Mental health screening approaches for refugees and asylum seekers: A protocol for a scoping review

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1. INTRODUCTION

The number of international refugees is at an all-time high. Approximately 79.5 million people around the world have been forced to leave their homes, and nearly 26 million are considered refugees. (UNHCR, 2020). Of these, 1.4 million refugees will be in need of urgent resettlement in 2020 (UNHCR, 2019a). 'Resettlement' is the selection and transfer of refugees from a State in which they have sought temporary protection to a third State that has agreed to admit them - as refugees - with permanent residence status. The status provided by the resettlement State ensures protection against refoulement and provides a resettled refugee and his/her family or dependents with access to civil, political, economic, social and cultural rights (UNHCR, 2019b). Providing adequate healthcare services, particularly mental health care, to this increasing population of refugees is a global challenge for many healthcare systems.

Refugees encounter many risk factors for poor mental health outcomes before, during and after migration and resettlement. Such factors include exposure to trauma or economic hardship, experience of physical harm and separation, and poor socioeconomic conditions once resettled, such as social isolation and unemployment (WHO, 2018). Refugees are at risk of developing common mental health disorders including depression, anxiety, posttraumatic stress disorder (PTSD) and related somatic health symptoms (Kirmayer et al., 2011, Kirmayer & Pedersen, 2014; Steel et al., 2009). Epidemiological studies indicate that the age-standardized point prevalence of PTSD and major depression in conflict-affected populations is estimated to be 12.9% and 7.6%, respectively (Charlson et al., 2016). As a comparison, it has been estimated that approximately 4.4% of the world population suffers from major depression (WHO, 2017) and 3.3% from PTSD (Stein et al., 2014). However, the true prevalence of common mental disorders among refugees could

be higher since there is no systematic or consistent approach to detect and diagnose mental disorders in this population (WHO, 2018).

Pre-resettlement overseas health assessment represents an important component of the migration process for refugees. Health assessment is essentially a medical examination, usually conducted by a registered medical practitioner (or "panel physician") based on a criteria set by the resettlement state (Wickramage & Mosca, 2014). Health assessments are conducted as a measure to limit or prevent transmission of diseases of public health importance to their host populations; and to avert potential costs and burden on local health systems (Wickramage & Mosca, 2014). These 'overseas' assessments support the health of migrating populations as well as protect domestic public health, promote collaboration with international health partners, and strengthen understanding of the health profiles of diverse arriving populations (Mitchell et al., 2019). Results are provided to local authorities so that appropriate care can be arranged for the refugees concerned on arrival. These medical exams do not presently routinely screen for common mental health concerns. Providing early care for treatable and common mental health conditions can help refugees benefit from their education, develop positive relationships, reduce intergenerational trauma, gain access to employment, and ultimately lead to more meaningful and productive lives. Adopting appropriate early screening instruments is therefore an important first step to integrate care for common mental disorders among refugees into existing primary healthcare services (Ali et al., 2016). If refugee health assessment processors are to meaningfully contribute to public health good, then they need to overcome exclusionary approaches, be linked to the national health systems, and be complemented by health promotion measures to enhance the health-seeking behavior of refugees (Wickramage & Mosca, 2014). There are 24 Resettlement States (See Appendix I) for whom up-to-date evidence on mental health screening approaches for refugees would be beneficial.

The majority of synthesized literature on refugee mental health to-date focuses on the prevalence of mental illness (for example, Amiri 2020; Morina et al., 2018; Blackmore et al., 2020), access to mental health services (for example, Due et al., 2020; Satinsky et al., 2019) and tailored interventions (for example, Hassan & Sharif, 2019; Gruner et al., 2020). To our knowledge, there is limited available evidence which characterizes the purpose, tools and procedures specific to assessing mental health among refugee populations. One systematic review identified only 7 screening tools for trauma and mental health assessment in refugee children (Gadeberg et al., 2017). Older reviews suggest that more tools have been used among adult populations, however the authors concluded that they had limited or untested validity and reliability in refugees (Hollifield et al., 2002; Davidson et al., 2010).

To date, a wide range of screening tools are available to detect common mental health disorders, but it remains unknown as to which have been specifically developed and implemented for refugee populations. This scoping review aims to offer preliminary work in this area by mapping evidence on existing and emerging mental health screening approaches for resettling refugees and asylum seekers.

2.   RESEARCH OBJECTIVES

The objective of this scoping review is to map and characterize mental health screening approaches for refugees and asylum seekers. This review aims to inform country-level resettlement policies and practices regarding identification of mental health conditions and linkage to care by addressing the following research question:

What are the characteristics of existing and emerging approaches to mental health screening for resettling refugees and asylum seekers? Specifically:

- ➢ In what setting(s) has refugee mental health screening been conducted?
- ➢ At what point in time during the migration pathway (pre-departure, post-arrival) is screening conducted and for what purpose (admissibility, identifying urgent needs, continuity of care, improved health and/or integration outcomes, other)?
- ➢ What tools have been used in the refugee population, and what conditions do they screen for?
- ➢ In which language(s) and formats are mental health assessments delivered?
- ➢ Have any of these tools been adapted, validated or evaluated specifically for use among refugees?
- ➢ What approaches are used to screen in vulnerable subgroups (women, children, LGBTQ+, people with disabilities, survivors of violence/trauma)?
- ➢ What are the professional characteristics and training of individuals who administer mental health assessments?
- ➢ What are the lessons learned from pilots/approaches that have been tried on the ground?

3. METHODOLOGY

We followed the PRISMA-P reporting guidelines (Moher et al., 2015), methodology by Arksey and O'Malley (2005) and guidance from the Joanna Briggs Institute (Aromataris and Dunn, 2020) for the development of this protocol. We developed a logic model (see Figure 1, right) outlining the conceptual pathway for screening of common mental health disorders among refugees and asylum seekers.

Figure 1: Logic model of overseas mental health screening approaches for refugees and asylum seekers.
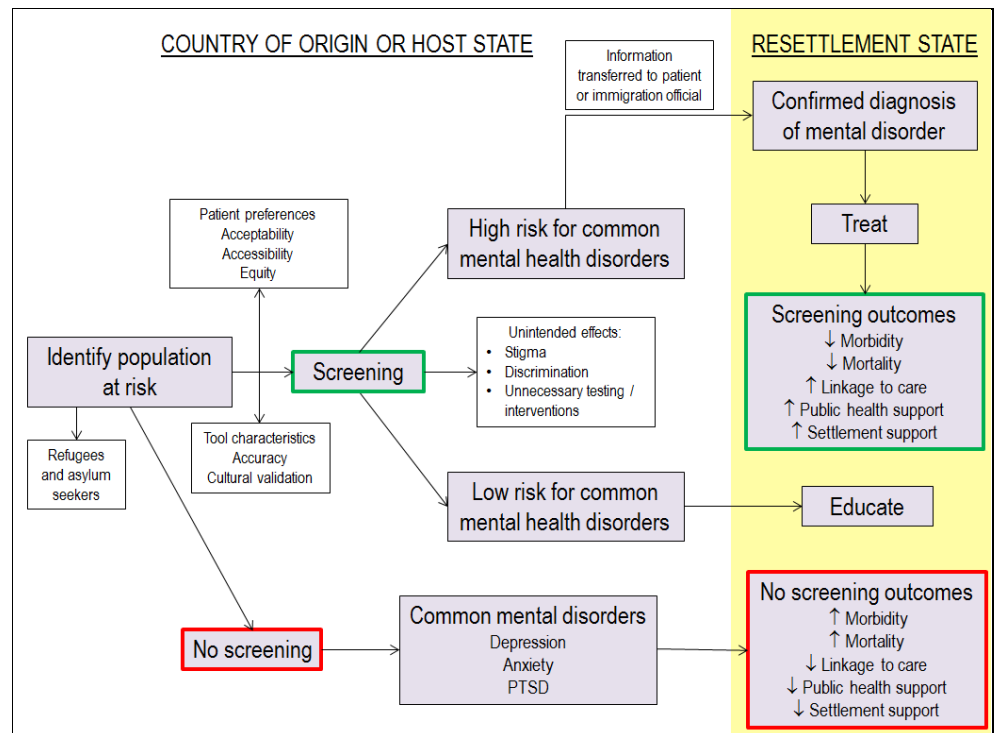
3.1 Eligibility criteria

We will include publications of quantitative, qualitative or mixed-methods designs that have been published in peer-reviewed journals, as well as unpublished grey literature which report on the approaches to screening of mental health disorders among 'resettling' refugees and asylum seekers of all ages. We define the 'resettling' period as 6 months prior to travel and 12 months after arrival in the resettlement country. We will exclude qualitative publications that focus on patient or provider experiences rather than characteristics of screening tools. As well, we will exclude systematic reviews of the literature but will hand-search their reference lists for

any relevant records. By "approach" we mean the process from assessment of mental health to transfer of results to the patient, immigration officials or healthcare providers, including the development of the assessment tool itself if it included pilot-testing and validation among refugees. We will consider documents published in any language. We will restrict the year of publication from 1995 to the present day to coincide with the creation of the Annual Tripartite Consultations on Resettlement (ATCR) and subsequent UNHCR Resettlement Handbook (UNHCR, 2019c).

Table 1: Eligibility criteria

SPIDER	Inclusion criteria	Exclusion criteria
Sample	Refugees and asylum seekers of all ages	All populations other than refugees and asylum seekers
Phenomenon of interest	Pre-settlement overseas screening approaches or post-arrival (<12 months) approaches for mental health	Screening for other health conditions Routine screening after 1 year post-arrival
Design	Experimental and quasi-experimental studies Observational studies Program evaluations Resettlement handbooks and manuals Policy documents Development & validation studies Clinical assessment studies	Systematic reviews Scoping reviews Literature reviews Commentaries/opinion Theoretical papers
Evaluation	Characteristics of screening approaches	Estimates of effect Experiences/views
Research type	Quantitative, qualitative or mixed-method documents published in peer-reviewed or grey literature	N/A
Other		
Year of publication	1995-2020	Prior to 1995
Language of publication	All languages eligible	N/A

3.2   Search methods

We will develop a search strategy in consultation with a health sciences librarian to search the following bibliographic databases using the keywords and MeSH terms in Table 2: EMBASE (Ovid), Medline (Ovid), PsycINFO (Ovid), Cochrane Central Register of Controlled Trials (CENTRAL) (Ovid), and Cumulative Index to Nursing and Allied Health Literature (CINAHL) (Ebsco).

Table 2: Preliminary search strategy (Medline)

1. (refugee* or migrant* or resettle* or immigra* or undocumented or newcomer*).ti,ab,kw.
2. (asylum adj1 seeker).ti,ab,kw.
3. (Forc* adj2 (immigrant* or migrant* or migration or displace*)).ti,ab,kw.

4. ((Undocumented or irregular) adj2 (immigrant* or migrant* or migration)).ti,ab,kw.

5. exp Refugees/

6. exp "Transients and Migrants"/

7. "Emigration and Immigration"/

8. or/1-7

9. (screen or screening or test or tests or tool or tools or instrument* or assess* or evaluation* or strateg* or diagnos* or protocol* or exam or exams or examination* or checklist*).ti,ab.

10. Symptom assessment/

11. 9 or 10

12. ((mental adj1 health) or anxiet* or anxious* or depress* or ptsd or posttrauma* or post-trauma* or trauma or suicid* or bipolar* or psycholog* or psychiatr*).ti,ab,kw.

13. Mental Health/ or Depression/ or Anxiety/ or Stress disorder, post-traumatic/ or psychological distress/ or exp suicide/ or suicidal ideation/ or exp Mental Disorders/

14. 12 or 13

15. 8 and 11 and 14

16. limit 15 to yr="1995 -Current"

In addition to searching bibliographic databases we will conduct a focused grey literature search. We will search OpenGrey for grey literature originating from Europe. We will also use a Google Custom Search Engine to search the websites of over 1500 non-governmental organizations (NGOs) and over 400 international governmental organizations (IGOs) (See Appendix II for a complete list). We will search the first 10 pages of results identified using these search engines. In addition, we will search government websites from the 24 countries listed in Appendix I. Finally, we will make three attempts to contact an immigration policy representative from each country of the Immigration and Refugee Health Working Group (Australia, Canada, New Zealand, United Kingdom, United States of America) and the International Organization for Migration (IOM) to identify any missing literature.

3.3   Screening and selection

A two-part study selection process will be used: (1) a title and abstract review and (2) full-text review. Two review authors will independently assess all potential studies and documents against a priori inclusion and exclusion criteria (Table 1). We will resolve any disagreements through discussion or, if required, we will consult a third review author.

3.4   Data extraction and management

We will develop a standardised extraction sheet. Two reviewers will extract data in duplicate and independently. They will compare results and resolve disagreements by discussion or with help from a third reviewer. In order to ensure the validity of the data extraction form, it will be piloted by both reviewers and accuracy of the content will be reviewed by a third reviewer. Reviewers will extract the following variables: Publication type and year, country, setting, study sample, purpose of assessment, timing of assessment, screening tool, language(s), mental health conditions assessed, number and types of items/domains,

response format/scale design, target populations (child/adolescent/adult), developed for refugee populations (y/n), adapted for refugee populations (y/n), validated for refugee populations (y/n), professional background/training of assessor, presence of interpreter (y/n), mode of administration, transmission of results, and author conclusions (lessons learned).

3.5   Critical appraisal

As a scoping review, the purpose of this study is to aggregate the findings and present an overview of the research rather than to evaluate the quality of the individual studies. As well, the breadth of study designs to be included would preclude a harmonized method to critically appraise and report the quality of evidence. Therefore, an overall assessment or appraisal of the strength of the evidence will not be performed.

3.6   Synthesis of results

We anticipate structuring results by geographic location, clinical context, resettling refugee population characteristics, and conditions screened for (as applicable). Results will be presented in tables with narrative description.

4. DISSEMINATION

We will work collaboratively with Immigration, Refugees and Citizenship Canada (IRCC) to produce a final policy-relevant report and reference library. Bruyère Research Institute may also draft a manuscript aimed for a peer-reviewed publication in an open-access journal and presentation of findings at conferences.

5. ROLE OF THE FUNDING SOURCE

This work is supported by Immigration, Refugees and Citizenship Canada, Government of Canada. The funders of the study will have no direct role in data collection, data analysis, data interpretation, or writing of the report. The corresponding author will have full access to all of the data in the study and will have final responsibility for the decision to submit for publication.

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APPENDICES

Appendix I: Resettlement States

Citation: United Nations High Commissioner for Refugees (UNHCR). (2018). UNHCR Resettlement Handbook and Country Chapters [Internet]. Accessed online 7/11/2019. Available from:
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Resettlement states:

1. Argentina
2. Australia
3. Belgium
4. Brazil
5. Bulgaria
6. Canada
7. Chile
8. Czech Republic
9. Denmark
10. Finland
11. France
12. Germany
13. Iceland
14. Ireland
15. Italy
16. Netherlands
17. New Zealand
18. Norway
19. Portugal
20. Romania
21. Sweden
22. United Kingdom
23. United States of America
24. Uruguay

Appendix II: Grey literature Google Custom Search Engine

- List of NGOs to be searched
- List of IGOs to be searched