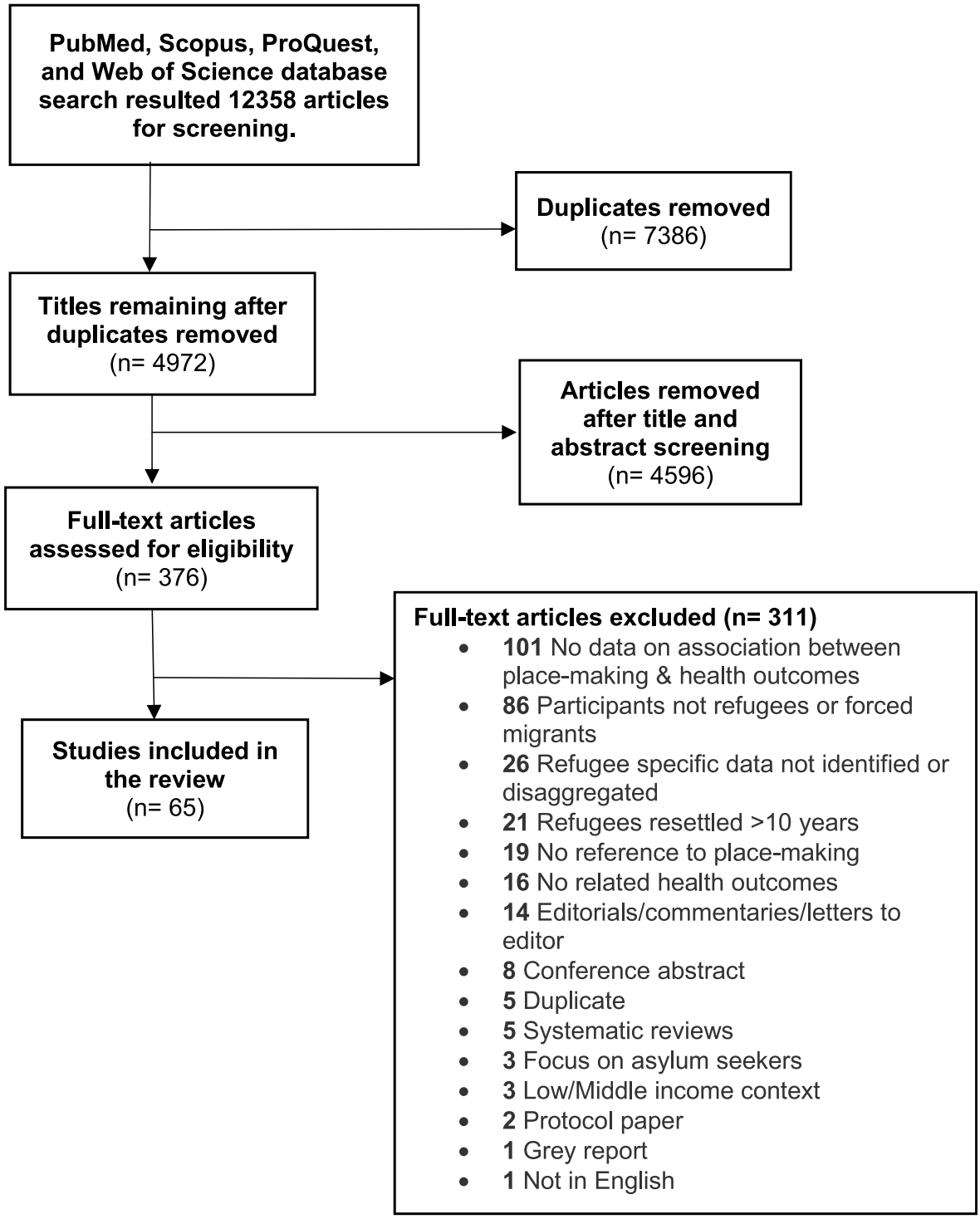

Fig. 1. PRISMA flow chart of systematic selection process.

health and wellbeing. Attendance of a place of worship was associated with decreased depressive symptoms (Alessi, 2016) and financial hardship (Chen et al., 2017b), and increased health (Chen et al., 2017b), and wellbeing (Walther et al., 2021; Weine et al., 2014) through enhancing protective factors such as resilience and hope (Frounfelker et al., 2019). Social networks and activities were reported to be created and maintained through places of worship (Baird, 2012), which provided emotional support, food, clothing, and transport (Carmody et al., 2021; Choummanivong et al., 2014; Ikafa and Hack-Polay, 2018; Weine et al., 2014).

2.1.4. Schools

Schools facilitated different types of social psychological experiences for refugee children that were relative to place-making. Schools were variously seen as places of authority (Harwood et al., 2021; Sampson and Gifford, 2010), support (Baker et al., 2019; Humam et al., 2017), and discrimination (Drolet and Moorthi, 2018; Osman et al., 2020; Riordan and Claudio, 2021; Ziersch et al., 2020). In some contexts, teachers and school psychologists played key emotional wellbeing support roles for refugee children (Baker et al., 2019; Bartlett et al., 2017; Humam et al., 2017; Walther et al., 2021), offering counselling, family

Table 3
Characteristics of included studies. [a]As described in study; [b]Refugee participants only.

First Author (Reference)	Year	Country	Refugee ethnic group (s)[a]	Participant type	Sample size[b] (n)	Methodology
Agyekum (Agyekum and Newbold, 2019)	2019	Canada	Somali & Ghanaian	Adult (disaggregated)	236	Quantitative
Ahmed (Ahmed et al., 2017)	2017	Canada	Syrian	Adult	12	Qualitative
Ahmad (Ahmad et al., 2021)	2021	Canada	Syrian	Adults (disaggregated)	1924	Quantitative
Ahmad (Ahmad et al., 2020)	2020	Canada	Afghan	Adults (disaggregated)	49	Quantitative
Alessi (Alessi, 2016)	2016	US and Canada	Multiple	Adult	26	Qualitative
Baird (Baird, 2012)	2012	US	South Sudanese	Adult	20	Qualitative
Baker (Baker et al., 2019)	2019	Australia	Arabic speaking	Parents & adolescents	49	Qualitative
Baranik (Baranik et al., 2018)	2018	US	Multiple	Adult	159	Mixed methods
Barnes (Barnes, 2001)	2007	US	Cuban	Adult & seniors	20	Qualitative
Bartlett (Bartlett et al., 2017)	2017	US	Multiple	High school students	23	Qualitative
Beiser (Beiser and Hou, 2016)	2016	Canada	Multiple	Teenagers	152	Quantitative
Beiser (Beiser and Hou, 2017)	2017	Canada	Multiple	Adult	651	Quantitative
Buccitelli (Buccitelli and Denov, 2019)	2019	Canada	Multiple	Adult	22	Qualitative
Campbell (Campbell et al., 2018)	2018	UK	Multiple	Adult & seniors	5678	Quantitative
Carmody (Carmody et al., 2021)	2021	Australia	Multiple	Adult	15	Qualitative
Caxaj (Caxaj and Berman, 2010)	2010	Canada	Not stated	Youth	7	Qualitative
Chen (Chen et al., 2019)	2019	Australia	Multiple	Teenagers	1723	Quantitative
Chen (Chen et al., 2017b)	2017	Australia	Multiple	Adult (disaggregated)	2399	Quantitative
Chen (Chen et al., 2017a)	2017	Australia	Multiple	Adult	2399	Quantitative
Choummanivong (Choummanivong et al., 2014)	2014	New Zealand	Multiple	Adult & seniors	61	Qualitative
Copelj (Copelj et al., 2017)	2017	Australia	Multiple	Young adult	6	Qualitative
Daou (Daou et al., 2021)	2021	Canada	Syrian	Children	6	Qualitative
Dharod (Dharod et al., 2013)	2013	US	Multiple	Adult	18	Qualitative
Dowling (Dowling et al., 2020)	2020	Australia	Multiple	Adult	19	Qualitative
Drolet (Drolet and Moorthi, 2018)	2018	Canada	Syrian	Adult	100	Mixed methods
Dubus (Dubus, 2018)	2018	Iceland	Syrian	Seniors	8	Qualitative
Due (Due et al., 2020)	2020	Australia	Multiple	Not stated	11	Qualitative
Frounfelker (Frounfelker et al., 2019)	2021	US	Somali Bantu	Adults & youth (disaggregated)	81	Qualitative
Gerber (Gerber et al., 2017)	2017	US	Nepali Bhutanese	Adults	50	Mixed methods
Guajardo (Guajardo et al., 2016)	2016	Australia	Iraqi	Adults (disaggregated)	450	Quantitative
Hadjiyanni (Hadjiyanni, 2007)	2007	US	Somali	Adults	8	Qualitative
Hansen (Hansen et al., 2014)	2014	Australia	Not stated	Not stated	2	Qualitative
Harwood (Harwood et al., 2021)	2021	Australia	Multiple	Youth	400	Qualitative
Hess (Hess et al., 2019)	2019	US	Burundian, Congolese, Iraqi	Adults	18	Qualitative
Hordyk (Hordyk et al., 2015)	2015	Canada	Multiple	Adults & children (disaggregated)	23	Qualitative
Humam (Humam et al., 2017)	2017	US	Acehnese	Adult	4	Qualitative
Ikafa (Ikafa and Hack-Polay, 2018)	2019	Australia	Sub Saharan African	Adult	30	Qualitative
Kivling-Boden (Kivling-Boden and Sundbom, 2002)	2002	Sweden	Yugoslavian	Adult	26	Quantitative
Lenette (Lenette et al., 2019)	2019	Australia	South Sudanese	Adults	Not stated	Qualitative
Liamputtong (Liamputtong et al., 2016)	2016	Australia	Afghan, Burmese, Sudanese	Not stated	111	Qualitative
Van Liempt (van Liempt and Staring, 2021)	2021	Netherlands	Syrian	Adult	49	Qualitative
Lobel (Lobel, 2020)	2020	Germany	Multiple	Adults	4459	Quantitative
Magan (Magan and Padgett, 2021)	2021	US	Somali	Adult	15	Qualitative
McGregor (McGregor et al., 2015)	2015	Australia	Multiple	Youth	50	Quantitative
Mendoza (Mendoza, 2006)	2006	US	Mexican	Adults	21	Qualitative
Momartin (Momartin et al., 2018)	2018	Australia	Multiple	Youth	32	Qualitative
Neil-Greene (Neil Greene, 2019)	2019	US	Multiple	Adult	290	Mixed methods
Nickerson (Nickerson et al., 2019)	2018	Australia	Multiple	Adult	1894	Quantitative
Osman (Osman et al., 2020)	2020	Sweden	Somali	Youth	47	Qualitative
Oudshoorn (Oudshoorn et al., 2020)	2019	Canada	Syrian	Family (2 adults + children, aggregated)	17	Qualitative
Patil (Patil et al., 2010)	2010	US	Multiple	Adult	175	Qualitative
Paudyal (Paudyal et al., 2021)	2021	UK	Syrian	Adult	12	Qualitative
Rees(Rees et al., 2009)	2009	Australia	West Papuan	Not stated	Not stated	Qualitative
Riordan (Riordan and Claudio, 2021)	2021	Australia	Multiple	Young adult	10	Qualitative
Sampson (Sampson and Gifford, 2010)	2009	Australia	Multiple	Youth	120	Qualitative
Savic (Savic et al., 2013)	2013	Australia	Sudanese	Adult	25	Qualitative
Sulaiman-Hill (Sulaiman-Hill and Thompson, 2012)	2012	Australia & New Zealand	Afghan & Kurdish	Adult	81	Mixed methods
Van de Boor (Van der Boor et al., 2020)	2020	UK	Multiple	Adult	16	Qualitative
Vasey (Vasey, 2011)	2011	Australia	Iraqi	Adult	26	Qualitative
Vasquez Guzman (Vasquez Guzman et al., 2020)	2020	US	Latin	Adults	24	Qualitative
Vitus (Vitus, 2022)	2021	Denmark	Not stated	Youth	3	Qualitative
Walther (Walther et al., 2021)	2021	Germany	Multiple	Adult	54	Qualitative

(*continued on next page*)

Table 3 (*continued*)

First Author (Reference)	Year	Country	Refugee ethnic group (s)[a]	Participant type	Sample size[b] (n)	Methodology
Weine (Weine et al., 2014)	2014	US	Burundian, Liberian	Youth & families	73	Qualitative
Ziersch (Ziersch et al., 2017)	2017	Australia	Multiple	Adult	50	Qualitative
Ziersch (Ziersch et al., 2020)	2020	Australia	Multiple	Adult	423	Mixed methods

assistance and conflict resolution (Weine et al., 2014). In others, refugee students documented school as a place of discrimination, where they were perceived as incapable by teachers (Osman et al., 2020), othered (Harwood et al., 2021), or bullied or abused by peers (Bartlett et al., 2017; Drolet and Moorthi, 2018; Riordan and Claudio, 2021; Ziersch et al., 2020) which in some cases lead to depression, hopelessness, and drop-outs (Riordan and Claudio, 2021).

2.1.5. Leisure spaces

Places of leisure, such as swimming spots (Walther et al., 2021; Weine et al., 2014), after school clubs (Bartlett et al., 2017), local libraries (Sampson and Gifford, 2010) and sports places (Baker et al., 2019; Harwood et al., 2021; Riordan and Claudio, 2021; Vitus, 2022) were reported as being conducive to mental wellbeing and important places of re-territorialization. Sport in particular increased self-worth and feelings of happiness (Harwood et al., 2021), a sense of acceptance into mainstream society (Walther et al., 2021), ability to make friends (Baker et al., 2019; Riordan and Claudio, 2021), and motivation for the future (Vitus, 2022). Female participants described community-based activities (sewing, cooking, painting) as important for enhancing resilience to stress and depression (Dowling et al., 2020), and offering a space for healing and negotiating bi-cultural tension (Harwood et al., 2021).

2.1.6. Green spaces

All refugee experiences of urban green spaces and gardens were reported as beneficial (Hordyk et al., 2015; Ikafa and Hack-Polay, 2018; Paudyal et al., 2021; Sampson and Gifford, 2010; Van der Boor et al., 2020; van Liempt and Staring, 2021), offering calm (Hordyk et al., 2015), healing (Paudyal et al., 2021) and restoration (Due et al., 2020; Sampson and Gifford, 2010; van Liempt and Staring, 2021). Green spaces fostered relationships (Hordyk et al., 2015) and created a sense of belonging and home (Ikafa and Hack-Polay, 2018; van Liempt and Staring, 2021). To an extent, this offset the impacts of inadequate housing, social isolation and stressful settlement (Hordyk et al., 2015). Community gardening was associated with social support and re-connection with cultural roots (Gerber et al., 2017), and home gardens a sense of comfort and control (Due et al., 2020).

2.2. Psychosocial place-making

Psychosocial place-making captures settlement factors affecting refugees' mental and physical health outcomes that were not primarily material or physical in nature (but may have been distally connected to material or physical place). These comprise internal psychological aspects such as, sense of belonging and resilience, and sociocultural aspects such as social connection, family, and culture.

2.2.1. Sense of belonging

Drawing on the concept of therapeutic landscapes (Bell et al., 2018), place-making includes spiritual, symbolic, and cultural dimensions. A sense of belonging, nostalgia and 'culture shock' all affected respondents' abilities create place attachment. Depression was linked to exclusion from society and a lack of belonging (Choummanivong et al., 2014; Van der Boor et al., 2020; Vasey, 2011). Psychological distress resulting from missing one's home country was notable in several studies (Baker et al., 2019; Daou et al., 2021; Paudyal et al., 2021; Vasey, 2011). This included nostalgia (Lenette et al., 2019), disappointment in decreased living standards (Drolet and Moorthi, 2018), as well as longing for a former pace of life and incidental nature of everyday social relations (Van der Boor et al., 2020; van Liempt and Staring, 2021). However, celebrating cultural diversity, notably through positive cultural and professional role models, enhanced one's sense of belonging (Bartlett et al., 2017; Riordan and Claudio, 2021; Vitus, 2022). Refugees noted a desire for certain cultural practices to be retained, while also encouraging education for their cultural community to help them adapt to their new context (Lenette et al., 2019).

2.2.2. Resilience

Resilience was described in various ways as a psychological state important to surviving hardship and acted as a protective factor to depression (Baird, 2012; Dowling et al., 2020; Walther et al., 2021). Resilience encompassed approaching challenges from a strengths-based perspective (Carmody et al., 2021; Copelj et al., 2017; Paudyal et al., 2021), acceptance (Walther et al., 2021), taking pride in being different (Copelj et al., 2017), finding self-reliance (Bartlett et al., 2017), a sense of purpose (Weine et al., 2014), and moving forward (Walther et al., 2021). For women, resilience-building was realised through learning how to drive, studying or working outside the home and managing finances (Baird, 2012; Dowling et al., 2020).

2.2.3. Social connection & community

Place-making entails the connection between people in relation to place (Courage et al., 2020). The link between social and relational connection and mental health was strongly identified. Loneliness was found to be associated with stress in a quantitative study of refugee teenagers (n = 1723), along with poorer overall health (Chen et al., 2019). Several studies found links between loneliness and poorer mental health (Copelj et al., 2017; Dowling et al., 2020), or depression (Ahmad et al., 2020; Alessi, 2016; Walther et al., 2021). Lack of local language skills posed an obstacle to growing social networks (Neil Greene, 2019), and living independently (Baranik et al., 2018; Hess et al., 2019; Van der Boor et al., 2020); resulting in depression (Baranik et al., 2018) exacerbation of stress, nervousness and anxiety (Dowling et al., 2020), and substance abuse (Osman et al., 2020).

Social contact increased general psychological wellbeing (Riordan and Claudio, 2021), improved feelings of self-worth and helped alleviate some stress (Dowling et al., 2020; Paudyal et al., 2021). Friends were described as a source of happiness (Carmody et al., 2021; Liamputtong et al., 2016), a way to fight the effects of trauma (Momartin et al., 2018), moral support (Alessi, 2016; Ikafa and Hack-Polay, 2018), and a form of therapy and mutual understanding (Baranik et al., 2018; Liamputtong et al., 2016; Paudyal et al., 2021; Rees et al., 2009). Implicit and explicit cultural norms and expectations sometimes prevented people from seeking psychological help (Baker et al., 2019; Paudyal et al., 2021; Walther et al., 2021). Making friends with the mainstream community was linked to improved psychological health (Walther et al., 2021) – as was access to equal rights (Frounfelker et al., 2019).

2.2.4. Family

Family, understood as a social practice and connection crucial to place-making, for some, compensated for the negative psychological impacts of settlement (Dowling et al., 2020). It did so by providing a source of strength (Alessi, 2016; Copelj et al., 2017; Walther et al., 2021)

Table 4
Example participant quotes pertaining to aspects of place-making.

Aspect	Sub-theme	Quote
Material/physical place-making	Home and housing	"It is like a box here. Back home the weather is good, we have a big garden and big trees, most of the time we are outside sitting, but here it is like a box. We are not used to staying indoors all the time." (Hadjiyanni, 2007)
		"This is my first time in my whole of my life that I live in a house like this with furniture … I never could imagine that I'm going to live in a house like this. I am happy in this house because I have everything here'. (Due et al., 2020)
	Neighbourhood	"I'm happy to lock the door and avoid going outside after it is dark. Past 9 o' clock I can't go out, I'm scared. Home before dark, can't go out after dark". (Ziersch et al., 2020)
		"My mother is not far but she cannot come and babysit because the bus system here is too complicated for her. I cannot ask her to take a bus and come to our house." (van Liempt and Staring, 2021)
	Places of worship	"I have so many friends in Church that really helping me. [P2]"
		"They [church] really helped me a lot, a lot, a lot … sometimes they just came home visit me. When I wasn't working they used to bring food for us. [P3]" (Carmody et al., 2021)
	Schools	"A lot of good friends, and it's very easy to learn because nobody actually makes fun of you if you say something wrong they correct you." (Sampson and Gifford, 2010)
		"There are a lot of teachers who joke about the girls' veils and ask why they do not take off their veils. They say, for instance, 'Isn't it warm?' They ask all those stupid questions, and then everybody looks at the girls and laughs." (Osman et al., 2020)
	Leisure & green spaces	"I don't have much money and I have a one-bedroom apartment that is small but we have a park like this one close to us and this helps us a lot. If we did not have a place like this to play in every day, I don't know." (Hordyk et al., 2015)
Psychosocial place-making	Employment & productivity	"Getting the job was very, very hard. No one help me. No one want me. This brought the upset for me. I got tired all the time from the worries and not feeling good in myself. I had broken sleeping, broken from of all the thinking about what can I do?" (Dowling et al., 2020)
	Sense of belonging	"It's hard because Sudanese woman now they are in the middle between, they not in the American culture, and they not in Sudanese culture. They just in the middle from nowhere." (Baird, 2012)
	Social connection & community	"It should be like we can go and visit them or the family can come and visit us. This way we would not feel like a bird in a cage or imprisoned. This is the most important and critical issue here. This is what can cause depression." (Ahmed et al., 2017)
		"As I told you before, I don't have any social networks or any people that I know in the U.S. The main obstacle for that is the language." (Neil Greene, 2019)
	Family	"Having depression—is when we are not like having our family here. We make our self like, close our door, not socialising with people, not talking with people." (Choummanivong et al., 2014)
		"I appreciate the importance of family as I think family can overcome many of the life challenges." (Copelj et al., 2017)
	Culture	"We have to teach her how to grow between … how to protect her culture and at the same time adapt to Australia because … the Aussies take her to a different world, to a different way." (Baker et al., 2019)
	Resilience	"What makes us strong is that we have been through a lot … but we look back and remember some of our people where they are. There are people suffering more than I am. When I look at my children, I always remember that there are other children suffering that is what makes us feel that we are strong." (Carmody et al., 2021)
Structural place-making	Discrimination & racism	"Sometimes when cars pass by me and they see that I wear headscarf, they insult me … that hurts a lot". (Ziersch et al., 2020)
		"I am friendly with my neighbors, but the people here, they say, 'You are a refugee, you live here on benefits. And we are paying taxes for you, for your benefits.' So I don't feel welcome here." (van Liempt and Staring, 2021)
	Governments, laws, policies	"I all time thinking if I was in Syria I have family, but if the women divorce her husband no one will give her any money, no one will give her any house, no one will give her anything. Here, I don't have this problem. I have my home, because the city council give a lot of people houses, and I have my benefit. That's make me feel more safe. I can feel safe." (Van der Boor et al., 2020)
		"We'd love to go out there and achieve, but we need to be given more opportunities … to show that we're not just dumb black people sitting in Australia. We actually have something upstairs as well … And don't look down on Africans. We just need … more opportunities to show ourselves." (Riordan and Claudio, 2021)
	Access to health & support services	"Here if you are sick, or if you have anything, you can go to the walk-in center, you are free to do that. And also you feel comfortable, confident having capable people to take care of you for whatever disease that you got." (Van der Boor et al., 2020)
		"The case manager helped to get the social security cards, IDs, employment authorization documents. We told him about a problem with food stamps and he told us to talk to the food stamps

(continued on next page)

Table 4 (*continued*)

Aspect	Sub-theme	Quote
		director. He helps with social needs and he helped to register the kids in school." (Weine et al., 2014)

and comfort (Carmody et al., 2021) – particularly against stress and anxiety (Dowling et al., 2020) – an antidote to loneliness (Dubus, 2018), fulfillment and purpose (Dubus, 2018; Vitus, 2022), as well as creating motivation for overcoming the ongoing impacts of trauma or torture (Hess et al., 2019). In fact, dealing with stressful issues was understood by many as a familial experience (Carmody et al., 2021; Caxaj and Berman, 2010; Choummanivong et al., 2014; Dowling et al., 2020; Hordyk et al., 2015; Ikafa and Hack-Polay, 2018; Paudyal et al., 2021; van Liempt and Staring, 2021).

Family separation was associated with negative mental health outcomes including depression and anxiety, among resettled refugees in Germany (n = 3400) (Lobel, 2020) and the US (n = 290) (Neil Greene, 2019); with several qualitative studies noting similar links (Carmody et al., 2021; Choummanivong et al., 2014; Paudyal et al., 2021; Savic et al., 2013; Vasey, 2011). An Australian study (McGregor et al., 2015) found that post-traumatic stress disorder (PTSD) symptoms rated higher for participants (n = 50) who settled without their immediate family. Distress about those left behind were linked to ongoing trauma (Vasey, 2011), loss of sleep and physical illness (Dowling et al., 2020) and for some, family separation led to suicidal ideation (Choummanivong et al., 2014). Remittance (sending money to family members in country of origin) also contributed to strained finances (Barnes, 2001; Choummanivong et al., 2014; Hadjiyanni, 2007; Hansen et al., 2014) and poorer mental health outcomes (Savic et al., 2013).

2.2.5. Culture

Culture shock faced by refugees during arrival was described as highly psychologically distressing (Ikafa and Hack-Polay, 2018) and the pressure to give up cultural identity a source of anxiety (Bartlett et al., 2017). Children saw cultural diversity and engagement in 'cultural activities' as associated with psychosocial wellbeing (Bartlett et al., 2017) including feelings of being 'well' and 'better' (Vitus, 2022). Positive psychological outcomes came from support from one's ethnic or cultural community (Baird, 2012; Barnes, 2001; Bartlett et al., 2017; Copelj et al., 2017; Humam et al., 2017; Ikafa and Hack-Polay, 2018; Magan and Padgett, 2021; Mendoza, 2006; Neil Greene, 2019; Riordan and Claudio, 2021; Weine et al., 2014) Refugees discussed culture as a source of strength (Lenette et al., 2019) and a way to overcome a sense of 'emptiness' (Walther et al., 2021). Wellbeing derived from nurturing ethnic connections (Vitus, 2022), pride in cultural heritage (Baird, 2012; Ikafa and Hack-Polay, 2018), and making friends with other migrants who are culturally similar (van Liempt and Staring, 2021).

2.3. Structural place-making

Factors related to the structural aspects of place-making were primarily linked to psychological wellbeing and mental health, and comprised experiences or perceptions of discrimination, including racism; governments, laws and policies; and access to healthcare and support services. Some of the sub-themes below (such as laws and policies, and access to services), tend to fall under ''resettlement' in migration research. We position these aspects, in concert with other structuring forces (such as discrimination and a sense of productivity), as important to the process or re-territorialization and re-placement. Indeed, while acknowledging the active role of refugees in the making of new places, these forms of agency are negotiated and need to be located within states and other institutions that dictate policies and instil societal norms.

2.3.1. Governments, laws, & policies

Achieving refugee status was associated with stability and subsequently linked to a reduction in worry and stress (Walther et al., 2021) and increased wellbeing (Van der Boor et al., 2020). Wellbeing was correlated with a newfound freedom in the country of settlement (Humam et al., 2017), including freedom of speech on social media (Van der Boor et al., 2020), or ability to speak politics, as well as make choices about one's role in the family (Van der Boor et al., 2020; Walther et al., 2021); all aspects that strengthen one's agency.

Gendered aspects centred around the acquisition of certain freedoms for female refugees including the ability for Acehnese women to marry outside their cultural group (Humam et al., 2017); divorced Syrian women to access government support which had not been possible in their country of origin due to gendered policies (Vasey, 2011); and for women to undertake physical exercise freely (Van der Boor et al., 2020; Walther et al., 2021) contributing to both physical and mental wellbeing. Participants in a UK study expressed feeling empowered by knowing their rights and access to legal systems, differing from origin countries where 'informal' laws had caused insecurity, stress (Van der Boor et al., 2020), and coercion through institutional bribery and corruption (Walther et al., 2021). Stress was reported as a result of unmet expectations at settlement (Ikafa and Hack-Polay, 2018; Rees et al., 2009) or pending legal status (Hordyk et al., 2015).

2.3.2. Discrimination & racism

Discrimination and racism occurred in resettlement countries (rather than origin country), and was primarily linked to reports of negative psychological and mental health outcomes including depression, anxiety, and stress (Baranik et al., 2018; Bartlett et al., 2017; Copelj et al., 2017; Drolet and Moorthi, 2018; Humam et al., 2017; Ikafa and Hack-Polay, 2018; Osman et al., 2020; Riordan and Claudio, 2021; Sampson and Gifford, 2010; Van der Boor et al., 2020; van Liempt and Staring, 2021; Vasquez Guzman et al., 2020; Vitus, 2022; Ziersch et al., 2020). A quantitative Canadian study reported perceived discrimination as more likely to impact mental health among refugee men than women (n = 152) (Beiser and Hou, 2017). Discrimination was often based on physical or verbal signifiers such as skin colour (Riordan and Claudio, 2021), non-Anglophone name (Baranik et al., 2018), literacy level or accent (Baranik et al., 2018; Vasquez Guzman et al., 2020), or for Muslim girls and women wearing a hijab (Caxaj and Berman, 2010; Humam et al., 2017; Osman et al., 2020; van Liempt and Staring, 2021; Ziersch et al., 2020). Othering and stereotyping were often at the core of discriminatory experiences including being labelled as 'dirty' (Drolet and Moorthi, 2018), a 'terrorist' (Bartlett et al., 2017), or an 'intruder' (Vitus, 2022). Experiences, or fear of verbal (Copelj et al., 2017; Osman et al., 2020; Ziersch et al., 2020) or physical (Sampson and Gifford, 2010; Van der Boor et al., 2020; Ziersch et al., 2020) abuse in public places including parks, or on public transport, were well noted in the identified studies. Workplaces (Patil et al., 2010; Van der Boor et al., 2020), realtor (Oudshoorn et al., 2020; Ziersch et al., 2020) and health care services (Paudyal et al., 2021; Vasquez Guzman et al., 2020; Ziersch et al., 2020) were places of discrimination or ostracization, with one US study reporting workplace discrimination being linked to physical exhaustion (Patil et al., 2010).

2.3.3. Employment & productivity

Work-related stress has effects beyond merely reducing employment capabilities. Unemployment, underemployment, and stress in the workplace lead to additional psychological and symbolic impacts for refugee populations. Unemployed refugees experienced higher rates of psychological distress (Sulaiman-Hill and Thompson, 2012) and poverty-induced physical health impacts (Dowling et al., 2020). Depression, stress, and anxiety were found to follow an inability to access work (Van der Boor et al., 2020), doing work different to what one was used to (Dharod et al., 2013) and particularly for men, an inability to provide for the family (Dowling et al., 2020). Deteriorating physical

health as a result of illegal, unsafe and poorly paid work was also reported (Dowling et al., 2020; Rees et al., 2009), including reproductive health (Patil et al., 2010) and psychological stress (Dowling et al., 2020; Rees et al., 2009). Conversely, productivity and purpose were the most pronounced themes related to trauma recovery (Hess et al., 2019; Kivling-Boden and Sundbom, 2002; Walther et al., 2021). Helping others (Alessi, 2016; Daou et al., 2021; Walther et al., 2021), working on a joint project (Momartin et al., 2018), or connecting with the local community (Van der Boor et al., 2020) were protective factors to wellbeing and decreased depression.

2.3.4. Access to health and support services

Access to social services was an important contributing factor to positive placemaking. Specific migrant services during the first stages of resettlement offered general assistance, social support (Drolet and Moorthi, 2018; Van der Boor et al., 2020), and links to legal services assisting psychological wellbeing. However, limited service caused stress (Drolet and Moorthi, 2018; Weine et al., 2014). Some respondents preferred refugee-specific services, as opposed to mainstream, due to holistic approaches that understand complex issues such as the impact of family separation (Savic et al., 2013).

In Australia, refugees voiced feeling relieved knowing they had access to universal public healthcare once resettled (Dowling et al., 2020). This was not the case in the US, where the direct cost of healthcare caused significant stress and financial strain (Patil et al., 2010). Refugees experienced a lack of consideration of cultural needs in housing allocation (Van der Boor et al., 2020) and healthcare (Vasquez Guzman et al., 2020). Those resettled in the UK (Paudyal et al., 2021) and Germany (Walther et al., 2021) discussed how stigma had impacted their decision to approach mental health services in fears of being labelled as 'crazy'. Specific migrant services during the first stages of resettlement offering general assistance, social support (Drolet and Moorthi, 2018; Van der Boor et al., 2020), and links to legal services (Drolet and Moorthi, 2018; Weine et al., 2014), assisted psychological wellbeing, however limitations to ongoing services also caused stress (Drolet and Moorthi, 2018; Weine et al., 2014). Difficulties navigating public services (e.g. postal service) in the US led to depression (Vasquez Guzman et al., 2020).

3. Discussion

The purpose of the review was to understand how aspects of placemaking are relevant to the health and wellbeing of refugees who had permanently and recently (within the last 10 years) resettled in high-income contexts. Studies in our review showed that place-making plays a critical role in mediating refugee experiences of new lives and social spaces, echoing a large body of geographical research on difference, inequality and encounter in diverse and multicultural cities (e.g. Amin, 2002; Fincher and Iveson, 2008).

The dominant tradition of research on resettlement identifies 'risk factors' and 'stressors' framing refugee migration experiences and health outcomes (see e.g. (Beiser and Hou, 2016; Chen et al., 2017a; Riordan and Claudio, 2021)). Drawing on these strands of research, our review departs from this work by integrating a geographical dimension which unearthed the multiple, complex interactions in place-making that contribute to different mental and physical states for refugees. Indeed, as urban geographers have also argued (Pykett, 2022; Richaud and Amin, 2019), the process of engaging with a place and its link to health and wellbeing is not reducible to categories of 'risk' or 'vulnerability' (Ahmed et al., 2017; Beiser and Hou, 2017; Sulaiman-Hill and Thompson, 2012); nor is place a simple or uniform backdrop for situations that refugees are passively exposed to. Instead, by taking an expansive approach we found diverse practices, activities, and relationships across material/physical, psycho-social and structural aspects of place-making that can be conducive to the process of re-territorialization or derail it. Our findings bring into view how place-making is negotiated through refugee *practices and agency*, and *processes* of inhabitation and 'situated encounters' (Wilson, 2016) in which place plays a crucial role – with various and dynamic effects that exceed straightforward ideas of refugee "stress" and "mental disorder" (Fazel et al., 2005), or "coping" (Ikafa and Hack-Polay, 2018; McGregor et al., 2015). At the same time, many studies in this review also reveal that possibilities and opportunities for place-making unfold amidst social and structural constraints (political, material, institutional and symbolic resources and discourse) that continue to prove central to refugee lives and experiences of 'resettlement'.

Our review found that place-making is experienced at *multiple, nested scales* (home, neighbourhood, city, society), including: in the country of resettlement and through transnational connections to one's home country; in public places and in contact with institutions; in local sites of neighbourhood encounters, or more demarcated migrant spaces. As such, this review complicates the idea that refugee health and wellbeing can entirely be understood via assessments of policy and services, disadvantage, characteristics of habitat, and availability of services or amenities. Rather, our review demonstrates it is the affordances of both the *material* and *social environment* that shape health and wellbeing for refugees through a process of *actively negotiating* the constraints and possibilities of a new place. For example, housing is important for refugees as a physical environment that provides good living conditions and safety (Ziersch et al., 2017), but even more so when it is a site of agency (deciding where to live, how to arrange one's home) (Due et al., 2020), and what kind of homemaking activities can take place in that space (Humam et al., 2017). Qualities and resources of the built environment reflecting locational advantage, such as spaces of leisure are significant for refugees' experiences of resettlement because they provide places for fulfilling activities and a respite from poor living conditions (Hordyk et al., 2015), and create 'places of sociality' (Sampson and Gifford, 2010). Participating in community or sports clubs can contribute to social belonging and enable a sense of autonomy and future-oriented thinking, which in some cases, result in positive wellbeing effects, and resilience (Dowling et al., 2020; Harwood et al., 2021). Hence, health and wellbeing for recently settled refugees is connected to the social and psychological dimensions of places, as much as their physical attributes.

Framing our investigation through place-making as a situated, relational approach that foregrounds 'how lived environments feel to those who inhabit and engage with them' (Richaud and Amin, 2019, p.S8) and how that in turn influences mental and physical health, broadens a 'social determinants of health' approach. Conceptually and methodologically, place-making opens up a more expansive view of refugees' complex lived experiences of resettlement. Place-making dynamics are both productive and attuned to indeterminacy, poised in the interplay between people and habitat, individual and collective factors, and in 'situations, spaces, and atmospheres of place' (Richaud and Amin, 2020, p.99). A focus on experiential, situated encounters through place-making for instance, expands our understanding of social connectedness beyond simple causal relationships (Yang et al., 2016). The studies we reviewed show refugees often seek a variety of connections with people and places, yet such relational complexities are not obvious barriers or enablers to health and wellbeing; but instead produce mixed outcomes (e.g. a reduction in depressive symptoms when socialising both inside and outside of one's cultural group) (Vitus, 2022; Walther et al., 2021). It is the reciprocal relations between subjects and their environments borne out of economies of affects, norms, institutional and material means, accumulated experiences, and social and structural positions/identities that mediate and give rise to different experiences of psychological (ill) health, resilience, and emotional wellbeing in specific sites and situations. Qualitative, ethnographic studies in geography have established this well. For example, the availability of urban greenspaces and other public spaces (Rishbeth et al., 2019), or occasional conversations with locals (Huizinga and van Hoven, 2018) in themselves are not enough to foster wellbeing and

belonging for people marked as different including migrants and refugees (Biglin, 2020; Wise et al., 2018). Sustained and repetitive encounters in mundane sites, and in ways that do not reify refugee status or identity dimension are significant along with addressing barriers to access and stigma or fear (Huizinga and van Hoven, 2018) (van Liempt and Staring, 2021) (Patil et al., 2010). Programs and deliberate strategies to facilitate access and experiences of diverse therapeutic places are therefore needed (Turner et al., 2020).

Our emphasis on place-making therefore does not imply a dichotomy between psychosocial and structural factors. While place-making is eminently social, our findings show encounters do not just happen - as if by osmosis - and that some environments provide more affordances than others. The structural components of social connection, relative locational (dis)advantage, and access to resettlement support and health services remain key issues. For instance, we found evidence that participation in places that recognise and legitimise one's culture, language, or religion is linked to wellbeing for refugee children (Bartlett et al., 2017; Vitus, 2022); these contribute to maintaining transnational ties to home countries which are additional vectors of psycho-social wellbeing. Hence, claims to difference and 'politics of recognition' (Fincher and Iveson, 2008) that legitimise diverse and particular experiences while not forcing reductive 'ethnic' or refugee identity categories can enable positive place-making.

Pathways to enhance psycho-social wellbeing through place-making for recently resettled refugees hinge on language competency (Vasquez Guzman et al., 2020), meaningful employment (Momartin et al., 2018), financial capacity, and the presence of family (Dowling et al., 2020), but also social attitudes (Vitus, 2022) and racial bias (Drolet and Moorthi, 2018) within host countries and from authority figures, media, government, and broader social discourses (Copelj et al., 2017; Humam et al., 2017). Routine othering, stigmatisation and even abuse experienced by refugees (Ziersch et al., 2020) also erode sense of self, belonging and hope, leading to poorer mental health outcomes (Beiser and Hou, 2016). Racism and discrimination are pervasive and negatively impact refugee's access to employment or housing and as a result, the possibility of inclusion in a new place, calling for anti-racism strategies and programs that address these issues within resettlement societies.

While our selection criteria for the review focused on permanently resettled refugees and therefore excluded asylum seekers and temporary visa holders, we want to acknowledge this group is likely to experience place-making in different ways, whether in transit countries or in host countries where they are seeking to resettle. Achieving permanent refugee status is associated with positive health and wellbeing outcomes, highlighting the role of immigration policy in shaping the possibilities and experiences of place-making in profound ways (Van der Boor et al., 2020; Walther et al., 2021).

The literature increasingly recognises that places are not fixed; nor are they the sum of physical attributes and services like parks, community centres and libraries. This review reveals that place for recently resettled refugees is relational and *plural*: as agentic subjects, refugees create and embrace a multidimensional understanding of belonging and connection to place that accrues over time, and can build resilience and wellbeing. By approaching the question of refugee health and wellbeing through an expanded lens of place-making that considers physical/material, psychosocial and structural aspects, a more nuanced and complex epistemological approach can be taken to future research in this field. In recognising this epistemological complexity, discourse and research in refugee health and wellbeing may be better positioned to consider the central role of place-making, which in turn may provide an opportunity to enhance the appropriateness and accessibility of strategies and programs aimed at benefiting resettled refugees.

Limitations

This systematic review was limited to peer-review and English language articles, and therefore may have missed potentially relevant information in grey literature articles, books, theses, and languages other than English.

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Declaration of competing interest

None to declare.

Data availability

Already published secondary data was used in this review

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