social sciences

MDPI

Review

A Systematic Review of the Protective and Risk Factors Influencing the Mental Health of Forced Migrants: Implications for Sustainable Intercultural Mental Health Practice

Hadi Farahani [1,*], Natalie Joubert [1], Janet Carter Anand [1], Timo Toikko [1] and Mohamad Tavakol [2]

[1] Department of Social Sciences, University of Eastern Finland, 70211 Kuopio, Finland; njoubert@uef.fi (N.J.); janet.anand@uef.fi (J.C.A.); timo.toikko@uef.fi (T.T.)
[2] Department of Sociology, University of Tehran, Tehran 1411713118, Iran; mtavakol@ut.ac.ir
* Correspondence: hadi.farahani@uef.fi or hadif@uef.fi

Abstract: This systematic review followed the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement. The primary aim of this research was to identify risks and protective factors for the mental health of forced migrants. The secondary aim was to suggest an alternative, more comprehensive approach in social work that surpasses usual diagnoses and intrinsically contradicts the medicalization of mental health issues of forced migrants. The search was conducted between January 2015 and January 2021. As a result, 29 studies met inclusion criteria. Medicalizing mental health issues by relying solely on the effectiveness of medicine was a controversial risk factor that negatively affected daily life activities of refugees and reduced their willingness for seeking professional mental health services. Empowering vulnerable minorities by giving them back their power and agency to be able to speak for themselves and raise voices of trauma and recovery was the missing protective factor for a sustainable mental health practice. The benefits of group-based interventions were highlighted in which communities and individuals address mental health issues as well as isolation through building collective identities and support networks. Information and communication technologies (ICTs) can add more strength to any kind of mental health interventions. Finally, the benefits of applying an ecological perspective for the study of the mental health of refugees, and its implications for a sustainable intercultural practice, were discussed. Social workers in this model are the representatives of at-risk groups, and thus require more agency and creativity in reflecting client's concrete needs.

Keywords: mental health; risk factor; protective factor; refugee; asylum-seeker; sustainable intervention

Citation: Farahani, Hadi, Natalie Joubert, Janet Carter Anand, Timo Toikko, and Mohamad Tavakol. 2021. A Systematic Review of the Protective and Risk Factors Influencing the Mental Health of Forced Migrants: Implications for Sustainable Intercultural Mental Health Practice. *Social Sciences* 10: 334. https://doi.org/10.3390/socsci10090334

Academic Editor: Karen Jacobsen

Received: 26 April 2021
Accepted: 1 September 2021
Published: 7 September 2021

1. Introduction

It has been established that exposure to the traumatic experiences associated with forced migration endangers the overall mental health of refugees, creating a worldwide mental health crisis (Siriwardhana et al. 2014; Hall and Olff 2016). The United Nations High Commissioner for Refugees estimates that global forced displacement has surpassed 82.4 million at the end of 2020 including 26.4 million refugees, and 4.1 million asylum seekers (United Nations High Commissioner for Refugees 2021). It defines refugees as people who have been forced to flee their country due to persecution, war or violence, and who have a well-founded fear of persecution for reasons of race, religion, nationality, political opinions or membership in a particular social group in the country of their nationality (United Nations High Commissioner for Refugees 2019). Asylum-seekers, on the other hand, live in a more precarious situation as they must await formal recognition as 'refugee' to be eligible for the protections afforded to those with refugee status (Hynie 2018). The International Organization for Migration (IOM) categorizes refugees and asylum seekers under the umbrella of "forced migration". Forced migrants according to IOM are

those whose migratory movements involve force, compulsion, or coercion (International Organization for Migration 2019).

Across Europe and internationally there is a pressing need for the development of culturally appropriate mental health services for socially excluded and marginalized populations (Mölsä et al. 2019). Approaches to mental healthcare have undergone significant reforms around mental health intervention and immigrants' health policies, wherein social scientists have realized that mental health and well-being are influenced by various social determinants (Hynie 2018; Marmot 2020). Through efforts to acquire holistic approaches towards mental health, social scientists have concluded that the social, cultural, and historical diversity of refugees adds to the complexity of mental health service delivery but also presents opportunities for reform (Murray et al. 2010; Hutchinson and Dorsett 2012).

Considering all of the issues faced by forced migrants, especially in a time that services are stretched thin, social workers play an important role in the mental health service delivery for refugee populations as a single medium between common top-down policies and forced migrants. Top-down policies place pressure on both social workers and forcibly displaced immigrants (Murray et al. 2010; Hutchinson and Dorsett 2012; Kim 2014). It is therefore imperative that social workers are informed by research about what culturally appropriate interventions can be attempted and which would be most effective. This is not easy in a culturally diverse refugee population with social workers from the host country who often have very limited in knowledge of refugees mental and cultural landscape. However, the baseline is that it is critical for social workers to understand the mental health needs of this often highly traumatized population, as well as having the cultural sensitivity necessary to be successful in helping refugees sustainably integrate into society and avoid mental health pitfalls.

At present, most of the research in the field of migration is reproduced through the same dominant top-down patterns, confined to pathology and diagnosis and highlighting only prevalence rates of the mental health issues. Thus, voices, interests, and expectations of the immigrant communities are ignored. However, with the continued migration of refugees, there is increased attention to how to address the ongoing needs of refugees, resulting in greater demands for services appropriate to their needs.

Mental health services are one of the most important services that forced migrants urgently need upon arrival to the host countries. However, Watters criticizes the Western Mental Health Care approach in the refugee situation as inappropriate (Watters 2001). The importance of post-migration stressors to refugee's mental health status suggests the need for sustainable therapeutic interventions with psychosocial elements that address the specific ecology of being a refugee as well as the conditions of refugees' lives. To do so, sustainable therapeutic interventions should be fully cognizant of the wide range of cultural diversities in refugees' population, with a predictable dissonance between their concepts of mental health and those of the host country.

1.1. Literature Review

The literature shows that mental health of forced migrants has been extensively studied. However, studies produced additional puzzles and noncomprehensive frameworks for analysis, and intervention. Research clearly indicates that refugees' mental health is highly influenced by the conditions that they find themselves in post migration (Li et al. 2016), often in abject squalor (such as the camps on the Turco-Syrian border). The clash of cultures, the fear of deportation, and the almost ubiquitous instability are only some issues. It is of great concern that refugees who have lived in a host country for more than five years continue, despite this time in a relatively safer environment, show higher rates of depressive and anxiety disorders than the host population (Cantor-Graae and Selten 2005; Lindert and Guglielmo 2011; Bogic et al. 2015; Ottisova et al. 2018; Chen et al. 2017). It is therefore clear that the stimuli for mental instability continue to have repercussions, whether in post-traumatic stress with nightmare or simply replay of traumas past. Of great concern is a Swedish study which showed higher incidence for psychotic disorders (i.e.,

more newly diagnosed psychotic disorders) in refugee compared with the host population (Hollander et al. 2016). This raises the question of epigenetics as an underlying element in people who have been exposed to high levels of trauma over long periods (Howie et al. 2019). Recently this recognition has embraced new directions of study for this condition, in particular defining populations with resilience and populations who are prone to PTSD and opening the possibilities of targeted novel PTSD therapies (Howie et al. 2019).

Other studies on utilizing mental health services by refugees show that despite higher prevalence rates of mental health issues being documented, there still exists an underutilization of Western mental health treatment by refugee populations, the reasons given include both structural and cultural barriers (Moreno et al. 2006; Lamkaddem et al. 2014; Agrawal and Venkatesh 2016). Thus, existing research on mental health service barriers has identified issues of stigma, distrust of services and social and cultural problems that impact on "how problems are understood" and the question about whether help should be sought and if so, how" (de Anstiss et al. 2009; Colucci et al. 2015; Brown et al. 2016). It is therefore important for social workers to understand the barriers and reasons why underutilization exists and how to better support this vulnerable population (Lamkaddem et al. 2014; Rankopo and Osei-Hwedie 2011).

It is evident from the literature review the mental health of forced migrants is a multidimensional phenomenon. It not only needs quick responses but also requires receiving constant feedback from the field. In other words, research must go beyond diagnosis and medical responses to the mental health needs of the forced migrants. Through identification of the commonly recognized risks and protective factors in this systematic review, we try to offer an alternative approach that guarantees sustainability of mental health practice, which values forced migrant's viewpoints as active agents, capable of trauma growth and resilience.

1.2. Applying an Ecological Perspective

When working with refugees, Kira and Tummala state the importance for social workers to adopt an ecological model of recovery (Kira and Tummala-Narra 2015). This provides a holistic approach in addressing the differing needs refugees face after resettlement. Informed by Urie Brofenbreener's ecological perspective (Bronfenbrenner 1979) human development is shaped by several systems or contexts, and social workers can then understand how an individual is impacted by their family, community, and environment (Bronfenbrenner 1979). This will better support refugees themselves when identifying the quality of interactions, they have with their micro, meso, and macro systems.

In a German study with Syrian refugee women in identifying and understanding the barriers in accessing mental health care, McLeroy's adaptation of the socio-ecological model (SEM) and the barriers on the various SEM layers, from an individual to a policy level. This explained how different individual and environmental factors determine health behavior in individuals (McLeroy et al. 1988). It is a useful framework since it conceptualizes human development by placing the individual into the centers of circles surrounding it, highlighting the interrelationship of multiple determinants of development and interactions at the personal, relational, and collective levels within this dynamic socio-ecological environment (Henderson and Baffour 2015; Kilanowski 2017). With this framework, there is an assumption that individual decisions and behaviors are determined by reciprocal interactions within and between the social and physical environment of individuals. Simultaneously, individuals contribute to their social ecology in terms of constructing norms, beliefs, and culture across multiple macro-systems (Henderson and Baffour 2015). Intrinsically, the SEM states that individual level behavior is shaped by multiple environmental factors and vice-versa, recognizing the important social environmental and biological factors that either cultivate or inhibit individual attitudes and behaviors (Wong et al. 2017).

Addressing the ecological perspective for mental health intervention is a critical component for cultural appropriate and sustainable practice, where the micro-system considers the individual and family relationship and interactions. The meso-system acknowledges the individual and what supports they have or lack within the community. The macro-system focuses on the programs, assessments, and policies that affect the lives of refugees and their families.

2. Rational for the Study

The primary aim of the study is to systematically review literature on the protective and risk factors for the mental health of forced migrants. Secondly, it focuses on providing an alternative approach to the mental health issues of the forced migrants that transcends from the usual pathologizing and medicalizing perspectives, highlighting the resilience, strength and capability of these vulnerable minorities. The need to explore this area is supported by the fact that cultural diversity of forced migrants calls for more in-depth practice research. Practice research is therefore the base for sustainable mental health intervention. This highlights the critical role of social workers who deal directly with forced migrants, grounded for more preventive approach in mental health care than diagnosis.

3. Materials and Methods

3.1. Design

The systematic review followed the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement (Liberati et al. 2009). The PRISMA statement includes 27-item checklist which assures the transparency, iteration, and complete reporting for systematic reviews.

3.2. Search Strategy

The search was conducted in ScienceDirect, Scopus, PubMed, Medline, Web of Science, ProQuest, Wiley, and Elsevier in December 2020 to January 2021. The electronic databases were searched using the below terms identified form the title, abstract, keywords, or headings: (‘mental health’ OR ‘refugee’ OR ‘asylum seeker’ OR ‘risk factors’ OR ‘protective factors’ AND ‘predictors’ OR ‘measurements’ OR ‘determinants’. The search terms were adapted from the previous review studies with a similar purpose. We also manually searched reference lists of relevant articles to identify additional publications. Finally, references of all included studies were listed to eliminate the duplications and resolve proper reporting guidelines for the selected articles. different synonyms were used for the search.

3.3. Eligibility Criteria

All quantitative and qualitative studies were considered for the systematic review. Studies were included if they: (1) evaluated overall mental health issues of the forced migrants; (2) assessed any association between depression, post-traumatic stress disorder, mental disorder determinants and migratory backgrounds; (3) tested any theoretical framework related to mental health; (4) compared mental health issues or its determinants between particular migrant populations or with general populations in the host societies; and (5) conducted a literature review, systematic review or meta-analysis/synthesis on mental health determinants of forced migrants e.g., refugees, and asylum seekers.

Studies published in full in peer-reviewed journals between January 2015 and January 2021 and in English language were included. First reason for choosing a six-year timeframe for this research were the critical aftereffects of the 2015 refugee crisis. Hagelund 2020, called this crisis as “exogenous shock” that generated different kinds of policy responses and accordingly impacted research in the field of migration (Hagelund 2020). Secondly, it has been a long time since the last comprehensive systematic review of the mental health of refugees is done and there is a need for further follow ups (Bogic et al. 2015).

Studies with less than 50 participants in quantitative articles were excluded. We eliminated dissertations, conference abstracts and organizational reports from the review. The different stages of sampling articles are illustrated in Figure 1. We reviewed risks, and protective factors for the three common mental health issues among forced migrants including post-traumatic stress disorder, depression, and mental disorder. These three negative mental health outcomes are reportedly frequent among forced migrants from the initial pre-migration stages to resettlement and post-resettlement in the host countries (Alemi et al. 2016).

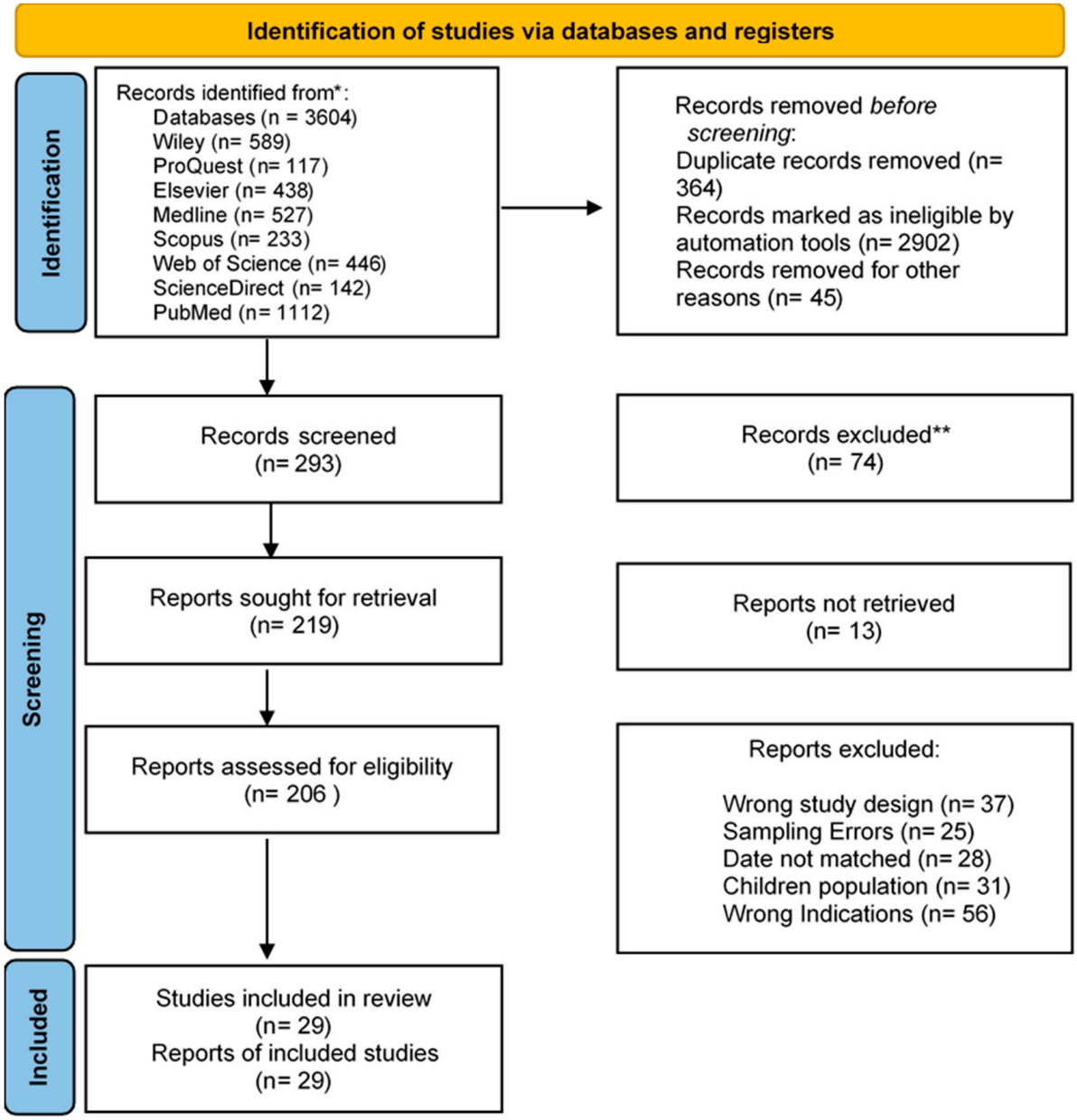

Figure 1. Flow diagram illustrating different stages of sampling (Page et al. 2021). * There could be more relevant databases on the topic. ** Excluded records in all stages were checked triple times to ensure justifiability.

3.4. Selection of the Studies

Titles and abstracts of the studies derived from the databases were reviewed twice by two independent authors before proceeding to the next stage of the review. To solve the disagreements between authors in eliminating or including papers in the review process, a third author was consulted. Full texts of all included studies were checked twice according to the eligibility criteria by the authors and disagreements were resolved.

3.5. Data Extraction

To ease the review process, data were entered into a previously prepared data extraction sheet. In the data extraction sheet, we itemized study characteristics including author names, publish year, and country; time that the research was done; sampling method; Data collection method; population of the study; sample size; age range; theoretical framework; key findings including risk, and protective factors for mental health. Characteristics of the included qualitative and quantitative studies are consecutively shown in Tables 1 and 2.

Table 1. Characteristics of the included qualitative studies.

N	Author (s) Country	Time Period	Sampling Method	Interview Method	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
1	(Page et al. 2021; Affleck et al. 2018) Canada	2012–2016	Convenience Snowball	Semi-structured	Sri Lankan Tamil refugee men	33	20–60	Grounded Theory	Participating in religious rituals, meditation, adherence to familial and community duties	Inability to protect family members, inability to fulfill cultural duties, inability to perform social roles, Un/Uder-employment, inner-family conflicts
2	(Alemi et al. 2017) USA	July–October 2012	Snowball	Semi-structure	Afghan refugees & asylum seekers	18 = (11) males, (7) females	36–71	Cutural Consensus Analysis	Family reunification, community support, prayers, successfulness of the children	Imprisonment of family members, arbitrary home invasions, constant fears of being killed or maltreated, harsh fleeing path, abrupt separation from family-cultural adjustment issues, fear of deportation, language learning barriers, intergenerational challenges with children, unemployment, cultural insensitiveness of social services, losing culture and identity
3	(Im et al. 2017) Kenya	Unknown	Purposive	Semi-structure and focus groups	Somali refugees	15 key informants, 31 focus group participants	18–56	Kleinman's (1991) Explanatory Approach	Counseling, job opportunities, mindfulness exercises, socializing, prayers, personal reflections,	lack of educational opportunities, work and decent life, isolation, daily physical health issues, distressing events, unfulfilled desires. insufficient means of support, losing loved ones, community violence

Table 1. *Cont.*

N	Author (s) Country	Time Period	Sampling Method	Interview Method	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
4	(Omar et al. 2017) Astralia	2013–2014	Purposive	Semi-structure and focus groups	Muslim refugees from Somalia, Eritrea, Ethiopia, and Djibouti	36	18–60	None (Inductive Ethnographic Analysis)	Prayer, confidence in Allah, family and community support, cultural rehabilitation methods (visiting African environment)	Unemployment, underemployment, intercultural conflicts in the host country, religious boundaries, inability to support families overseas, lack of mental health literacy, doubt in identifies treatment strategies (faith-based) treatments,
5	(Savic et al. 2016) Australia	Unknown	Unknown	Semi-structure	Refugees, health service providers	45	+18	None (Inductive Framework Approach)	Community counselling, community supports	Pre-migration experiences e.g., exposure to violence, rape, loss of loved ones, distrust of western mental health services, medicalized nature of western mental health services, stigmatization of mental health issues, incompatibility of needs and offered mental health services
6	(Poudel-Tandukar et al. 2019) USA	Unknown	Convenience Snowball	Focus groups	Bhutanese refugees	67	+18	PEN-3 Cultural Model	Community supports, sharing problems with peers, cultural empowerments and raising awareness	language learning issues, decreased support systems, increased responsibilities in the host countries, socio-economic disadvantages, lack of access to services, change in family dynamics, discrimination, stigmatization

Table 1. *Cont.*

N	Author (s) Country	Time Period	Sampling Method	Interview Method	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
7	(Yaser et al. 2016) Australia	2015–2016	Convenience Snowball	Semi-structure	Afghan Refugees	150 = (74) males, (76) females	20–45	The Mental Health Literacy	Improving diet or exercise, raising self-awareness, psychotherapy focusing on the past events, finding new hobbies, physical activity, socializing, meditation, herbal medication,	None
8	(Yassin et al. 2018) Lebanon	August–November 2015	Convnience	Semi-structure	Palestinian refugees	49 = (28) refugees, (11) service providers, (10) local community representatives	24–58	Inductive Thematic Content Analysis	Easy access to services, home visits of social workers, individual based treatments, raising awareness of refugees about mental health, access to the history of mental health issues of refugees, sustainability of the mental health services, prompt access to mental health services upon entry to the country	None

Table 1. *Cont.*

N	Author (s) Country	Time Period	Sampling Method	Interview Method	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
9	(Yu et al. 2018) South Korea	July–August 2013	Purposive	Semi-structure	North Korean refugees	10 = (8) females (2) males	20–69	None (Inductive Qualitative Analysis)	Prompt treatment upon arrival, raised self-awareness, counselling	Absence of mental health awareness, issues of survival, stigmatization, lack of access to mental health services, trauma experienced during the escape, cultural encounter shocks, isolation and lose identity
10	(Vitale and Ryde 2016) U.K.	2015	Purposive	Semi-structure	Refugees (Iraq-Sudan-Iran-Eritrea-Morocco-Somalia)	9	29–62	None (Exploratory and inductive)	Voluntary works, target oriented work trainings	Stress of deportation, asylum seeking process, sense of powerlessness, confinement in the detention centers, inadequate supports, feelings of re-traumatization, un/underemployment, high expectations upon arrival, inadequate means of living, lack of practical information, lack of integration in the host community, inability to establish new networks, cultural barriers, inadequate mental health services, no opportunities to be an active citizen

Table 2. Characteristics of the included quantitative studies.

N	Author (s) Country	Time Period	Methodology	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
11	(Poole et al. 2018) Greece	January 2017	Survey	Syrian Refugees	135	18–61	Patient Health Questionnaire-8 (PHQ-8)	Not mentioned	Gender (being women), having children, increased time in the asylum process
12	(Chung et al. 2018) Turkey, Sweden	2017	Survey	Syrian Refugees	1197 (482 females, 715 males)	+18	Centrality of Event Scale, Harvard Trauma Questionnaire, General Health Questionnaire-28	Age (younger refugees are more resilient), stable relationship with community, employment, social networks	Location of resettlement, came alone of with family, having less community networks
13	(Hocking and Sundram 2015) Australia	Not metioned	Survey	Refugees (n = 33) and asylum seekers (n = 98) form Zimbabwe, Afghanistan, Iran, Iraq, Lebanon, Pakistan, Sri Lanka	131	+18	The Harvard Trauma Questionnaire-Revised (HTQ) and the Hopkins Symptom Checklist-25 (HSCL), Post-Migration Living Difficulties Checklist (PMLDC)	Social networks, employment	Gender, age, social isolation, low socio-economic status, family separation, unclear residence status, detention experience, mode of arrival
14	(Campbell et al. 2018) U.K.	2005–2007	Longitudinal survey	Refugees	5678	+18	Health Survey Questionnaire	Involvement in community networks, easy access to healthcare services	unemployment, language barriers, unsatisfactory accommodation, being victims of discrimination, infrequent contact with relatives

Table 2. *Cont.*

N	Author (s) Country	Time Period	Methodology	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
15	(Şimşek et al. 2018) Turkey	2015	Cross-sectional, interview	Refugees	458 = females, 15–49 years old	15–49	Reproductive Health Assessment Toolkit for Conflict-Affected Women, General Health Questionnaire 12	social support, community-based and culturally sensitive health education programs, inclusion of mental health care within basic primary care services	Household size, difficulty to get health services
16	(Dietrich et al. 2019) Germany	Not mentioned	Interview, survey	Refugees from Syria and Iraq	2057	18–24.9	Essen Trauma Inventory, Short Screening Scale for Posttraumatic Stress Disorder	social support and networks, higher education	Experience of violence, poor housing and sense of insecurity
17	(Georgiadou et al. 2018) Germany	Not metioned	Survey	Syrian refugees	518	18–63	Essen Trauma Inventory, Patient Health Questionnaire—Depression Module (PHQ-9), Generalized Anxiety Disorder (GAD-7)	Inclusive welfare system	Death of a loved one, age, shorter validity of residence permit, longer duration of asylum procedure, poor economic conditions
18	(Schweitzer et al. 2018) Australia	2013–2015	Cross-sectional survey	Refugees	104	18–70	Harvard Trauma Questionnaire (HTQ), Hopkins Symptom Checklist (HSCL-37), Post-migration Living Difficulties Checklist (PMLD)	Access to health and welfare services, improved pre-arrival information about the host societies	Traumatic experiences, racial discrimination

Table 2. *Cont.*

N	Author (s) Country	Time Period	Methodology	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
19	(Segal et al. 2018) Lebanon	2012–2013	Survey, interview	Palestinian refugees	254	18–89	Primary Care Posttraumatic Stress Disorder (PTSD), Kessler-6	Housing stability, economically gainful employment, social networks, immediate access to mental health clinics	Traumatic experiences, human right violations
20	(Grupp et al. 2018) Germany	Not mentioned	Survey, focus groups	African refugees, German population	239	18–54	Revised Illness Perception Questionnaire (IPQ-R)	Praying, ability to fulfill religious rituals	Isolation, Intergenerational conflicts
21	(Kandemir et al. 2018) Turkey	Not mentioned	Survey	Syrian refugees	355	Mean: 11 (SD: 3.67)	Children's Depression Inventory, Screen for Child Anxiety Related Disorders	Social and welfare supports, education, social networks	Traumatic experiences, gender, proper housing, enough food, experiences of discrimination and racism
22	(Shawyer et al. 2017) Australia	Not mentioned	Survey	Refugees, and asylum-seekers	135	18–66	Kessler-10 (K10), PTSD-8	Culturally responsive mental health services, early mental health assessments and treatments	Human right violations, stressful migration experiences, cultural and language barriers to get access to mental health services, country of origin
23	(Slewa-Younan et al. 2017) Australia	2013	Interview, survey	Afghan refugees	150	Mean: 32.8 (SD: 12.2)	Hopkins Symptoms Check List (HSCL-25), Afghan War Experience Scale (AWES)	Early intervention programs	Past traumatic experiences

Table 2. *Cont.*

N	Author (s) Country	Time Period	Methodology	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
24	(Tinghög et al. 2017) Sweden	2011–2013	Cross-sectional survey	Syrian refugees	1215	18–64	Hopkins Symptom Checklist (HSCL-25), Harvard Trauma Questionnaire (HTQ), WHO-5 Well-being Index	Reunion with family members	Gender, traumatic experiences, lower education, Isolation in host society, ethnic discrimination
25	(Lillee et al. 2015) Australia	Not mentioned	Survey	Refugees	300	18–70	The Kessler Psychological Distress Scale (K10), General Health Questionnaire (GHQ-12)	Routine use of mental health services, culturally sensitive mental health care	Marital status, having more children, past traumatic events, stigmatization,
26	(Leiler et al. 2019) Sweden	Not mentioned	Survey, interview	refugees and asylum seekers	510	+18	Patient Health Questionnaire-9, General Anxiety Disorder 7, Primary Care PTSD Screen, WHOQOL-BREF	Safety, access to health care upon arrival, shortening asylum process	unclear residence permit status, poor neighborhoods
27	(Rizkalla and Segal 2018) Jordan	2014–2016	Survey	Syrian refugees	250	16–75	Harvard Trauma Questionnaire, War Events Questionnaire, K6, The PTGI, The HTQ	Active NGOs, refugee-friendly mental health services	Traumatic events, un/underemployment, poor neighborhood disadvantages
28	(Acarturk et al. 2018) Turkey	March–May 2013	Survey, interview	Syrian refugees	781	Mean: 35.2 (SD: 11)	Impact of Event Scale–Revised, Beck Depression Inventory	Inclusive public health policies	Traumatic events, losing sources of income, gender, living in camps

Table 2. *Cont.*

N	Author (s) Country	Time Period	Methodology	Study Population	Sample Size	Age Range	Theoretical Framework	Protective Factors	Risk Factors
29	(Pandya 2018) Europe	Not mentioned	Survey	Refugees	4504	+30	Trauma Screening Questionnaire (TSQ), Life Orientation Test-revised (LOT-R), Mental Health Inventory-38 (MHI-38)	Voluntary participation in mental health programs, self-practice willingness, spirituality, group-based interventions	Country of origin, refugee status duration, gender, past traumatic experiences

3.6. Quality Assessment

The quality of the eligible studies e.g., heterogeneity and variability in the design, was assessed by the GRADE approach for grading the quality of evidence and the strength of the recommendations in systematic reviews. GRADE approach was developed to improve the transparency of the process of systematic reviews and presenting a logical support or evidence and recommendations (Schünemann et al. 2009; Guyatt et al. 2011; Balshem et al. 2011). According to the GRADE guidance, five main quality factors of evidence are as follows: (1) risk of biases, (2) inconsistency of results, (3) indirectness of evidence, (4) impression, and (5) publication bias. Most of the selected studies were non-experimental and their quality were ranked as low. Articles were excluded in this review if they were seriously lacking experimental feature. The main author doubly checked selected studies to assess the quality. A second author checked for the precision of the assessment. Disagreements were resolved through discussion.

3.7. Data Analysis

Due to the heterogeneity of the measurements, methods, and theoretical bases of the selected studies, utilizing statistical methods to combine data for further analysis were impossible. Moreover, the studied countries, population characteristics and data collection methods were different. As a result, data were narratively synthesized in the systematic review. Selected studies were categorized by the origin of the sample population, mental health risk factors and protective factors, and the prevalence rates of the identified mental health issues (e.g., depression, post-traumatic stress disorder, and other mental disorders). Within each category, consistency or contradictions regarding the results of the selected studies were synthesized. Reasons for conflicting results in the prevalence rates, or risks and protective factors for mental health were interpreted according to the evidence and study characteristics (e.g., methodological errors, sampling bias, or measure shortcomings).

4. Findings

4.1. Comparing Risk and Protective Factors across Mental Health Diagnosis

The evidence presented in this systematic review supports the findings of previous studies that mental health issues of vulnerable populations are multidimensional, and widely measured outcomes of health issues are of great concern. However, the measures and perspectives that attempted to explain mental health issues especially in the included quantitative studies in this systematic review were top-down, and less of them by nature were supported to really explain refugees' points of views. This fact became more evident after comparing the quality and the depth of the findings in terms of the identified risks and protective factors in each of the included articles.

4.2. Risk Factors

Socio-demographic factors in this literature review appeared to reflect the findings of previous research. Women were at greater risk of developing poorer mental health than men and poor mental health was associated with having more children (Poole et al. 2018; Segal et al. 2018). Due to the possibility of adapting to a new environment and behavioral resilience, young refugees found adjustment to a new culture easier compared to the older age refugees (Georgiadou et al. 2018). The country of origin and the reasons for migration appeared to be positively associated with mental health, post-traumatic stress disorder and depression symptoms (Pandya 2018). Low socioeconomic and educational levels were strongly associated with mental health outcomes, as poorly educated refugees with lower incomes were at greater risks of developing adverse mental health outcomes (Im et al. 2017; Şimşek et al. 2018; Dietrich et al. 2019). However, it is proven that recently resettled refugees with higher education and socioeconomic backgrounds were at greater risks of developing mental health issues during the period leading up to the outcome of their asylum application (Carswell et al. 2011).

Unemployment was another important risk factor that was referred to across the selected studies (Hocking and Sundram 2015; Campbell et al. 2018; Dietrich et al. 2019; Segal et al. 2018). However, the causation of the link between unemployment (or under-employment) and mental health remains contentious (Dietrich et al. 2019; Beiser and Hou 2001). Campbell et al. referred to the direct effect of unemployment on mental health issues in which unemployed people suffer negative side effects in daily life (Campbell et al. 2018). Unemployment may result in financial problems and loss of self-esteem, loss of social networks and social participation, and may increase the risk of dangerous behaviors, such as smoking, drinking, and drug abuse (Omar et al. 2017).

Another common risk factor was the effect of housing quality. Some refugees were accommodated outside urban areas in poor quality collective shelters. Dissatisfaction with accommodation resulted in isolation and low self-esteem and both factors endangered the mental health of refugees and asylum seekers (Campbell et al. 2018; Phillimore and Goodson 2006). Accommodation policies of the host countries have been a growing area of controversy. Phillimore and Goodson, long before the 2015 refugee crisis contended that policies for accommodating refugees in dispersal areas resulted in higher levels of unemployment. They concluded that these processes together exacerbated the general levels of social exclusion in the host societies (Phillimore and Goodson 2006).

Infrequent contact and interaction with relatives and friends were found to be associated with poorer mental health outcomes (Chung et al. 2018). Development of new social networks in host countries found to be an offsetting element (Şimşek et al. 2018). Distrust of western mental health practice, and dissatisfaction with the centrality of the medicine in the treatment of the mental health issues, were controversial risk factors calling for more in-depth research (Omar et al. 2017; Savic et al. 2016; Yassin et al. 2018). The importance of language acquisition for social interaction was highlighted. Involvement in social activities and community networks requires acceptable knowledge of language skills (Campbell et al. 2018). Without linguistic skills, no connection, and consequently, no integration is possible. This problem was mostly common amongst older refugees. The potential for learning a new language decreases as age raises (Beiser and Hou 2001). Thus, social isolation, due to not having enough language skills, was strongly associated with negative mental health issues.

Perceived discrimination and prejudice appeared to be associated with poorer mental health. Victims of discrimination and physical violence reported that they suffered from adverse well-being feelings (Szaflarski and Bauldry 2019). They constantly worried about the recurrence of such incidents and feel angry. This made these victims feel isolated as time passed on, and in extreme cases, individuals responded with violent behaviors (Valtonen 2008).

4.3. Protective Factors

Selected qualitative studies in the current review provided more in-depth view of the risks and protective factors for mental health issues. In terms of protective factors, community support and social networks of refugees seemed to play a crucial role in dealing with mental health issues (Alemi et al. 2017; Im et al. 2017; Omar et al. 2017; Poudel-Tandukar et al. 2019; Valtonen 2008). According to the findings of Affleck et al. community representatives of Sri Lankan Tamil refugees were actively screening mental health of each member of the community and, in doing so, those who were recognized suffering from various mental health issues were closely taken care and treated according to the traditional practices (Affleck et al. 2018). This can be a good example for a sustainable mental health program that shows how to use community potentials to manage its members' well-being and health.

Cultural empowerments of service providers and raising awareness of the people in the host countries through sustainable intervention plans were another effective protective factor for the mental health of refugees (Poudel-Tandukar et al. 2019). Cultural awareness, especially in the side of social workers and service providers, creates mutual understanding of refugees' various needs. The compatibility of the services with the cultural beliefs and expectations of the stakeholders, as Pandya mentions, raises voluntary participation and self-practice willingness towards mental health services among refugees and asylum seekers (Poudel-Tandukar et al. 2019; Pandya 2018).

Considering all of the risks and protective factors for the mental health of forced migrants, qualitative studies proved to be more detailed and reliable, especially when it comes to the practice research and seeking sustainable solutions for the issues of forced migrants. Selected qualitative studies in this review also merited acquiring bottom-up approaches in which refugees and asylum seekers actively participate in the research process. This is in line with our contends on the benefits of the ecological perspective when dealing with vulnerable populations.

5. Discussion

Pre-migration conditions, movement difficulties, and resettlement challenges are interwoven periods in forced migration that can have adverse mental health effects lasting for years or even generations (Ceri et al. 2017). However, a review of the literature proved that involving forced migrants, and using community potentials in research and further in mental health intervention plans can yield positive, sustainable effects (Affleck et al. 2018; Shawyer et al. 2017; Slewa-Younan et al. 2017; Lillee et al. 2015; Rizkalla and Segal 2018; Acarturk et al. 2018; Pandya 2018).

Some of the important pre-migration risk factors identified in the included studies were experiencing discrimination, constant fear, abrupt separation from family, leaving close kin behind, and witnessing the death of family members or relatives (Alemi et al. 2016; Savic et al. 2016). These risk factors clearly call for providing quick access to mental health services upon arrival of the forced migrants in host communities (Yassin et al. 2018; Yu et al. 2018; Campbell et al. 2018; Şimşek et al. 2018; Segal et al. 2018). However, culturally sensitive mental health services are missing protective factor that positively impact willingness in seeking sustainable services in forced migrants (Şimşek et al. 2018; Shawyer et al. 2017; Lillee et al. 2015; Rizkalla and Segal 2018; Pandya 2018).

Movement difficulties commonly occurred in the migration phase through borders and usually associate with human right violations, migrants smuggling, and systematic discrimination in transit countries (Yu et al. 2018; Shawyer et al. 2017). Traumatic experiences of movement periods usually remain forever and need attention as soon as possible but, it is the duty of the international organizations such as UNHCR or IOM to hold transit countries accountable, encouraging them to legally recognize forced migrants' human rights (Perrin 2010). As for the resettlement phase in the host countries, we found structural factors that could negatively associate with mental health of forced migrants. Some of those identified factors included un/under employment, neighborhood disadvantages, prolonged asylum application process, short length of residence permits, stigmatization, isolation, impossibility of reunion with the rest of the family members, and cultural encounters (Vitale and Ryde 2016; Hocking and Sundram 2015; Georgiadou et al. 2018; Grupp et al. 2018; Kandemir et al. 2018; Shawyer et al. 2017; Lillee et al. 2015; Leiler et al. 2019; Rizkalla and Segal 2018). These structural level issues could be dealt with in the host countries by actively revising, and updating policies towards forced migrants' wellbeing (Hagelund 2020).

5.1. Promoting Mental Health Care—Implications for Sustainable Social Work Practice

The bold fact of leaving one's home forever and adapting to a new environment and culture is highly stressful, and when associated with lack of social integration and unemployment, stress increases in a stepwise manner (Wood 2019). The high prevalence of mental disorders associated with refugees can pose significant challenges such as the impact of pre-migration traumas on mental health in the settlement context. Very few studies have found that mental health interventions such as narrative exposure therapy have been successful. Sometimes therapies can focus on diagnostic features of PTSD whilst overlooking aspects such as relationships and a sense of meaning (Nickerson et al. 2011; van Wyk et al. 2014; Turrini et al. 2017). Interventions should include social integration, facilitate access to care as well as fostering engagement to promote and provide good mental healthcare to these groups in a culturally appropriate, holistic, and sensitive manner.

There are certain gaps in the research identifying what factors in specific contexts would help. Nevertheless, the literature has reported that certain interventions are more ecologically valid. Naturalistic mental health interventions could be seen as alternatives for refugees where treatment is provided in the context of an existing service including social and medical services (van Wyk et al. 2014). Interventions that absolutize available information and communication technologies (ICTs) would be seen to be advantageous. One of the most salient mental health issues results from refugees missing their loved ones and being concerned about their well-being. ICTs have not only facilitated refugees' well-being by facilitating their journey to their destination but also helps them find out critical information post-arrival of their host country. Most importantly it bridges the gap between separated families. Therefore, it would be practical and innovative to use communication technologies that refugees already widely use that would even further facilitate diagnostic testing and address language barriers. The issue of mental health is therefore a complex one and due to the synergistic relationship between refugee mental health and the broader social context, it is important that more research is conducted identifying who benefits from certain interventions and at what point in their integration trajectory would be most effective. This knowledge is relevant for social work and policymakers to design and deliver sustainable mental health care services with an ecological perspective harnessing the practical tools that refugees already possess. This can ultimately enhance the social wellbeing of this frequently marginalized population and it is also relevant to the whole process of successful integration which ultimately benefits economies of the receiving countries.

5.2. Limitations

Systematic reviews are useful methods for informing policy and practice and was chosen in this study since it allows us to combine various conceptualized topics from quantitative and qualitative research, by comparing current research traditions with comprehensive and rigorous judgements. Although "systematic reviews" are generally considered as rigorous, transparent, replicable, and unbiased ways to assess the quality of the evidence following a fixed process (Mallett et al. 2012), they have considerable shortcomings as every other scientific method intrinsically acquire.

In summary, systematic reviews provide a more rigorous method of reviewing the literature to inform decision making, although the quality can be unreliable, and the results are decontextualized. A limitation of the present study is the fact that different sample populations in the selected studies made it difficult to generalize the findings. Refugees and asylum seekers that were studied in the current review had mostly Middle Eastern, African, or South Asian backgrounds. Although all of the participating persons in selected studies were categorized as refugees or asylum seekers, they had different experiences of internal war in terms of the time, cultural, and religious backgrounds. One cannot sort all of them in a single category and generalize the findings to the whole refugee and asylum-seeker population. We think that the latter limitation is very important as systematic reviews decontextualize the studies from their specific context.

6. Conclusions

The findings of the current study indicate that risks and protective factors for mental health are multi-dimensional and closely knitted with everyday lives of forced migrants. To address the mental health risks and protective factors amongst vulnerable refugee populations, the application of the bottom-up approaches would be more feasible. There are clear potentials within refugee communities that if recognized by practice research and empowered by policy, sustainability of mental health interventions and therapies would increase.

We highlighted the need for acquiring a holistic approach in the field of mental health of forced migrants and insisted that socio-ecological framework is a critical component for a sustainable, and culturally relevant practice. When socio-ecological perspective is in the forefront of a social worker's approach dealing with forced migrants, this vulnerable population's needs will be more sustainably served in a more culturally responsive manner. In the context of the barriers that forced migrants face in accessing mental health care services, socio-ecological approach serves at least in a rudimentary way as a useful framework in identifying, systematically organizing, and analyzing the risk factors. This approach could be highly beneficial in intercultural mental health practice by empowering stakeholders to actively participate in research process, identifying barriers and utilizing existing opportunities within their communities, to design culturally accepted mental health services. Socio-ecological approach is also recommended specially for hard to access forced migrants whom they are highly suspicious of western mental health practice. This approach could be feasible if being used in future intercultural intervention programs for the mental health of forced migrants. It needs to be further assessed in terms of functionality in planning sustainable intervention programs in forced migrant groups coming from various cultural backgrounds.

Author Contributions: Conceptualization, H.F., J.C.A., T.T., M.T.; methodology, H.F., J.C.A., T.T., M.T.; Software, H.F.; Validation, H.F., N.J., J.C.A., T.T., M.T.; writing, review, and editing H.F., N.J., J.C.A., T.T., M.T.; Visualization: H.F.; supervision, J.C.A., T.T., M.T.; funding acquisition, J.C.A., H.F. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by Finnish National Agency for Education, grant number TM-18-11025, the APC was funded by the University of Eastern Finland.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: Not applicable.

Conflicts of Interest: The authors declare no conflict of interest.

References

Acarturk, Caren, Mustafa Cetinkaya, Ibrahim Senay, Birgul Gulen, Tamer Aker, and Devon Hinton. 2018. Prevalence and Predictors of Posttraumatic Stress and Depression Symptoms among Syrian Refugees in a Refugee Camp. *The Journal of Nervous and Mental Disease* 206: 40–45. [CrossRef]

Affleck, William, Umaharan Thamotharampillai, Judy Jeyakumar, and Rob Whitley. 2018. "If One does Not Fulfil His Duties, He must Not be a Man": Masculinity, Mental Health and Resilience Amongst Sri Lankan Tamil Refugee Men in Canada. *Culture, Medicine and Psychiatry* 42: 840–61. [CrossRef]

Agrawal, Pooja, and Arjun Krishna Venkatesh. 2016. Refugee Resettlement Patterns and State-Level Health Care Insurance Access in the United States. *American Journal of Public Health (1971)* 106: 662–63. [CrossRef] [PubMed]

Alemi, Qais, Sigrid James, and Susanne Montgomery. 2016. Contextualizing Afghan Refugee Views of Depression through Narratives of Trauma, Resettlement Stress, and Coping. *Transcultural Psychiatry* 53: 630–53. [CrossRef] [PubMed]

Alemi, Qais, Susan C. Weller, Susanne Montgomery, and Sigrid James. 2017. Afghan Refugee Explanatory Models of Depression: Exploring Core Cultural Beliefs and Gender Variations. *Medical Anthropology Quarterly* 31: 177–97. [CrossRef] [PubMed]

Balshem, Howard, Mark Helfand, Holger J. Schünemann, Andrew D. Oxman, Regina Kunz, Jan Brozek, Gunn E. Vist, Yngve Falck-Ytter, Joerg Meerpohl, Susan Norris, and et al. 2011. GRADE Guidelines: 3. Rating the Quality of Evidence. *Journal of Clinical Epidemiology* 64: 401–6. [CrossRef] [PubMed]

Beiser, Morton, and Feng Hou. 2001. Language Acquisition, Unemployment and Depressive Disorder among Southeast Asian Refugees: A 10-Year Study. *Social Science & Medicine (1982)* 53: 1321–34.

Bogic, Marija, Anthony Njoku, and Stefan Priebe. 2015. Long-Term Mental Health of War-Refugees: A Systematic Literature Review. *BMC International Health and Human Rights* 15: 29. [CrossRef]

Bronfenbrenner, Urie. 1979. Contexts of Child Rearing: Problems and Prospects. *The American Psychologist* 34: 844–50. [CrossRef]

Brown, Menna, Alexander Glendenning, Alice E. Hoon, and Ann John. 2016. Effectiveness of Web-Delivered Acceptance and Commitment Therapy in Relation to Mental Health and Well-being: A Systematic Review and Meta-Analysis. *Journal of Medical Internet Research* 18: e221. [CrossRef]

Campbell, Mark R., Kay D. Mann, Suzanne Moffatt, Mona Dave, and Mark S. Pearce. 2018. Social Determinants of Emotional Well-being in New Refugees in the UK. *Public Health* 164: 72–81. [CrossRef] [PubMed]

Cantor-Graae, Elizabeth, and Jean-Paul Selten. 2005. Schizophrenia and Migration: A Meta-Analysis and Review. *The American Journal of Psychiatry* 162: 12–24. [CrossRef]

Carswell, Kenneth, Pennie Blackburn, and Chris Barker. 2011. The Relationship between Trauma, Post-Migration Problems and the Psychological Well-being of Refugees and Asylum Seekers. *International Journal of Social Psychiatry* 57: 107–19. [CrossRef]

Ceri, Veysi, Zeliha Özlü-Erkilic, Ürün Özer, Tayyib Kadak, Dietmar Winkler, Burak Dogangün, and Türkan Akkaya-Kalayci. 2017. Mental Health Problems of Second Generation Children and Adolescents with Migration Background. *International Journal of Psychiatry in Clinical Practice* 21: 142–47. [CrossRef]

Chen, Wen, Brian J. Hall, Ling Li, and Andre MN Renzaho. 2017. Pre-Migration and Post-Migration Factors Associated with Mental Health in Humanitarian Migrants in Australia and the Moderation Effect of Post-Migration Stressors: Findings from the First Wave Data of the BNLA Cohort Study. *The Lancet. Psychiatry* 4: 218–29. [CrossRef]

Chung, Man, Nowf AlQarni, Mariam AlMazrouei, Shamsa Al Muhairi, Mudar Shakra, Britt Mitchell, Sara Al Mazrouei, and Shurooq Al Hashimi. 2018. Posttraumatic Stress Disorder and Psychiatric Co-Morbidity among Syrian Refugees of Different Ages: The Role of Trauma Centrality. *Psychiatric Quarterly* 89: 909–21. [CrossRef]

Colucci, Erminia, Harry Minas, Josef Szwarc, Carmel Guerra, and Georgia Paxton. 2015. In or out? barriers and facilitators to refugee-background young people accessing mental health services. *Transcultural Psychiatry* 52: 766–90. [CrossRef] [PubMed]

de Anstiss, Helena, Tahereh Ziaian, Nicholas Procter, Jane Warland, and Peter Baghurst. 2009. Help-Seeking for Mental Health Problems in Young Refugees: A Review of the Literature with Implications for Policy, Practice, and Research. *Transcultural Psychiatry* 46: 584–607. [CrossRef]

Dietrich, Hans, Radwan Al Ali, Sefik Tagay, Johannes Hebebrand, and Volker Reissner. 2019. Screening for Posttraumatic Stress Disorder in Young Adult Refugees from Syria and Iraq. *Comprehensive Psychiatry* 90: 73–81. [CrossRef] [PubMed]

Georgiadou, Ekaterini, Ali Zbidat, Gregor M. Schmitt, and Yesim Erim. 2018. Prevalence of Mental Distress among Syrian Refugees with Residence Permission in Germany: A Registry-Based Study. *Frontiers in Psychiatry* 9: 393. [CrossRef]

Grupp, Freyja, Marie Rose Moro, Urs M. Nater, Sara M. Skandrani, and Ricarda Mewes. 2018. "It's that Route that Makes Us Sick": Exploring Lay Beliefs about Causes of Post-Traumatic Stress Disorder among Sub-Saharan African Asylum Seekers in Germany. *Frontiers in Psychiatry* 9: 628. [CrossRef] [PubMed]

Guyatt, Gordon H., Andrew D. Oxman, Victor Montori, Gunn Vist, Regina Kunz, Jan Brozek, Pablo Alonso-Coello, Ben Djulbegovic, David Atkins, Yngve Falck-Ytter, and et al. 2011. GRADE Guidelines: 5. Rating the Quality of Evidence—publication Bias. *Journal of Clinical Epidemiology* 64: 1277–82. [CrossRef] [PubMed]

Hagelund, Anniken. 2020. After the Refugee Crisis: Public Discourse and Policy Change in Denmark, Norway and Sweden. *Comparative Migration Studies* 8: 1–17. [CrossRef]

Hall, Brian J., and Miranda Olff. 2016. Global Mental Health: Trauma and Adversity among Populations in Transition. *European Journal of Psychotraumatology* 7: 31140–3. [CrossRef] [PubMed]

Henderson, Dawn, and Tiffany Baffour. 2015. Applying a Socio-Ecological Framework to Thematic Analysis using a Statewide Assessment of Disproportionate Minority Contact in the United States. *Qualitative Report* 20: 1960.

Hocking, Debbie, and Suresh Sundram. 2015. Demoralisation Syndrome does Not Explain the Psychological Profile of Community-Based Asylum-Seekers. *Comprehensive Psychiatry* 63: 55–64. [CrossRef]

Hollander, Anna-Clara, Henrik Dal, Glyn Lewis, Cecilia Magnusson, James B. Kirkbride, and Christina Dalman. 2016. Refugee Migration and Risk of Schizophrenia and Other Non-Affective Psychoses: Cohort Study of 1.3 Million People in Sweden. *BMJ* 352: i1030. [CrossRef]

Howie, Hunter, Chuda M. Rijal, and Kerry J. Ressler. 2019. A Review of Epigenetic Contributions to Post-Traumatic Stress Disorder. *Dialogues in Clinical Neuroscience* 21: 417–28.

Hutchinson, Mary, and Pat Dorsett. 2012. What does the Literature Say about Resilience in Refugee People? Implications for Practice. *Journal of Social Inclusion* 3: 55–78. [CrossRef]

Hynie, Michaela. 2018. *The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review*. Los Angeles: SAGE Publications.
Im, Hyojin, Aidan Ferguson, and Margaret Hunter. 2017. Cultural Translation of Refugee Trauma: Cultural Idioms of Distress among Somali Refugees in Displacement. *Transcultural Psychiatry* 54: 626–52. [CrossRef]
International Organization for Migration. 2019. *IOM Glossary on Migration*. Grand-Saconnex: International Organization for Migration, pp. 1–248.
Kandemir, Hasan, Hülya Karataş, Veysi Çeri, Filiz Solmaz, Sultan Kandemir, and Abdullah Solmaz. 2018. Prevalence of War-Related Adverse Events, Depression and Anxiety among Syrian Refugee Children Settled in Turkey. *European Child & Adolescent Psychiatry* 27: 1513–17.
Kilanowski, Jill F. 2017. Breadth of the Socio-Ecological Model. *Journal of Agromedicine* 22: 295–97. [CrossRef] [PubMed]
Kim, Robinson. 2014. Voices from the Front Line: Social Work with Refugees and Asylum Seekers in Australia and the UK. *The British Journal of Social Work* 44: 1602–20.
Kira, Ibrahim Aref, and Pratyusha Tummala-Narra. 2015. Psychotherapy with Refugees: Emerging Paradigm. *Journal of Loss & Trauma* 20: 449–67.
Lamkaddem, Majda, Karien Stronks, Walter D. Devillé, Miranda Olff, Annette A. M. Gerritsen, and Marie-Louise Essink-Bot. 2014. Course of Post-Traumatic Stress Disorder and Health Care Utilisation among Resettled Refugees in the Netherlands. *BMC Psychiatry* 14: 90. [CrossRef]
Leiler, Anna, Anna Bjärtå, Johanna Ekdahl, and Elisabet Wasteson. 2019. Mental Health and Quality of Life among Asylum Seekers and Refugees Living in Refugee Housing Facilities in Sweden. *Social Psychiatry and Psychiatric Epidemiology* 54: 543–51. [CrossRef]
Li, Susan, Belinda Liddell, and Angela Nickerson. 2016. The Relationship between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers. *Current Psychiatry Reports* 18: 1–9. [CrossRef]
Liberati, Alessandro, Douglas G. Altman, Jennifer Tetzlaff, Cynthia Mulrow, Peter C. Gøtzsche, John P. A. Ioannidis, Mike Clarke, P. J. Devereaux, Jos Kleijnen, and David Moher. 2009. The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses of Studies that Evaluate Healthcare Interventions: Explanation and Elaboration. *BMJ* 339: b2700. [CrossRef]
Lillee, Alyssa, Aesen Thambiran, and Jonathan Laugharne. 2015. Evaluating the Mental Health of Recently Arrived Refugee Adults in Western Australia. *Journal of Public Mental Health* 14: 56–68. [CrossRef]
Lindert, Jutta, and Schinina Guglielmo. 2011. Mental Health of Refugees and Asylum Seekers. In *Migration and Health in the European Union*. Edited by Rechel Bernd, Mladovsky Philipa, Deville Walter, Rijks Barbara, Petrova-Benedict Raumyana and Mckee Martin. Berkshire: Open University Press, pp. 169–81.
Mallett, Richard, Jessica Hagen-Zanker, Rachel Slater, and Maren Duvendack. 2012. The Benefits and Challenges of using Systematic Reviews in International Development Research. *Journal of Development Effectiveness* 4: 445–55. [CrossRef]
Marmot, Michael. 2020. Health Equity in England: The Marmot Review 10 Years On. *BMJ* 368: m693. [CrossRef]
McLeroy, Kenneth R., Daniel Bibeau, Allan Steckler, and Karen Glanz. 1988. An Ecological Perspective on Health Promotion Programs. *Health Education Quarterly* 15: 351–77. [CrossRef] [PubMed]
Mölsä, Mulki, Marja Tiilikainen, and Raija-Leena Punamäki. 2019. Usage of Healthcare Services and Preference for Mental Healthcare among Older Somali Immigrants in Finland. *Ethnicity & Health* 24: 607–22.
Moreno, Alejandro, Linda Piwowarczyk, Wayne LaMorte, and Michael Grodin. 2006. Characteristics and Utilization of Primary Care Services in a Torture Rehabilitation Center. *Journal of Immigrant and Minority Health* 8: 163–71. [CrossRef] [PubMed]
Murray, Kate E., Graham R. Davidson, and Robert D. Schweitzer. 2010. Review of Refugee Mental Health Interventions Following Resettlement: Best Practices and Recommendations. *American Journal of Orthopsychiatry* 80: 576–85. [CrossRef]
Nickerson, Angela, Richard A. Bryant, Derrick Silove, and Zachary Steel. 2011. A Critical Review of Psychological Treatments of Posttraumatic Stress Disorder in Refugees. *Clinical Psychology Review* 31: 399–417. [CrossRef]
Omar, Yusuf Sheikh, Justin Kuay, and Can Tuncer. 2017. 'Putting Your Feet in Gloves Designed for Hands': Horn of Africa Muslim Men Perspectives in Emotional Wellbeing and Access to Mental Health Services in Australia. *International Journal of Culture and Mental Health* 10: 376–88. [CrossRef]
Ottisova, Livia, Patrick Smith, Hitesh Shetty, Daniel Stahl, Johnny Downs, and Sian Oram. 2018. Psychological Consequences of Child Trafficking: An Historical Cohort Study of Trafficked Children in Contact with Secondary Mental Health Services. *PLoS ONE* 13: e0192321. [CrossRef]
Page, Matthew J., Joanne E. McKenzie, Patrick M. Bossuyt, Isabelle Boutron, Tammy C. Hoffmann, Cynthia D. Mulrow, Larissa Shamseer, Jennifer M. Tetzlaff, Elie A. Akl, Sue E. Brennan, and et al. 2021. The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews. *Systematic Reviews* 10: 89. [CrossRef]
Pandya, Samta. 2018. Spirituality for Mental Health and Well-being of Adult Refugees in Europe. *Journal of Immigrant and Minority Health* 20: 1396–403. [CrossRef]
Perrin, Benjamin. 2010. Just Passing through? International Legal Obligations and Policies of Transit Countries in Combating Trafficking in Persons. *European Journal of Criminology* 7: 11–27. [CrossRef]
Phillimore, Jenny, and Lisa Goodson. 2006. Problem Or Opportunity? Asylum Seekers, Refugees, Employment and Social Exclusion in Deprived Urban Areas. *Urban Studies (Edinburgh, Scotland)* 43: 1715–36. [CrossRef]

Poole, Danielle N., Bethany Hedt-Gauthier, Shirley Liao, Nathaniel A. Raymond, and Till Bärnighausen. 2018. Major Depressive Disorder Prevalence and Risk Factors among Syrian Asylum Seekers in Greece. *BMC Public Health* 18: 908. [CrossRef]
Poudel-Tandukar, Kalpana, Cynthia S. Jacelon, Genevieve E. Chandler, Bhuwan Gautam, and Paula H. Palmer. 2019. Sociocultural Perceptions and Enablers to Seeking Mental Health Support among Bhutanese Refugees in Western Massachusetts. *International Quarterly of Community Health Education* 39: 135–45. [CrossRef] [PubMed]
Rankopo, Morena J., and Kwaku Osei-Hwedie. 2011. Globalization and Culturally Relevant Social Work: African Perspectives on Indigenization. *International Social Work* 54: 137–47. [CrossRef]
Rizkalla, Niveen, and Steven P. Segal. 2018. Well-Being and Posttraumatic Growth among Syrian Refugees in Jordan. *Journal of Traumatic Stress* 31: 213–22. [CrossRef]
Savic, Michael, Anna Chur-Hansen, Mohammad Afzal Mahmood, and Vivienne M. Moore. 2016. 'We Don't have to Go and See a Special Person to Solve this Problem': Trauma, Mental Health Beliefs and Processes for Addressing 'mental Health Issues' among Sudanese Refugees in Australia. *International Journal of Social Psychiatry* 62: 76–83. [CrossRef]
Schünemann, Holger, Andrew Oxman, Jan Brozek, Paul Glasziou, Patrick Bossuyt, Stephanie Chang, Paola Muti, Roman Jaeschke, and Gordon Guyatt. 2009. GRADE: Assessing the Quality of Evidence for Diagnostic Recommendations. *ACP Journal Club* 149: 2. [CrossRef]
Schweitzer, Robert D., Lyn Vromans, Mark Brough, Mary Asic-Kobe, Ignacio Correa-Velez, Kate Murray, and Caroline Lenette. 2018. Recently Resettled Refugee Women-at-Risk in Australia Evidence High Levels of Psychiatric Symptoms: Individual, Trauma and Post-Migration Factors Predict Outcomes. *BMC Medicine* 16: 149. [CrossRef] [PubMed]
Segal, Steven, Vicky Khoury, Ramy Salah, and Jess Ghannam. 2018. Contributors to Screening Positive for Mental Illness in Lebanon's Shatila Palestinian Refugee Camp. *The Journal of Nervous and Mental Disease* 206: 46–51. [CrossRef] [PubMed]
Shawyer, Frances, Joanne C. Enticott, Andrew A. Block, I-Hao Cheng, and Graham N. Meadows. 2017. The Mental Health Status of Refugees and Asylum Seekers Attending a Refugee Health Clinic Including Comparisons with a Matched Sample of Australian-Born Residents. *BMC Psychiatry* 17: 76. [CrossRef]
Şimşek, Zeynep, Nebiye Yentur Doni, Nese Gül Hilali, and Gokhan Yildirimkaya. 2018. A Community-Based Survey on Syrian Refugee Women's Health and its Predictors in Şanliurfa, Turkey. *Women & Health* 58: 617–31. [CrossRef]
Siriwardhana, Chesmal, Shirwa Sheik Ali, Bayard Roberts, and Robert Stewart. 2014. A Systematic Review of Resilience and Mental Health Outcomes of Conflict-Driven Adult Forced Migrants. *Conflict and Health* 8: 13. [CrossRef]
Slewa-Younan, Shameran, Anisa Yaser, Maria Gabriela Uribe Guajardo, Haider Mannan, Caroline A. Smith, and Jonathan M. Mond. 2017. The Mental Health and Help-Seeking Behavior of Resettled Afghan Refugees in Australia. *International Journal of Mental Health Systems* 11: 56. [CrossRef] [PubMed]
Szaflarski, Magdalena, and Shawn Bauldry. 2019. The Effects of Perceived Discrimination on Immigrant and Refugee Physical and Mental Health. In *Immigration and Health*. Bingley: Emerald Publishing Limited, pp. 173–204.
Tinghög, Petter, Andreas Malm, Charlotta Arwidson, Erika Sigvardsdotter, Andreas Lundin, and Fredrik Saboonchi. 2017. Prevalence of Mental Ill Health, Traumas and Post Migration Stress among Refugees from Syria Resettled in Sweden After 2011: A Population-Based Survey. *BMJ Open* 7: e018899. [CrossRef] [PubMed]
Turrini, Giulia, Marianna Purgato, Francesca Ballette, Michela Nosè, Giovanni Ostuzzi, and Corrado Barbui. 2017. Common Mental Disorders in Asylum Seekers and Refugees: Umbrella Review of Prevalence and Intervention Studies. *International Journal of Mental Health Systems* 11: 51. [CrossRef] [PubMed]
United Nations High Commissioner for Refugees. 2019. *Global Trends: Forced Displacement in 2018*. Geneva: United Nations High Commissioner for Refugees.
United Nations High Commissioner for Refugees. 2021. *Global Trends: Forced Displacement in 2020*. Copenhagen: Knowledge Bylanes.
Valtonen, Kathleen. 2008. *Social Work and Migration*. Abingdon: Routledge.
van Wyk, Sierra, Sierra van Wyk, Robert Schweitzer, and Robert Schweitzer. 2014. A Systematic Review of Naturalistic Interventions in Refugee Populations. *Journal of Immigrant and Minority Health* 16: 968–77. [CrossRef] [PubMed]
Vitale, Agata, and Judy Ryde. 2016. Promoting Male Refugees' Mental Health After they have been Granted Leave to Remain (Refugee Status). *The International Journal of Mental Health Promotion* 18: 106–25. [CrossRef]
Watters, Charles. 2001. Emerging Paradigms in the Mental Health Care of Refugees. *Social Science & Medicine (1982)* 52: 1709–18.
Wong, William Chi Wai, Sealing Cheung, Heidi Yin Hai Miu, Julie Chen, Kelley Ann Loper, and Eleanor Holroyd. 2017. Mental Health of African Asylum-Seekers and Refugees in Hong Kong: Using the Social Determinants of Health Framework. *BMC Public Health* 17: 153. [CrossRef]
Wood, Tamara. 2019. Who is a Refugee in Africa? A Principled Framework for Interpreting and Applying Africa's Expanded Refugee Definition. *International Journal of Refugee Law* 31: 290–320. [CrossRef]
Yaser, Anisa, Shameran Slewa-Younan, Caroline A. Smith, Rebecca E. Olson, Maria Gabriela Uribe Guajardo, and Jonathan Mond. 2016. Beliefs and Knowledge about Post-Traumatic Stress Disorder Amongst Resettled Afghan Refugees in Australia. *International Journal of Mental Health Systems* 10: 31. [CrossRef] [PubMed]

Yassin, Nasser, Nasser Yassin, Asma Taha, Asma Taha, Zeina Ghantous, Zeina Ghantous, Mia Atoui, Mia Atoui, Fabio Forgione, and Fabio Forgione. 2018. Evaluating a Mental Health Program for Palestinian Refugees in Lebanon. *Journal of Immigrant and Minority Health* 20: 388–98. [CrossRef]

Yu, Shieun, Jungeun Jang, Jin-Won Noh, Young Dae Kwon, Hyunchun Park, and Jong-Min Woo. 2018. What is it to be Mentally Healthy from the North Korean Refugees' Perspective?: Qualitative Research on the Changes in Mental Health Awareness among the North Korean Refugees. *Psychiatry Investigation* 15: 1019–29. [CrossRef]