"I PROCESSI DI RILEVAZIONE DELLE FORME DI DISAGIO DEI MIGRANTI"

MASSIMO CLERICI

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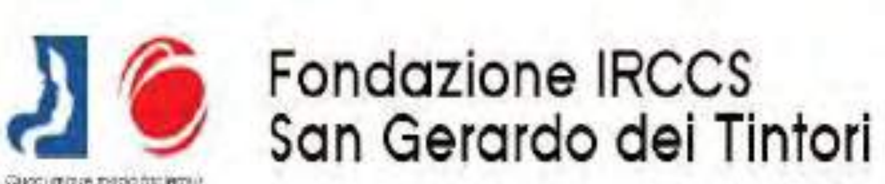

Working Group on Providing Mental Health Care for Refugees and Migrants

I processi di rilevazione delle forme di disagio dei migranti

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WORLD PSYCHIATRIC ASSOCIATION

WPA Position Statement on Europe Migrant & Refugee Crisis
In partnership with the Centre for Applied Research and Evaluation – International Foundation (Careif)

WHO Global Competency Standards for Refugee and Migrant Health Services – Strengthening the health workforce to provide quality health services to refugees and migrants

Segnalibro

- **WPA: Understanding needs of migrants for their mental health**
- **Una cornice operativa: il Progetto FAMI ATS Monza/Il Programma Innovativo Fondazione IRCCS San Gerardo Monza**
- **Assessment & Screening: opportunities ad barriers**

IS MIGRATION AN ISSUE?

Migration is increasingly seen as a high-priority policy issue

the traditional or newer forms of media focus frequently on negative aspects

Despite the often polarized political, public and media discussions and debates on migration, evidence, knowledge and balanced views continue to be critical to developing a better understanding of the various forms and manifestations of migration as well as how best to enhance its opportunities and benefits and respond to the challenges that it can present

IS MIGRATION A PUBLIC POLICY ISSUE?

- In recent years there have been a significant increase in displacement, both internal and across borders, which has largely stemmed from civil and transnational conflict, including acts of violent extremism outside actual war zones
- Current projection was that by 2050 international migrants would account for 2.6 per cent of the global population or 230 million (a figure that has already been surpassed)
- While most international migration occurs legally, some of the greatest insecurities are associated with illegal migration
- **Migration has helped improve people's lives in both origin and** destination countries and has offered opportunities for millions of people worldwide to forge safe and meaningful lives abroad
- But not all migration occurs in positive circumstances, however: we have in recent years seen an increase in migration and displacement occurring due to conflict, persecution, environmental degradation and change

Migration is also called as a process of people adapting to a new environment which involves making decision, preparations, going through the procedure, shifting physically to another geographical area, adjusting to the local cultural needs and becoming a part of the local system

The concept of migration is a broader one and different synonyms have been used

MIGRANTS

Movement of people to a new area or country in order to find work or better living conditions. There is no consensus on a single **definition of a 'migrant': migrants** might be defined by foreign birth, by foreign citizenship, or by their movement into a new country to stay temporarily (sometimes for as little as a year) or to settle for the long-term

ASYLUM SEEKERS

A person who has left his country of origin for any reason and applied for the shelter and protection in other country

REFUGES

A person who is residing outside the country of his or her origin due to fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion

Asylum seekers (AS) are individuals who request international protection and whose claims for refugee status have not yet been determined. An AS apply for asylum for persecution caused by race, religion, political belief, or nationality in their home country.

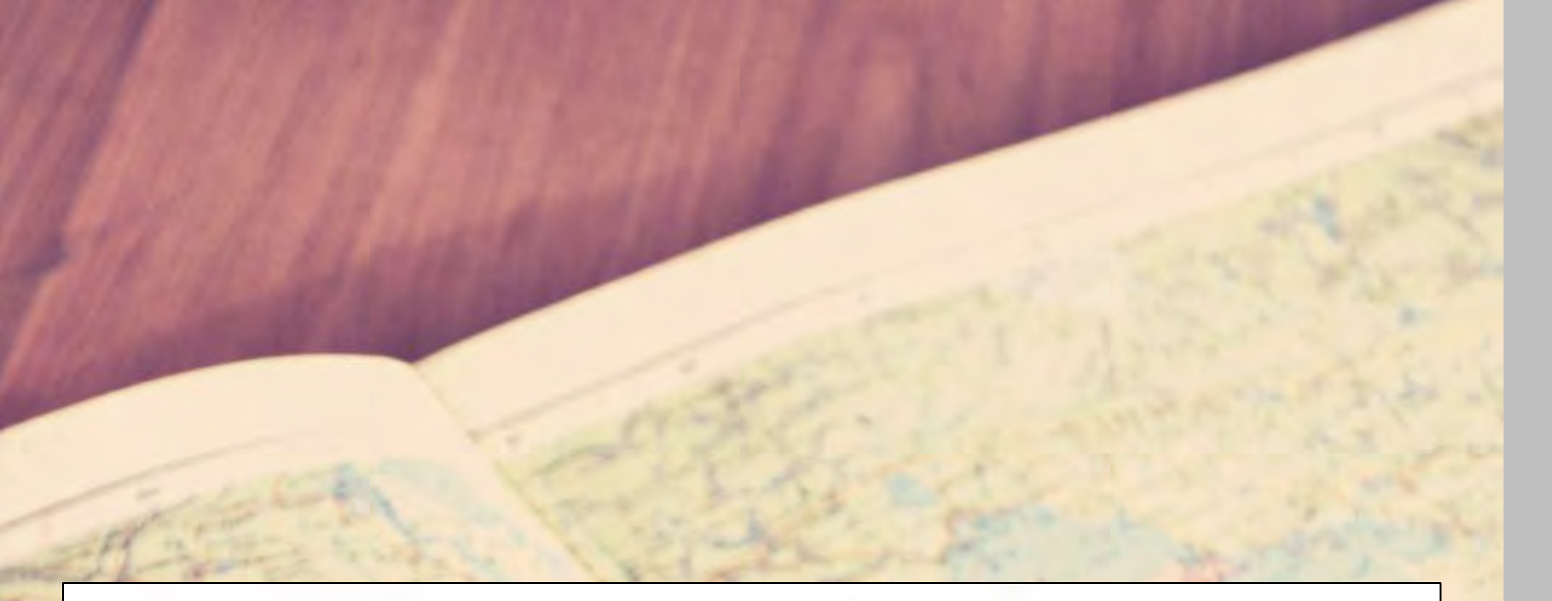
Refugees are people forced to leave their country to escape war, natural disaster or persecution. A refugee is an AS whose application for asylum has been successful.

Mental illness among refugees and AS is a major problem in these years and is continuously increasing. *Nevertheless, the initial period of resettlement for refugees and AS is difficul*t and it is a considerable cause of distress, so **it is crucial that a screening procedure for mental illness is performed also to plan the correct interventions**

Globally, there are an estimated **258 million international migrants, and 763 million internal migrants**

Globally, there are an **estimated 80 million people forcibly displaced** from their homes

Developing countries **host 86%** of the forced displaced population



Push factors	Pull factors
Not enough jobs	Job opportunities
Few opportunities	Better living conditions
Primitive conditions	Political and/or religious freedom Enjoyment
Desertification	Education
Famine or drought	Better medical care
Political fear or persecution	Attractive climates
Slavery or forced labor	Security
Poor medical care	Family links
Loss of wealth	Industry
Natural disasters	Better chances of marrying
Death threats	
Lack of political or religious freedom pollution, poor housing	
Landlord/tenant issues	
Bullying	
Discrimination	
Poor chances of marrying	
War	

Approximately 79.5 million people around the world have been forced to leave their homes, and nearly 26 million are considered refugees.

The COVID-19 pandemic has also created unprecedented delays in resettlement. In 2022, 1.47 million refugees will need urgent resettlement.

"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*.

Early screening and care for common mental health disorders is now recognized as a priority for resettlement programs.

Resettlement ensures protection against refoulement and provides a resettled refugee and their family or dependents with access to civil, political, economic, social, and cultural rights.

Conversely, an **asylum seeker** is someone whose claim for protection and resettlement has not yet been finally decided on by the country in which the claim is submitted

PHYSICAL & MENTAL HEALTH OF MIGRANTS

Rechel et al. 2013); Zimmerman et al. 2008; Raphaely and O’Moore 2010)

Variations in health among different migrant categories

- **For asylum seekers, research has focused on the physical and mental impact of conflict and war in some countries of origin; mortality and organic comorbidity, trauma associated with migration and settlement processes including isolation, loss of social status, poverty and insecure legal immigration status; and impact of government policies such as detention and dispersal in the receiving society**
- **Studies across European countries point to higher rates of depression and anxiety among asylum seekers and refugees compared to the national population or other migrant categories**
- **Particularly vulnerable groups are children, and women who have suffered sexual and physical abuse**

MIGRATION & MENTAL HEALTH

Migration influences human life and the environment around in many ways

- **A rare quantitative survey of women internally or internationally trafficked for sex work or domestic service in selected European countries found that 70% of women had experienced both physical and sexual abuse during trafficking and that the majority exhibited severe physical and mental health symptoms such as back and abdominal pain, headaches, dizziness, gynaecological infections, depression and anxiety**
- **Migration** involves certain phases to go through; hence, it **is a process**. Lack of preparedness, difficulties in adjusting to the new environment, the complexity of the local system, language difficulties, cultural disparities and adverse experiences may cause distress and a negative impact on mental well-being of such population

Trauma is a pivotal element in the development of psychiatric disease causing a short and long-term alteration. Migration is a particular type of psychological trauma consisting of exposure to stressful events, like torture, impoverishment, difficulties in adaptation to a new different environment, separation from friends and family. Factors like poor social support, individual and community low resilience are potential mediators between migration and mental health potential problems. *Post-traumatic stress disorders (PTSD), anxiety, depression, impulse control disorders (as different kinds of violence and substance-related and addictive disorders) seem to be more prevalent among refugee and AS*. **The screening procedure must be sensible to pre-migration vulnerability but also to stress or illness caused by the migration itself. Different factors can contribute to the fact that often psychiatric illness among this population remain undiagnosed**

MIGRATORY PROCESSES & *LINKS TO PSYCHOLOGICAL ADJUSTMENTS*

Pre-migration, is when the individuals decide to migrate and plan the move

Process of migration itself and the physical transition from one place to another, involving all the necessary psychological and social steps

Post-migration, is when the individuals deal with the social and cultural frameworks of the new society, learn new roles and become interested in transforming their groups

- Primary migrants may be followed by others. Once they have settled down and had children, the second generation is not a generation of migrants, but it will have some similar experiences in terms of cultural identity and stress

Pre-migration trauma like violence exposure, torture, and violent death of family members are strong predictors to depression and PTSD development in refugee, especially minors. Furthermore, post-traumatic stress reaction could persist and even increase over time many years after the resettlement.
This vulnerability may not only be linked to pre-migration trauma but also to **post-migration difficulties** likewise separation from family, difficulties with housing and asylum procedure, detention and unemployment.
Moreover, **a consistent problem in the evaluation of mental health in the migrant population is the administration of a cultural bias-free assessment scale**. *Cross-cultural differences consist in expectation, attitudes, language, setting and perception of an individual. People of some cultures may be not familiar with terms and subjects measured by the scale*. Additionally, the use of cultural free psychometric instruments or scales validate in the culture of interest has a pivotal role in giving clear and real data.
Another point of interest consists of the administration of scale that could be understood regardless of instruction and intelligence levels

MIGRATION & MENTAL HEALTH

- **Asylum seekers and refugees are more likely to experience poor mental health than the local population, including higher rates of depression, PTSD and other anxiety disorders**
- **The increased vulnerability to mental health problems that refugees and asylum seekers face is linked to pre-migration experiences (such as war trauma) and post-migration conditions (such as separation from family, difficulties with asylum procedures and poor housing)**
- **Research suggests that asylum seekers are five times more likely to have mental health needs than the general population and more than 61% will experience serious mental distress.[7] However, data shows that they are less likely to receive support than the general population on different topics…**

Fazel, Wheele, & Danesh (2005). Prevalence of serious mental disorder in 7,000 refugees resettled in Western countries: A systematic review. The Lancet, 365, 1309–1314; Tempany (2009). What research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: A literature review. Transcultural Psychiatry, 46, 300–315; Steel, Chey, Silove, Marnane, Bryant & van Ommeren (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. JAMA, 302, 537–549; Eaton, Ward, Womack & Taylor (2011). Mental Health and Wellbeing in Leeds: An Assessment of Need in the Adult Population. NHS Leeds; Aspinall & Watters (2010). Refugees and asylum seekers: A review from an equality and human rights perspective. Equality and Human Rights Commission Research report 52, University of Kent

1st TOPIC. SEXUAL VIOLENCE AGAINST WOMEN IN CONFLICT SITUATIONS

Sexual violence (SV) is common particularly in conflict situations. In recent decades, human rights groups have campaigned for sexual violence to be recognised as a crime and a tactic/weapon of war culminating in a summit convened in June 2014 by the UK **"to end sexual violence in conflict",** with up to 148 countries participating

Conclusions: Wartime sexual violence is highly traumatic, causing multiple, long-term negative outcomes. The number and quality of studies published does not match the significance of the problem. The findings highlight the need for care of the survivors and their relatives and raise concerns about how they and their children will be affected in the long term.

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2nd TOPIC. MIGRATION & LINKS *WITH VIOLENT EXTREMISM & TERRORISM*

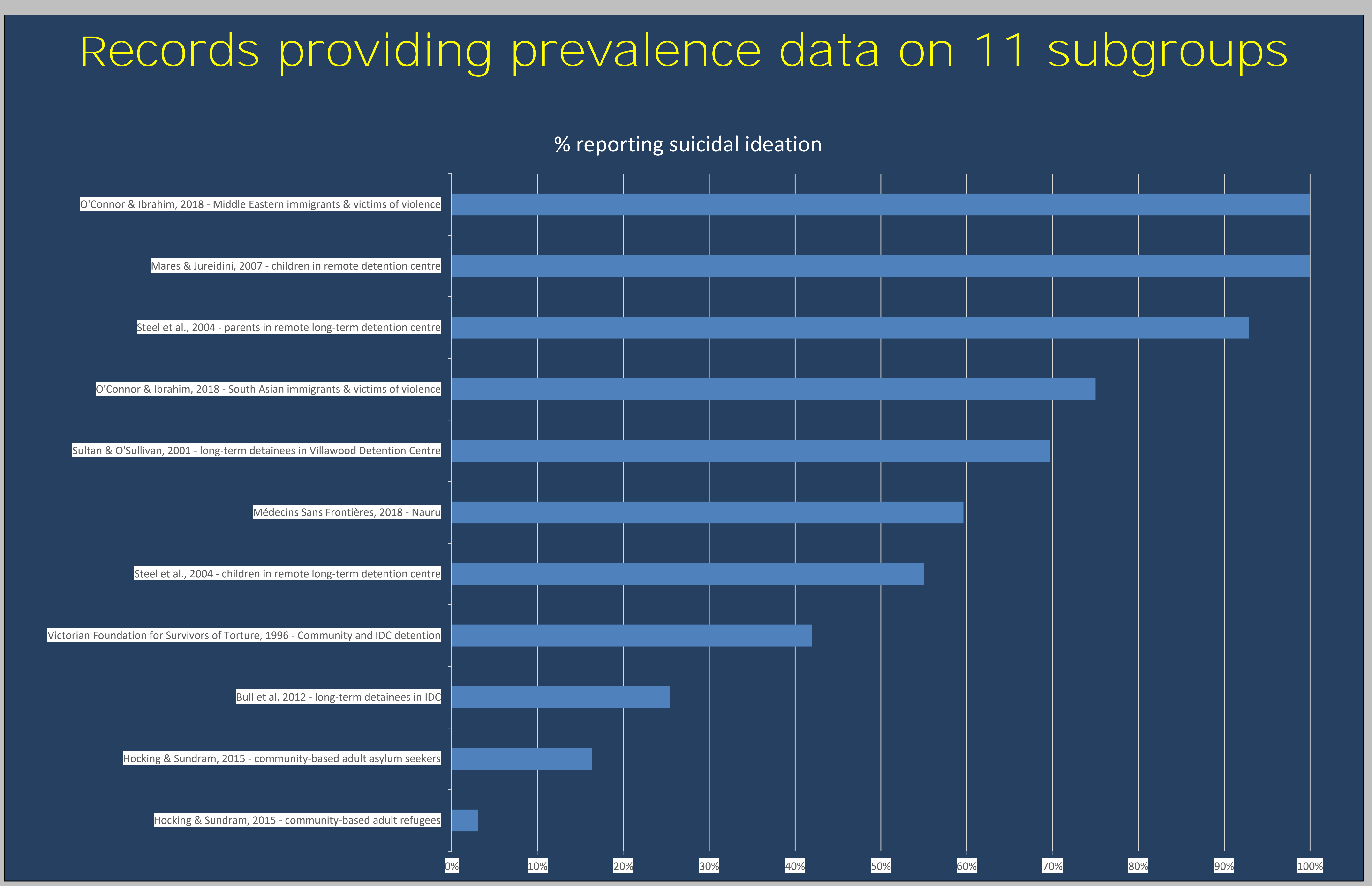
- Violent extremism as a driver for displacement and migration
- Risk of radicalization in refugee and possibly migrant transit camps and centres
- Risk of terrorist infiltration of migration and asylum flows
- The challenges of integration resulting in social exclusion

3rd TOPIC. SUICIDAL IDEATION

In a report called "Infinite Despair", Médecins Sans Frontières denounce the extreme mental health suffering of people detained in Nauru Island (Australia)

Among the 208 refugees and asylum seekers MSF treated in Nauru, 124 patients (60%) had suicidal thoughts and 63 patients (30%) attempted suicide. Children as young as 9 were found to have suicidal thoughts, committed acts of self-harm or attempted suicide

3rd TOPIC. RISK OF/ATTEMPTED SUICIDE



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**. *As a comparison, it has been estimated that approximately 4.4% of the world's population suffers from major depression and 3.3% from PTSD*. However, **the true prevalence of common mental disorders among refugees could be higher since there is no systematic or consistent approach to diagnose mental disorders in this population**. A health assessment is a medical examination, usually conducted by a registered medical practitioner based on criteria set by the resettlement state. **Health assessments are conducted as a measure to limit or prevent the transmission of diseases of public health importance to their host populations and to avert potential costs and burdens on local health systems**. These assessments support promote collaboration with international health partners, and strengthen understanding of the health profiles of diverse arriving populations. *Currently, there are 24 official resettlement states for whom pre-departure mental health screening approaches for refugees could be beneficial*

WPA's WORK & SOME SPECIFIC INITIATIVES

WPA POSITION STATEMENT ON SOCIAL JUSTICE FOR PERSONS WITH MENTAL ILLNESS (MENTAL DISABILITY)

BILL OF RIGHTS FOR PERSONS WITH MENTAL ILLNESS

WPA POLICY DOCUMENT on Global migration and the increasing number of minority groups, including migrants, asylum seekers, refugees and ethnic minorities

WAY FORWARD? WHAT CAN BE DONE?

BILL OF RIGHTS FOR MIGRANTS MENTALLY ILL

Right to accessible and affordable mental and physical healthcare,
Right to live independently in the community as other citizens,
Right to work and opportunities to work and protections at work,
Right to adequate income to meet their basic needs for food, housing, clothing and other basic necessities,
Right to accessible, integrated, affordable housing,
Right to training and education as available to other citizens,
Right to freedom of movement and removal of restrictions on free travel,
Right to own, inherit, and dispose of property, and to be provided adequate support to exercise this right,
Right to marry, have and adopt children, and raise families, with additional support when required,
Right to determine their future and make their own life choices,
Right to vote and be elected to public office,
Right to be recognized as equal before the law as other citizens, and the right to full protection of the law,
Right to be free from cruel, inhuman, degrading treatment, and punishment,
Right to confidentiality and privacy and, finally,
Right to participate in the cultural and social life of the community and practice a religion of their choice

RESPECT MIGRANT’s PERSPECTIVES

Understanding migration from migrants’ perspectives, principally by listening to and learning from migrants is limited. While all migrants make decisions before and during their journeys, some decisions being of greater consequence than others, and even involving life and death scenarios

- First, there have long been acknowledged distinctions between the ***desire*** to migrate, the ***intention*** to migrate and ***actual migration behaviour***
- Second, how migrants think about and undertake migration occurs in dynamic and sometimes fast-paced environments, so that people may need to respond to changes in circumstances quickly
- Third, there has been less of a focus on people who do not want to migrate, partly because remaining at home is often considered the norm

BARRIERS ACCESSING SERVICES

There are migrants who fall outside the existing health and social services, something which is particularly true for asylum seekers and undocumented migrants

- Exclusionary policies in relationship of access to health services on behalf of asylum seekers have been documented
- Undocumented migrants may not access health care services for causes such as administrative obstacles or fear of being reported to the police
- Lack of adequate information about the available health care facilities and communication (language) problems
- In the case of psychological problems, it may result an obstacle the fact that mental health problems may lead to stigmatisation of that group

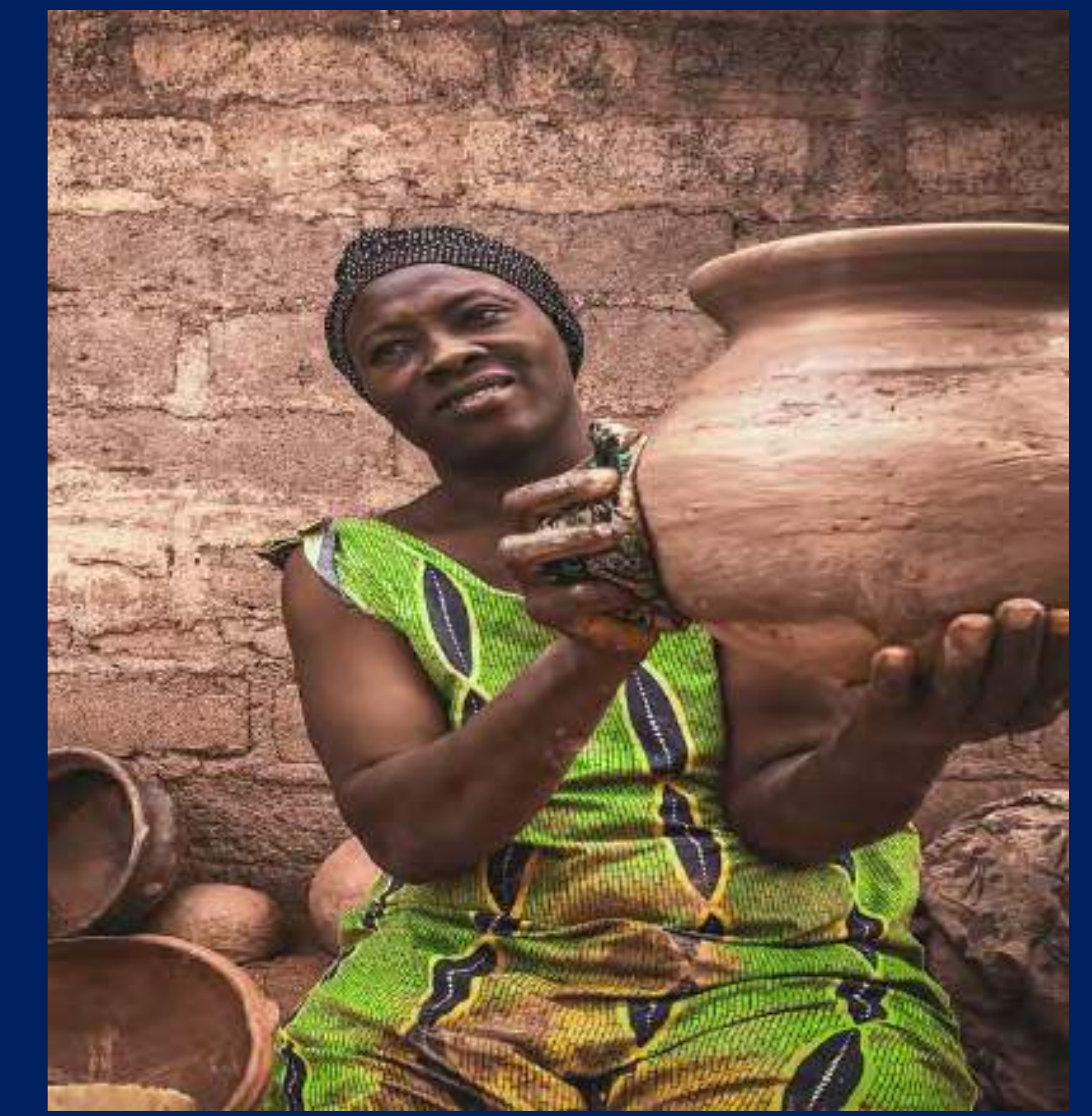
2019-23

PROGETTI FAMI - ASST MONZA

- Progetto FAMI ATS “Nuova Rete Salute Mentale”

- Progetto FAMI Ca.Re.

PROGRAMMA INNOVATIVO “MIGRANTI” - Fondazione IRCCS San Gerardo Monza



L’OMS

invita i Servizi di Cura ad essere sensibili alle esigenze dei richiedenti asilo e dei rifugiati

In questa popolazione

tuttavia l’accesso ai Servizi di Salute Mentale è ancora basso, per ragioni che vanno dalle barriere linguistiche, ad aspetti culturali, allo stigma rispetto alla sofferenza psichica

Carrer S., Meuti V., Catino E. et all (2011), Immigrazione, trauma, difficoltà vitali e psicopatologia. Uno studio preliminare in un setting di medicina generale, Rivista di psichiatria, 46, 2

Progetti FAMI (Fondo Asilo Migrazione Integrazione)

Obiettivo Specifico: 1. Asilo – Obiettivo Nazionale: ON 1 - Accoglienza/Asilo – lett. c –
Potenziamento del sistema di 1° e 2° accoglienza – Tutela della salute

Progetto FAMI ATS Brianza

Asst Monza
Asst Brianza
Asst Lecco
Rete Salute
Comunità Montana
Offertasociale

Progetto FAMI Ca.re.

Comune di Mantova — Sol.Co Mantova
Comune di Cremona — Sol.Co Cremona
Comune di Desio — Consorzio Comunità Brianza
Asst Mantova — Mestieri Lombardia
Asst Cremona
Asst Monza
Asst Spedali Civili Brescia

Programma Innovativo "Migranti" Regione Lombardia

Fondazione IRCCS San Gerardo Monza

Progetto FAMI “Salute Mentale”

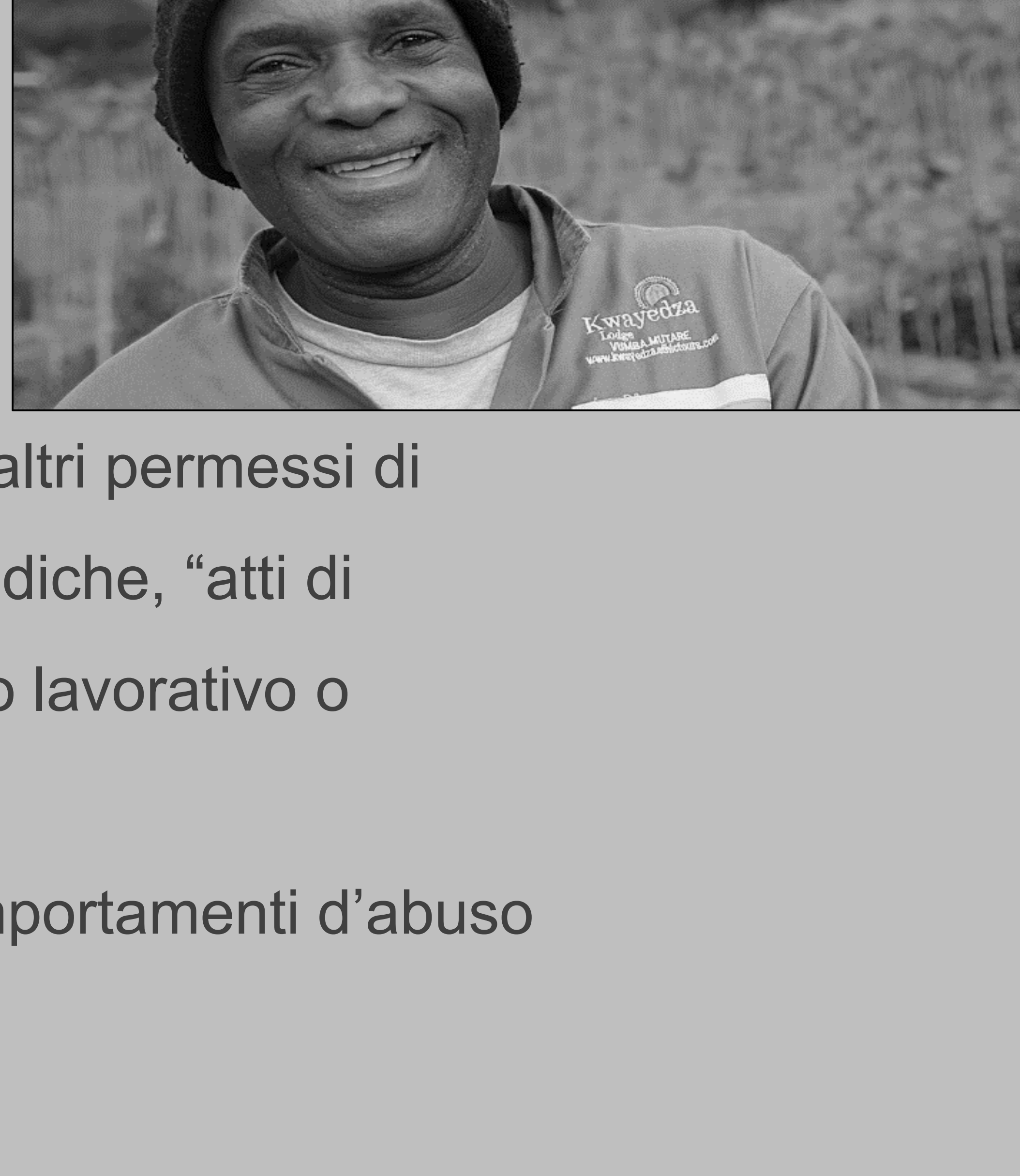
Nuova rete della salute mentale per i richiedenti asilo in ATS BRIANZA

OBIETTIVI:

- **tutelare la salute di richiedenti protezione internazionale e rifugiati in situazione di vulnerabilità** e, in particolare, sui titolari e richiedenti protezione che presentano quadri clinici psicopatologici manifesti, latenti o sub-clinici accolti nel territorio di competenza di ATS della Brianza (province di Monza e Brianza e Lecco)
- assicurare l’introduzione di un **sistema condiviso di rilevazione delle vulnerabilità**, in coerenza con gli obiettivi nazionali stabiliti nel PROGRAMMA NAZIONALE FAMI 2017
- intervenire attraverso il **rafforzamento della governance** del territorio, la sistematizzazione di percorsi per la presa in carico dei soggetti vulnerabili, la **formazione specifica** degli operatori sanitari nella diagnosi e trattamento del disagio di richiedenti protezione internazionale e rifugiati, **l’erogazione di servizi**, tra cui la sperimentazione di forme innovative di **residenzialità protetta**
- definire **linee guida territoriali** finalizzate a condividere ed omogeneizzare percorsi di presa in carico e prassi operative

Progetto FAMI “Salute Mentale”

Criteri d’accesso



1) Età >= 18 anni (con accesso anche a minori non accompagnati segnalati da ATS)

2) Migranti richiedenti asilo e titolari di asilo; Migranti con protezione sussidiaria; Migranti con altri permessi di soggiorno al di fuori della procedura di richiesta per: permesso di soggiorno calamità, cure mediche, “atti di particolare valore civile” (rilasciati dal Ministero), casi speciali (protezione sociale, sfruttamento lavorativo o sessuale, violenza, etc)

3) Migranti con forme di disagio psicologico e psichico, correlate a eventi traumatizzanti e comportamenti d’abuso avvenuti in fase pre-migratoria, migratoria o post-migratoria

4) Migranti residenti sul territorio di competenza dell’ ASST Monza

5) Adesione al progetto FAMI e firma del consenso informato

6) Possesso di permesso di soggiorno o documentazione amministrativa comprova soggiorno

<u>criteri di esclusione</u>**:**

1) Protezione umanitaria e umanitaria in transito (ex casi speciali in regime transitorio)

2) Protezione speciale per persone a rischio di persecuzione e tortura

3) Condanne penali in corso

4) Provvedimenti di espatrio in corso

Programma Innovativo Fondazione IRCCS San Gerardo Monza

CREAZIONE DI RETI DI INCLUSIONE SUL TERRITORIO

Creare, in collaborazione con realtà del territorio, una rete informale di enti - pubblici e privati - orientati all'inclusione dei AS/R, per facilitare:

- esperienze pro-sociali in contesti protetti dal rischio di traumatizzazioni secondarie (volontariato assistito e partecipazione attiva alle iniziative cittadine)
- ampliamento della rete sociale
- ***una più efficiente e consapevole fruizione delle risorse territoriali***

Attivare percorsi di inclusione per gli AS/R, in parallelo all'esistenza delle misure di protezione ad opera della Prefettura, può infatti agevolare:

- forme naturali di affiliazione
- processi di inclusione sempre più allargati e solidali agenti come fattore protettivo nel contenimento dei rischi di marginalizzazione e devianza a cui questo target può essere esposto (specie in fase di cessazione delle misure di accoglienza)

Quali obiettivi in ambito di salute mentale?

DALLA PRESA IN CARICO INTEGRATA AL TRATTAMENTO

- *Presa in carico precoce del disagio psichico/disturbo mentale in soggetti AS/R*
- *Definizione di un programma riabilitativo a carattere psico-sociale, se possibile*
- *Implementazione progetti di rete finalizzati all'inclusione sociale e lavorativa di migranti forzati con fragilità psichica*
- *Alfabetizzazione alla salute mentale con i target migratori più a rischio attraverso il continuo dialogo con le reti di prima e seconda accoglienza*
- *Promozione della cultura dell'inclusività sul territorio*

Interventi formativi

Interventi di formazione su specificità cliniche del target AS/R e di facilitazione all'avviamento di progetti di assistenza di rete con:

- Altre strutture DSM IRCCS Fondazione San Gerardo:
  NOA
  SERT
  Consultori
  Reparti malattie infettive
  Altri Servizi specialistici medici

- Enti territoriali:
  Servizi Sociali Adulti
  Servizi Sociali Famiglia e minori

- Altri attori: MMG; Avvocati

Interventi clinici

+ Percorsi di supporto psicologico alla salute mentale e di gestione culturalmente mediate della farmacoterapia
+ Percorsi di sostegno psico-sociale e socio-educativo
+ Case management (redazione progetti socio-educativi, monitoraggio percorsi, redazione relazioni, ricerca opportunità di estensione della rete, lavoro in rete con altri partner)
+ Attività centrata sull'ascolto che favorisca lo sviluppo di (a) una cornice relazionale protettiva rispetto allo stress legato ai processi di trans-culturazione e (b) l'aderenza alle attività del percorso riabilitativo mediante colloqui di:

- raccolta della storia migratoria
- facilitazione al superamento della barriera linguistica
- sostegno al progetto di vita (studio e lavoro)
- **Screening disagio psichico e assessment disturbi mentali**

IN PARTICOLARE

Screening e selezione degli strumenti di rilevazione

K10

(Kessler Psychological Distress Scale)

Depressione e ansia

Mancanza di evidenze di validità in studi su campioni multiculturali

SRQ-20

(Self Reporting Questionnaire WHO)

Disturbi mentali

Nato per popolazion dei Paesi Occidentali

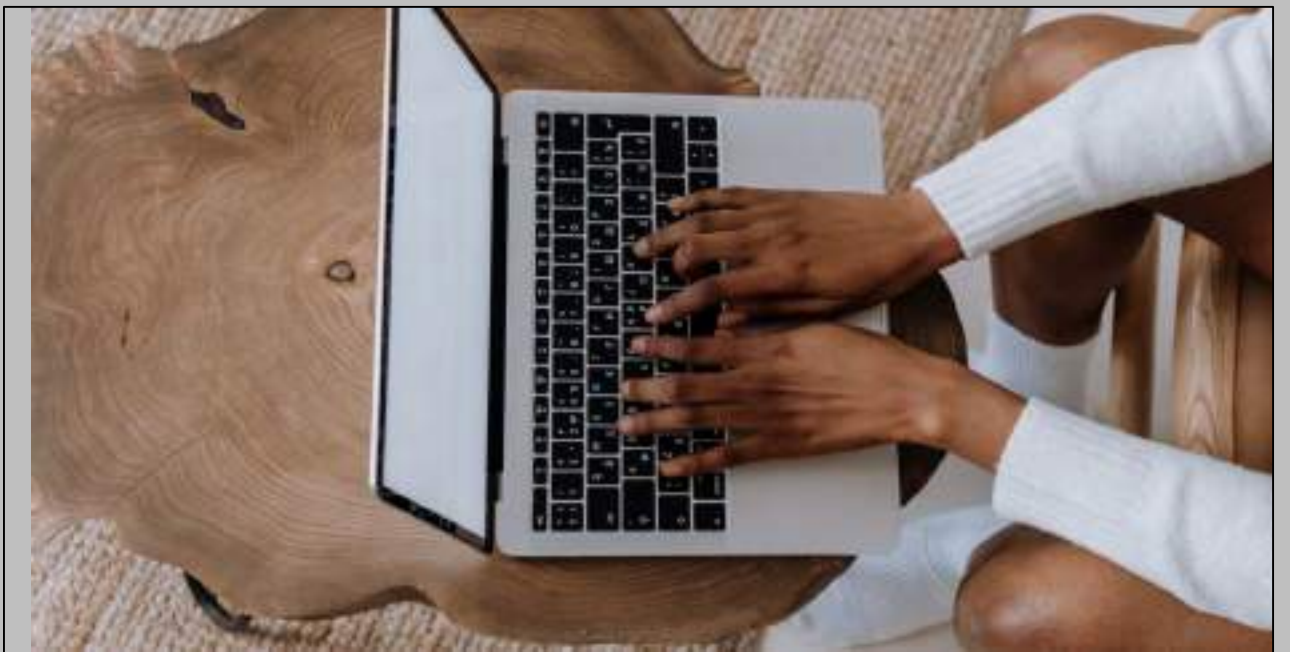
Non validato vs interviste psichiatriche standardizzate

RHS-15

(Refugee Health Screener 15)

Sviluppato per popolazioni di rifugiati, ma non validato su richiedenti asilo o vs gold standard

Da somministrare in setting clinici



STRUMENTI GOLD STANDARD

HSCL -25

(Hopkins Sympthom Checklist)

Disturbi depressivi

Valido anche su popolazione di rifugiati e migranti forzati

HTQ-R

(Harvard Trauma Questionnaire)

Disturbi trauma-correlati

Largamente utilizzato su popolazioni di migranti forzati

(utilizzate parte 1- eventi traumatici e parte 4- sintomi da trauma)

PERI-D

(Psychiatric Epidemiology Research Interview -Demoralization Scale)

Distress non specifico

Utilizzata con popolazioni provenienti da scenari bellici, popolazioni cliniche e comunità etniche

PMLDC

(Post Migration Living Difficulties Checklist)

Life stressor attuali

Utilizzata specificamente nella popolazione dei richiedenti asilo

Maj, 2018

EDITORIAL

Why the clinical utility of diagnostic categories in psychiatry is intrinsically limited and how we can use new approaches to complement them

DSM-5 Table of Contents

Section I: DSM-5 Basics

Section II: Diagnostic Criteria & Codes

Neurodevelopmental Disorders
Intellectual disabilities
Intellectual di...
...Hyperactivity Disorder
ADHD
Specific Learning Disorder
Motor disorders
Developmental Coordination Disorder
Stereotypic Movement Disorder
Tic Disorders
Tourette's Disorder
Persistent (Chronic) Motor or Vocal Tic Disorder
Provisional Tic Disorder
Other Neurodevelopmental Disorders
Other specified Neurodevelopmental

Unspecified Catatonia

Bipolar and Related Disorders
Bipolar I Disorder
Bipolar II Disorder
Cyclothymic Disorder
...Single & Recurre...
Persistent Depressive Disorder (Dysthymia)
Premenstrual Dysphoric Disorder
Substance/Medication Induced Depressive Disorder
Depressive Disorder Due to Another Medica... Cond.

Anxiety Disorders
Separation Anxiety Disorder
Selective Mutism
Specific Phobia
Social Anxiety Disorder (Social Phobia)
Panic Disorder
Panic Attack (Specifier)
...l Cond.

Acute Stress Disorder
Adjustment Disorders
...der
...tion Disorder
...lated Disorders
...Factors Affecting Other Medical
...ers
...ke Disorder
Hypersomnolen...
Narcolepsy
Breathing-Rela...
Obstructive Slee...
Central Sleep Ap...
Sleep-Related H...
Circadian Rhyth...

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Your Guide to DSM-5®
AMERICAN PSYCHIATRIC ASSOCIATION

DSM-III Diagnostic and Statistical Manual of Mental Disorders
DSM-III-R Diagnostic and Statistical Manual of Mental Disorders
DSM-IV™ Diagnostic and Statistical Manual of Mental Disorders
DSM-IV-TR™ Diagnostic and Statistical Manual of Mental Disorders
DSM-5 Diagnostic and Statistical Manual of Mental Disorders

American Psychiatric Association
DSM-5 Development

MA DI FRONTE ALLE PROFONDE MODIFICAZIONI SOCIALI IN CORSO ED ALLA NECESSARIA RIORGANIZZAZIONE DEI SERVIZI PSICHIATRICI SU NUOVE TEMATICHE COME SI COLLOCA OGGI LA DIAGNOSI IN SALUTE MENTALE?

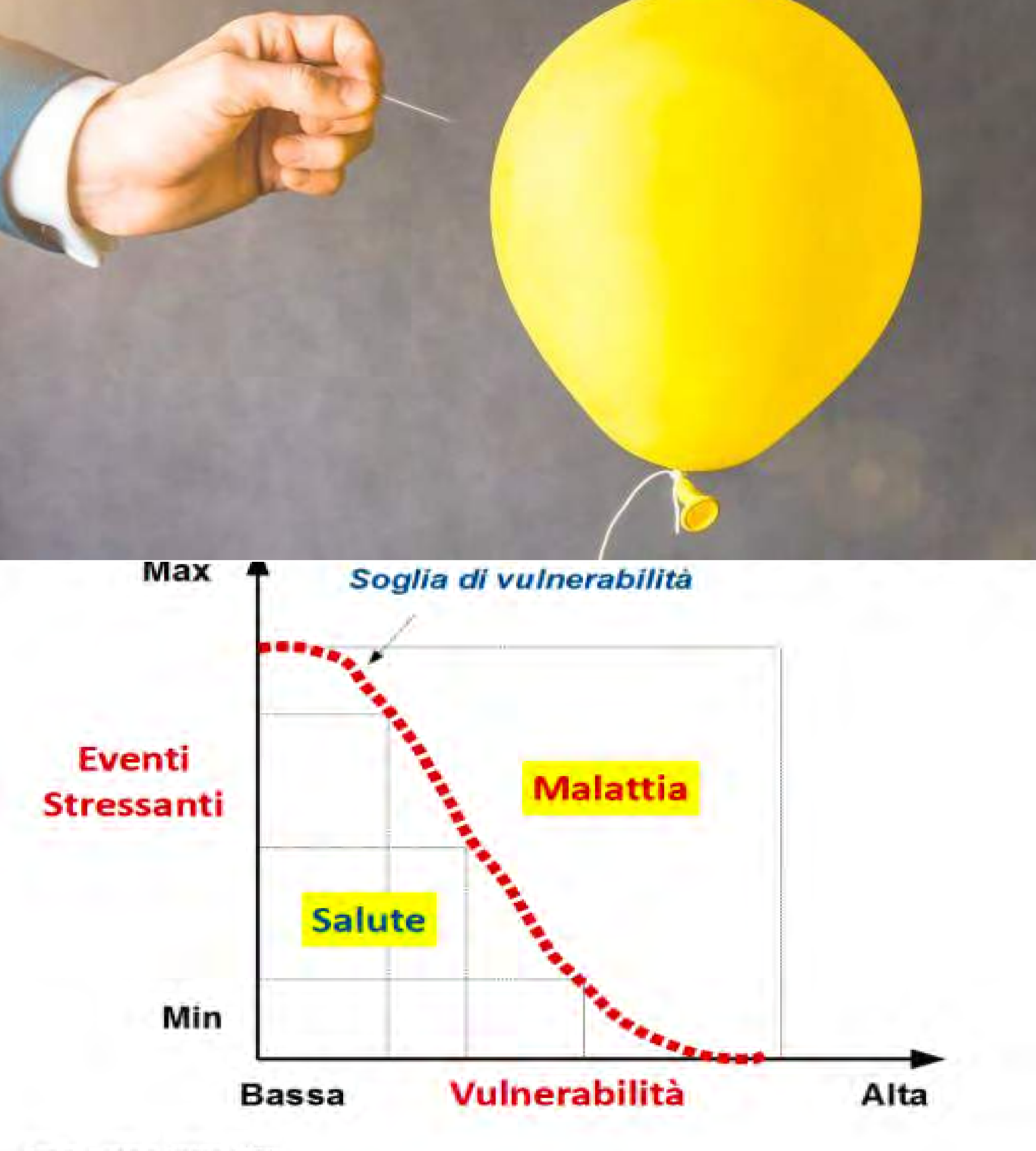
dalla diagnosi ancorata ai **modelli teorici** “classici” dell’eziopatogenesi onnicomprensiva, al **modello** causale **“aperto”** (vulnerabilità-stress), al **modello “narrativo”** personalizzato, fino al modello diagnostico su base epidemiologico-statistica dei sistemi categoriali DSM e ICD

Modello Vulnerabilità-Stress

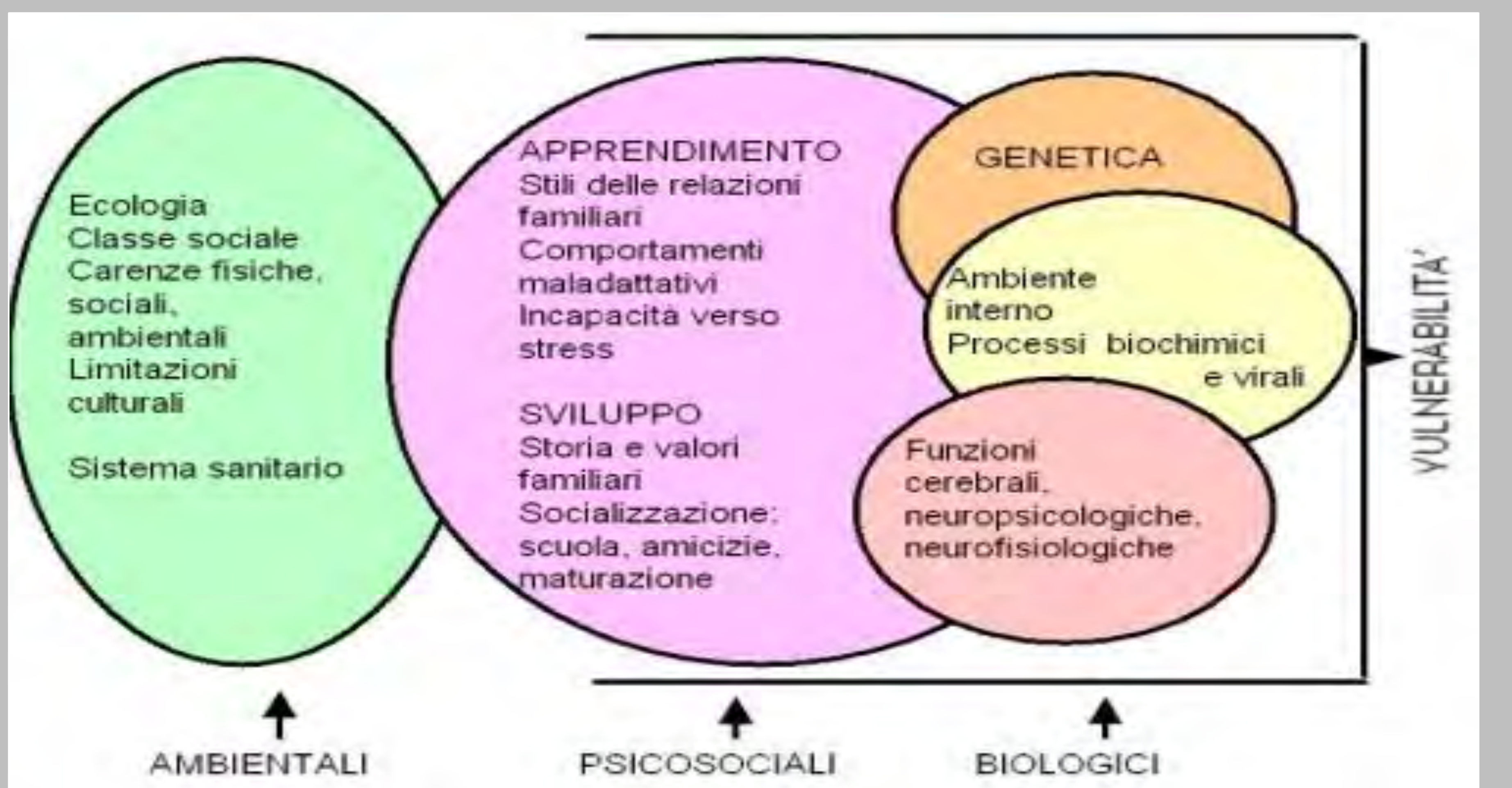
Il modello vulnerabilità-stress è una teoria della patogenesi dei disturbi mentali, che sottolinea l'effetto combinato di vulnerabilità genetica e stress

Il **modello vulnerabilità-stress** è una teoria esplicativa della patogenesi dei disturbi mentali, secondo la quale in alcune persone l'effetto combinato della vulnerabilità genetica e di fattori stressanti supera la soglia di adattamento bio-psico-sociale e favorisce la comparsa dei sintomi del disturbo mentale a cui la persona è vulnerabile (Zubin et al., 1992).

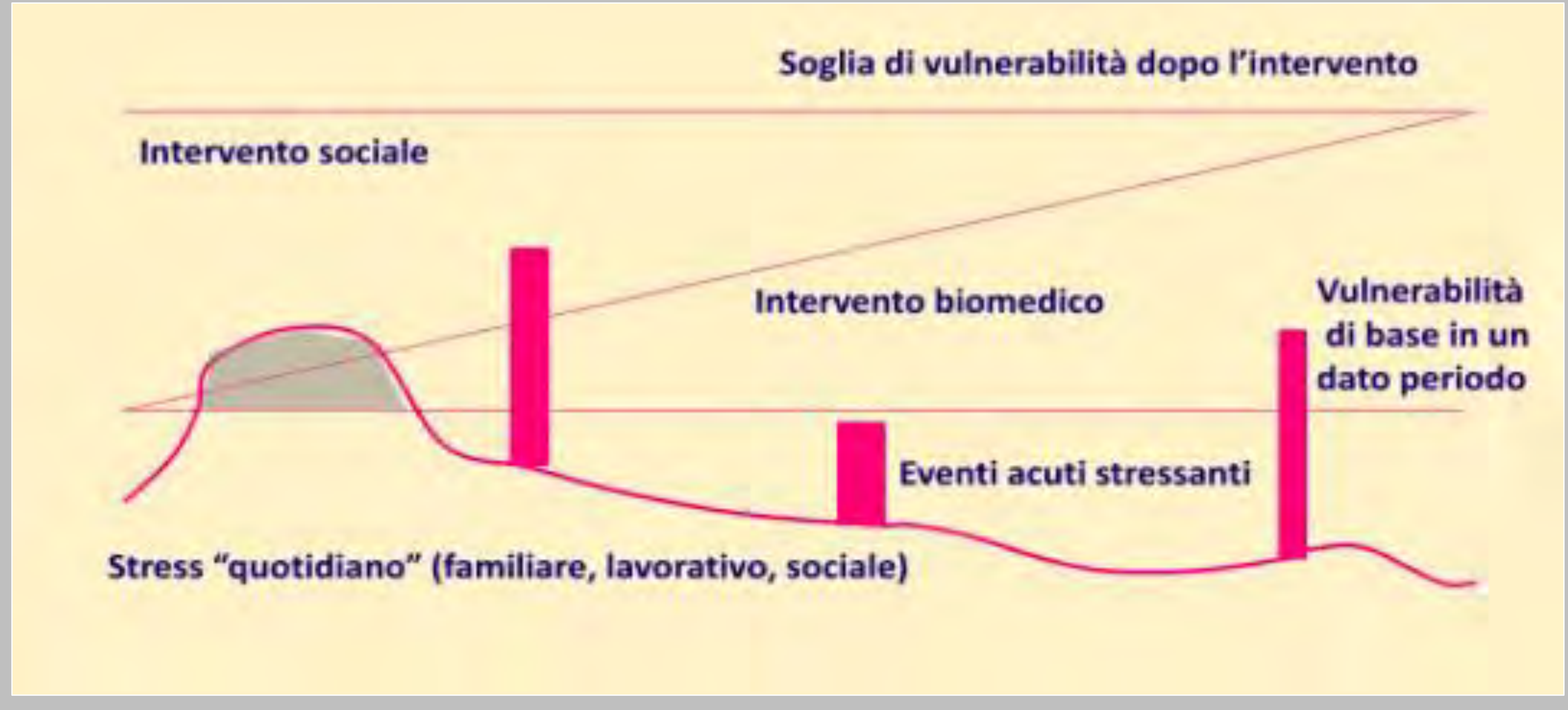
Per definizione, la vulnerabilità a un disturbo funge da antecedente all'insorgenza del disturbo. Termini come rischio e vulnerabilità (o diatesi) sono spesso usati come sinonimi, e in effetti non vi è dubbio che questi costrutti si sovrappongano sostanzialmente. Tuttavia è importante notare che, al contrario di quanto accade con i termini diatesi e vulnerabilità, che sono usati in modo intercambiabile, vulnerabilità e rischio non sono intercambiabili.



Come diversi ricercatori hanno osservato (ad esempio, Ingram et al., 1998; Luthar & Zigler, 1991; Rutter, 1987), il rischio descrive fattori associati o correlati e con una maggiore probabilità di portare a un disturbo. Tuttavia, la presenza del rischio suggerisce solo una maggiore probabilità di insorgenza di un disturbo; non specifica che cosa causa il disturbo. I fattori di rischio non sono informativi sugli effettivi meccanismi che determinano uno stato di psicopatologia. Ad esempio, il genere può essere un fattore di rischio ben consolidato per alcuni disturbi, ma questa sola conoscenza non è informativa sul perché le donne o gli uomini, a seconda dei casi, hanno maggiori probabilità di sperimentare determinati disturbi. Al contrario la vulnerabilità delinea in modo più chiaro le relazioni causali tra determinate variabili e insorgenza del disturbo.


Ecologia
Classe sociale
Carenze fisiche, sociali, ambientali
Limitazioni culturali
Sistema sanitario
APPRENDIMENTO
Stili delle relazioni familiari
Comportamenti maladattativi
Incapacità verso stress
SVILUPPO
Storia e valori familiari
Socializzazione: scuola, amicizie, maturazione
GENETICA
Ambiente interno
Processi biochimici e virali
Funzioni cerebrali, neuropsicologiche, neurofisiologiche
VULNERABILITA'
AMBIENTALI
PSICOSOCIALI
BIOLOGICI

TROUBLE

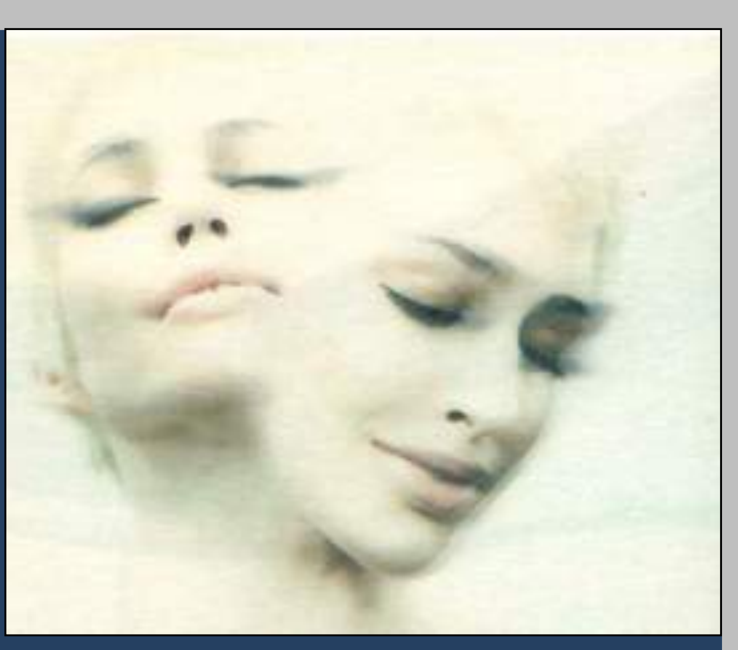

Soglia di vulnerabilità dopo l'intervento
Intervento sociale
Intervento biomedico
Vulnerabilità di base in un dato periodo
Eventi acuti stressanti
Stress "quotidiano" (familiare, lavorativo, sociale)

Prinicipi generali del modello vulnerabilità-stress

Secondo Monroe e Simons (1991) e Monroe e Hadjiyannakis (2002), i modelli di stress psicopatologico suggeriscono che tutte le persone hanno un certo livello di fattori di rischio predisponenti (diatesi) per un qualsiasi disturbo dato. Tuttavia, per gli individui c'è un punto in cui si manifesta un determinato disturbo, un punto che dipende dall'interazione tra la presenza di fattori di rischio e il grado di stress sperimentato dall'individuo. Poiché i **modelli di vulnerabilità-stress** analizzano le interazioni tra fattori di rischio premorbosi e fattori di stress situazionali, essi sono utili per descrivere chi potrebbe sviluppare un disturbo e chi no. Molti — forse la maggior parte – degli psicopatologi hanno riconosciuto l'utilità concettuale ed empirica della combinazione tra diatesi e stress e, di conseguenza, diversi modelli di psicopatologia tendono a essere **modelli di stress-diatesi**, che illustrano i diversi modi in cui l'**interazione vulnerabilità-stress** può essere concettualizzata. L'esame di questi modelli, teorizzati soprattutto per alcuni disturbi mentali, suggerisce diversi principi generali che caratterizzano le interazioni diatesi-stress.

IL SENSO E IL POSSIBILE

IMPIEGO DEL CONCETTO DI VULNERABILITA' – STRESS IN SALUTE MENTALE



- **Di fronte all'osservazione dei più diversi "fattori di rischio" identificabili in relazione al modello vulnerabilità-stress, nel Manuale DSM non si presume che ciascun disturbo mentale sia un'entità distinta con confini netti (discontinuità) dagli altri disturbi mentali o dalla condizione "nessun disturbo mentale"**

- Scopo della diagnosi è dunque quello di fornire descrizioni il più possibile definite di quanto osservato definendo "categorie" col fine di consentire a clinici e ricercatori di individuare il problema, eventualmente diagnosticare il disturbo, ipotizzare la cura e comunicare informazioni chiare a tutti gli interlocutori definendo confini coerenti e accettabili

L’ATTUALE APPROCCIO DIAGNOSTICO IN PSICHIATRIA

La diagnosi in psichiatria propone quindi una “sistemazione nosologica” delle varie entità osservate partendo dalla descrizione formale e contenutistica delle diverse manifestazioni del sistema di funzionamento psichico…

…per arrivare ad una valutazione globale del paziente non necessariamente limitata all’identificazione dei soli disturbi mentali…

(assessment)

I sistemi diagnostici più recenti ed internazionalmente condivisi – come il DSM, ma anche l'ICD – sono considerati come "**DESCRITTIVI**" nel senso che…

le definizioni dei disturbi in essi contenute si limitano alla descrizione di caratteristiche cliniche sovrapponibili a sintomi o "segni comportamentali" facilmente identificabili, escludendo sempre ogni riferimento causale

Attualmente l'**approccio generale** alla definizione ed alla classificazione dei disturbi mentali è sostanzialmente

ATEORETICO…

ciò non implica che le teorie sull'eziologia dei vari disturbi mentali non siano importanti in altri contesti, ad esempio nel formulare i piani di trattamento, ma queste non devono interferire con la "costruzione" dei criteri diagnostici

- **Nel “percorso” diagnostico la taratura delle soglie risente dell’interferenza culturale?**

E’ importante che il clinico non impieghi il DSM in modo meccanico, insensibile alle differenze di linguaggio, di valori, di norme comportamentali e di espressioni idiomatiche di disagio…

Quando la classificazione e i criteri diagnostici vengono usati per valutare un individuo di un gruppo etnico o culturale diversi da quello del clinico - in particolare se di cultura non occidentale - dovrebbe essere adottata una specifica cautela al fine di assicurarsi che il loro impiego sia sempre transculturalmente valido: ad es., riti di elaborazione del lutto, possessione, somatizzazione del disagio psichico, etc. …

- **Nel “percorso” diagnostico la taratura delle soglie risente dell’interferenza culturale?**

LE CATEGORIE DEL DSM NON SI BASANO SU RICERCHE APPROFONDITE IN POPOLAZIONI NON OCCIDENTALI. Ad esempio:

- l’esperienza allucinatoria della voce del defunto nelle prime settimane di lutto
- gli stati di trance e/o di possessione in contesti rituali
- particolari sintomi somatici associati con specifiche manifstazioni del disagio psichico

se vengono riscontrati in membri di specifici e differenti gruppi etnici, in gran parte nel mondo non occidentale, non dovrebbero essere considerati automaticamente come patologici in quanto totalmente nella norma per una particolare cultura

EDITORIAL

The political mission of psychiatry

STEFAN PRIEBE

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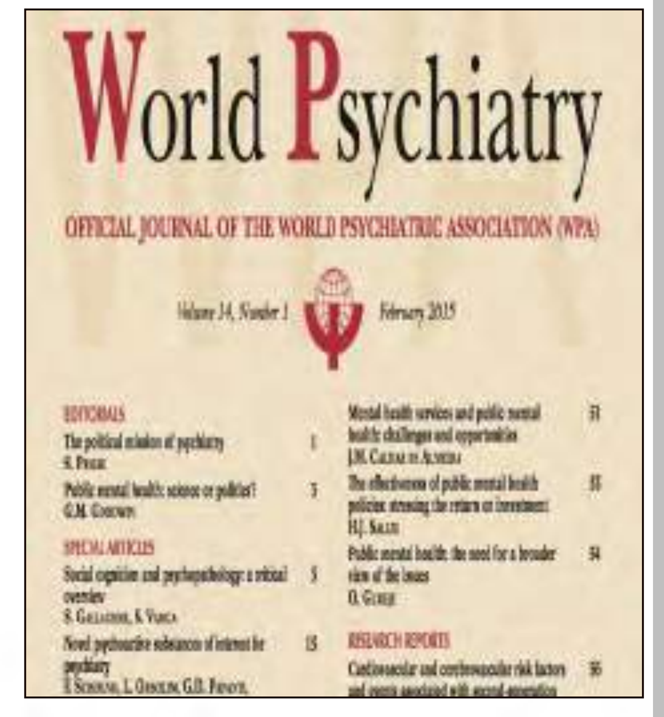

What contributes to poor mental health is well known (1): adverse childhood conditions; experience of war, persecution and torture (2); social isolation; unemployment and social exclusion; poverty, poor education and low socio-economic status; and social inequality.

In this issue of the journal, K. Wahlbeck (1) calls for action and requests that the evidence is translated into practice. What should be done? Obviously, in order to achieve substantial improvements in public mental health, we require societies to change and implement all those factors that promote mental health: societies should provide safe and supportive upbringing conditions; secure peace within and between countries; eradicate poverty; guarantee good education; strive for full employment; promote social cohesion and functional communities; and have little social inequality. These requirements are clear and unequivocal, no more

with such calls from experts in other fields may strengthen the

to change the welfare system or stop wars just because they are told by experts that this would be better for public mental health.

Despite this, raising our professional voice in the political arena might still be important. How can we – as mental health academics or clinicians – know the central importance of societal factors for mental health and not call for the political action to improve them – loudly and clearly?

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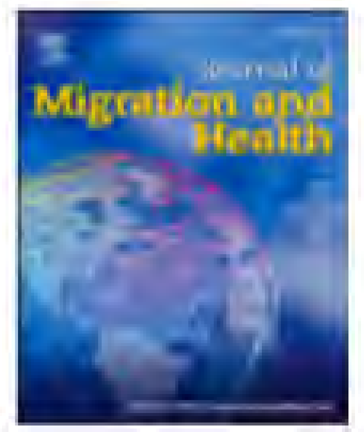
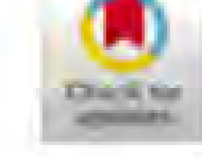


To screen or not to screen: Exploring and addressing effective screening processes for trauma among forced migrants



Nima Sheth[a,*], Seini O'Connor[b], Sheetal Patel[c], Mary Ann Dutton[d]

Background: Existing literature points to higher rates of trauma disorders for forced migrants than general or immigrant populations. The process of identification and screening for trauma in this population however is not straightforward and is actually controversial in some circles. Furthermore there are no definitive guidelines for mental health and social service providers on the "when" "who", "what" "why", "where", and "how" of trauma screening.

identify and analyze key themes from **focus group interviews with key informants** (service providers and trauma experts providing social and medical services in the community) and forced migrants (in this case from Cameroon, Ethiopia, Honduras, and Tanzania)

This study sought to capture **views on appropriate screening practices** from the perspectives of both forced migrants and key informants, producing new insights into how trauma screening can be effectively and ethically approached in service and clinical settings. In particular, although there was **complementarity between the two groups' views**, by integrating both perspectives the study provides a fuller picture of trauma screening benefits and pitfalls and provides insights into practice improvement

experiences with and impacts of screening, limitations and negative aspects of screening, helpful screening practices, effective tools and questions for screening

Evidence drawn from across the globe indicates that forced migrants — refugees, asylum seekers, survivors of trafficking, and individuals fleeing from other violence, persecution or oppression — exhibit significantly **higher rates of mood disorders and post- traumatic stress disorder** (PTSD) than the general population and voluntary migrants (Fazel et al., 2005; Lambert, Alhassoon, 2015; Lindert et al., 2009; Shawyer et al., 2017; Steel et al., 2009

Screening for mental disorders (including symptoms and experiences) can help ensure forced migrants receive appropriate care; however it is considered controversial or inadvisable in some circles (Pottie et al., 2011; SAMHSA, 2014). Furthermore, cultural constructs of distress, including symptoms of trauma, vary across countries and cultural groups, making accurate identification of traumatic stress among forced migrants (Nickerson et al., 2017)

Appropriateness of screening "when" and "If" to screen

There are conflicting recommendations for clinicians regarding whether forced migrants should be routinely screened for PTSD or other mental health conditions. **The Canadian Collaboration for Immigrant and Refugee Health recommends against conducting routine screening for exposure to traumatic events** because "pushing for disclosure of traumatic events in well-functioning individuals may result in more harm than good" (Pottie et al., 2011, p. 828; Canadian Collaboration for Immigrant and Refugee Health, 2019). The authors recommend screening for depression **only if an integrated treatment program is available** and eschew routine screening for PTSD in favor of remaining alert for "unexplained somatic symptoms, sleep disorders or mental health disorders such as depression or panic disorder" that may be symptomatic of PTSD (Pottie et al., 2011, p. 829). **Routine screening creates risks of "over-diagnosis and medicalization of suffering"** (Kronick, 2018, p. 292)

In contrast, the **US CDC** suggests that a “history of exposure to traumatic events” should be elicited from **all refugees over the age of 16**. Different US States have followed CDC guidance in developing recommendations for mental health screening, suggesting that **primary care and other health clinics seeing refugees within 90 days of their arrival** should ask **five mental health questions as a basis for referral for a comprehensive mental health assessment** (Minnesota Department of Health Refugee Health Program, 2014). Recommendations further propose that **ideal mental health screening tools should be** *valid, concise, worded in lay language, elicit “yes-or-no” answers, provide space for a respondent’s subjective self-assessment, and be administered by a medical professional*.

The **US Office of Refugee Resettlement** also advocates for **early mental health screenings**, with the aim of avoiding future mental health crises due to untreated symptoms and helping refugees better integrate into their new communities (National Partnership for Community Training, 2018)

The **International Society for Traumatic Stress Studies** notes that *“screen-and-treat” approaches* that identify traumatized individuals directly in the community can be an efficient tool to overcome barriers to treatment for refugees” (Nickerson et al., 2017, p. 13). The **American Psychological Association’s Guidelines for Trauma Competencies and Education** also suggest that psychologists should routinely be screening all patients for trauma histories in early sessions to inform appropriate treatment plans (American Psychological Association, 2015).

Noting the *potential risks of screening*, the **Refugee Center** states that screening should be carried out in a way that *protects the client from distress or “re-traumatization”* (National Partnership for Community Training, 2018). Specifically, they suggest conducting screening with a goal of establishing safety and trust between the provider and the client over time and *focusing on symptoms over stories of torture and trauma*: trauma may be under-reported and fragmented due to experiences of dissociation, flashbacks and shame, common psychological responses to torture (Burnett, Ndovi, 2018)

Some Authors (Burnett and Ndovi, 2018) further stress that any trauma disclosures should be carefully documented and appropriately shared between providers to *reduce the need for patients to share their traumatic experiences repeatedly*.

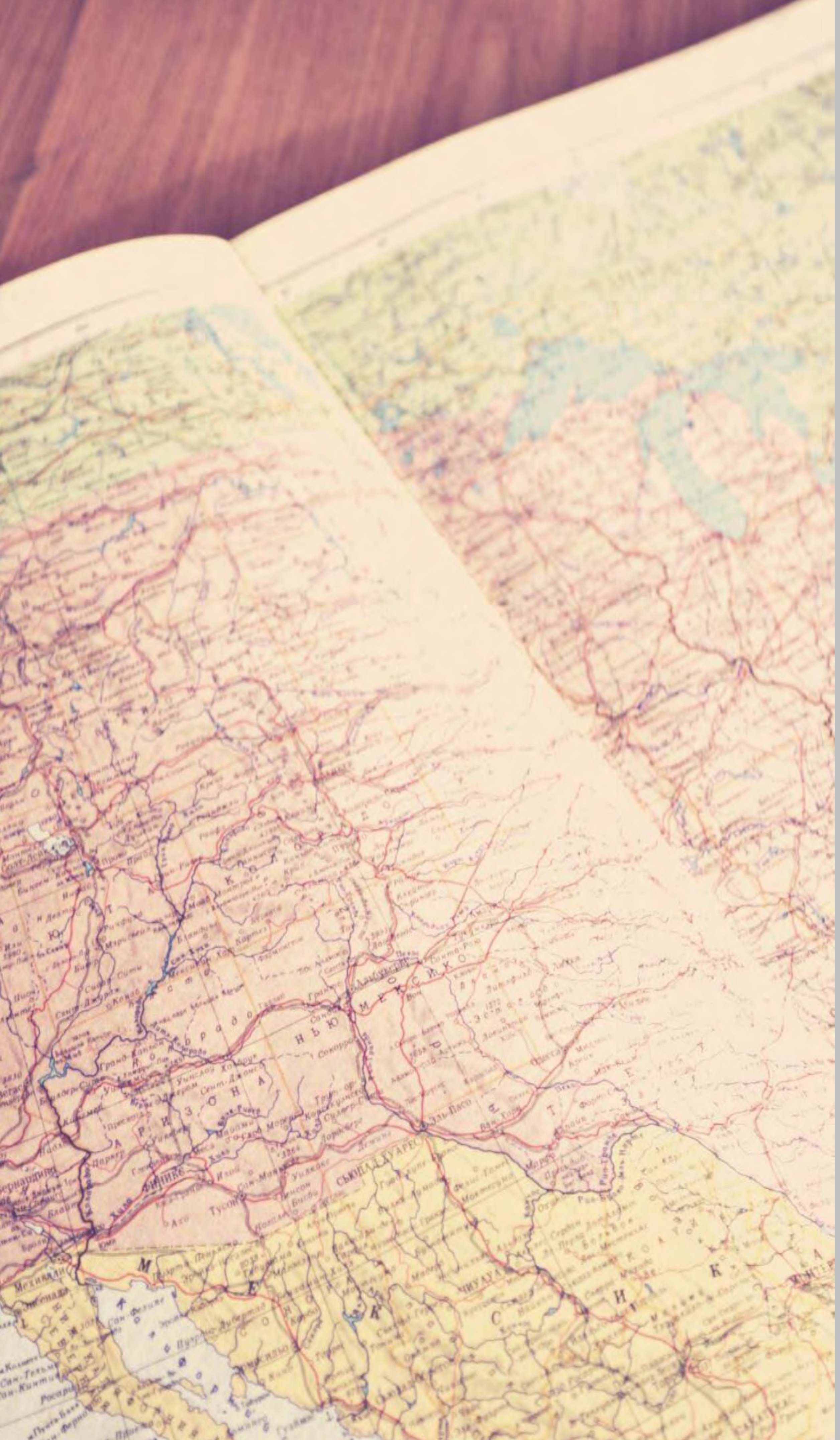
The importance of tracking disclosures and of following up over time is also stressed by the **CDC** (2015), which notes that symptoms may not be shared at initial screenings and may emerge months or years after resettlement. To help encourage reporting of concerning symptoms, *CDC suggests explaining to refugee that:*

> **"Most refugees will experience short-term psychological and social difficulties simply as a result of resettlement. ...If you feel these symptoms are excessive and are interfering with your life or if you have thoughts of hurting yourself or others, you can always come back to our clinic and ask for help"** (p. 6)

Challenges in trauma screening
"Who" and "Where" to screen

If providers do decide to conduct screening, a key challenge to doing so appropriately is **deciding who should do it**, and **in what setting**. Initial barriers often include difficulty establishing contact, rapport and trust between a forced migrant and a screener.

Migrants are more likely to seek out physical than mental health services (Afkhami, Gorentz, 2019), *placing the responsibility on primary care physicians and other service providers* to undertake screening and offer initial mental health education and referrals (Johnson, 2005; Pollard et al., 2013). *This is especially the case for forced migrants who do not go through a formal refugee resettlement process* (such as asylum seekers) in which they have an initial relationship with a resettlement office (and contact with agency staff and case managers who may conduct screenings)



Research is also emerging on the **effectiveness of lay helpers in delivering basic mental health screening** (Hocking et al., 2018; Mewes et al., 2018) **and group interventions in community settings**, in line with recently developed **WHO** protocols (Khan et al., 2019). This approach to screening for psychological distress may help overcome some of the **barriers to accessing extensively trained professionals** and seems to be ***a promising form of task-shifting*** (Nickerson et al., 2017). *Others emphasize the importance of situating the screening process within a wider context* (Kronick, 2018) *identifying several important principles such as including the family, community and social milieu in assessment processes, and using trained interpreters and cultural brokers to help increase disclosure and improve clinical care.*

Challenges in the "How" of trauma screening, choosing appropriate questions or tools

There are currently **multiple screening tools and instruments** in use among providers serving forced migrant populations (Sigvardsdotter et al., 2016), some of which are intended exclusively for screening …

The **RHS-15** and **RHS-13** have shown to be valid and effective screeners for likely *cases of PTSD, depression and anxiety across a range of cultural settings, but are not intended to be diagnostic* (Hollifield et al., 2013, 2016; Kaltenbach et al., 2017).

Other screening instruments, such as the **Harvard Trauma Questionnaire** (Mollica et al., 2004), capture a more comprehensive picture of trauma experiences and are more *closely aligned with diagnostic and statistical manual (DSM) criteria for trauma and stressor related disorders.*

However, many instruments have not yet been updated to align with DSM-V criteria (Dietrich et al., 2019) Furthermore, although the DSM-V includes a recommended cultural formulation process for assessing how cultural factors may influence presentation of symptoms for various disorders during a clinical interview, many practitioners have identified *important differences in the way cultural groups experience and report traumatic sequelae* (e.g., with more of a somatic or spiritual focus) and routinely respond to questions (e.g., with underendorsing styles) in screening tools (Nickerson et al., 2017; SAMHSA, 2014)

Because these variations may limit the cross-cultural validity of diagnoses based on DSM-aligned screening measures, Wylie et al. (2018) emphasize the *importance of a transcultural approach* in screening, urging care providers to **include more open-ended questions**, **use interpreters and expand their training** in working with diverse populations. Some researchers have also developed appropriately *translated, validated, and culture-specific versions of various screening measures* (Brink et al., 2016; Hollifield et al., 2016; Kaltenbach et al., 2017; Lepper et al., 2017; Mollica et al., 2004; Tagay et al., 2011; Zilber et al., 2004)

Another important point to consider is that **most screening instruments focus on *symptoms* of trauma, rather than on the trauma itself**. A smaller number have been designed to ask specific questions about traumatic events: parts I and II of the **Harvard Trauma Questionnaire**; the **Comprehensive Trauma Inventory** (Hollifield et al., 2005) and the **Refugee Trauma History Checklist** (Sigvardsdotter et al., 2017). *As with questions about symptoms, however, there may also be cultural and demographic variations in the ways that questions about experiences are interpreted and responded to* (Westermeyer et al., 2011)

Furthermore, although the diagnosis of PTSD under DSM criteria is contingent on the patient having been exposed to a traumatic event, **important indicators of traumatic stress may be identified without having to go into a detailed trauma history** (Nickerson et al., 2017). This raises the *question of whether and when*, trauma screening should involve **documentation of details of the traumatic events**, especially given that this may cause recurrence/worsening of symptoms for the patient. ***The CDC recommends that mental health screening processes for asylum seekers be designed with consideration of the capabilities to provide mental health services*.**

In one survey of state refugee health coordinators, only 9% used formal assessment tools and 68% indicated that screening occurred via informal conversation (Rhema et al., 2013; Shannon et al., 2012a). Another study interviewing *professionals from health care centers, placement and voluntary agencies* found that *only 6 of 16 routinely conducted formal mental health assessments*, with others including general questioning about general health complaints (e.g., problems sleeping) in their intakes and **referring out for mental health assessment** only if refugees directly raised psychological complaints or had these concerns flagged by field workers (Afkhami, Gorentz, 2019; Al-Obaidi et al., 2015)

Effective screening may be limited not only by institutional capacity but also by inadequate validation or reliability of the screening tools used, biases introduced through the use of interpretation and cultural stigma around sharing mental health concerns (Al-Obaidi et al., 2015; Johnson, 2005)

Furthermore, even if a screen is positive, forced migrants may not access appropriate mental health care due to cost barriers, transport limitations, family or work priorities, concerns about navigating the complex healthcare system, or the lack of provider availability (Afkhami, Gorentz, 2019)

It is unclear what forced migrants themselves think about undergoing trauma screening. In one of the few studies that has examined migrant experiences, *more than two-thirds of refugees reported that their trauma histories were never mentioned by themselves or their doctors yet*; 74% of participants stated that they wanted their doctors to know about their war trauma, particularly as it may have been impacting their health (Shannon et al., 2012b).

Barriers to trauma disclosure included not knowing if it was appropriate information to share without being asked by their doctors, not seeing the impact of war as relevant to their health and wanting to avoid reliving painful memories (Shannon et al., 2012b). In another study, refugee participants shared how they wanted their doctors to spend more time with them, help them feel comfortable, take initiative over this conversation, directly ask about their mental health, and provide psychoeducation to understand their symptoms (Shannon, 2014)

RECOMMENDATIONS FOR SCREENING

First, Providers engaging in trauma screening should establish if there is **adequate follow-up available** as well as sufficient tools and resources to provide patients for their distressing symptoms. The screening process should also ideally include an assessment of what types of interventions the patient may feel are helpful and that are culturally relevant. **Caution if screening is only during a one-time assessment**

Second, Agencies regularly review and reflect on their trauma screening procedures, with an emphasis on **being flexible and adapting screening processes so that they best fit the needs of the population being screened**. We advise *against mass standardization of trauma screening* and encourage the *use of different assessment tools and methods* with consideration of the unique characteristics of the population, the availability of providers and the reasons for trauma histories and symptoms to be known

Third, Individuals conducting trauma screenings should ideally reflect on how they can **create a sense of psychological safety for those being screened**, which entails prioritizing rapport building, inquiring about and assisting with immediate and basic needs first, and maintaining a focus on resilience and strengths throughout the interview

Fourth, *Make these screeners and their adaptations free and open to the public*: providers consider referrals to **resources outside of the traditional psychotherapy and medication treatment model**, such as spiritual leaders and mind body interventions

Importance of incorporating forced migrant perspectives on health

These findings indicate that there *may be some important differences in the ways that migrants and providers conceptualize trauma*. For example, migrants indicated that trauma impacts both body and mind, but many standardized trauma screening tools focus more on psychological symptoms. This divergence is consistent with past research pointing to important cultural differences in the way that trauma is experienced and reported (Nickerson et al., 2017; Shannon et al., 2015).

Similarly, *many of the ways that forced migrants reported coping with trauma (e.g., helping others, joining a spiritual community) fell outside of the boundaries of what is routinely considered to be mental healthcare in a US/european cultural context*, highlighting the lower likelihood of mental health providers being a first point of contact for forced migrant screening (Afkhami, Gorentz, 2019) and pointing towards a wider set of potential referral options for migrants who are found to have trauma symptoms

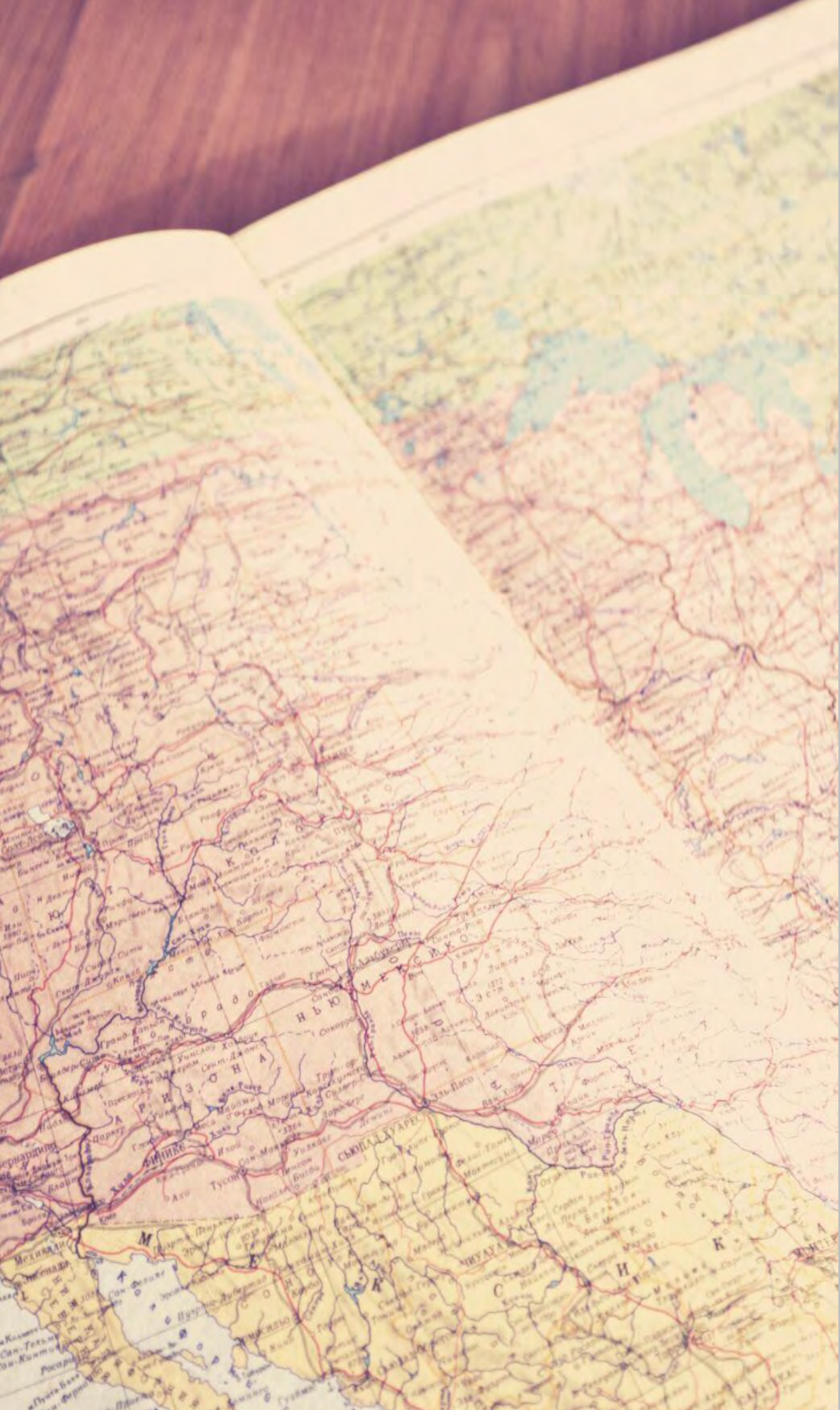
When migrants did seek out healthcare, they reported mixed experiences: some positive interactions that illuminate helpful practices for healthcare providers to follow (e.g., patient-focused, flexibly-paced, and culturally-adapted care), but also some important challenges (e.g., cultural disconnects, redundancy of disclosure, and confusion about services offered) that point to **weaknesses in current systems**. These perspectives add emphasis to advice (Burnett, Ndovi, 2018) that providers should focus on **building rapport and trust over time**, optimize information sharing in order to **reduce unnecessary repetition of trauma histories and create an effective referral pathway** with minimal information loss or unnecessary repetition

Insights on effective screening practices

In terms of the location of screening **("where")**, in expressing their reservations about trauma screening, migrants noted **barriers to accessing different providers** (e.g., lack of clarity about which providers offered which services, and concerns about cost) that may render less accessible or well-known provider sites less suitable for wider scale screening

Migrants also noted the **importance of privacy when sharing sensitive information**. In reflecting on helpful practices, key informants suggested that any screening site should be situated within an integrated institutional context with a clear referral system for appropriately responding to migrants' needs, while **balancing information sharing with an emphasis on confidentiality and informed consent**.

In terms of *screener skills and identity* **("who")**, migrants emphasized the quality of the relationship with the provider as important for building trust and comfort with screening and expressed a *desire to have some options for culture, gender, and social identity matching that could increase their comfort with being vulnerable*. Key informants similarly emphasized the importance of screeners being able to offer empathy and elicit trust through relational, trauma-informed care, but also noted the **importance of the screener's institutional role** - in particular, their capacity to ensure information collected during screening could be used to appropriately support migrants



These findings on the “where” and “who” of screening add further nuance to past research suggesting that screening be conducted by physicians, who are often the first point of contact with the health system that forced migrants have (Johnson, 2005)*, or by lay mental health workers, who are able to connect with migrants within their communities* (Hocking et al., 2018; Khan et al., 2019; Mewes et al., 2018). In addition, the **security of the space in which screening is conducted**, and the quality of the relationship with the screener, appear to be important considerations.

With respect to *timing of the screening* **(“when”)**, migrants highlighted the importance of **having time to develop trust and feeling like their most urgent needs took priority**. This suggests that **screening should not be conducted too early** or abruptly in the processes of either establishing a provider relationship or referring forced migrants to appropriate longer-term care. *Key informants also noted that screening could cause migrants to feel they were being asked to open up without appropriate time to process their reactions or connect them to resources for managing their more immediate concerns, and that thorough screening could be time-consuming*

This suggests that **screening should ideally not be conducted in a highly time-limited setting**. Furthermore, key informants highlighted that *single time-point screening could miss the development of trauma-related concerns over time and may not occur at an opportune moment to connect migrants to the best care* (especially relevant for services where eligibility is restricted to certain time periods). These findings suggest that **a "one size fits all" approach to screening may have considerable pitfalls** (Pottie et al., 2011)

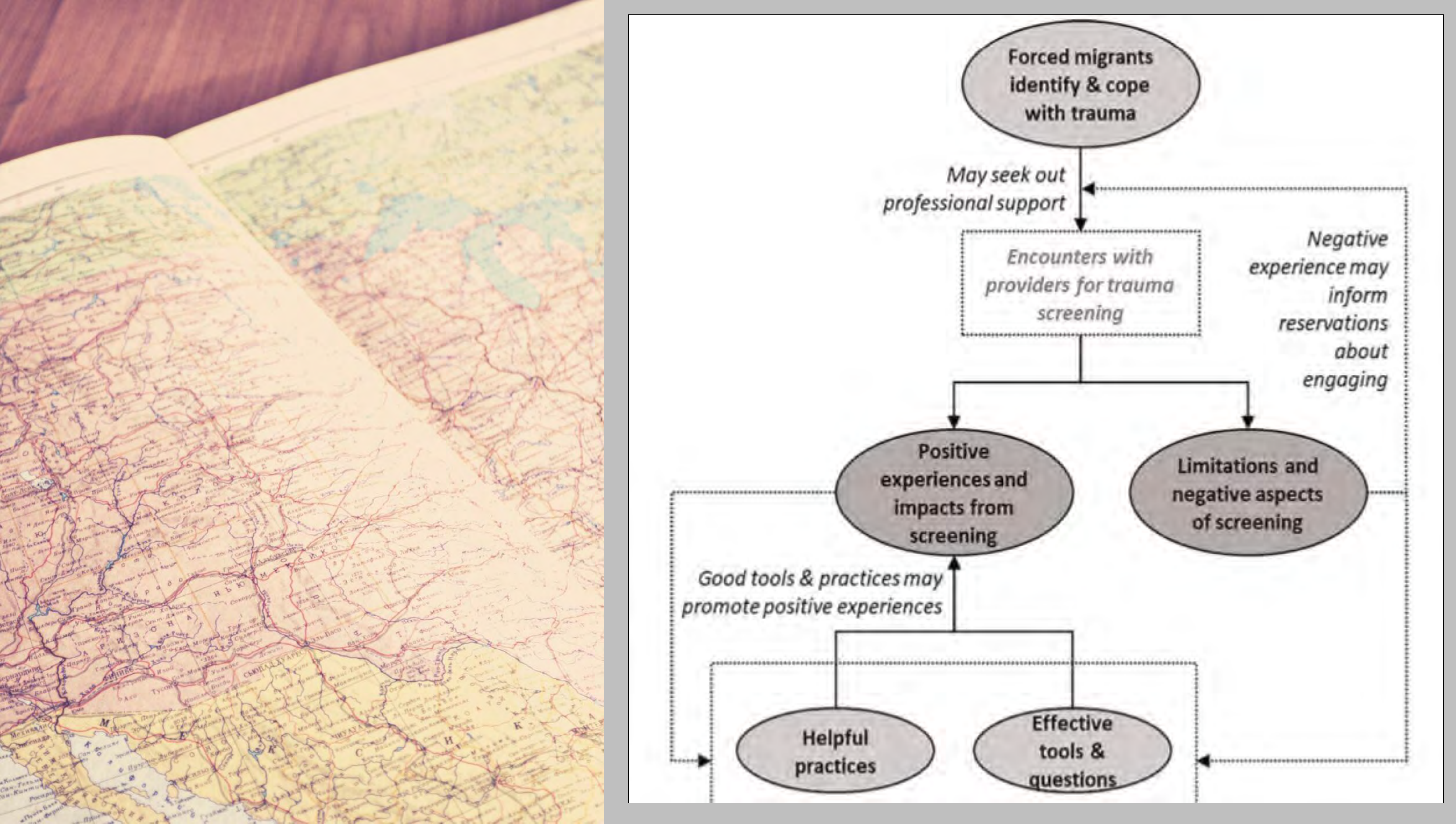
In terms of the best form of trauma screening **("what" is screened for, and "how")**, migrants shared varying perspectives. As noted earlier, many of their descriptions of trauma related symptoms included more *physical or cognitive aspects* (e.g., negative thoughts about self, sleeplessness, appetite loss), suggesting these *should be attended to within the screening process*. Some also expressed **discomfort with being asked standardized questions that felt insensitive to their personal history and cultural beliefs** (e.g., being asked about alcohol or drug use, or being asked directly about suicidal thoughts), or being probed for many details of the trauma itself, rather than just their current wellbeing

They offered suggestions for making patients comfortable at the outset and throughout the screening process by centering their needs and noted ways in which suicidality could be sensitively assessed for. Migrants also reflected on the relative merits of **paper-based versus clinical interview style assessments**, noting that *having the option to describe their trauma-related experiences in more detail (or not) could feel important in managing their emotional state*. Key informants noted similar benefits of screening approaches that allowed clinicians more **adaptability and space to be more or less comprehensive** in their assessments (potentially, for instance, assessing for history and for resilience factors in addition to current symptoms, as appropriate, and integrating therapeutic interventions to help clients manage emotional responses). Key informants also highlighted the **importance of being able to screen in forced migrants' own languages** - which could create a new layer of complexity (and need for clinical caution) if **including an interpreter in the assessment**, in the absence of a validated written translation

Finally, in terms of the reasons for screening **(“why”)**, forced *migrants appeared to feel most comfortable when feeling assured that health care processes were focused on attending to their needs* - suggesting that **screening should be clearly linked to subsequent support**.

Key informants offered a similar view, noting the *importance of fully informing migrants about how their data would be used, and offering choice wherever possible*. However, *key informants also indicated that they did not always have the freedom to choose the form of screening that may best fit migrants’ needs* - for instance, they noted that *they may feel obliged to use particular screening tools specified by funders.* At the same time, being able to access further funds (including insurance payments) for healthcare is a clear potential benefit of gathering screening data for providers and migrants, and information on trauma symptomatology enhances providers’ ability to write assessments and plan out service provision

Il “percorso” di screening



Forced migrants identify & cope with trauma
May seek out professional support
Encounters with providers for trauma screening
Negative experience may inform reservations about engaging
Positive experiences and impacts from screening
Limitations and negative aspects of screening
Good tools & practices may promote positive experiences
Helpful practices
Effective tools & questions

Identifying and coping with trauma

When forced migrants were asked to define trauma from their own understanding, they described it in ways that relate to trauma's etiology, its phenomenology, and its impact on their interactions with others. **Etiologically**, they noted it was linked to past events (e.g., "something that happened to you in the past", "bitter experience that keeps on coming"). **Phenomenologically**, they described trauma as eliciting negative feelings and thoughts about themselves (e.g., "whenever it comes to you, you feel sad"; "you feel mad that you can't be stronger"), bringing up unwanted feelings, thoughts or memories (e.g., "unwanted fear", feeling "helplessness because someone has more powers than you, they can do what they want but you cannot") and ***affecting both body and mind*** (e.g., "lack of appetite and anxiety", feeling "very weak", having a "combination of physical and psychological tragedy", "depression, difficulty sleeping, anxiety, loneliness"). **In terms of interactions with others, they described trauma as being difficult to discuss** ("you don't want to talk about it").

To cope with trauma, forced migrants primarily identified **relational strategies**, but also identified some important **intra-psychic strategies**.

Relationally, *they coped by finding ways to help others* (e.g., “I was able to help myself and others”, “if someone is knocking on the door and someone can open it, why not open it?”), *connecting with community, family, and friends* (e.g., “phone calls from home”, “social media” and “videos from your culture”, “need to socialize with people”, being with community of same nationality “to feel like you feel belonging” and “like you are reconnecting”), *praying and joining a spiritual community* (“praying removes whatever is there”, “church is good”, or *seeking help from a mental health provider* (e.g., “I can talk to any doctor or psychiatrist, they will have some words that can help”).

Intra-psychically, some reported *working to maintain a positive mindset* (e.g., “attach a positive thing to a negative thought that comes in your head”, “find something good”)

Experiences in working with health providers around their trauma…

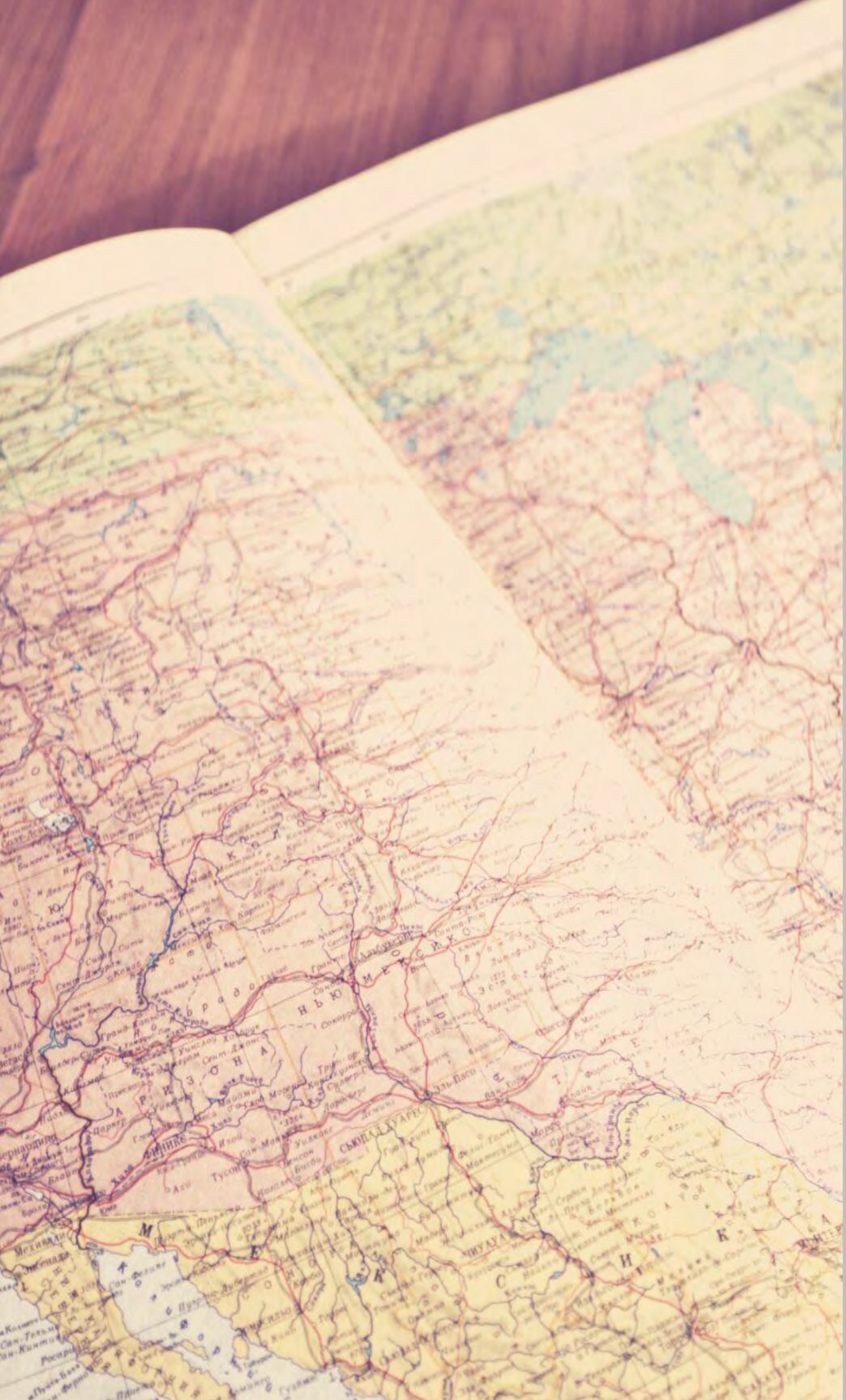
The negative experiences of **R/AS** with providers who undertook trauma screening encompassed both internal discomfort around their own lack of information or resources, and uncomfortable interactions.

In terms of their **own resources impacting negatively** on their experiences, they described *being unsure of which providers do what* (e.g., wanting "to look at the definitions of who everyone is" to understand different provider types, if provider is the "right fit" for what they are going through) and *feeling worried about payments* (e.g., receiving large unexpected medical bills "you have to pay", or feeling they "don't want to approach" care because of bills).

In relation to **uncomfortable or dissatisfying interactions**, they described *cultural differences in talking about mental health* (e.g., one participant reported "my head was so heavy" and talking about "stress", but did not feel comfortable labeling this as a "mental health" concern, which the provider "who comes from a different culture" did…

Experiences in working with health providers around their trauma

Another noted “when you say mental....you think I’m crazy”); *standardized screening feeling offensive or not patient-centered* (e.g., offensive to be automatically asked about using drugs - “I was like, I don’t even smoke”- or thoughts of killing themselves - ”You know I don’t want to kill myself, I have a family. You can skip”; *concern at being asked questions in not fully-private settings*, e.g., with the doctor “not looking at me, just looking at the computer and typing”); *screening processes asking for too much information too soon* (e.g., feeling providers “wanted me to tell my whole story”); *re-living while talking* (e.g., mentally going “back to the situation”, “had tears”, “when I remember bad experiences from the past I feel the same as I did in those moments”); *repetition of questioning feeling unnecessarily traumatizing* (e.g., feeling “you are living in it” each time a new person “asks the same questions:); and receiving unhelpful advice



Experiences in working with R/AS…

In a similar vein, **key informants** identified *several limitations of existing screening tools and processes, relating to the content, the process and the outcomes of screening*. In particular, they noted that **these tools and processes are not necessary or sufficient for trauma-informed care** (e.g., stating that "trauma informed care is essential but trauma screening is not necessarily a part of that", and a "strength-based resiliency model" based on the assumption of some experience of trauma "would get us there faster", focusing "more on future goals than on past experiences"). They also expressed concerns that *screening may focus more on problems* (e.g., in contrast with "resiliency screening" or functional assessment that looks at "what is working", and identifies "what's not working in terms of mental health". Practically, they noted that *screening can be time-consuming* (e.g., "we don't have the time to do that deeper historical assessment") and may be restricted in what they identify (e.g., "listing [trauma experiences] doesn't really help", "not sure if the linguistics capture the essence of what we're trying to convey")

Experiences in working with R/AS…

They also noted that *screening can be difficult to administer with children*; for instance if parents fill out measures “with small children, it becomes an issue of whether you’re getting the child’s own trauma or the parents’ trauma observing their child’s trauma”, or if older children are “asked about trauma in front of their parents” or “if the trauma experienced by the child happened with the knowledge of the caregiver” there may be **bias in the responses**.

Key informants expressed concern that *screening tools often have not been well-studied or contextualized*, stating “cultural sensitivity...is a major gap”, they “would like to know more about the tools themselves, how effective are they, what is missing?”, and feel concerned about “how the translation is worded”. Further, they expressed concern that *using screening tools may not lead to improved mental health because even if screened for trauma*, “most of my patients decline services because of the stigma”

Experiences in working with R/AS…

They noted that *the screening process may be limited or prescribed by funding*, e.g., “federal and international funding is tied to legal definitions” that require the use of questions or tools specified by funders, so “for many organizations, the screening process is wrapped “for insurance purposes, you need to see the symptoms... a provider always feels pressure to screen to provide a diagnostic code”.

Key informants also indicated that they felt screening tools and processes could be potentially harmful for forced migrant patients. In particular, they identified that *forced migrants may feel pressured* to “tell us everything” (there is “definitely a risk of opening people up in session”...and providers “often can’t know if discussing it will re-traumatize someone”), *feel restricted by the presence of an interpreter* (e. g., “some may actually prefer a phone interpreter rather than an in-person one if the community is quite small”), and have *individualized responses that aren’t readily taken into account with standardized approaches* (e.g., “the timeframes of “standard” experiences aren’t always accurate, because symptoms may vary in a given day or week or month”).

Experiences in working with R/AS

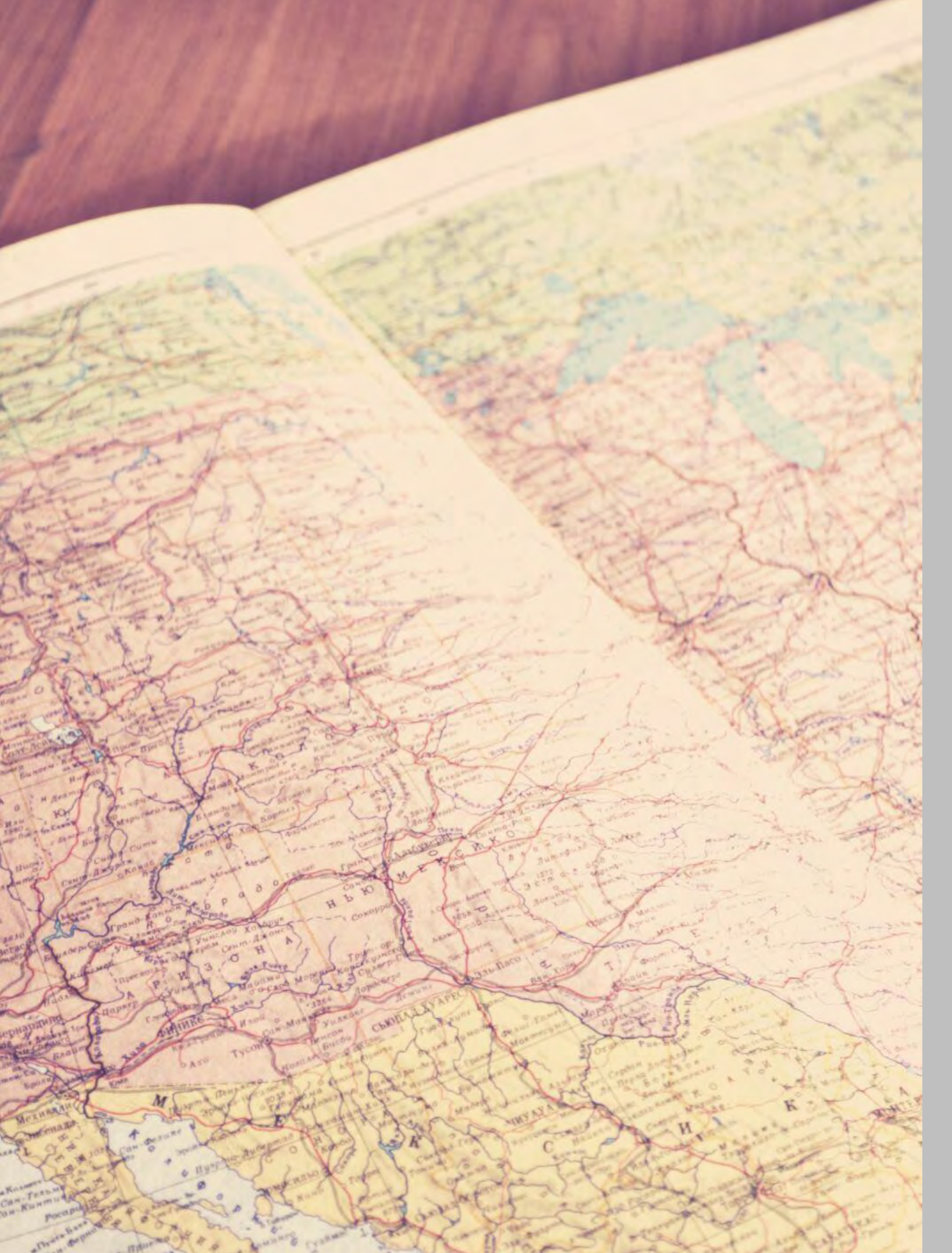
Additionally, key informants identified, from their experiences engaging in trauma screening, *common responses or reactions* from forced migrants that could make screening more challenging for providers to conduct trauma screening.

These included *reluctance to responding or providing details* (e.g., “if you have no relationship, the answers may be sparse”); *a sense of pressure related to immigration status* (e.g., “usually told by a lawyer to tell us everything, like they want to be believed”, “those sent by a lawyer may be more willing to answer questions, but also can tend to report higher levels of things in order to improve their case”); *frustration* (e.g., “sometime there is a negative reaction if people have had negative prior experiences with other less effective organizations”, “some respond with irritation because they already know the trauma is there, so asking about it seems frustratingly obvious”, or “they may want to get some other relief”); *family intervention* (e.g., “we ask complex and personal questions to women, and a male relative will intervene to stop interview...sometimes we cannot talk to a survivor alone, and have to deal with whole family together”) and a *desire to elaborate* (e.g., “they may be trying to explain a lot and not answer questions”). Less challenging but of note was that some key informants found forced **migrants responded with curiosity about the screening tool and its results** (e.g., wanting to know “what their screening score means” or to “point out that certain things aren’t relevant”)

Positive impacts of trauma screening for providers and forced migrants

They perceived *screening tools and processes* to be *beneficial in their efforts to assist forced migrants by helping to collect data to support ongoing services* (e.g., “it goes back to funding again, trying to attract donors, painting a picture through data that’s most appealing to donors”) or by *helping medical staff take a holistic health approach* (e.g., “my colleagues don’t understand how trauma affects everything else...a holistic approach is often helpful for primary care physicians to reframe physical conditions”). Furthermore, they noted that screening *tools with good psychometric properties and cross-cultural validation are useful for psychological evaluations in asylum cases* (e.g., “assessment tools have helped my patients win their asylum cases”, when used alongside qualitative interview).

Key informants also indicated that appropriately selected screening tools and processes could benefit forced migrant patients more directly



They noted that such tools could *help migrants feel relief at sharing* (e.g., they may “feel a release”, or “feel they have a voice”), and to *connect their past experiences with current symptoms* (e.g., by “psychoeducation on how past trauma affects health”). In terms of **functional relationships**, they suggested that appropriate screening can help forced migrants form a connection between seeing service providers and achieving safety (e.g., “building towards some sense of safety in terms of concrete rewards, meeting their needs”), and **get connected to other resources** (e.g., if the forced migrant “gets referrals even as we are doing informal screening” and can be offered a “good warm hand over” or can “connect people to different organizations that offer [other] resources”)

From their perspective, forced migrant participants reported some positive psychological experiences and outcomes from past trauma screening and opportunities to talk about their trauma

These encompassed: *feeling more comfortable talking over time* (e.g., can tell their story “more confidently” and “without crying anymore”; started with psychiatrist and now can “talk with others too”), *feeling relief in sharing* (e.g., feeling “like [taking] a breath”, “pushing a weight off your shoulders”, “dropped a bag of rice”, or felt something “lift off your shoulders”), *receiving tangible support and help* (e.g., “got a solution” to concerns, “drugs or prescription”, “a moral booster” - although one participant also pointed out that “sometimes people can’t help you”), and *feeling heard* (e.g., feeling “not the only one”, that “people hear you”)

Helpful practices in trauma screening

Forced migrant participants identified several types of *helpful practices for healthcare providers to consider when undertaking trauma screening*, spanning both relational style and practical approach

They identified it as *helpful when providers offer thoughtful psychoeducation* (e.g., “need to be schooled on what mental health is about”, “learned a lot about myself”); *ask appropriate questions that help patients process trauma and build positivity* (e.g., “it’s good to be asked because many people don’t talk about what they are carrying inside”, “go deeper”, “ask the important questions”, “take cultural background into account”, “bring positivity” to the patient); *meet patients where they are and screen when patients are ready* (e.g., important that provider can understand context and “know what you are passing through”, asking patient “what do you want to get rid of today? let’s work on that”, noting that it “depends on the individual” - for some “right away is good” while others “need time” and “can speak out more when settled”; and not asking screening questions when patient is in an unsafe or unstable place i.e., “not in detentions....it retraumatizes you”); *focus on the most urgent needs* (e.g., “immediate needs can be a trigger, if you can’t afford you basic needs”, “instead of giving me a business card give me a metro card”); *build rapport and a trusting relationship* (e.g., “sit down with clients and offer coffee before collecting documents”, “comfort is important’, “show the person some love”, “we are coming from darkness, we have to have hope and light”, “takes time to develop trust”); and *provide opportunities to talk in native language* (e.g., “need to have a translation”)

When reflecting on their experience with providers who have conducted trauma screening, forced migrants indicated that in general, it did not matter who the screening provider is as long as the rapport is good (e. g., it “could be any doctor” as long as they “feel comfortable, that they care”). They also noted that *some providers may be more in tune with the patient’s emotions* (e.g., “I don’t know if a physician will be interested in emotional health,” “I would talk to a therapist” (or other provider) who is “better equipped” to focus on mental health). Further, they suggested that *provider cultural or gender identity can matter according to individual preference* (e.g., “I want my doctor to be from the same place or country or from a similar situation”, prefer “older doctors with more experience”, “ more empathy comes from women...I would prefer female”, “prefer to talk with a male”, and “it would be good to be asked” if they prefer a male or female provider)

In a similar vein, **key informants** identified **eight general conditions** they believed were important for engaging in trauma screening effectively.

One was a *facilitative context or institutional setting*: “screening should only be done if there’s a referral system in place” and in a safe, integrated context where information can be used and shared effectively (e.g., “have an integrated model that is an ideal model for not stigmatizing people and offering choice in terms of what can be integrated into the primary care practice”).

Another important condition was *adequate administrator competence and resourcing*; administrators should have an empowered role (e.g. “social workers can have the essential training to communicate to the specialized health organizations to push files forward”), *have training and skills in relationship formation and trauma-informed question administration* (e.g., the “most important key is that this is being done with someone that the person can build a relationship with, and this person can be different depending on the setting - it doesn’t always have to be a clinical professional if there’s quality trauma training”), *be familiar with forced migrant contexts* (“service providers should have strong resiliency understanding and ethics, and they need to be sensitive to particular individuals’ opinions and background”), *be aware of their own counter-transference and triggers* (e.g. “when providers have the same experiences as their patients...the provider has to keep their own experience separate”), and have *organizational support* (“can have burnout and vicarious trauma”, so “organizational leadership is important”)

Additionally, key informants emphasized the **importance of clearly explaining and observing confidentiality** (e.g., noting that migrants may have “concern from trust violations in their home country context...[so] it’s important to reiterate confidentiality concerns, for example letting them know “this will or will not go to government agencies” and asking “for permission to share with a colleague or supervisor or supervisee, demonstrating that the patient has the right to say yes or no throughout the process”). **This included approaching mandatory reporting with transparency and sensitivity** (e.g., letting the patient know “they have a legal obligation to disclose those particular topics”). Further, they suggested that appropriate timing was important, and that administrators should consider the best time to screen; they also acknowledged that immediately after arrival may be too soon (“when people just come to the country they may be in a “honeymoon” phase, and screening gives a snapshot of one time but their distress comes out later”

“In acute stages, their symptoms may be related to primary needs not being met, a lack of sleep”). They suggested it was *important to establish a relationship first* (e.g., “understand the patient’s goal from the visit, focus on why they are there, creating rapport, and then in the second or third visit you’re having the conversation involving trauma”), and that *providers should link screening procedures to a time when screening can help patients connect to other services* (e.g. “if a screener opens a door to a resource, then it’s a good time to use it”). Key informants noted that regular screening could be helpful, and “ideally there should be a general “are you ok?” check that happens at every point” in the patient’s journey through support systems. Further, key informants emphasized that *screening would be more effective when it had a clear purpose* (e.g. “refugees may not want to be forthcoming with mental health conditions out of fear it will make them more difficult to be resettled in the US” - especially as screening completed out-of-country is often used to assess “grounds for inadmissibility”, so “how you explain what you’re doing makes a difference”).

In addition, it is important to *enable judicious use of translators* (e.g., noting that “sometimes the translator can’t handle the trauma being discussed”, or “the person being screened may have reactions to the translator”). They suggested that *culturally-sensitive interpretation of patient responses was crucial* (e.g., considering “what does trauma mean in their culture?”, understanding that “western definition may not be understood by a different culture”).

Finally, they noted that it was important to *develop support systems for managing difficult emotions that come up* (e.g., “start sessions with breathing to emphasize grounding “, “give them a handout with psy-choeducational issues”, “give a handout on grounding and breathing”, “give people “palm cards” with resources if they felt they were in danger”).

Effective screening tools and questions

Forced migrants offered some specific suggestions for the **types of questions that could be included in future screening efforts**. They suggested that screening should cover *demographics and basic needs* (e.g., Do you have a job? Do you have somewhere to live? Do you need any social support?), *health concerns* (e.g., Do you feel well? What symptoms do you notice? Are you sleeping?), *patient goals for interaction* (e.g., What do you want to tell me? What is bothering you today?), *trauma-related questions* (e.g., Do you feel comfortable sharing your story, or would you like me to ask questions? What happened to you?), *coping-related questions* (e.g., In the past if you find yourself in this situation, what do you usually do?), and *sensitively-worded questions around hopelessness and suicidality* (e.g., What are the things that make you feel like you're nobody? What are the things that make you insecure? or other "open ended questions to open the door") - although participants also cautioned that **patients should be made comfortable before coming to these questions**, and that screeners should "start slowly" and "provide a comfortable zone before you go directly to that question"

Additionally, forced migrants indicated that they had different preferences for how they would ideally be asked to complete screening measures. *Some preferred speaking aloud and having opportunities to explain* (e.g., stating that “saying it is better” than writing, that providers should “let the person express, then have the questionnaire”, “skip the questions that don’t apply”, and “give an opportunity to say what you have been through” and explain themselves so as to not misdiagnose or confuse patients “based on the questionnaire”). *Others preferred responding to questions on paper* (e.g., “I see it differently...they can be just yes or no questions instead of talking about them,” it “depends on the person”, to “fill on paper” can “save from shedding tears”).

Speaking from their perspective, key informants identified general characteristics of the types of trauma screening tools they believe to be most effective, spanning both content and administration

Important characteristics they identified were: that the *tool should be easy to administer* (e.g., “a more basic screener for community workers to use and know how or what to refer”); *clinically relevant* (e.g., there are “limitations of standardized tools that generate scores and clinical cut-offs”); *resiliency-focused* (e.g. “changing the screening tool so it’s not pathology-focused” and moves “away from only symptom-based screening”); *focused on relevant topics* (e.g., screen for torture history by asking “people in your situation might have experienced [this], has this ever happened to you?”, and “ask about medical history”; *culturally relevant* (e.g., “should be based on an understanding of what trauma means for different cultures”); *somewhat flexible* (e.g., so providers “can use clinical skill to know when and how to ask a question”), and *well-phrased* (with destigmatized language that can “normalize the questions for patients”)

Screening approach

First, transcultural issues must be considered.
Second, the first approach to refugees is different around the world and, in many initial settings, the first care professionals who approach the refugees are not mental health workers and they are not familiar with the tools usually used in a clinical or research setting.
Third, analyzing the scales it is important to consider that some of them require a significant time of administration and are complex not only for the care worker but also for the subject who is usually from a difficult background, has language difficulties and finds himself in a very difficult and stressful situation

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Review

Mental Health Screening Approaches for Resettling Refugees and Asylum Seekers: A Scoping Review

Olivia Magwood [1,2], Azaad Kassam [3,4,5], Dorsa Mavedatnia [6], Oreen Mendonca [1], Ammar Saad [1,7,8], Hafsa Hasan [1,9], Maria Madana [6], Dominique Ranger [1], Yvonne Tan [1,10] and Kevin Pottie [1,11,*]

Studies pre-departure and post-arrival to a resettlement state searched in six bibliographic databases for articles published between 1995 and 2022: publications that evaluated **early mental health screening approaches for refugees of all ages** (25,862 citations and 70 met the full eligibility criteria:

- 45 publications that described mental health screening programs,
- 25 screening tool validation studies,
- 85 mental health screening tools,
- 2 grey literature reports described pre-departure mental health screening,
- 3 reported on two programs for women, 11 on programs for children and adolescents, and four on approaches for survivors of torture

PTSD, depression and anxiety disorders

36 scales, *used in the assessment of Post-Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD) in refugees or to investigate the presence of traumatic experiences in this population*: amongst these tools, the majority of whose are not specific for refugees, **Harvard Trauma Questionnaire** represented an interesting cross-cultural screening and one of the most employed to assess not only PTSD and MDD (often with **Hopkins Symptoms Checklist-25 (HSCL-25)** and the **Beck Depression Inventory**, but, eventually, *also to verify the presence of a torture history*. Of note, *some of them* - both diagnostic tools and screening scales - *investigate also other psychiatric conditions, such as suicide risk, psychosis, sleep disturbances and anxiety*. This kind of use could be self-administered or clinical, that is conducted by a mental health professional.

Clinical Global Impression Severity Scale and **Global Assessment of Functioning** score the severity of the illness and its impact on patients' functioning, as well as **Prolonged Grief-13 scale** investigate the presence of this particular syndrome

There are screening tools used to *detect potential psychiatric disorder or distress* (**General Health Questionnaire-28**, **Perceived Stress Scale**, **Kessler Psychological Distress Scale**) also in primary healthcare setting: among whom, **Self-Reporting Questionnaire-20** evaluate not only psychological distress, but also suicidality.

Other scales consent to monitor the progress of the therapy and, consequently, the outcome (i.e. psychological outcome profiles), but also tools to assess positive outcomes described by people who have suffered from traumatic experiences (**Post-traumatic Growth Inventory**).

Different scales focus on the *quality of life*, measuring the physical and mental wellbeing or the social relationships and support (**EQ-5D-5L**, **Quality of Life Inventory**, **WHO Disability Assessment Schedule 2.0**, **WHO Quality of Life-BREF**, **WHO-5 Well-being Index**, **Medical Outcome Study**, **Health of the Nation Outcome Scales**), largely used also to monitoring the conditions of refugees

Among the scales used for *adolescents*, there is an interesting tool, named **Acholi Psychosocial Assessment Instrument**: it consists of 60 items gathered in six subscales created to assess depression-like, anxiety-like and conduct problems in Ugandan war-affected adolescents

Psychosis

The **Prodromal Questionnaire – Brief PQ-B** was used to screen for prodromal symptoms of psychosis. This *self-report scale* is a six-item scale and it is used in particular as a screening measure for psychosis risk syndromes: it represents the brief version of the 92-item Prodromal Questionnaire. This procedure was used in a study protocol for Syrian refugees, among other scale to assess mental illness in this population with the aim to test the efficacy of **group problem management plus (gPM+)**, a low-intensity psychological intervention for adults experiencing psychological distress

Substance Use Disorders

Two specific tools were used to screen for substance use disorders among refugees and asylum seekers: the **Alcohol User Identification Test (AUDIT)** and the **Alcohol, Smoking and Substance Involvement Test-linked Brief Intervention (ASSIST-linked BI)**.

The Alcohol Use Disorder Identification Test - **AUDIT** was administered in a face-to-face interview in a study on 8000 refugees examining the prevalence of hazardous and harmful alcohol consumption among Bhutanese refugees in Nepal and to identify predictors of elevated risk and understand the best possible interventions on this population. This tool was originally developed by the World Health Organization (WHO) as a screening instrument in primary health care with a well-validated threshold score of 8 (hazardous or harmful consumption) and 20 or greater (possible alcohol dependence). The AUDIT has been found to be suitable for use in identifying hazardous or harmful consumption also among patients of different cultural backgrounds

The **ASSIST-linked BI interview** consist of eight questions on current and lifetime khat's use. The intervention part consists of providing feedback on the individual risk score as well as information on individual risks for health and social life, weighing up good and less good things about the individual's consumption pattern and discussing his concerns. Finally, change-thoughts are strengthened and advice on how to reduce risks is given, supported by handing out a self-help booklet and emphasizing patient´s responsibility and confidence.

Suicide

The suicidal tendencies in the population of asylum seekers or refugees were studied with the scale **"Suicidal tendencies (DSI-SS)"**: a 4 items self-reported scale, subscale of the **Hopelessness Depression Symptom Questionnaire**, originally developed as a brief screening tool for suicide risk in general health settings

There is a significant variability and heterogeneity in the tools used to assess PTSD, depression and more: such as number of items and administration. For example, some of them like the **Clinician-Administered PTSD Scale (CAPS-5)** must be administered by a clinician; others, like the Harvard Trauma Questionnaire (HTQ) are self-report. Also, not all the scales are used for follow-up after a first assessment.

Finally, is important to note that - in different studies - general scales of screening for mental illness such as the **Mini International Neuropsychiatric Interview (MINI)**, the **Composite International Diagnostic Interview (CIDI)**, the **Patient Health Questionnaire (PHQ-15)** or the **Structured Clinical Interview for DSM (SCID)** are used

Refugees' mental health is also highly influenced by the conditions they live in **post-migration** (Li et al, 2016). Mental health for R/AS may get worse due to ***post-migration social determinants of health***: *the impact of those determinants may increase over time and exposures to these stressors may also be cumulative*. *R/AS often leave behind most of their material possessions, savings and even documents about their qualification and profession. They may also face great challenges in having their credentials recognized, because they may not be able to produce records of their training*. Generally, many of R/AS arrive and stay in a situation of relative poverty and this can last for years: there is a *clear relationship between refugees' mental health and measures of their socioeconomic status*, the right to work and access to employment (Hynie M, 2018). As the choice of when and where to migrate is not under their control, so R/AS often arrive not speaking the official language of the new country and, frequently, that is the major barrier to employment (Bogic M. et al, 2012; Banki S., 2006; Carter TS et al., 2009; Hynie M et al, 2016; Momartin S et al, 2006; Shishehgar S et al, 2017; Chen C et al., 2010)

They may spend months or even years without access to legal employment and permanency may be a remote or even impossible outcome. If they are often overqualified for the available employments, unavoidable unemployment negatively affects mental health due to the lack of economic survival, pursued well-being and poor sense of self-worth (Bambra C et al., 2009; Braveman P et al, 2014; Miller G et al, 2009; Allen J et al., 2014)

Therefore**, language skills, discrimination, family separation, poverty and other stressors can contribute to social isolation of the R/AS**. The difficulty in accessing care and, consequently, in asking for help in case of psychological distress, contributes to the worsening of clinical conditions (Hynie et al, 2018)

Clinical tools that can identify post-migration difficulties in order to screen migrants (R/AS) at greater risk of developing psychological distress are represented by items related to immigration issues, employment challenges, access to various types of health services and isolation/loneliness/separation. Responses are rated on a five-point Likert-type scale ranging from "0" ("no problem at all") to "4" ("a very serious problem") with total scores ranging from 0 to 96 (Schweitzer, 2006)

Postmigration experiences have been important in predicting psychological well-being (Schweitzer, 2006) and comprise both difficulties and levels of social support. Regarding postmigration difficulties, the most common items claimed by R/AS referred to concerns about *family not living in hosting city, difficulties in working, in accessing public health care and difficulties adjusting to cultural life* (such as communication difficulties). These **life difficulties were associated with increased depression, anxiety and somatization**. In terms of social support, mental distress is strongly associated with lack of social network in the host country, family separation and communication difficulties (Hamrah, 2020).

Most relevant PMLDs were *"loneliness and boredom", "poor access to emergency medical care", and "poor access to counselling services"*, suggesting that social isolation and perceived lack of medical and welfare support are key factors for mental health's well-being (Aragona, 2011; 2013). This is particularly relevant because all patients (the"undocumented" groups included) were actually entitled to receive emergency medical care from the NHS and to access counselling services

LIMES (LIST OF MIGRATION EXPERIENCES)

This tool is a check-list of 59 events that migrants may have experienced in the course of their lives. Item responses are framed as presence/absence of the event and, *if present*, the same experience *can be rated to have occurred before leaving the country, during the journey, and/or in the host country* (Aragona et al, 2014). The items are clustered in two main groups: (1) **traumatic experiences** (e.g. war/conflicts, intentional traumas including rape and torture, witnessing of traumatic events occurred to family members etc.) and (2) **living difficulties** (e.g. barriers/difficult access to assistance, poverty, unemployment, problems at work, problems in the legal procedure in the host country, discrimination, cultural/social maladjustment, etc.). It is also possible to *group items in eleven subscales*, namely: *Generic traumas; Intentional traumas; War/conflict conditions; Traumas and worries for family members; Poverty; Difficult cultural/social adaptation; Difficult access to welfare facilities; Problems with legal procedures; Work problems; Discrimination; Migration blues*

Pre-Departure Mental Health Screening

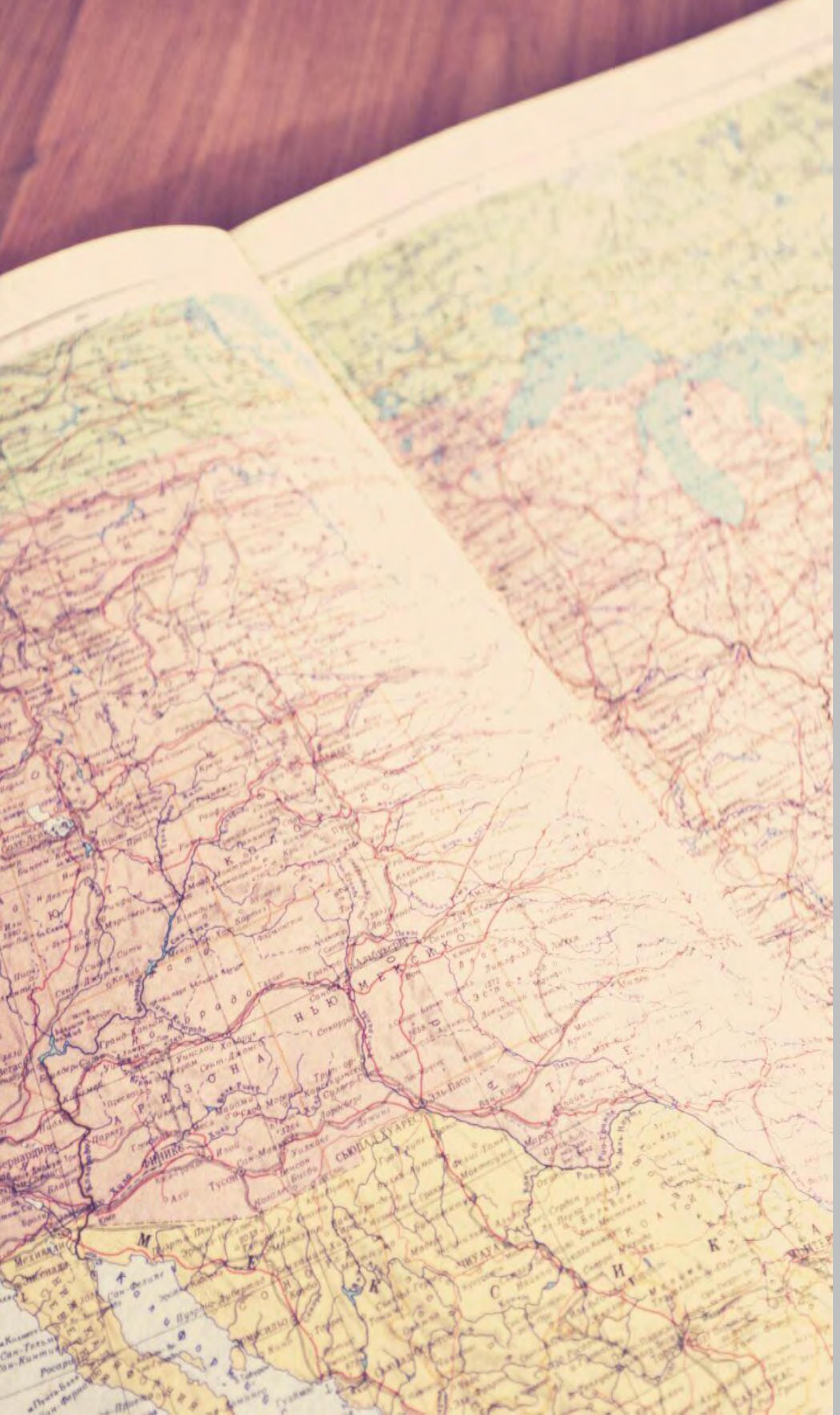
The International Organization for Migration **(IOM)** conducts several pre-migration health activities at the request to **identify health conditions of public health importance and to provide continuity of care linking the pre-departure, travel and post-arrival phases**. These assessments include detection of non-communicable diseases, including mental health assessments. *In one year, 48.8% of assessments were conducted among females and 51.2 among males. The majority of health assessments were among refugees younger than 30 (67.1%), with the highest number in the under-10 age group. Mental health conditions were identified in 2249 pre-departure health assessments conducted among refugees (2.0%)*.

Global Mental Health Assessment Tool (GMHAT) was used in Syrian refugees. This *clinically validated, computerized assessment tool* was administered by a range of healthcare staff and was designed to detect common psychiatric disorders and serious mental health conditions *within the time span of 15–20 min*

Pre-Departure Mental Health Screening

Findings suggested that a pre-departure mental health assessment could be *a useful tool to assist in the preparation for refugee arrivals to overseas resettlement facilities* and serve as a valuable resource for general practitioners. *Other potential benefits included overcoming barriers such as trust and language, expediting referral and treatment, increasing awareness of mental health issues, and improving support and integration of refugees by proactively addressing concerns*. Several considerations were identified to improve the impact and roll out of pre-departure mental health assessments.

Firstly, *the GMHAT identified 9% of participants with a likely diagnosis of mental illness and an additional 1.5% of participants were referred post-arrival based on clinical judgment*; as such, it was noted that **the pre-arrival assessment should not be used in isolation or as a replacement for routine psychological assessments post-arrival**, and that practitioners should use their clinical expertise to pick up on any missed diagnoses



Secondly, the use of the tool was deemed appropriate, but it was noted that *participants' cases took longer to process than those who had not undergone an assessment*. Though it was not possible to distinguish whether the GMHAT was the cause of the delay, this is an important consideration. An evaluation of the program indicated that additional information is needed to estimate the impacts on costs and case processing times. Further, it is important to *ensure that the information obtained from the pre-assessment will not lead to the rejection of vulnerable refugees based on their mental health status nor based on the resettlement country's service availability*. **Clear parameters should be defined to determine the flow of information sharing, and usage should be defined a priori**, as it was noted that *some healthcare workers were unsure on how the information was intended to be used and whom it could be shared with*, ultimately devaluing the purpose of this tool. Lastly, it is important to ensure adequate post-arrival mental health service delivery, since pre-departure assessments can also pose a *risk of raising expectations of the care* that refugees hope to receive upon resettlement.

The most frequent **pre-migratory events** were related to *forced separation from the other members of the family, violence* (against other worshippers and often the patients themselves), *ostracism and uncertainty*: particularly, being *deprived and discriminated as part of a religious minority group, being victim of perceived injustice, being neglected, being unable to control their own life*. Regarding **resettlement**, the most frequent problems were *worries about the family left at home, difficult cultural/social adaptation, migration blues, and legal/work problems* (Aragona et al, 2014). The impact of migration trauma (using Limes) on *Suicidal and Self-Harm Behaviours (SSHB)* of migrants in jail is underlined (Marchi et al, 2020). The condition of isolation during **imprisonment** has been confirmed to increase the risk of suicide by itself (Roma et al., 2013) in terms of vulnerability and social precariousness (about a third of the cohort were illegal immigrants and two-thirds reported to have never been employed before detention)

Social instability and marginality are well-known risk factors for involvement in criminal networks (Archuleta et al, 2020). It could be assumed that since illegal migrants cannot have access to most of the welfare programs, and particularly to ones related to work and health-care, nor to alternative measures to the detention in case they offend, *a vicious cycle of further social detriment self-perpetrates*.

Migrants in custody who experienced trauma in the post-migration period, attempt SSHB seven times more frequently than those without traumas at any time.

War trauma and post-migration trauma due to exposure to violence seem to be more strongly associated with SSHB, also controlling for psychiatric diagnosis, ongoing psychopharmacological therapy and substance abuse.

RPMS (THE REFUGEES POST-MIGRATION STRESS SCALE)

The **refugees post-migration stress scale (RPMS)** is a *21-item instrument assessing stress related to post-resettlement experiences and life conditions* across seven domains:

- Perceived discrimination
- Lack of host country specific competences
- Material and economic strain
- Loss of home country
- Family and home country concerns
- Social strain
- Family conflicts

All domains of post-migration stress of the tool showed *significant correlations with anxiety, depression and PTSD scores, and significant negative correlations with mental well-being scores*. Post-migration stress primarily relating to social and economic factors seems to be associated with mental illness among refugees, which points out the need for interventions targeting discrimination, unemployment, and social isolation (Malm, 2020)

PERCEIVED DISCRIMINATION

The effect of perceived discrimination on the mental health of Afghan refugees (Alemi, Stempel, 2018) was assessed using *a 4-item scale* developed through preliminary qualitative interviews with members of the Afghan community to identify and develop items with strong face validity that covered a broad range of experiences with discrimination. *Two items are standard questions about personal experiences of discrimination and the other two were developed inductively to capture perceived threats and unfair treatment after the events of 9/11*. The two standard items focused on perceptions of unfair treatment when seeking employment and housing or other public situations. The item responses were coded into three categories, ranging from 0 to 2, and scores are an equally weighted sum of these items ranging from 0 to 8, with higher scores indicative of higher perceived discrimination (Alemi, Stempel 2018). *Discrimination show a significant positive association with psychological distress*

THE POST TRAUMATIC GROWTH INVENTORY SHORT FORM (PTGI-SF)

The **Posttraumatic Growth Inventory Short Form (PTGI-SF)** is a *10-item self-report scale derived from* the **21-item PTGI scale** and measure *post-traumatic growth, post-traumatic stress symptoms, depressive symptoms, post-migration stressors and their association with quality of life* in an outpatient psychiatric population with a refugee background in Norway (Teodorescu et al, 2012). It contains *five factors* (2-items in each): *relating to others, new possibilities, personal strength, spiritual change and appreciation of life*. The items are rated on *a 6-point Likert scale* from 0 (no change) to 5 (very great degree of change), with domains scores ranging from 0 to 10 and where higher scores indicate a greater positive change. Was found a significant, medium negative correlation between PTG and PTSD symptoms in patients who were exposed to traumatic events many years ago, suggesting that *the passage of time aids in the development of an authentic growth that should be negatively related to psychopathology*

Mental Health Screening for Survivors of Torture

We identified four studies which described **screening approaches and tools for survivors of torture**:

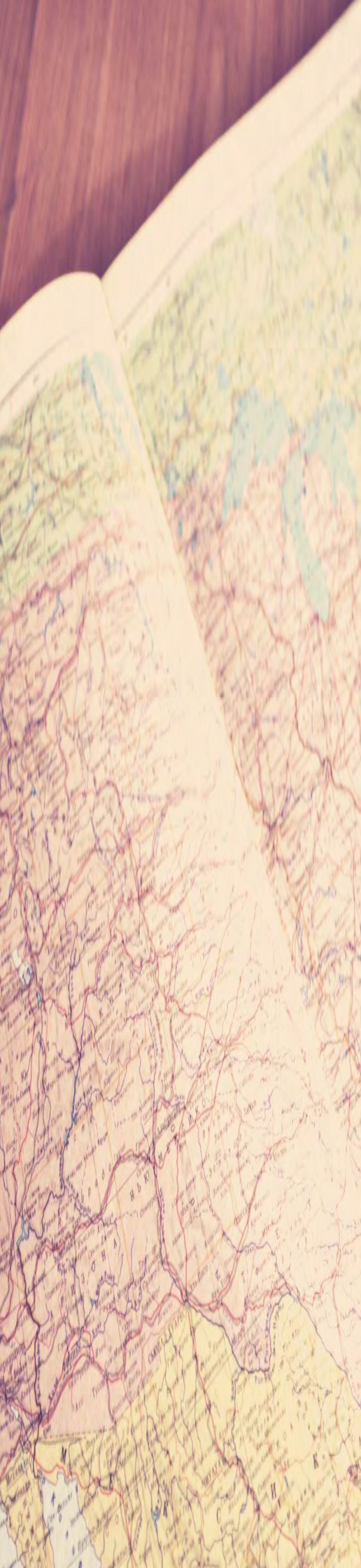
- *the WHO's General Health Questionnaire* and a clinical interview conducted by physicians,
- *the Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment (PROTECT) Questionnaire*, which identifies symptoms of PTSD and depression and *categorizes asylum seekers into risk categories*, supporting a two-stage approach to mental health screening. The questionnaire was specially developed to be *administered by nonmedical/psychological staff for the early identification* of asylum seekers who suffered traumatic experiences (e.g., experiences of torture). The tool was administered directly in refugee reception centres and refugee accommodations. The validity of the PROTECT Questionnaire was confirmed concluding (Wulfes et al., 2016), that the use of the PROTECT Questionnaire could be more efficient than other brief screening tools (eight-item short-form Posttraumatic Diagnostic Scale (PDS-8) and the Patient Health Questionnaire (PHQ-9)) because it detects two conditions at once

Program for Survivors of Torture (PSOT) exists, in US, to offer services to clients who experienced torture. At PSOT, asylum seekers were screened for PTSD with the Harvard Trauma Questionnaire (HTQ) and Major Depressive Disorder (MDD) screening was conducted with the Patient Health Questionnaire-9 (PHQ-9). If a client screened positive for MDD or PTSD at intake, they were referred for a mental health evaluation and management through PSOT.
Severe cases were evaluated urgently by a PSOT psychologist or psychiatrist. Of those clients diagnosed with depression and PTSD, *94% received follow-up, defined as either referral to a psychiatrist, psychologist, or support group, or pharmacologic management by a primary care provider*. The high follow-up rate was attributed to the unique multidisciplinary medical home structure of the program, which has significantly more allied health professionals, live interpreters, and support staff than an average primary care clinic in the area

Mental Health Screening Approaches for Refugee Women…

Two mental health screening programs specifically for refugee women of reproductive age. A protocol for a screening program whose acceptability and feasibility has been evaluated, but whose effectiveness *(outcome) data are not yet available*. Both studies screened for mental health conditions post-arrival in a clinic specifically aimed at assessing and treating refugee women (*pregnant women in the perinatal and postnatal period at their first appointment, with screening repeated in the third trimester;women seeking obstetric and/or gynaecological care*), not differentiating between pregnant and non-pregnant women.

The **Refugee Health Screener-15 (RHS-15)** with a cultural health navigator to screen women for PTSD, depression, and anxiety: for women, *the aim was to complete the screening independently and confidentially without the presence of spouses, family members, or friends, as this may influence patient responses*



Mental Health Screening Approaches for Refugee Women

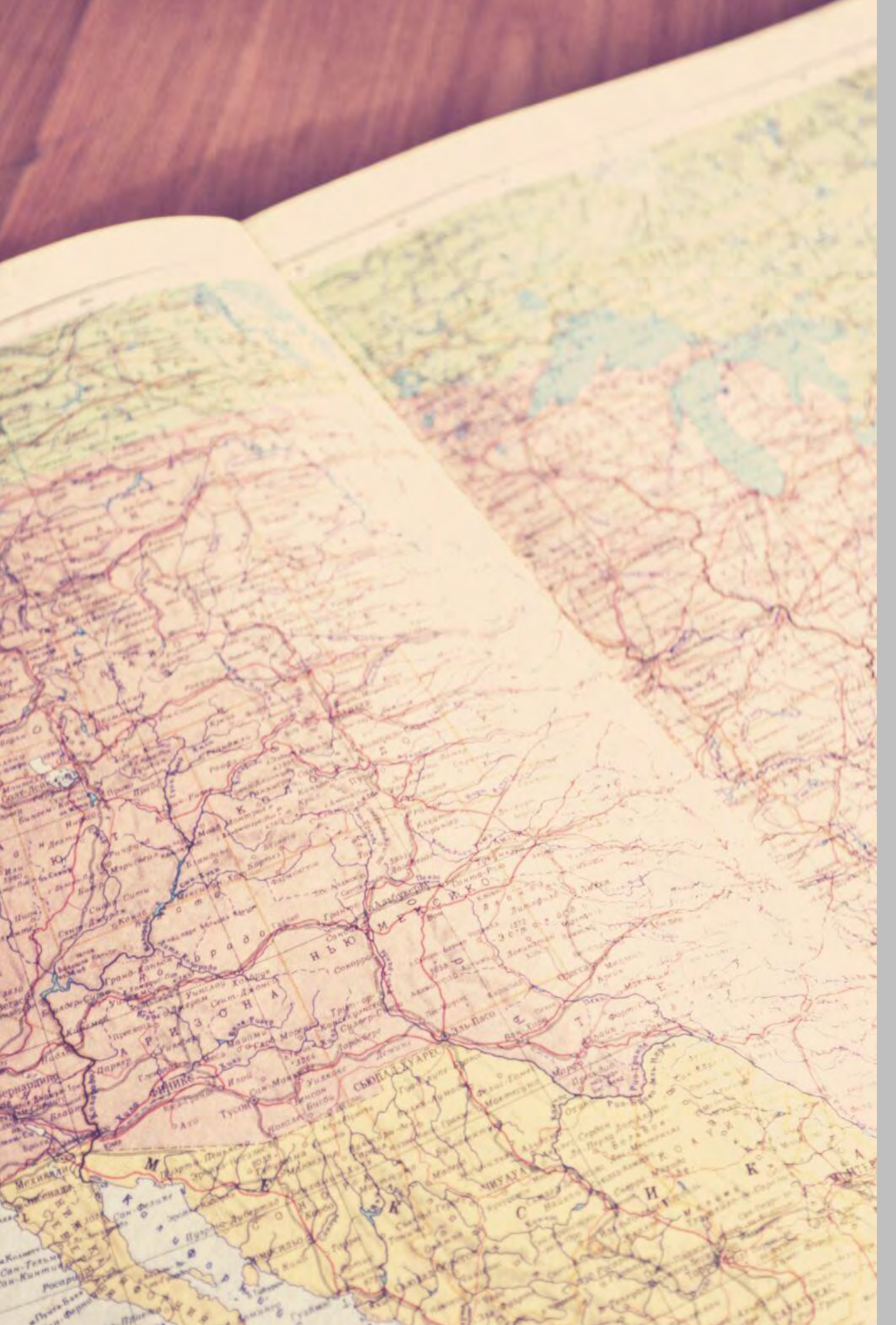
The Edinburgh Postnatal Depression Scale to assess depression and anxiety in the perinatal period.

The Monash Health psychosocial needs assessment tool to assess perinatal *mental health disorders, such as past birthing experiences, violence and safety, and social factors* (finances and housing). Women will complete both assessments on a tablet in their chosen language and *interpreters or bicultural workers* are *available to assist*.

The Refugee Women's Health Clinic employed multilingual cultural health navigators; program managers skilled in social work who reflected the ethnic and cultural diversity of the patient population and helped with the administration of the screening tool. They were *all female, which helped to build strong rapport and trusting relationships for refugee women to feel more comfortable discussing sensitive concerns in their native language*. The implementation of their program was dependent on a *interdisciplinary models of care, gender-matched multi-disciplinary health care providers, and patient health navigators and interpreters* are necessary for integrated approaches and community empowermen. Many women still do not enroll in mental health care after assessment. It was speculated that **one reason women may decline care is due to the social stigma of mental health** which could be introduced via social desirability bias and may be heightened through the verbal administration of questionnaires

Mental Health Screening Approaches for Refugee Children and Adolescents

Eleven studies were identified that investigated *mental health screening approaches specific to refugee children and adolescents between the ages of 6 months to 18 years old* were included. All studies included adolescent populations (ages 10–18) and fewer studies included children below the age of 10. The programs reported that there is **variability in the timing of presentations of mental health disorders**; thus, an early assessment of the psychological needs of children and families allows for *timely targeted support*. Children and adolescent screening programs focused on a wider range of conditions which consider critical developmental stages. The **psychological factors**: *emotional problems, conduct problems, hyperactivity, peer problems and prosocial behavior, stressful life events, PTSD, anxiety, depression, and somatization disorder*; *health risk behaviours, health-related quality of life, and physical and psychosocial well-being, including physical functioning, body pain, emotional problems, self-esteem, and family cohesion* were also screened for. **The most common mental health condition screened for was PTSD**, as 10/11 identified studies included a questionnaire which screened for it



Various “child-centered” approaches were described. Two studies, consistent with trauma, offered children the **possibility to be accompanied by a person they trusted as support. In contrast, another study recommended seeing adolescents alone during consultations.** Children, regardless of their age, were offered *help to read the items on the questionnaire, to clarify and ensure understanding of the concepts being screened for in the questionnaire*. When administering questionnaires to children, investigators noted that **it is important to not overload them with various instruments as it may cause confusion and a decrease in completion rates**. Furthermore, children can experience *difficulties with Likert scales and question formats*, despite surveys being constructed with attention to literacy, linguistic, and culture issues. The approaches emphasized the importance of interdisciplinary collaboration and discussions regarding **confidentiality**. Children and adolescents often require diverse services; thus, multidisciplinary healthcare was recommended to manage health risk behaviours (e.g., medical, sexual, reproductive, mental, social services)

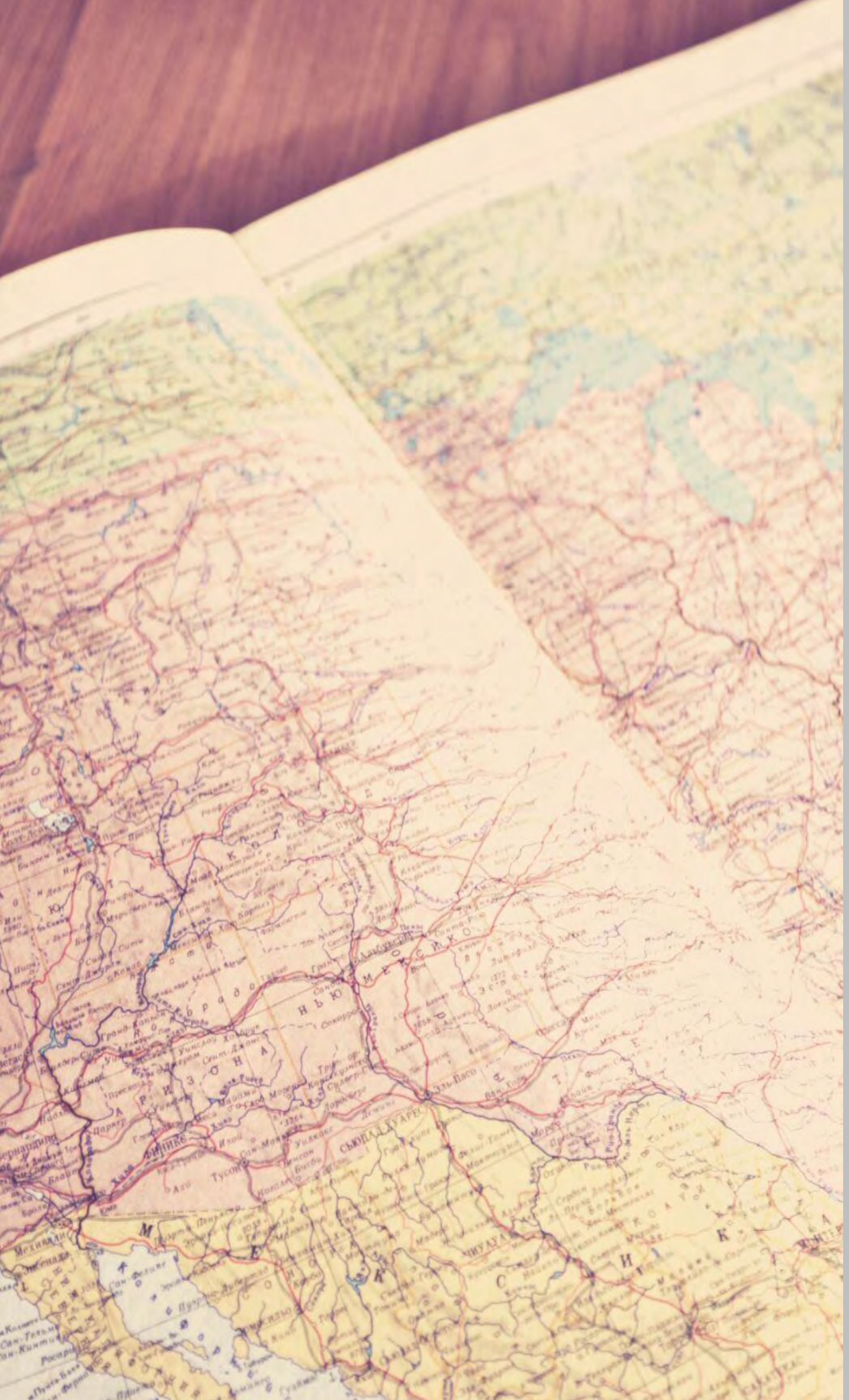
Only two publications reported on the **digital administration of mental health screening with adolescents**: a computer-based system (laptops and touch-screen function) to administer their screening questionnaires to unaccompanied adolescents with limited school backgrounds. The computer-based tool is named **'Providing Online Resource and Trauma Assessment' (PORTA)**, which *combines disorder-specific questionnaires on the topics of trauma (CATS), depression and anxiety (RHS + PHQ-9), behavioural problems (SDQ), and self-harm and suicidality (SITBI)*. Investigators found that regardless of how they rated their own reading and writing abilities, or how many years of formal schooling they had, they were *able to complete the computer-based assessments independently*, and there was a *minimal need for interpreters*.

Several studies included **pediatric populations** in addition to adults, but these studies were not exclusive to children or adolescents. These studies represent community and primary care settings that do not separate out the children, adolescents, women, and men, but rather provide services to families and any individual patient

LGBTQ+ and people living with disabilities

These subgroups of refugees may be understudied due, in part, to complex intersecting identities and experiences which are not captured by immigration systems or other institutions. *Concepts of "impairment", "disability", and "gender" can differ enormously among different cultures and societies, and these identities are often excluded from refugee registration and assistance programs*. Despite this, our findings noted that refugee mental health screening programs were often tailored to the refugee population by applying the principles of trauma-informed and person-centered care, including linguistically and culturally appropriate approaches and the evolution of gender- and age-specific programs.

When selecting the most appropriate mental health screening tool, *program developers must consider the specific refugee population, the estimated prevalence of mental health disorders, cultural idioms of distress, and the complex environmental stressors and traumatic events that may provoke mental health issues*. A comprehensive biopsychosocial assessment and meaningful intervention may need to occur over time with trusting, supportive therapeutic relationships and sometimes with specialized mental health care teams



Mental Health Screening Tool Validation Studies

A total of 25 studies evaluated the validity of mental health screening tools among a cumulative sample of N = 4341 refugees and asylum seekers. *Screening took place post-arrival or in transit to the host country,* which varied between studies and included the United States (n = 6), Sweden (n = 4), Germany (n = 5), Italy (n = 2), The Netherlands (n = 3), Australia (n = 1), Norway (n = 2), Greece (n = 1), and Switzerland (n = 1). Sixteen studies screened for mental health conditions among refugees, seven among asylum seekers, and one among unaccompanied migrant minors regardless of their legal migration status and their age. Studies seldom screened for just one mental health condition and most commonly screened for multiple; trauma-spectrum disorders, such as posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD), as well as traumatic events and experiences, were the most commonly screened conditions across studies (n = 21/25), followed by major depression (n = 12/25), anxiety (n = 8/25), somatization (n = 1/25), general psychological needs (n = 1/25), and environment safety (n = 1/25).

CONCLUSIONS

Four screening tools emerged as the most commonly used among the identified validation studies.

The Harvard Trauma Questionnaire (HTQ) screened for posttraumatic stress disorder and traumatic events and was validated in six studies. Translation of the tool to non-English languages was reported in four studies and the use of interpreters to facilitate its administration was reported in three. Was discussed the importance of distinguishing *two trauma subtypes* when screening for PTSD: *physical trauma and lack of necessities*.

The Refugee Health Screener (RHS), both the 13- and 15-item versions, screened for depression, anxiety, and posttraumatic stress disorder and was validated in five studies. The tool was translated in all studies and the use of interpreters to facilitate its administration was reported in four of five. All studies reported the ade- quate validity of the RHS tool in screening depression, anxiety, and posttraumatic stress disorder

The Hopkins Symptom Checklist (HSCL-25) screened for depression and anxiety and was validated in two studies that translated the tool to the language of screened refugees and asylum seekers and used *interpretation services to facilitate its administration*.

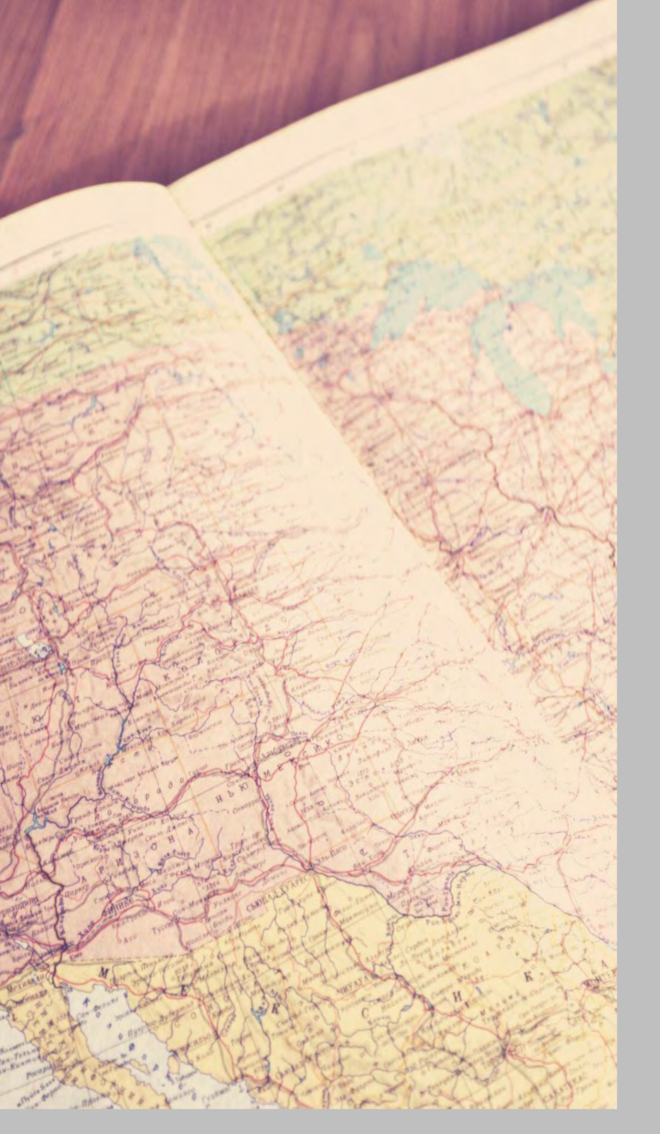
The Mini International Neuropsychiatric Interview (MINI) was adapted and validated in two studies. The first study translated the instrument into Arabic and tested its validity in screening major depressive episodes, PTSD, panic disorders, generalized anxiety disorder, and agoraphobia among Syrian, Iraqi, and Palestinian refugees. When compared to the PHQ-9, authors reported the high validity of the MINI instrument in screening for depression, anxiety, and PTSD. The second study validated the major depression and PTSD sections of the French version of the MINI among asylum seekers from Europe, Asia, and Africa. The authors of this study concluded that *the tool could be used to systematically screen for depression and PTSD among refugees from different origins*

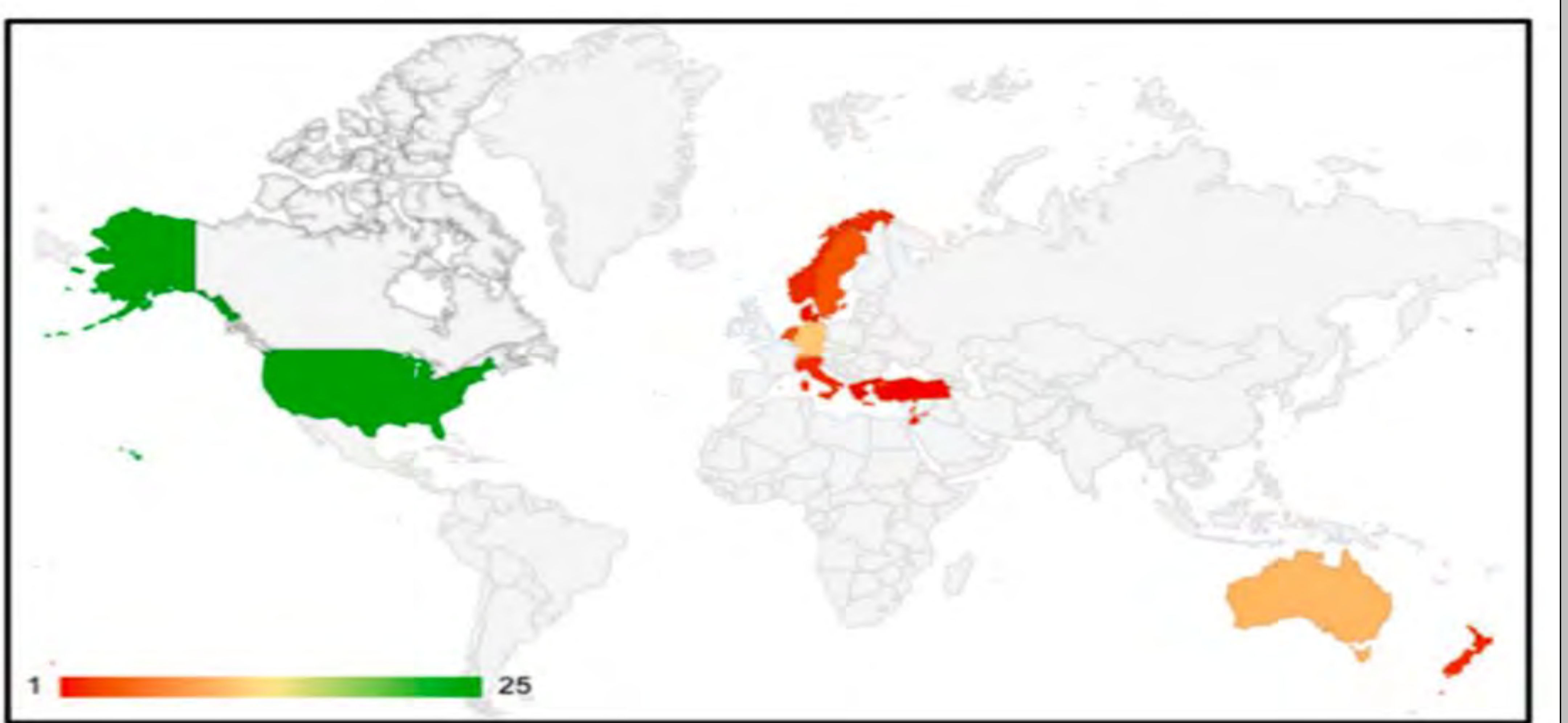
It could be more useful to get evaluation tools aimed at identifying more accurately even the different period of post-migration: immediate vs late difficulties such as finding a place to house, get money for food, having clear directions to follow for work or long-period survival skills to move without feeling lost and abandoned. **We need also unified and validated screening tools to uniquely assess pre- and post-migration traumas and psychopathological characteristics related to follow-up** throughout the all period in the host country. There are enormous difficulties in hooking them up to do screening and long-term follow-up because they lack the organization, resources and facilities to do so.

These available tools are substantially self-administered with the risk of wrong results due to lack of language comprehension. Furthermore, **the scales, are not specific to a diagnosis but are aimed at assessing various psychological difficulties**. The goal of future should be a more precise revision of the items and their adaptation to the phases, periods and needs of migration pathways

Current health assessments do not routinely screen for common mental health concerns. Providing early care for treatable mental health conditions could help refugees benefit from resettlement, language, cultural and employment training programs, develop positive relationships, reduce intergenerational trauma, gain access to employment, and ultimately lead to more meaningful and productive lives. *Developing early common mental health screening and treatment programs is therefore an important first step when integrating refugees into local primary healthcare services*.

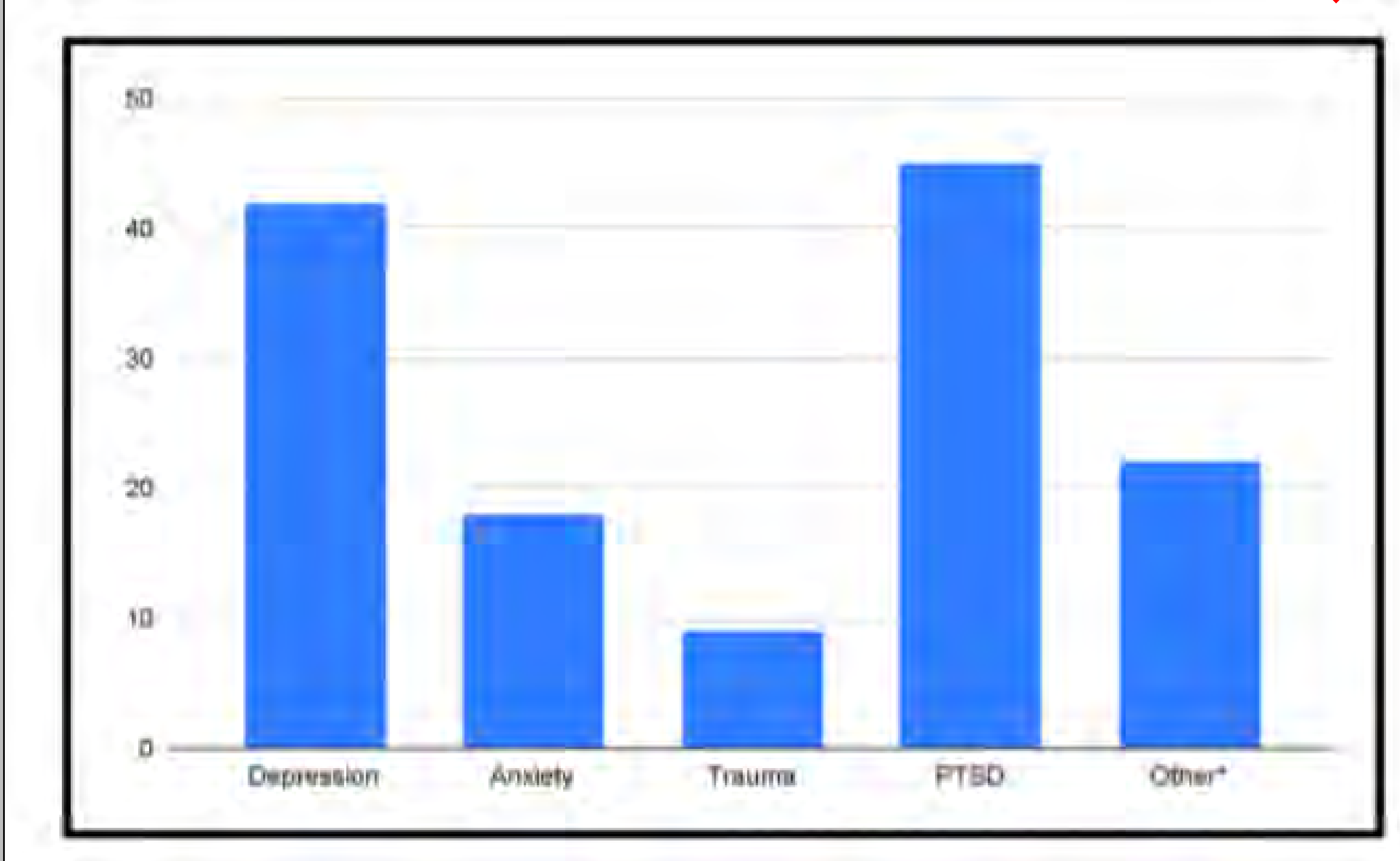
The majority of synthesized literature on refugee mental health focuses on the prevalence of mental illness, access to mental health services and tailored programs and interventions. There is limited available evidence which characterizes screening tools and procedures specific to assessing mental health among refugee and asylum-seeking populations during resettlement

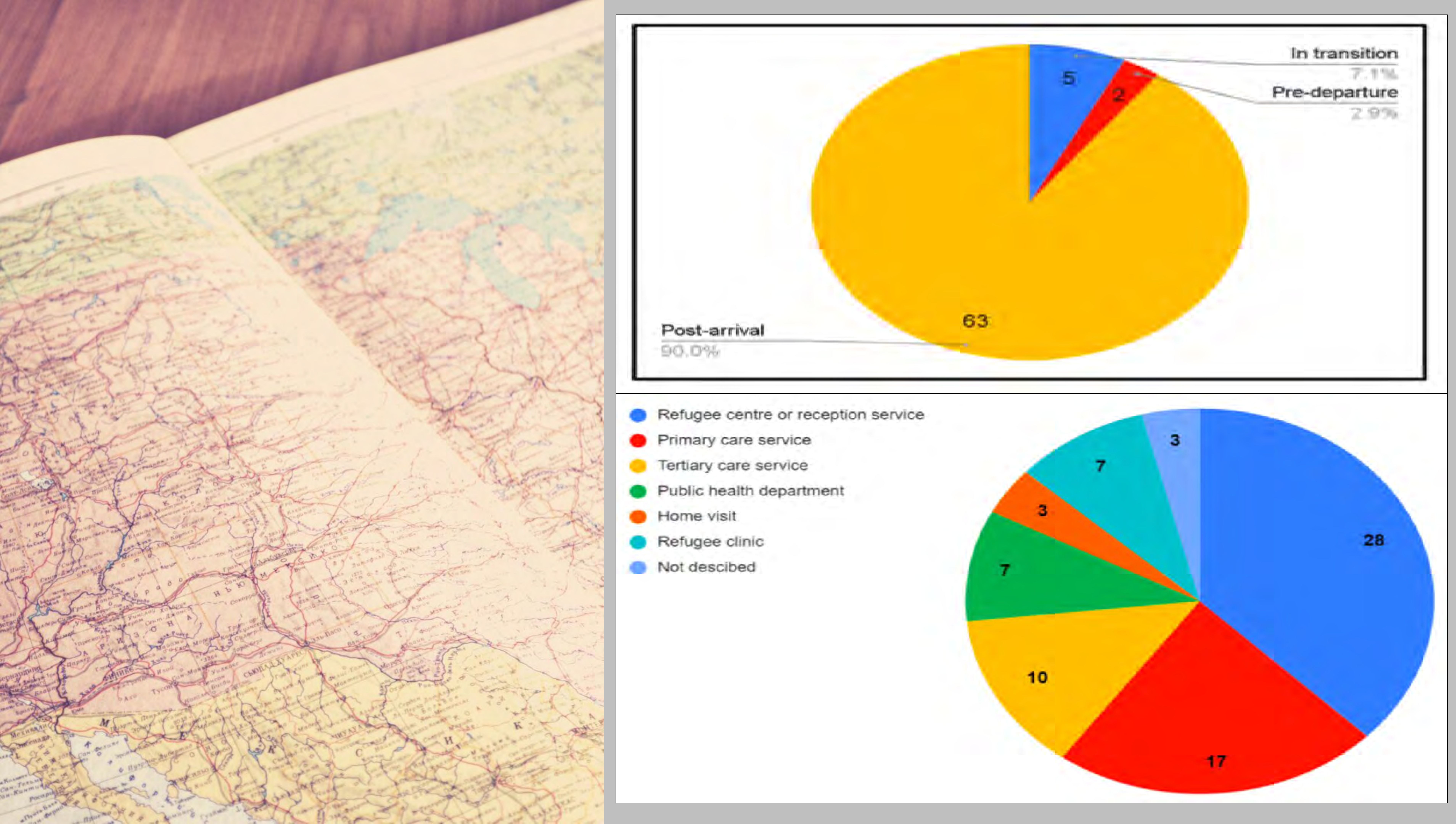




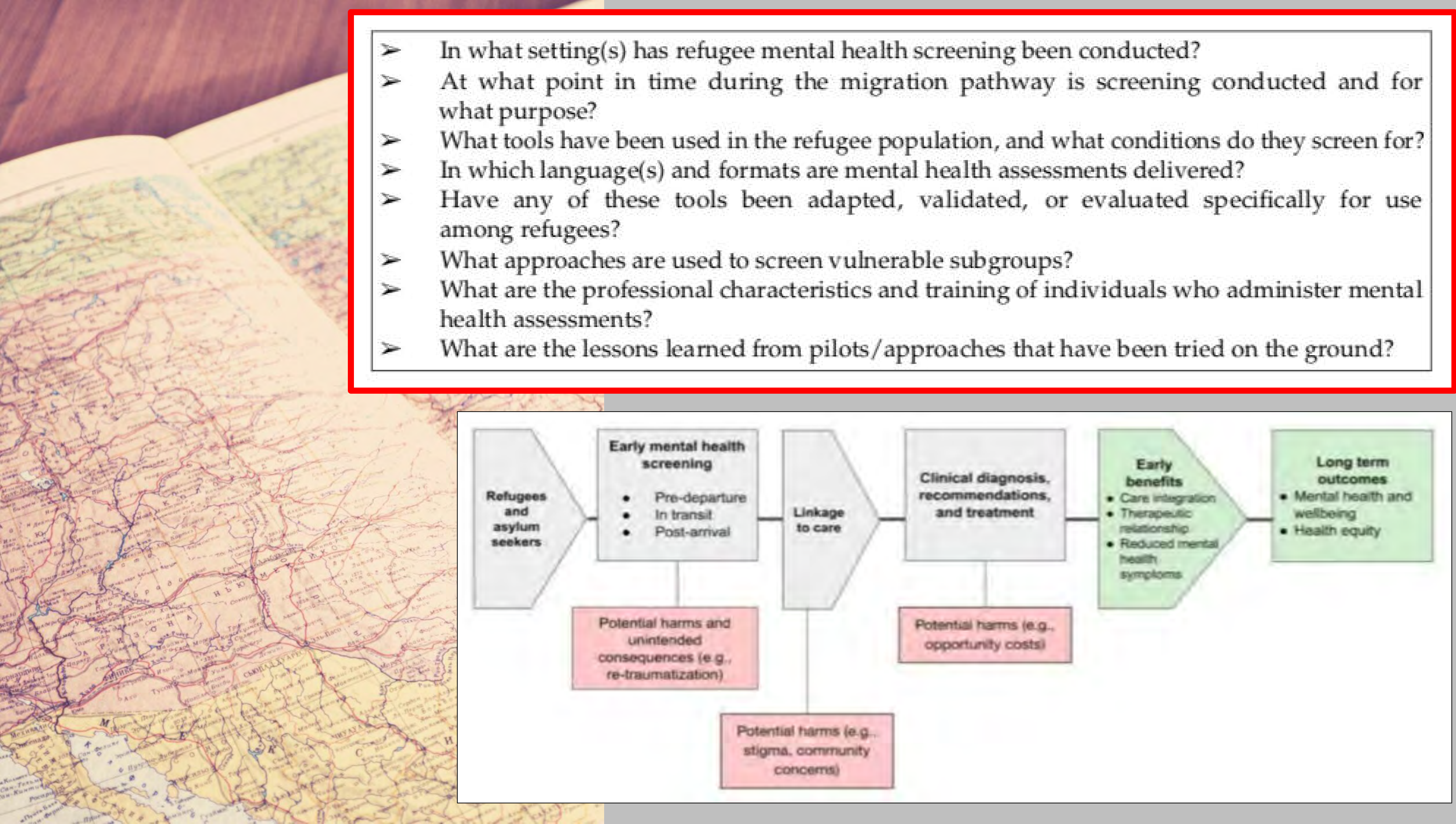
Overview of mental health conditions assessed among refugees and asylum seekers. NB: Any mental health assessments that did not include depression, anxiety, trauma, or PTSD were categorized as 'Other' (e.g., general mental health, panic disorders, adverse childhood events, etc.)

A total of **85 mental health screening tools** were identified. Several of these are *available in multiple languages* and are either *self-administered/administered by various trained professionals such as primary care providers (PCPs), mental health specialists (MHSs), or community health workers (CHWs)*. Several tools could also be administered by *a lay person without clinical training*. The **most common** tools were the Harvard Trauma Questionnaire (HTQ), the Hopkins Symptom Checklist-25 (HSCL-25), the Mini International Neuropsychiatric Interview (MINI), and the Refugee Health Screener-15 (RHS-15)

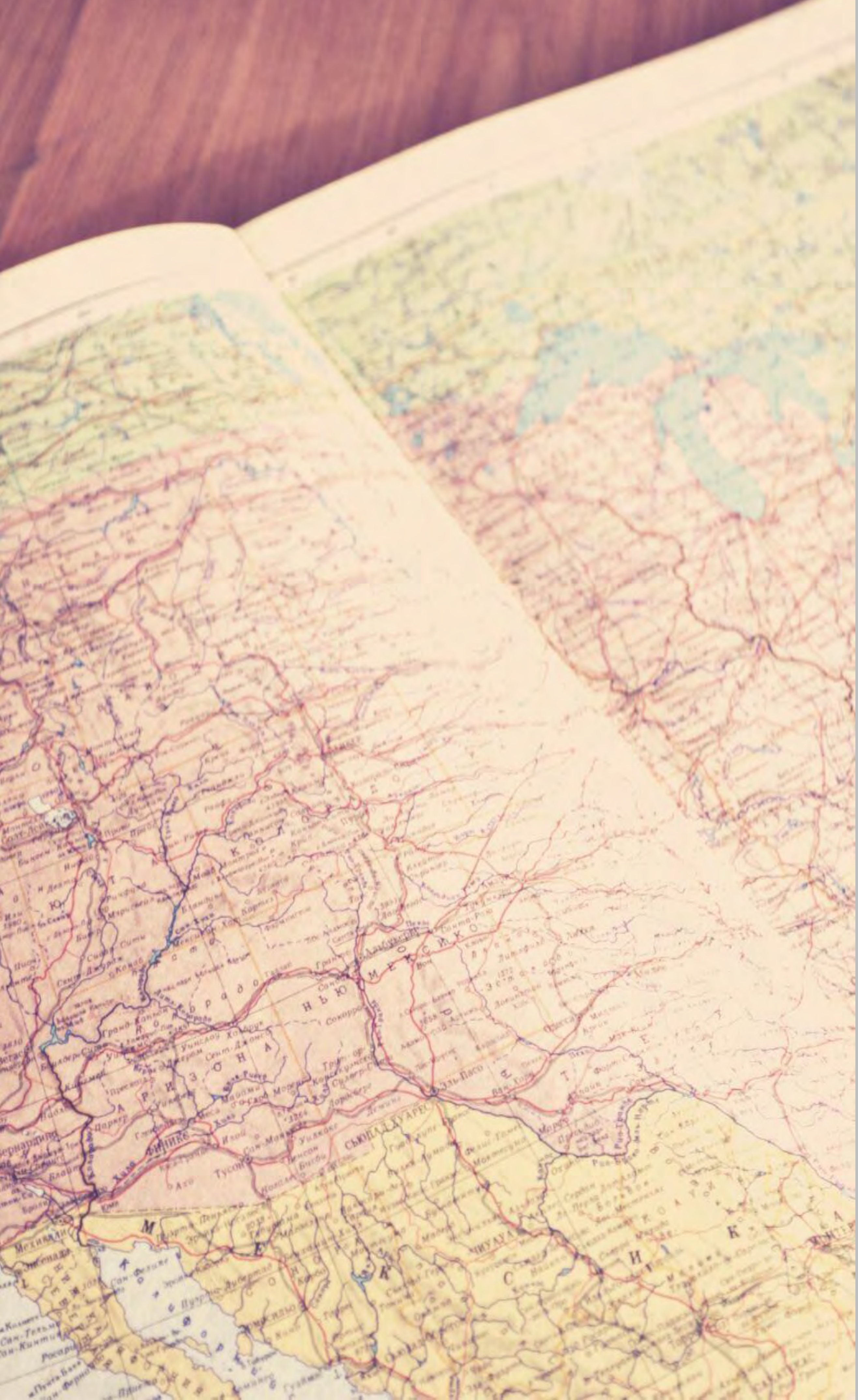




In transition
7.1%
Pre-departure
2.9%
Post-arrival
90.0%
5
2
63
Refugee centre or reception service
Primary care service
Tertiary care service
Public health department
Home visit
Refugee clinic
Not descibed
28
17
10
7
3
7
3



➢ In what setting(s) has refugee mental health screening been conducted?
➢ At what point in time during the migration pathway is screening conducted and for what purpose?
➢ 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 vulnerable subgroups?
➢ 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?
Refugees and asylum seekers
Early mental health screening
Pre-departure
In transit
Post-arrival
Linkage to care
Clinical diagnosis, recommendations, and treatment
Early benefits
Care integration
Therapeutic relationship
Reduced mental health symptoms
Long term outcomes
Mental health and wellbeing
Health equity
Potential harms and unintended consequences (e.g., re-traumatization)
Potential harms (e.g., opportunity costs)
Potential harms (e.g., stigma, community concerns)



Implications for Practice

Most refugee mental health assessments were held in refugee-specific clinics or services with interdisciplinary primary care, primary care clinics, and hospital services. *As cultural idioms of distress and the presentation of mental health symptoms vary across cultures, it is essential that health care workers are supported and equipped with the training and tools to adequately assess the mental health of refugees and asylum seekers in a sensitive and culturally appropriate manner*. **Mental health care is often specialized, but most refugees and asylum seekers will initially present to primary care clinics**. *It is important to remember that mental health disorders are most often experienced as social, cultural, spiritual, and medical issues, and these can lead to a range of first presentations, often to family, friends, and religious leaders*. Primary care clinics need interdisciplinary programs with co-located physical and mental health services, and these programs need screening and monitoring tools to help engage team members in identifying illness, monitoring care, and detecting the severity of symptoms

It is important to understand if there are evidence-based benefits to performing the assessment of mental health at different time points (i.e., pre-departure, during their transition, or post- arrival) in order to determine how the timing of the assessment can impact immigration, referral to care, access to support, and overall health outcomes.

Who administers mental health screening? Most mental health assessments are administered by a trained health professional with various levels of mental health expertise. This includes *general practitioners, nurses, psychiatrists, psychologists, and community health workers*. However, *some tools can be self-administered* (for example, the Refugee Health Screener) *and completed on paper or using digital technology such as a tablet or computer*. **We identified a few mental health screening tools (PROTECT Questionnaire; STAR-MH; Refugee Health Screener) administered by staff without medical or psychological health training**. Regardless of who administers the mental health assessment, numerous studies highlighted the *importance of a trained interpreter or translator to assist* in the assessment and prevent misinterpretations and miscommunications

Which mental health screening tool should be administered?

There is *no international consensus regarding the most effective mental health screening tool to be applied in the context of resettlemen*t. While several tools are gaining popularity (for example, the Harvard Trauma Questionnaire or the Refugee Health Screener), **there is currently insufficient effective research to guide the selection of mental health screening tools for national level programs**. Currently, tools are chosen to reflect the cultural sensitivity and geographical diversity of refugee groups, but *as migration patterns change rapidly, it is difficult to specify a singular set of tools that can be applicable to a large array of refugee populations*. **It is well recognized that Western diagnostic classifications of mental health conditions have significant limitations with refugee populations because of variations in causality, sociocultural context, and symptom manifestation**. *Screening tools should be (1) self-reported or administered by trained non-medical health workers; (2) responsive to change; with (3) a demonstrated acceptable response rate, reliability, and validity in displaced populations; and (4) a minimal response burden*

When should mental health screening take place?

Despite the existence of country-level guidance for pre-migration mental health screening (for example, USA, Australia or New Zealand), there are very few published reports evaluating these processes. *Most assessments occur post-arrival to the resettlement state*. Post-arrival programs can leverage community partnerships and medical home models to *ensure efficient and appropriate linkages to care*. Some studies noted the difficulty of following up with refugees as they often get transferred from one location to another in the first few months post-arrival. Further, Australian and UK studies reported **challenges with the information transfer between and within pre-migration and post-arrival health systems**, causing *duplication of avoidable tests, increased costs, inefficiencies, and possible clinical consequences*. To date, there is **neither consensus** nor sufficient program research **to identify the optimal time to screen and assess the mental health needs** of refugees and asylum seekers

Where does mental health screening take place?

The majority of mental health screening takes place in a primary care community setting, including refugee specific clinics or services where professionals were trained and familiar with the caseload. Individuals presenting to primary care have come for help and **accepted the "patient" role**; therefore, psychiatric case finding and offering treatment may be less intrusive than it would be in other settings. Furthermore, *because this setting is not defined as "psychiatric," the stigma associated with mental health treatment may be more easily minimized*. One study reported a high rate of refusal during a clinic-based post-arrival health assessment and found that *mental health screening was more effective when conducted during a home visit*

Do screening programs facilitate linkages to care?

Post-arrival screening programs usually include a linkage to care, either on-site or through referrals to community organizations or further specialized care. **Programs which operate a medical home model can offer direct multidisciplinary care with allied health professionals and interpreters**. The evidence on **pre-departure screening** is less conclusive: while this information could *function as an "early warning" to help local authorities prepare for individuals needing additional support*, the impact of the screening is likely to be limited by resource availability and access to specialist mental health services. *Existing community resources may not be appropriate for the specific mental health needs of refugees who have fled conflict or experienced violence, torture, or trauma*. However, as these pre-departure reports provide valuable information which is usually not available on arrival or takes time and trust to elicit from a patient, **pre-departure mental health screening may help primary care providers save time and take appropriate action more proactively**

How can mental health screening be implemented?

Several studies highlighted that *funding for mental health screening and care programs is essential*. Although many factors affect program success, *the loss of program funds has been identified as the primary factor contributing to staff reductions and implementation failure*. Further, basic training about the context and important health issues of resettled refugees and administration procedures is necessary for all clinical and non-clinical staff. **Processes should be streamlined to reduce the time required to complete the assessment**. National training programs can provide technical assistance and support culturally relevant behaviours, attitudes, and policies in clinical practice, and help address mental health stigma. Finally, two studies suggest that *sequential screening (i.e., categorizing refugees by level of risk to inform linkage to care) is a pragmatic strategy that can reduce the response burden and facilitate the detection of mental health conditions in settings with a scarcity of mental health specialists*

Implications for Policy

While the benefit of the treatment of symptomatic mental illness among refugees is well-recognized, several factors influence the timing and feasibility of these assessments and subsequent treatment interventions. **Ensuring refugee communities understand the goal and privacy of mental health screening, and ensuring access to care after screening, are essential factors for program success.** Community-based screening with links to a holistic health settlement process is the most common and feasible approach. This may include formal routes of **intersectoral collaboration between various services to provide multidisciplinary health care** (e.g., medical, sexual, and reproductive health, mental health, allied health, educational agencies, social services, governmental bodies). **Pre-departure overseas screening may provide some benefits**, but more evaluation and refugee community support is required

Grazie dell’attenzione