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An overview of systematic reviews on mental health promotion, prevention, and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons (Protocol)

Uphoff E, Purgato M, Churchill R, Barbui C

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[Overview of Reviews Protocol]

An overview of systematic reviews on mental health promotion, prevention, and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons

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ABSTRACT

This is a protocol for a Cochrane Review (Overview). The objectives are as follows:

To map the characteristics and methodological quality of existing systematic reviews and published review protocols on the promotion of mental health and prevention and treatment of common mental disorders among refugees, asylum seekers, and internally displaced persons.

Characteristics of interest are:

- the type of systematic review (Cochrane, non-Cochrane, meta-analysis, narrative synthesis);
- population (refugees, asylum seekers, internally displaced persons, age, mental health diagnosis);
- setting (country of origin and study setting);
- types of studies (randomised controlled trials, other designs);
- types of interventions (promotion, prevention, treatment; CBT, other psychotherapy, transdiagnostic, medication);
- types of comparators (no treatment, placebo, waiting list, treatment as usual, other treatment);
- intervention provider (professional, lay health worker);
- review characteristics (number of included studies, review quality).

Whereas an overview of systematic reviews, would normally seek to answer questions related to the effectiveness or efficacy results of studies included in the identified reviews, this overview will provide a description of the depth and breadth of the literature available and will not answer questions of effectiveness. Data on study characteristics are extracted to give an overview of systematic reviews, ongoing or published, on this topic.

This review is part of a Cochrane Global Mental Health satellite project to identify priorities for Cochrane Reviews in global mental health. We will produce an evidence map, which will represent a lay summary of literature identified in the overview, which will provide a basis to engage with stakeholders within and outside of academia to prioritise Cochrane Reviews of mental health of refugees, asylum seekers and internally displaced persons. This will ensure that the Cochrane Global Mental Health Satellite takes forward research questions seen as a priority by stakeholders to promote a strong evidence base in global mental health.

BACKGROUND

The United Nations estimates that worldwide there are around 40 million internally displaced persons, 25 million refugees, and three million asylum seekers, and their numbers are growing (UNHCR 2019). While most research with forced migrants takes place in high-income countries, most live in low- and middle-income countries (Wainberg 2017). Regardless of the country of settlement, the circumstances in which many who have been forced to leave their homes will have been extremely stressful and often violent and unsafe. A large priority exercise by the World Health Organization (WHO) Global Forum for Health Research identified people exposed to violence/trauma as top priorities for intervention in global mental health (Sharan 2009).

Compared to the general population, migrants who were forced to leave their home are more likely to experience common mental disorders and the efficacy of psychological therapies (talking therapies) may be different in this population. Apart from language and cultural barriers, the availability of treatment and access to treatment may be additionally restricted, depending on the host country. Even in the UK, a high-income country with a National Health Service, refugees and asylum seekers may, for example, face organisational and logistic as well as cultural, or language barriers to care. For example, the lack of a permanent home address might make it difficult for migrants to register with a GP and receive notification letters of medical appointments and subsequent results (Fassil 2015).

The Cochrane Global Mental Health Satellite aims to support the production, dissemination, and implementation of systematic reviews relevant to mental health in low- and middle-income countries (Barbui 2017). This includes reviews on the effectiveness of mental health promotion and the prevention and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons. To ensure that Cochrane Reviews on this topic fill important gaps in the literature, we plan to undertake an overview of systematic reviews, sometimes called a scoping review or review of reviews, to produce a map of the evidence that is currently available. Rather than synthesising data on the effectiveness of interventions from individual studies, in this overview of systematic reviews we will describe the characteristics of systematic reviews, published or ongoing (including registered protocols), on mental health promotion, prevention, and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons. The resulting evidence map will highlight the breadth and depth of the evidence and help to identify priority research questions and inform the development of Cochrane Reviews on this topic.

Description of the condition

Common mental disorders considered in this review will include all depressive and anxiety disorders, including post-traumatic stress disorder (PTSD).

Major depressive disorder is characterised by a period of at least two weeks of depressed mood, and is nearly always accompanied by a persistent loss of interest or pleasure in activities which were previously considered enjoyable (APA 2013). A range of symptoms may accompany these key features of depression, including weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, loss of energy, feelings of excessive guilt and worthlessness, diminished concentration, and recurrent thoughts of death (APA 2013). Other depressive disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) include those which occur in specific situations (for example, premenstrual dysphoric disorder), disruptive mood dysregulation disorder in children, and persistent depressive disorder (previously also called dysthymia; symptoms last at least two years). Bipolar disorder is not categorised as one of the depressive disorders, although depressive episodes occur as part of bipolar disorder.

Symptoms of depression and anxiety may be present simultaneously (APA 2013). Anxiety disorders, such as generalized anxiety disorder (GAD), and trauma-related disorders, such as PTSD, are treated as separate types of disorders in DSM-5 (APA 2013). For this review we will consider anxiety disorders (GAD, phobias, panic disorder) and trauma- and stressor-related disorders (reactive attachment disorder, disinhibited social engagement disorder, PTSD, acute stress disorder, and adjustment disorder).

Anxiety disorders share symptoms of excessive fear, worry, and anxiety, and related behavioural changes. Fear is the emotional response to a perceived imminent threat, which may be real or not, whereas anxiety is the anticipation of a threat in the future. Fear is often associated with immediate and quick responses and behaviours, including panic attacks, whereas anxiety is associated with tension, stress, and behaviours of caution and avoidance. Depending on the type of anxiety disorder and varying between patients, other symptoms may include fatigue, restlessness, irritability, difficulty sleeping, and impaired concentration. GAD and PTSD may co-occur (APA 2013).

PTSD can develop after experiencing a traumatic event, or recurring or chronic traumatic experiences. These include experiences or events witnessed first-hand, as well as contact with others exposed to trauma. PTSD may develop immediately, shortly after the trauma occurs, or more than six months after the traumatic event (delayed-onset) (APA 2013). PTSD symptoms include: re-experiencing traumatic events or moments (nightmares, memories, feelings, reactions); avoidance (of people, places, conversations, feelings); hyperarousal (insomnia, irritability, poor concentration); and negative thoughts and feelings (less positive feelings, loss of interest in pleasurable activities, feeling distant from others) (APA 2013).

Even though their circumstances and experiences will differ, all refugees and asylum seekers have left their country of origin because of a well-founded fear of persecution, conflict, violence, or other dangerous circumstances (UNHCR 2019). All are likely to have experienced adverse circumstances and insecurity in their home country, challenges associated with the migration journey, and challenges upon arrival and through resettlement processes in a new country. A review of Afghan refugees resettled in industrialised countries identified a range of common adverse experiences that impact on mental health, such as witnessing atrocities, losing family members, stressful escape and transit experiences, living in refugee camps, cultural and language barriers, mental health stigma, unemployment, financial hardship, and loss of status, culture, and identity (Alemi 2014).

Studies on prevalence rates of mental illness among migrants, including refugees and asylum seekers, report widely varying estimates. A review of refugees and labour migrants reported pooled prevalence estimates of 44% depression and 40% anxiety among

refugees, compared to 20% and 21% respectively among labour migrants (Lindert 2009). A review including 17 studies of adult refugees resettled in Western countries found a prevalence rate of PTSD of around 9% (Fazel 2005). A 2019 study of 1000 Syrian refugee children and adolescents living in Lebanon and Jordan found that 46% had developed PTSD (Khamis 2019).

People who are internally displaced have been forced to leave their homes over serious safety concerns, and are staying elsewhere but within their country of origin. Prevalence rates of PTSD reported for this group include 54% of adult internally displaced persons in northern Uganda (Roberts 2008), and 56% for people who fled from the aftermath of a tsunami in Sri Lanka (Ranasinghe 2007).

Description of the interventions

This overview includes interventions relating to mental health promotion, prevention of common mental disorders, and treatment of common mental disorders.

We categorise interventions as follows.

Mental health promotion

Mental health promotion interventions include those delivered at an individual level or in a group-based format. These interventions may be delivered to the general population (universal), or targeting high-risk populations such as refugees, asylum seekers, and IDPs (selected health promotion), but they are not targeted at people with mental health problems. For example, activities to encourage good mental health and development for children may take place in the classroom or in refugee camps. Programmes might be delivered in villages or neighbourhoods, for example in low- and middle-income countries hit by humanitarian crises.

Prevention of common mental disorders

Whereas mental health promotion interventions are likely to encourage good general mental health, prevention can either be focused on general mental health or on specific common mental disorders. Interventions may seek to prevent deterioration of mental health in people who already show symptoms of mental health problems (indicated prevention). Children may receive trauma-focused cognitive behavioural therapy (CBT) for the prevention of PTSD, which can be delivered in groups in the case of a large-scale shared trauma (NICE 2018). Single-session psychologically-focused debriefing is not recommended for the prevention of PTSD in adults or children as it may increase rather than decrease the risk of PTSD and depression (Rose 2002).

Treatment of common mental disorders

This scoping review may identify many different interventions for the treatment of different common mental disorders, most commonly depression, anxiety, and PTSD. We therefore briefly summarise the most commonly used interventions, and courses of treatment recommended by the UK National Institute for Health and Care Excellence (NICE).

For the purpose of categorising interventions in this review, we will use the following framework.

Cognitive Behavioural Therapy (CBT)

Certain types of CBT may apply specifically to this population, such as Narrative Exposure Therapy (NET), trauma-focused CBT, stress inoculation therapy or training, and culturally sensitive CBT. Trauma-focused CBT can be used for those diagnosed with PTSD, or those with PTSD symptoms, while NET is most often used for those with complex or multiple traumas.

Other psychotherapy

Therapies for common mental disorders, depending on the severity of symptoms and specific diagnosis, range in intensity from active monitoring, psychoeducation and low-intensity psychological interventions (relaxation exercises, counselling/non-directive supportive therapy, self-help, behavioural activation) to high-intensity psychological interventions (interpersonal therapy, psychodynamic therapy) (Kendrick 2012). Patients with PTSD may be offered Eye Movement Desensitization and Reprocessing therapy (EMDR). Some argue that arts-based programmes and expressive and creative therapies (music, drawing, play) may increase accessibility and reduce social stigma among refugee children (McDonald 2017). Creative writing and 'writing for recovery' approaches are used for adults and children in the treatment of PTSD (Baker 2018).

Treatment may be delivered to individuals, couples, or groups. In low- and middle-income countries or settings with limited resources, task-shifting and multi-agency collaborative treatments may be more appropriate than one-to-one therapy led by highly trained mental health professionals (Silove 2017). Lay counsellors or health workers who have undertaken a short training programme may deliver counselling, behavioural therapy, or social community interventions.

Transdiagnostic approaches

Over the last few years, experts in global mental health have called for a move away from the traditional system of categorising patients and treatments according to diagnosis, to a more integrated 'transdiagnostic approach' of treatment according to similarity in symptoms. In low- and middle-income countries in particular, this approach may allow for a better use of limited resources in the treatment of patients with a range of symptoms and comorbid mental health conditions (McEvoy 2009). Two examples implemented and evaluated in low- and middle-income countries are Problem Management Plus and the Common Elements Treatment Approach (CETA) (Dawson 2015 and Murray 2014 respectively).

Medication

Antidepressants might be used for depression and anxiety for children and adolescents when first line talking therapies have not worked or in the case of severe symptoms or where talking therapies are not available (NICE 2019). For adults, medication may be indicated, particularly for more severe forms of PTSD, anxiety and depression, and if someone has a preference for drug treatment. For adults with PTSD, antipsychotics may be prescribed to treat disabling psychotic symptoms or psychotic symptoms unresponsive to other treatments in PTSD (NICE 2018).

How the intervention might work

As the types of interventions identified may vary widely, we describe below the hypothesised working mechanisms of the psychological and pharmacological interventions most commonly used to treat anxiety, depression, and PTSD, as well as treatments which are not currently recommended for these conditions.

Cognitive Behavioural Therapy (CBT)

CBT for depression, anxiety, and PTSD addresses patterns of thought, particularly negative thoughts and beliefs, and aims to change this way of thinking as well as changing behaviours that may accompany negative patterns of thought (Beck 1979).

In NET, a type of CBT, the patient is guided through the construction of a narrative, with a focus on traumatic experiences (Schauer 2011). The creation of a coherent narrative is thought to help process the traumatic event by integrating traumatic memories into the narrative (Schauer 2011). This is a form of exposure therapy, in which a therapist exposes a patient to a traumatic situation, event, or memory. Exposure may be gradual or all at once, and may be aided by images or virtual reality. When a fear is activated by facing it, this fear can then be reprocessed as the patient becomes used to the exposure (habituation), and symptoms are reduced (Foa 2016). Stress inoculation therapy is an example of non-trauma focused therapy, derived from CBT, designed to help people cope with stress.

Trauma-focussed CBT was originally developed for children and adolescents who suffered from sexual abuse and is now used for children, adolescents, and adults (Cohen 2012). It differs from generic CBT in that it is recognises the influence of the child's family, it addresses problems (cognitive, behavioural, somatic, relational) relating to the trauma, and it is adaptable and mindful of family and community values and culture. Components of the intervention, such as engagement with the narrative of the exposure and education on trauma, can be adapted to the age of the patient.

Transdiagnostic CBT is designed for multiple mental disorders, and for people with multiple mental disorders, to target the common elements of multiple and co-occurring illnesses. It is based on the idea that certain cognitive and behavioural elements are shared across a range of mental health problems and diagnoses (Mansell 2009). Transdiagnostic CBT is both a type of CBT and a 'transdiagnostic approach', but is considered part of the 'CBT' category in this overivew.

Other psychotherapy

Third wave CBT and behavioural approaches

Third wave CBT approaches target the individual's relationship with cognitions and emotions, and focus on the function of cognition such as thought suppression or experiential avoidance (an attempt or desire to suppress unwanted internal experiences, such as emotions, thoughts and bodily sensations (Hofmann 2008). Strategies used to change thinking processes include acceptance and commitment therapy, compassionate mind training, mindfulness-based therapy, and dialectic behaviour therapy.

Behavioural therapies, for example behavioural activation, seek to achieve change in behavioural patterns and activities rather than cognitive patterns (Kanter 2012).

EMDR

EMDR involves treatment in which the therapist instructs the patient to focus on associations with trauma through images, memories, emotions, and thoughts, while simultaneously using visual (rapid eye movements), auditory, or tactile stimuli. This bilateral stimulation is hypothesised to facilitate reprocessing of the disturbing information associated with traumatic memories. after which symptoms reduce (Shapiro 2017). There is an ongoing discussion as to whether the bilateral stimulation is an active ingredient of the therapy and a variety of working mechanisms have been proposed. Some argue that relaxation in response to a stimulus in the absence of danger leads to positive mental and physiological changes, while others argue that traumatic images are made less vivid and emotional as the working memory is used for tasks performed simultaneously during EMDR treatment (Landin-Romero 2018).

Social skills and assertiveness

The social interactions in different contexts are the focus of social skills training and assertiveness training for anxiety and depression (Jackson 1985).

Psychodynamic therapies

Grounded in psychoanalytic theory (Freud 1949), psychodynamic therapy uses the therapeutic relationship to explore and resolve unconscious conflict through the redirection of emotions to the therapist (transference) and interpretation, with relief of symptoms as an indirect outcome.

Creative therapies

Creative therapies may use writing, music, arts, dance/ movement, or drama to recall traumatic memories and process trauma associated with PTSD in a non-verbal way. Mechanisms of action are thought to include relaxation, activation and expression of memories and emotions, facilitating a sense of control and empowerment resulting from the creating art, exposure through symbolic art, and rebuilding of self-esteem (Baker 2018).

Interpersonal, cognitive analytic, humanistic, and other integrative therapies

Humanistic therapies focus on the therapeutic relationship, and therapist values of empathy, genuiness, and unconditional positive regard are hypothesised to facilitate patient insight and change in symptoms (Rogers 1951). Integrative therapies, including counselling, interpersonal therapy, and cognitive analytic therapy, form a group of therapies that combine components of different psychological therapy models, for example from CBT, psychodynamic therapy, and person-centered approaches (Stiles 2008).

Transdiagnostic approaches

Transdiagnostic approaches vary in terms of their key mechanisms of action and may borrow from and combine different treatment approaches. Examples of transdiagnostic approaches implemented in low- and middle-income countries in the last few years include Problem Management Plus and CETA.

Problem Management Plus combines psychoeducation, motivational interviewing, problem solving therapy and behavioural techniques. Problem solving therapy and behavioural therapy helps people to manage the day-to-day practical problems (such as work, relationships) associated with mental illness. Psychoeducation educates patients both on the effects of adversities on mental health and the rationale of the treatment, while motivational interviewing is used to promote engagement with the treatment (Dawson 2015).

CETA were developed to be delivered by people who are not mental health specialists, in settings with limited resources. People who deliver the interventions are thought common elements of treat-

ment that can be delivered in different combinations to address various symptoms. Elements of CETA include encouraging engagement with the intervention, psychoeducation on symptoms and the intervention, relaxation strategies, behavioural activation to encourage participation in rewarding activities, coping with emotions, and exposure therapy (Murray 2014).

Medication

Antidepressants affect the activity of neurotransmitters such as serotonin and noradrenaline, which in turn is hypothesised to affect the regulation of mood and emotions. Selective Serotonin Reuptake Inhibitors (SSRIs) reduce the reabsorption of serotonin by the brain, which can increase positive feelings. Serotonin and Noradrenaline Reuptake Inhibitors (SNRIs) block the reabsorption of serotonin and noradrenaline. Tricyclic antidepressants (TCAs) are an older class of anti-depressants which are no longer commonly used. Most TCAs work by preventing the reuptake of serotonin or noradrenaline, or both (Feighner 1999).

Why it is important to do this overview

Refugees, asylum seekers, and internally displaced persons are a large and vulnerable group of people, who are more likely than the general population to be suffering from a common mental disorder. At present, no Cochrane Review exists on interventions for the promotion of mental health, or the prevention or treatment of common mental disorders, in this population. Future Cochrane Reviews may focus on mental health promotion, prevention or treatment, across several common mental disorders, for a wide range of interventions, in different age groups and populations, across different settings. This overview will provide an evidence map of systematic reviews conducted on this topic, to identify priority research questions and inform the development of Cochrane Reviews on this topic.

OBJECTIVES

To map the characteristics and methodological quality of existing systematic reviews and published review protocols on the promotion of mental health and prevention and treatment of common mental disorders among refugees, asylum seekers, and internally displaced persons.

Characteristics of interest are:

- the type of systematic review (Cochrane, non-Cochrane, meta-analysis, narrative synthesis);
- population (refugees, asylum seekers, internally displaced persons, age, mental health diagnosis);
- setting (country of origin and study setting);
- types of studies (randomised controlled trials, other designs);
- types of interventions (promotion, prevention, treatment; CBT, other psychotherapy, transdiagnostic, medication);
- types of comparators (no treatment, placebo, waiting list, treatment as usual, other treatment);
- intervention provider (professional, lay health worker);
- review characteristics (number of included studies, review quality).

Whereas an overview of systematic reviews, would normally seek to answer questions related to the effectiveness or efficacy results of studies included in the identified reviews, this overview will provide a description of the depth and breadth of the literature available and will not answer questions of effectiveness. Data on study characteristics are extracted to give an overview of systematic reviews, ongoing or published, on this topic.

This review is part of a Cochrane Global Mental Health satellite project to identify priorities for Cochrane Reviews in global mental health. We will produce an evidence map, which will represent a lay summary of literature identified in the overview, which will provide a basis to engage with stakeholders within and outside of academia to prioritise Cochrane Reviews of mental health of refugees, asylum seekers and internally displaced persons. This will ensure that the Cochrane Global Mental Health Satellite takes forward research questions seen as a priority by stakeholders to promote a strong evidence base in global mental health.

METHODS

Our overview will summarise systematic reviews that includes a wide range of participants, interventions, comparators, and outcomes. We will follow general principles for conducting an overview of reviews, for example in the search strategy, screening of studies, and appraisal of the methodological quality of included reviews. Other methods, however, such as the appraisal of primary studies and synthesis of results, are not relevant to the objectives of this overview. The methodology that will be used for this overview therefore also draws on guidance from the Campbell Collaboration on evidence and gap maps (Campbell 2019), methodological guidance published by O'Leary and colleagues (O'Leary 2017), and a review of evidence maps (Miake-Lye 2016). The protocol is based on the Cochrane systematic review protocol format, as specified in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011). Reporting follows PRISMA and PRISMA-P guidance where applicable (Moher 2009; Shamseer 2015).

Criteria for considering reviews for inclusion

Types of studies

We will include all systematic reviews and protocols of systematic reviews. Reviews will have to be clearly identified by the authors as a 'systematic review' or 'meta-analysis' in either the title or abstract of the review; and the authors will have to present evidence of a systematic search. This also includes Cochrane systematic reviews and meta-analyses. We will include systematic reviews regardless of the study design and methodology of studies they reviewed.

Types of participants

We will include refugees, asylum seekers, and internally displaced persons of all ages. We will adopt the following definitions of the UN Refugee Agency (UNHCR), which are derived from the 1951 Convention on the Status of Refugees (UNHCR 2019).

- Refugee: a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country.
- Asylum seeker: an individual who is seeking asylum, but whose claim has not yet been finally decided on.
- Internally displaced persons: persons or groups of persons who have been forced or obliged to flee or to leave their homes or

places of habitual residence, in particular as a result of, or in order to avoid the effects of, armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized border.

Depending on the type of intervention (promotion of mental health, prevention, treatment), participants may either be diagnosed with depression, anxiety, or PTSD, or experience symptoms associated with one or more of these disorders, or not have any reported symptoms. This scoping review includes studies with any of these groups of patients.

Types of interventions

All interventions to promote mental health, or to prevent or treat common mental disorders, are eligible for inclusion. We consider common mental disorders to include anxiety disorders, including PTSD, and depressive disorders as described in the Description of the condition section above. These interventions may include psychotherapies and medication, individual or group treatments, as well as interventions delivered by professionals and lay health workers. We will categorise interventions as follows, according to the classification presented in the Description of the interventions section.

- Mental health promotion
- Prevention of common mental disorders
- Treatment of common mental disorders: CBT, other psychotherapy, transdiagnostic approaches, medication.

This classification will be adapted if interventions are identified that do not fit any category.

We will only include interventions aimed at the promotion of mental health, or the prevention or treatment of common mental disorders. For example, we will exclude studies evaluating the effects of nutrition or physical activity on mental health outcomes unless the main aim of the intervention is to promote or improve mental health.

Comparator

All types of interventions are eligible for inclusion. This includes any other type of intervention including those part of 'treatment as usual', no intervention (including waiting list), or any type of placebo.

Types of outcome measures

Studies that include any mental health related outcomes are eligible, irrespective of the measure used or length of follow-up. These may include outcomes relating to symptoms (e.g. severity of anxiety symptoms), diagnosis (e.g. recurrence of depression), functioning, disability, quality of life, or adverse events.

Search methods for identification of reviews

Information sources

We will search the following bibliographic databases using key terms relating to the population (refugees, asylum seekers or internally displaced persons; and mental health, including depression, anxiety, PTSD), together with a filter for systematic reviews and meta-analyses.

- Ovid MEDLINE (1946 onwards) (Appendix 1);
- Ovid Embase (1974 onwards);
- Ovid PsycINFO (all years);
- Ovid Global Health (all years);
- ProQuest PTSDpubs (all years);
- Web of Science Core Collection (Science and Social Science Indices) (all years);
- BIREME/PAHO Latin America and the Caribbean Database (LILACS) (all years).

We will supplement this with a search of the following review databases (all available years).

- Cochrane Database of Systematic Reviews (CDSR) (www.cochranelibrary.com)
- NIHR Journals Library – Health Technology Assessment (www.journalslibrary.nihr.ac.uk/HTA/#/)
- Centre for Reviews and Dissemination (CRD) Databases (archived) (www.crd.york.ac.uk/crdweb)
- DoPHER (Database of Promoting Health Effectiveness Reviews) (eppi.ioe.ac.uk/webdatabases4/Intro.aspx?ID=9)
- Epistemonikos (www.epistemonikos.org)
- Health Evidence (www.healthevidence.org)
- 3ie International Initiative for Impact Evaluation (www.3ieimpact.org/en/evidence/systematic-reviews/)
- PROSPERO (www.crd.york.ac.uk/prospero)

We will check the reference lists of included studies (systematic reviews) to identify additional evidence which may have been missed by the searches.

Data collection and analysis

We will de-duplicate, upload and screen records in Covidence software.

Selection of reviews

Two review authors will independently screen titles and abstracts against inclusion criteria. We will obtain full-text manuscripts for all titles that are selected during this process, contacting study authors if necessary. Full-text articles will be screened by two review authors independently, and we will resolve disagreements through discussion, with a third review author to arbitrate if necessary. We will record reasons for excluding full-text articles, and present a 'Characteristics of excluded studies' table. We will collate multiple reports of the same systematic review should we find them.

We will base selection of reviews on the inclusion and exclusion criteria relating to types of studies, participants, and interventions. We will include systematic reviews regardless of reported outcomes, date and language of publication, and study quality.

Data extraction and management

We will create a data extraction sheet in Microsoft Excel to collect data from included systematic reviews, and we will pilot the data extraction sheet by entering data from the first three included systematic reviews, making adjustments if necessary.

We will record the following information: first author, year of publication, research group, type of review (Cochrane or non-Cochrane), published protocol (yes/no), meta-analyses (yes/no), population (refugees, asylum seekers, IDP), included countries/regions of origin, included study settings (country), age (adult/child/mix), mental health diagnosis (PTSD, anxiety, depression, mix, other), intervention type (psychological, pharmaceutical, other), specific intervention (see Description of the interventions), comparators (no treatment, placebo, waiting list, treatment as usual, other treatment), intervention provider (professional, lay worker, mix, other), number of included studies, types of studies (RCTs, other designs), quality assessment.

We will develop a guidance document with an explanation of these different variables and their categories for all authors taking part in data extraction, to ensure that authors extract the same data using the same categories for the different variables of interest.

No information on outcomes reported in the studies included in reviews will be reported, as this does not fit the aim of this overview.

For all reviews, we will extract references of included studies so that we can create a matrix to report the unique primary studies identified through each of the included systematic reviews. This will allow us to assess overlap in the primary studies reported by various reviews. We will not extract further information from these individual studies, because for this overview we are interested in characteristics of the review rather than the studies that were included in these reviews.

Data entry will be performed in duplicate by two reviewers, and we will resolve any disagreements through discussion, with the involvement of a third author if required.

Since this overview does not report outcome data, we will not include a 'Summary of findings' table.

Assessment of methodological quality of included reviews

We will use AMSTAR 2 to critically appraise included systematic reviews (Shea 2017). This tool is suitable for reviews including randomised and non-randomised studies. It includes 16 domains relating to the research question, study design, search strategy, study selection, data extraction, justification for excluded studies, description of included studies, risk of bias, sources of funding, meta-analysis, heterogeneity, publication bias, and conflicts of interest.

For many of the AMSTAR 2 domains, a positive response is only possible if the required information is reported in the review paper or protocol. The quality rating of the design and conduct of a review therefore depends heavily on the quality of the reporting of a review. We will contact authors in case of missing information and use this information to inform the quality assessment.

We will use findings from the AMSTAR 2 critical appraisal to understand the certainty of the primary evidence base, which will in turn inform what future systematic reviews and primary research is needed. AMSTAR 2 includes a rating of the overall confidence in the findings of each review based on the criterial appraisal domains. We use this approach instead of the GRADE approach frequently used for quality assessment of studies in Cochrane Reviews.

Data synthesis

We will report results as a narrative synthesis of the characteristics of included systematic reviews.

We will include the following.

- Table or tables of all characteristics of included studies specified in the 'data extraction' section.
- A description of ongoing studies with study characteristics based on registered or published review protocols.
- An inventory of all interventions and comparators included in the identified systematic reviews.
- A matrix of unique primary studies included in the systematic reviews and an assessment of overlap in primary studies.

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REFERENCES

Additional references

Alemi 2014

Alemi Q, James S, Cruz R, Zepeda V, Racadio M. Psychological distress in Afghan refugees: a mixed-method systematic review. *Journal of Immigrant and Minority Health / Center for Minority Public Health* 2014;**16**(6):1247-61.

APA 2013

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). 5th Edition. Washington DC: American Psychiatric Association, 2013.

Baker 2018

Baker FA, Metcalf O, Varker T, O'Donnell M. A systematic review of the efficacy of creative arts therapies in the treatment of adults with PTSD. *Psychological Trauma : Theory, Research, Practice and Policy* 2018;**10**(6):643-51.

Barbui 2017

Barbui C, Purgato M, Churchill R, Adams C, Amato L, Macdonald G, et al. Cochrane for global mental health. *Lancet Psychiatry* 2017;**4**(4):e6.

Beck 1979

Beck AT, Rush AJ, Shaw BF, Emery G. Cognitive Therapy of Depression. New York: Guilford Press, 1979.

Campbell 2019

Campbell Collaboration. Making an evidence and gap map (EGM). campbellcollaboration.org/explore/making-an-evidence-and-gap-map-egm.html (accessed 12 April 2019).

Cohen 2012

Cohen JA, Mannarino AP, Deblinger E. Trauma-focused CBT for children and adolescents: treatment applications. New York: Guilford Press, 2012.

Dawson 2015

Dawson KS, Bryant RA, Harper M, Tay AK, Rahman A, Schafer A, et al. Problem Management Plus (PM+): a WHO transdiagnostic psychological intervention for common mental health problems. *World Psychiatry* 2015;**14**(3):354-7.

Fassil 2015

Fassil Y, Burnett A. Commissioning mental health services for vulnerable adult migrants. Available at www.mind.org.uk/media/3168649/vulnerable-migrants_2015_mindweb.pdf.

Fazel 2005

Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet* 2005;**365**(9467):1309-14.

Feighner 1999

Feighner JP. Mechanism of action of antidepressant medications. *Journal of Clinical Psychiatry* 1999;**60**(Suppl 4):4-11.

Foa 2016

Foa EB, McLean CP. The efficacy of exposure therapy for anxiety-related disorders and its underlying mechanisms: the case of OCD and PTSD. *Annual Review of Clinical Psychology* 2016;**12**:1-28.

Freud 1949

Freud S. An outline of psychoanalysis. London: Hogarth Press, 1949.

Higgins 2011

Higgins JP, Green S (editors). Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0 (updated March 2011). The Cochrane Collaboration, 2011. Available from handbook.cochrane.org.

Hofmann 2008

Hofmann SG, Asmundson GJG. Acceptance and mindfulness-based therapy: new wave or old hat?. *Clinical Psychology Review* 2008;**28**(1):1-16.

Jackson 1985

Jackson HJ, Moss JD, Solinski S. Social skills training - an effective treatment for unipolar nonpsychotic depression. *Australian and New Zealand Journal of Psychiatry* 1985;**19**(4):342-53.

Kanter 2012

Kanter JW, Ajeng JP, Maria MS, Gabriela AN. Behavioural activation: history, evidence and promise. *British Journal of Psychiatry* 2012;**200**(5):361-3.

Kendrick 2012

Kendrick T, Pilling S. Common mental health disorders: identification and pathways to care: NICE clinical guideline. *British Journal of General Practice* 2012;**62**(594):47-9.

Khamis 2019

Khamis V. Posttraumatic stress disorder and emotion dysregulation among Syrian refugee children and adolescents resettled in Lebanon and Jordan. *Child Abuse & Neglect* 2019;**89**:29-39.

Landin-Romero 2018

Landin-Romero R, Moreno-Alcazar A, Pagani M, Amann BL. How does eye movement desensitization and reprocessing therapy work? A systematic review on suggested mechanisms of action. *Frontiers in Psychology* 2018;**9**:1395.

Lindert 2009

Lindert J, von Ehrenstein OS, Priebe S, Mielck A, Brähler E. Depression and anxiety in labor migrants and refugees: A systematic review and meta-analysis. *Social Science & Medicine (1982)* 2009;**69**(2):246-57.

Mansell 2009

Mansell W, Harvey A, Watkins E, Shafran R. Conceptual foundations of the transdiagnostic approach to CBT. *Journal of Cognitive Psychotherapy* 2009;**23**(1):6-19.

McDonald 2017

McDonald A, Save the Children. Invisible Wounds. Available at www.savethechildren.org.uk/content/dam/global/reports/emergency-humanitarian-response/invisible-wounds.pdf.

McEvoy 2009

McEvoy PM, Nathan P, Norton PJ. Efficacy of transdiagnostic treatments: a review of published outcome studies and future research directions. *Journal of Cognitive Psychotherapy* 2009;**23**(1):20-33.

Miake-Lye 2016

Miake-Lye IM, Hempel S, Shanman R, Shekelle PG. What is an evidence map? A systematic review of published evidence maps and their definitions, methods, and products. *Systematic Reviews* 2016;**5**:28.

Moher 2009

Moher D, Liberati A, Tetzlaff J, Altman DG. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of Internal Medicine* 2009;**151**(4):264-9.

Murray 2014

Murray LK, Dorsey S, Haroz E, Lee C, Alsiary MM, Haydary A, et al. A common elements treatment approach for adult mental health problems in low- and middle-income countries. *Cognitive and Behavioral Practice* 2015;**21**(2):111-23.

NICE 2018

NICE. NICE guideline [NG116]. Post-traumatic stress disorder. www.nice.org.uk/guidance/ng116.

NICE 2019

NICE. NICE guideline [NG134]. Depression in children and young people: identification and management. Available at www.nice.org.uk/guidance/ng134.

O'Leary 2017

O'Leary BC, Woodcock P, Kaiser MJ, Pullin AS. Evidence maps and evidence gaps: evidence review mapping as a method for collating and appraising evidence reviews to inform research and policy. Available at environmentalevidencejournal.biomedcentral.com/articles/10.1186/s13750-017-0096-9. [DOI: doi.org/10.1186/s13750-017-0096-9]

Ranasinghe 2007

Ranasighe PD, Levy BR. Prevalence of and sex disparities in posttraumatic Sstress disorder in an internally displaced Sri Lankan population 6 months after the 2004 tsunami. *Disaster Medicine and Public Health Preparedness* 2007;**1**(1):34-41.

Roberts 2008

Roberts B, Ocaka KF, Browne J, Oyok T, Sondorp E. Factors associated with post-traumatic stress disorder and depression amongst internally displaced persons in northern Uganda. *BMC Psychiatry* 2008;**8**(1):38.

Rogers 1951

Rogers C. Client-centered therapy: its current practice, implications and theory. London: Constable, 1951.

Rose 2002

Rose SC, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews* 2002, Issue 2. [DOI: 10.1002/14651858.CD000560]

Schauer 2011

Schauer M, Schauer M, Neuner F, Elbert T. Narrative exposure therapy: A short-term treatment for traumatic stress disorders. 2nd Edition. Boston: Hogrefe Publishing, 2011.

Shamseer 2015

Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, et al. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. *BMJ* 2015;**350**:g7647.

Shapiro 2017

Shapiro F. Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures. New York: Guilford Publications, 2017.

Sharan 2009

Sharan P, Gallo C, Gureje O, Lamberte E, Mari JJ, Mazzotti G, et al. Mental health research priorities in low- and middle-income countries of Africa, Asia, Latin America and the Caribbean. *British Journal of Psychiatry* 2009;**195**(4):354-63.

Shea 2017

Shea BJ, Reeves BC, Wells G, Thuku M, Hamel C, Moran J, et al. AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ* 2017;**358**:j4008.

Silove 2017

Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry* 2017;**16**(2):130-9.

Stiles 2008

Stiles WB, Barkham M, Mellor-Clark J, Connell J. Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. *Psychological Medicine* 2008;**38**(5):677-88.

UNHCR 2019

UNHCR UN Refugee Agency. 1951 Convention on the status of refugees. https://www.unhcr.org/asylum-and-migration.html (accessed 1 March 2019).

Wainberg 2017

Wainberg ML, Scorza P, Shultz JM, Helpman L, Mootz JJ, Johnson KA, et al. Challenges and opportunities in global mental health: a research-to-practice perspective. *Current Psychiatry Reports* 2017;**19**(5):28.

APPENDICES

Appendix 1. Ovid MEDLINE Search

Database: Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily <1946 onwards>
Search Strategy:
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1 refugees/
2 "transients and migrants"/
3 "emigrants and immigrants"/ or undocumented immigrants/
4 human migration/ or "emigration and immigration"/
5 *vulnerable populations/ and (psychology or prevention & control or therapy or rehabilitation).fs.
6 acculturation/
7 asylum.ti,ab,kf.
8 refugee*.ti,ab,kf.
9 (migrant? or immigrant? or emigrant?).ti,ab,kf.
10 (force? adj2 (migrat* or immigrat* or emigrat*)).ti,ab,kf.
11 (displac* adj1 (internal* or forced or mass or person* or people* or population*)).ti,ab,kf.
12 floating population.ti,ab,kf.
13 exp "Warfare and Armed Conflicts"/
14 Torture/ and (psychology or prevention & control or therapy or rehabilitation).fs.
15 exp Disasters/ and (psychology or prevention & control or therapy or rehabilitation).fs.
16 (humanitarian adj3 (aid or affair* or agenc* or assistance or catastrophe* or crisis or crises or disaster* or effort* or emergenc* or evacuation* or integration or reintegration or mission or organization* or organisation* or program* or relief or setting* or support* or task force or work*)).ti,ab,kf.
17 (genocide or armed conflict* or mass execution* or mass violence).ti,ab,kf.
18 (cataclysmic or catastroph* or natural disaster* or drought* or earthquake* or mass evacuation* or famine* or flood or floods or hurricane or cyclone* or landslide* or land slide* or mass casualt* or tsunami* or tidal wave* or volcano*).ti,ab,kf.
19 (torture* or (politic* adj2 (detention or detainee? or persecut* or prison* or imprison* or violen*))).ti,ab,kf.
20 ((war or warfare) adj5 (abuse* or crime* or rape* or surviv* or victim*)).ti,ab,kf.
21 (postconflict* or post conflict*).ti,ab,kf.
22 (Medecin? San? Front* or Red Cross or Red Crescent).mp.
23 or/1-22
24 mental health/
25 mental disorders/
26 anxiety disrders/ or agoraphobia/ or anxiety, separation/ or neurocirculatory asthenia/ or neurotic disorders/ or panic disorder/ or phobic disorders/ or phobia, social/
27 mood disorders/ or depressive disorder/ or depression, postpartum/ or depressive disorder, major/ or depressive disorder, treatment-resistant/ or dysthymic disorder/ or premenstrual dysphoric disorder/ or seasonal affective disorder/ or cyclothymic disorder/
28 "trauma and stressor related disorders"/ or adjustment disorders/ or stress disorders, traumatic/ or combat disorders/ or psychological trauma/ or stress disorders, post-traumatic/ or stress disorders, traumatic, acute/
29 (mental* or psychiatr*).ti,kf.
30 (mental* adj1 (health* or ill* or well* or disease* or disorder* or promot* or prevent*)).ti,ab,kf.
31 (depress* or dysthymi* or affective disorder? or affective symptom* or dysthymi* or mood? or anxiety or GAD or agoraphobi* or panic or phobi* or social engagement disorder?).ti,ab,kf.
32 (PTSD or ((posttrauma* or post-trauma* or post trauma*) adj3 (stress* or disorder? or psych* or symptom*)) or acute* stress* or traumatic* stress* or stress disorder? or combat disorder? or war neuros*).ti,ab,kf.
33 ((emotional or psycho*) adj (stress* or distress* or trauma*)).ti,ab,kf.
34 (adjustment disorder? or attachment disorder? or (emotional adj (adjustment? or disorder?))).ti,ab,kf.
35 (grief or grieving).mp.
36 or/24-35
37 (systematic or structured or evidence or trials or studies).ti. and ((review or overview or look or examination or update* or summary).ti. or review.pt.)
38 (0266-4623 or 1469-493X or 1366-5278 or 1530-440X or 2046-4053).is.
39 meta-analysis.pt. or (meta-analys* or meta analys* or metaanalys* or meta synth* or meta-synth* or metasynth*).ti,ab,kf,hw.
40 ((systematic or meta) adj2 (analys* or review)).ti,kf. or ((systematic* or quantitativ* or methodologic*) adj5 (review* or overview*)).ti,ab,kf,sh. or (quantitativ$ adj5 synthesis$).ti,ab,kf,hw.
41 (integrative research review* or research integration).tw. or scoping review?.ti,kf. or (review.ti,kf,pt. and (trials as topic or studies as topic).hw.) or (evidence adj3 review*).ti,ab,kf.
42 review.pt. and ((medline or medlars or embase or pubmed or scisearch or psychinfo or psycinfo or psychlit or psyclit or cinahl or electronic database* or bibliographic database* or computeri#ed database* or online database* or pooling or pooled or mantel haenszel or

peto or dersimonian or der simonian or fixed effect or ((hand adj2 search*) or (manual* adj2 search*))).tw,hw. or (retraction of publication or retracted publication).pt.)
43 or/37-42
44 (23 and 36 and 43)

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CONTRIBUTIONS OF AUTHORS

EU and RC conceived the idea for this study. EU drafted the first version of this protocol, and all authors contributed to revising this draft and writing the final version of the protocol.

DECLARATIONS OF INTEREST

EU: no conflicts of interest

MP: no conflicts of interest

RC: leads and has responsibility for Cochrane Common Mental Disorders, which has supported parts of the review process and is largely funded by a grant from the National Institute of Health and Research (NIHR) in the UK.

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External sources

- No sources of support supplied