

Title: Improving community mental health services for refugees and asylum seekers by exploring the stepped care approach: a scoping review protocol

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1. Introduction

The World Health Organization (WHO) states that the poorer health outcomes of resettling refugees and other migrants are related to a lack of inclusive health policies and health systems [1]. Refugee and asylum seekers, with numbers reaching over 60 million in 2021 [1], often face substandard work and living conditions, and underdeveloped community mental health programs [2,3]. The process of migration and resettlement can predispose migrants to many stressors and subsequently common mental disorders, such as depression, anxiety, post-traumatic stress and somatic symptom disorders [4]. This highlights the importance of inclusive

mental health care for this population, where prevention and early access to care could significantly improve health outcomes [5,6].

Access to mental health services for refugees and asylum seekers is often limited due to both intercultural factors and system level barriers [4,7]. This is particularly true for people with a history of psychological trauma who face barriers to accessing primary health care and are less likely to seek out mental health services [7]. Many studies have highlighted the benefit of integrating mental health services and support into primary care to improve access and patient outcomes [4]. Approaches include more streamlined referral systems, trauma and violence informed care and cultural sensitivity training for primary care providers, collaborating with community outreach groups, and increasing access to interpreters and healthcare navigators [8,4].

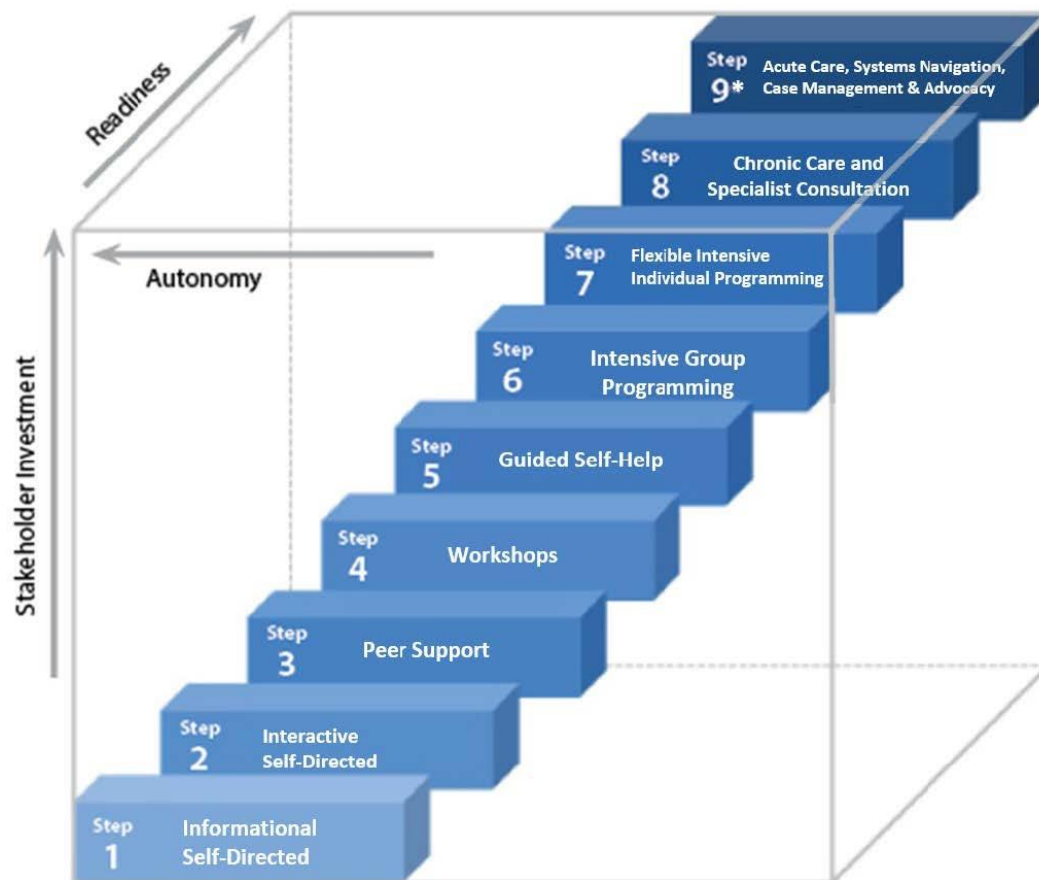
Barriers to accessing mental health care are not limited to migrant populations. Mental health services are often time consuming and expensive, requiring highly trained clinicians and therapists. Demands for community mental health care often surpass the available supply, leading to long wait times and loss to follow-up [9]. Stepped care has been suggested by community psychiatrists as a sustainable and inclusive solution to increasing access to appropriate care [10]. In a stepped care approach, mental health services are organized and delivered in a hierarchy of intensity, where the least intensive level of the intervention, and potentially most community oriented, is offered first. Depending on their level of function, diagnosis, sense of safety, and severity of symptoms, patients can be triaged and assessed following the stepped model and offered services that best correlate with their needs. They can subsequently be “stepped” up or down, as their illness or symptoms evolve [9]. This flexible approach to mental health services has been particularly useful in primary health care settings, where patient presentations and needs are varied. A notable example of a successful stepped care approach to mental health services was demonstrated by Clark and colleagues in the UK with Improving Access to Psychological Therapy (IAPT), which emphasized low-intensity interventions as an effective component of mental health care [11]. Since this study, stepped care has been studied in many countries, including Australia, Norway, Japan and Canada [12].

The patient-centered clinical method has emerged as a tailored approach for primary health care [13]. In this approach the primary care clinician asks the patient about their feelings, ideas, function, fears and expectations for care, and works with the patient to come up with a provisional diagnosis and management plan. The recovery model of mental health care [14], which has been the overriding principle of mental health care for over two decades, focuses on meeting the patient where they are and collaborating on assessment and treatment planning. It involves active listening, rebalancing power dynamics, motivational interviewing and an emphasis on the patient as central in decision-making, even in those who may not be fully capable of making decisions at this moment of their illness journey. The patient-centered clinical method with a recovery focus is in many ways analogous to the stepped care approach, but it does include all the components of mental health care.

Stepped care 2.0 presents a new avenue for stepped care. Developed in Canada by Peter Cornish and colleagues [10], it reimagines a patient-centered stepped care model for a hybrid

community environment, integrating online and virtual mental health programs with a focus on rapid access to care. Initially adapted for university students, stepped care 2.0 aims to prevent mental health problems from progressing into serious conditions by offering more flexibility, using a patient-centered approach to guide decision making when stepping up or down in care. This adaptation brings together the patient-centered and stepped care approaches to empower patients by emphasizing their autonomy and preferences. It also integrates components of the recovery model [14], aiming not only to treat symptoms but to also build resiliency, while highlighting the process of recovery (see Figure 1).

Figure 1 – Structuring Stepped Care 2.0 (Mental Health Commission of Canada, 2021)



2. Research Objectives

The objective of this scoping review is to map out the existing literature on stepped care approaches to mental health care for refugees and asylum seekers. Specifically, we aim to understand and characterize how stepped care has been conceived and implemented globally in order to inform resettlement programs. To achieve our research objective, we aim to answer

the following research question: What are the characteristics of existing stepped care approaches for refugees and asylum seekers with common mental disorders?

3. Methods

We will follow the PRISMA-P reporting guidelines [15], methodology by Arksey and O'Malley [16] and guidance from the Joanna Briggs Institute [17] for the development of our protocol. We will follow the PRISMA-ScR guidelines in reporting this scoping review [18].

4. Eligibility Criteria

We will identify eligible studies using the SPIDER acronym, detailed in **Table 1**. We will include publications where refugees and/or asylum seekers are the primary patient population. Studies where refugees and/or asylum seekers are mentioned, but do not make up more than 50% of the population with independent data, will be excluded. We define the term refugee as “someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion”, and asylum seeker as “someone who is seeking international protection but has not yet been granted refugee status” [19]. Included publications must mention a stepped care approach for delivering health care, including mental health services. We will include peer reviewed publications of qualitative, quantitative, or mixed-methods designs, as well as protocols describing stepped care programs or interventions. We will include studies published from the year 2000 onwards as stepped care was developed in the UK around this time [20].

Table 1: Eligibility Criteria

SPIDER	Inclusion	Exclusion
Sample	Refugees and/or asylum seekers (no age exclusions)	All other populations
Phenomenon of interest	Stepped care approach for patients with mental health concerns	Approaches to mental health services other than stepped care
Design	Experimental studies Observational studies Program evaluations Provider/patient perspectives	Theoretical papers Systematic reviews Literature reviews Scoping reviews Letters, commentaries, opinions
Evaluation	Characteristics of stepped care approaches to mental health care	-

Research type	Qualitative, quantitative and mixed-method publications in peer-reviewed or grey literature	-
Other		
Language of publication	Available in English	Unavailable in English
Year of publication	2000 to present	Prior to 2000

5. Information sources and search strategy

We will search the following electronic databases: Medline, EMBASE, and PsychINFO (via OVID), and CINAHL (via EBSCO). We will develop a search strategy with the assistance of a health sciences librarian from the University of Ottawa, using both subject headings and keywords.

6. Data management, selection, and collection

Publications will be screened by: (1) title and abstract and (2) full-texts. Two authors will independently screen all publications against our eligibility criteria described in Table 1. Any disagreements will be resolved through discussion or, if required, in consultation with a third review author. Data will be collected and managed using Covidence [21].

7. Data extraction

We will create a standardized data extraction sheet. Two authors will independently extract data and any conflicts will be resolved with help from a third author. The following general variables will be extracted: study design (if applicable), study year, country, language, setting, sample size (if applicable), target population, participant selection, and mental health condition(s) addressed.

The following variables related to stepped care will be extracted, if discussed: type(s) of clinician(s) involved, use of interpreters, number of stepped levels, types of stepped levels, criteria for ascending or descending in steps, patient outcomes, clinician acceptability, patient acceptability, study costs, and cultural adaptability.

8. Risk of bias / confidence

This is not a requirement for scoping reviews and thus we did not conduct a quality assessment [17].

9. Data synthesis

Results will be presented in tables; the first (**Table 3**) will be structured by study design, country/geographic location, clinical setting, target population and target mental health condition(s), whereas the second (**Table 4**) will contain descriptive information specific to the stepped care approaches.

- 1) step* adj3 care).ti,ab,kw.
- 2) (stepped).ti,ab,kw.
- 3) 1 or 2
- 4) exp Refugees/
- 5) exp "Transients and Migrants"/
- 6) exp "Emigration and Immigration"/
- 7) (refugee* or migrant* or resettle* or immigra* or undocumented* or newcomer*).ti,ab,kw.
- 8) (asylum adj seeker).ti,ab,kw.
- 9) (forc* adj2 (immigrant* or migrant* or migration or displace*)).ti,ab,kw.
- 10) ((Undocumented or irregular) adj2 (immigrant* or migrant* or migration)).ti,ab,kw.
- 11) 4 or 5 or 6 or 7 or 8 or 9
- 12) 3 and 11
- 13) limit 12 to last 22 years

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