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REVIEW

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Mental health training programs for non-health professionals and volunteers working with asylum-seekers and refugees: scoping review

Programas de treinamento em saúde mental para profissionais, que não de saúde, e voluntários que trabalham com solicitantes de asilo e refugiados: revisão de escopo

Programas de formación en salud mental para profesionales no sanitarios y voluntarios que trabajan con solicitantes de asilo y refugiados: revisión de alcance

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ABSTRACT

Objective: To identify and describe the mental health training programs for non-health professionals and volunteers who work, have worked, or would work with asylum seekers and/or refugees. **Method:** Scoping review following JBI methodology. Search carried out in MEDLINE, CINAHL, ERIC, SCOPUS, PsycINFO, Psychology & Behavioral Sciences Collection, RCAAP, ProQuest, and websites of Clinical Trials, UNHCR, International Organization for Migration, WHO, Save the Children, International Migration, Integration and Social Cohesion in Europe, and International Federation of Red Cross and Red Crescent Societies. Studies written in English, Portuguese, French, Spanish and Swedish. **Results:** Of the 8954 articles identified, 16 were included reporting on 11 training programs: Mind-Spring, PM+, MHFA, Cognitive-Behavioral Training for Community and Religious Leaders, EmpaTeach, Suicide Prevention Education Program, Teaching Recovery Techniques, Handbook for Teachers of Vietnamese Refugee Students, PFA, Psychosocial support of volunteers and CBP&MHPSS. **Conclusion:** Training programs from scientific literature focus on mental health disorders, while non-governmental organizations' documents focus on resilience and self-care. The current mental health training programs might be insufficient.

DESCRIPTORS

Refugees; Mental Health; Education; Nursing.

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INTRODUCTION

The world as we know is changing, especially due to worldwide migrations. As a result of wars, violence, persecution, human rights violations, and events that seriously disturb public order, 89,3 million individuals worldwide were forcibly displaced by the end of 2021[1]. Of the 89,3 million people, 27,1 million are refugees, 53,2 million are internally displaced people, 4,6 million are asylum seekers[2]. Almost 70% of refugees came from the Syrian Arab Republic (6,8 million); Venezuela (4,6 million); Afghanistan (2,7 million); South Sudan (2,8 million); and Myanmar (1,1 million). The low- and middle-income countries hosted 83% of refugees, being Turkey the host country that receives the largest number of refugees worldwide (3,8 million), followed by Colombia (1,8 million), Uganda (1,5 million), Pakistan (1,5 million) and Germany (1,3 million)[1,2].

In the last years, the forcibly migratory fluxes have been a concern to the European Union as the number of people seeking protection in Europe has grown considerably. From 2014 until the end of 2021, Italy, Cyprus, Malta, Greece, and Spain received 2,300,881 million sea and land arrivals[3]. These data focus on forced displaced people by the end of 2021. Along with the war in Ukraine in early 2022, which caused until now 7 million people to be internally displaced and 6 million people refugees, the statistics on influxes of European migration are dramatically changing[1].

Forcibly displaced people are obligated to abruptly leave all belongings and often their family members to seek international safety and protection. The loss of material resources (e.g., house, clothing, belongings), identity references (e.g., social and cultural relations), as well as adequate access to essential care and resources such as health and education, are factors of vulnerability in mental health[4,5]. Forced displacement is increasing and several mental health studies are being conducted to understand the impact of this situation on people's mental health. A recent systematic review of psychiatric disorders in refugee and internally displaced persons after forced displacement, including 38 studies that provided data from 39,518 participants from 21 countries, show that participants suffer from post-traumatic stress, depression, and anxiety disorders[6]. Mental health disorders are linked with pre-, ongoing, and post-migration situations and involve traumatic events, such as violence, separation, sexual abuse, trafficking, harassment, and lack of basic needs[7–9]. The lack of basic needs is not only present in the country of origin. As a result of some countries' political arrangements, asylum seekers are getting stopped at the borders. For example, if asylum seekers arrive in Europe, they must wait years for the refugee legal status to have the right to get out of a refugee camp/shelter/reception centre, most of them with inhumane conditions[10].

To maintain safety, well-being and safeguard the asylum seekers' rights, the United Nations High Commissioner for Refugees (UNHCR) works in partnership with 900 entities, most of them Non-Governmental Organizations (NGOs)[11], which are mainly composed of civil society volunteers[12]. Motivational factors drive volunteers to spend their time working on helping others. Yet they have the major challenge of dealing with the suffering of asylum seekers and refugees (AS&R) as they listen about the serious traumatic trajectories in their pre, during, and post-migration period on a daily basis[13]. Volunteers working with AS&R in a chronic stress environment may increase their vulnerability to adverse consequences, such as anxiety, burnout, and depressive feelings, over-involvement with AS&R, callousness, apathy, self-destructive behaviour, interpersonal conflict, and secondary traumatic stress[14–16]. Several studies show that volunteers' psychological distress can vary depending on previous training[17–19]. Psychologically trained refugee-helpers had lower burnout values and somatic symptoms when compared with untrained aid workers[20].

Psychological training is relevant not only for volunteers' mental health preparation and safety but also to provide better and adequate care for AS&R. Improving mental health competencies, skills, and knowledge of volunteers, non-health professionals, i.e., who do not have a mental health background education, is likely to have a positive impact in the AS&R' health. Mental health training for volunteers working with AS&R has shown evidence of empowering them to make earlier and correct decisions about prevention, early detection, and appropriate referral for specialized mental care, reducing stigma and discrimination, and improving AS&R rights[21,22]. The UNHCR defends that interventions towards the promotion of psychosocial support with AS&R can be provided by non-specialized mental health volunteers, yet they must be trained and supervised[22]. This evidence reinforces the importance of mental health training programs for volunteers in this fieldwork.

The scientific research with volunteers and their work with AS&R is slowly increasing[21]. A systematic overview to understand the kind of mental health competencies training available to prepare volunteers for their work with AS&R is demanded. Mental health competence is understood as the ability (attitudes, knowledge, skills, and behaviours)[23] to effectively promote prevention, care, treatment, and advocacy for mental health. This competence requires knowledge to protect their self-mental health; to recognize people's suffering, based on their cultural competencies; to provide basic psychosocial support to vulnerable populations during their overwhelming life transitions; and an empowerment skill to refer people for specialized mental care or to mental health professionals[24].

Nurses are vital in the promotion of health and health literacy[25,26], and they are the key factor in the health responses of these populations[27,28]. Therefore, this scoping literature review aims to identify and describe the mental health training programs for non-health professionals and volunteers who work, have worked, or will work with AS&R regardless of the context, i.e., mental health training programs and courses available for the civil society members, who do not have a health or mental health background but need to develop those skills to deal with AS&R. This review is fundamental to understand the people conducting these training programs, the places where the training takes place, and the educational domains and strategies that are used.

METHOD

Design of Study

This scoping review was conducted according to the JBI methodology for scoping reviews[29,30], following an *a priori* published protocol which describes the methodological procedures used[24].

The PCC (Population, Concept, and Context) mnemonic[29,30] was used. P representing studies with or addressed or designed for participants aged ≥18 years, volunteers, and non-health professionals, without mental health training, independent of their educational level, who had work, were working, or would work with asylum seekers or/and refugees. C represented studies reporting on the training of adults in mental health competencies. C was considered to be any environment where the study was developed. The review aimed to respond to the main research question: What are the mental health training programs that have been used in the preparation of non-health professionals and volunteers who do not have mental health training to work with AS&R?

An initial search was carried out in MEDLINE (PubMed) and CINAHL (EBSCO) databases to analyse the terms used to describe the articles relevant to the study. Then, a full search strategy described in Chart 1 with terms adapted for each source, was carried out in the MEDLINE (EBSCO), CINAHL (EBSCO), ERIC, SCOPUS, PsycINFO, Psychology & Behavioral Sciences Collection, and in the grey literature databases The Scientific Open Access Repository of Portugal (RCAAP), and ProQuest. In the scoping review protocol[24], the authors identified as a source of grey literature the OpenGrey database. However, OpenGrey was discontinued in 2021. To be able to integrate international grey literature in this review, the authors came to the consensus of including the ProQuest database. The scoping review search also included the websites of ClinicalTrials, UNHCR, International Organization for Migration (IOM), WHO, Save the Children, International Migration, Integration and Social Cohesion in Europe (IMISCOE), and International Federation of Red Cross and Red Crescent Societies (IFRC). The NGO websites listed as sources of information were provided by a WHO Guidance Note that identifies them as NGOs with developed work on protecting and supporting the mental health and psychosocial well-being of refugees, asylum seekers, and migrants[31]. In the NGO websites, the search was made through the search bottom, in the documentation section, with the common words "mental health training" or "training". On the ClinicalTrials website, the search included six combinations of common words: i) mental health training AND refugees; ii) mental health training AND asylum seekers; iii) mental health training AND refugee volunteers; iv) mental health AND asylum seekers volunteers v) mental health AND refugee workers; vi) mental health AND asylum seekers workers.

Selection Criteria

The review considered studies reporting training or training' protocols of mental health competencies for adults, non-health professionals and volunteers without mental health training,

Chart 1 – Scoping review databases' search strategy – Porto, Portugal, 2021.

Information resource	Search strategy
MEDLINE (EBSCO)	(MH "Mental Health" OR TI Mental OR AB mental OR TI (well-being or wellbeing or "well being") OR AB (well-being or wellbeing or "well being")) AND (MH education OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (MH Refugees OR MH "Refugee Camps" OR MH "United Nations" OR TI (refugee* OR "asylum seeker*" OR "forced migrant*") OR AB (refugee* OR "asylum seeker*" OR "forced migrant*"))
CINAHL (EBSCO)	(MH "Mental Health" OR TI Mental* OR AB mental OR TI (wellbeing or well-being or "well being") OR AB (wellbeing or well-being or "well being")) AND (MH education OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (MH Refugees OR MH "Refugee Camps" OR MH "United Nations" OR TI (refugee* OR "asylum seeker*" OR "forced migrant*") OR AB (refugee* OR "asylum seeker*" OR "forced migrant*"))
ERIC	(DE "Mental Health" OR DE ""Mental Health Programs" OR TI mental OR AB mental OR TI (well-being or wellbeing or "well being") OR AB (well-being or wellbeing or "well being") OR TI emotional OR AB emotional OR TI psychological OR AB psychological) AND (DE education OR DE training OR DE "Volunteer Training" OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (DE Refugees OR DE migration OR TI (refugee* or "asylum seekers") OR AB (refugee* or "asylum seekers"))
SCOPUS	((TI=("mental health" OR well-being or wellbeing or "well being")) OR AB=("mental health" OR well-being or wellbeing or "well being")) AND ((TI=(educational OR training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) OR AB=(educational OR training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND ((TI=(Refugee* OR "asylum seeker*" OR "forced migrant*")) OR AB=(Refugee* OR "asylum seeker*" OR "forced migrant*"))
PsycINFO	(MA "Mental Health" OR TI (Mental OR wellbeing OR well-being OR "well being") OR AB (Mental OR wellbeing OR well-being OR "well being")) AND (MA education OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (MA (refugees OR "refugee camps" OR "United Nations") OR TI (refugee* OR "asylum seeker*" OR "forced migrant*") OR AB (refugee* OR "asylum seeker*" OR "forced migrant*"))
Psychology and Behavioral Sciences Collection	(MH "Mental Health" OR TI Mental OR AB mental OR TI (well-being or wellbeing or "well being") OR AB (well-being or wellbeing or "well being")) AND (MH education OR TI (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*) OR AB (training* OR course* OR "educational model*" OR program* OR approach* OR procedure* OR method* OR strateg*)) AND (MH Refugees OR MH "Refugee Camps" OR MH "United Nations" OR TI (refugee* OR "asylum seeker*" OR "forced migrant*") OR AB (refugee* OR "asylum seeker*" OR "forced migrant*"))
RCAAP	i) TXT ((mental health) AND training AND refugee) ii) TXT ((mental health) AND training AND (asylum seeker))
ProQuest	ab("mental health") AND ab(refugee OR "asylum seeker") AND (volunteer OR "non-health professional") AND ab(training)

who had work, are working, or will work with asylum seekers or/and refugees without the context restrictions, available in English, Swedish, Portuguese, Spanish, and French. For this review it was considered for inclusion primary studies, quantitative, qualitative, mixed- and multi-method study designs, reviews, protocols, conference abstracts and text opinion papers with relevant information until December of 2021. In addition, several relevant websites were searched to identify information that might not be available in scientific databases, such as the websites of reputable NGOs, as described in the previous section. Specially from these sources the participants could be named as field workers, which is a common designation for someone who works in the humanitarian field.

Data Collection

Data collection took place from December 15th to December 31st of 2021. Initially, all the articles found were uploaded into EndNote™ X8 software, and the duplicates were removed. After this process, the studies were uploaded into the Rayyan software to proceed with the initial screening of titles and abstracts by two independent reviewers. The full text of selected citations was assessed in detail against the inclusion criteria by two independent authors. At each stage, the doubts about the article's selection were discussed by reviewers and ultimately decided by the principal investigator. The selection process was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist[32].

Data Analysis and Treatment

Two independent authors extracted data from the sources included in the scoping review using a data extraction tool developed by the reviewers presented in the published scoping review protocol[24]. The principal investigator gathered and compiled in tables all the extracted information according to the developed tool. All members of the team were involved in the development of the data extraction form. The form was piloted test independently by two researchers (LTS, FV). The form was then revised in consultation with an experienced reviewer (WA) to promote consistent and reliable extraction. The extracted information was analysed according to the following categories: study identification (ID); reasons for inclusion or exclusion; characteristics of study population/paper, participants, settings, educational mental health domains, and the strategies that were used for the training; and a category about research methods used in the study/paper.

Data extraction was performed independently by five researchers (LTS, FV, JS, LT, IA) and reviewed by a senior researcher with extensive review experience (WA). Conflicts were discussed, and where necessary, a third author was consulted (LTS) in consultation with an experienced reviewer (WA).

Ethical Aspects

The reliability and fidelity of the information extracted from the selected publications were ensured through proper referencing and rigour in data treatment and presentation. This review was conducted under a PhD project named APT4U2, which was approved by the Ethics Committee of the Health Sciences Research Unit: Nursing (no. 0 P742 12/2020).

RESULTS

The search strategy identified a total of 8,954 publications. After excluding the 5,562 duplicates, 3,392 studies were selected for title and abstract analysis. A total of 167 were selected for full reading analysis, with the remaining 16 articles included in the review, as shown in Figure 1.

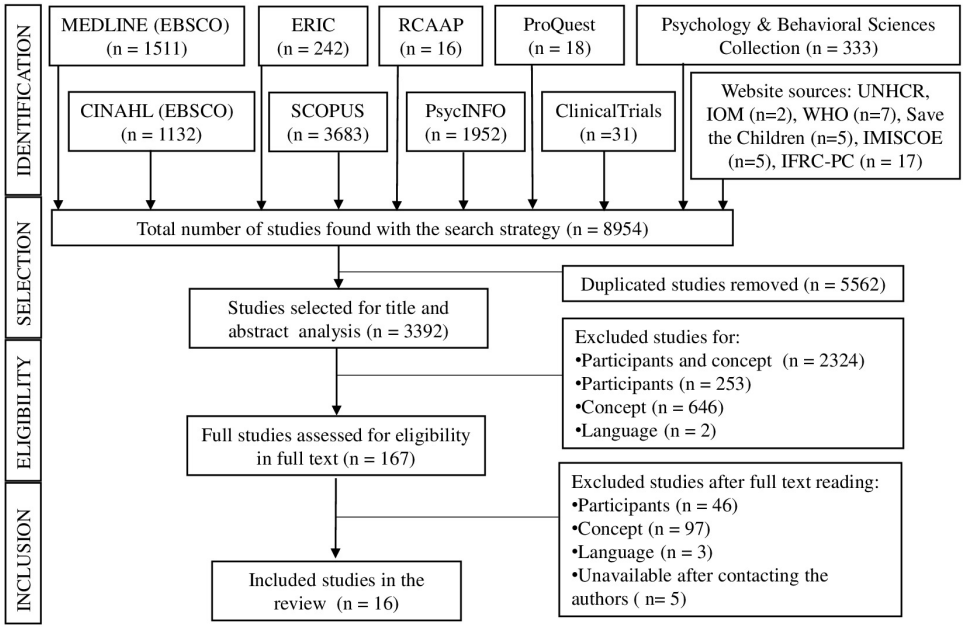

Figure 1 – Scoping review structure flowchart. Porto, Portugal, 2022.

Chart 2 – Studies included in the scoping review – Porto, Portugal, 2022.

ID	Study's name	Year
1	Handbook for Teachers of Vietnamese Refugee Students[33]	1977
2	Psycho-education and psychosocial support in the Netherlands; a program by and for refugees[34]	2005
3	Psychological first aid: Guide for field workers[35]	2011
4	Caring for Volunteers, A Psychosocial Support Toolkit[36]	2012
5	Psychological first aid: Facilitator's manual for orientating field workers[37]	2013
6	Caring for volunteers: Training Manual[38]	2015
7	Mental health first aid training for the Bhutanese refugee community in the United States[39]	2015
8	Expanding mental health services delivery for depression in the community from burma in North Carolina: A paraprofessional training program[40]	2016
9	Community-based protection & mental health psychological support[41]	2017
10	Effectiveness of a peer-refugee delivered psychological intervention to reduce psychological distress among adult Syrian refugees in the Netherlands: study protocol[42]	2020
11	Lay-therapist-delivered, low-intensity, psychosocial intervention for refugees and asylum seekers (PROSPER): Protocol for a pilot randomised controlled trial[43]	2020
12	The EmpaTeach intervention for reducing physical violence from teachers to students in Nyarugusu Refugee Camp: A cluster randomised controlled trial[44]	2021
13	An Evaluation of Suicide Prevention Education for People Working with Refugees and Asylum Seekers: Improvements in Competence, Attitudes, and Confidence[45]	2021
14	Islamic Trauma Healing: Integrating Faith and Empirically Supported Principles in a Community-Based Program[46]	2021
15	Task-Sharing Psychosocial Support with Refugees and Asylum Seekers: Reflections and Recommendations for Practice from the PROSPER Study[47]	2021
16	Readiness of Allied Professionals to Join the Mental Health Workforce: A Qualitative Evaluation of Trained Lay Trauma Counsellors' Experiences When Refugee Youth Disclose Suicidal Ideation[48]	2021

The 16 studies included in the scoping review are presented in Chart 2.

All the articles included were published in English, and those from the website sources[35–38,41] were translated into at least three more languages. Eleven articles were taken from scientific databases[33,34,39,40,42–48], six of which were experimental studies carried out in the Netherlands[34], United States of America[39,40], Tanzania[44], Australia[45], and Sweden[48]. Of the other five studies, two were randomized controlled trial protocols to be carried out in the Netherlands[42], and the United Kingdom[43], and three studies described an intervention without results from implementation[33,46,47]. Of the five included from website sources, two are from OMS[35,37], two from the Psychosocial Centre of the IFRC[36,38], and one from UNHCR[41]. All of these reported interventions for training in mental health competencies to work with AS&R but did not describe examples of implementation.

As for the year of publication, the first study that was made available on the databases concerning this subject dates back to 1977[33]. The number of scientific publications on the topic has increased since 2015, and 2021 was the year with the highest number of records (n = 5)[44–48].

Answering the main question of this study, different programs were identified as training programs in mental health competencies for lay people working with AS&R, namely Mind-Spring[34], Problem Management Plus (PM+)[42,43,47], Mental health first aid (MHFA)[39], Cognitive-Behavioral Training (CBT) for Community and Religious Leaders[40], EmpaTeach[44], Suicide Prevention Education Program[45], Teaching Recovery Techniques (TRT)[47], and a Handbook for Teachers of Vietnamese Refugee Students[33]. From the organization's website sources, five documents reported on interventions on training in mental health competencies for field workers to work in crises situations. Although not specific to work with AS&R, the included documents present case scenarios, activities or the description of crises situations involving situations with AS&R, namely: Psychological First Aid (PFA)[35,37], Psychosocial support of volunteers[36,38], Community-based protection and Mental health psychological support (CBP & MHPSS)[41].

The studies' characteristics regarding the trainers, educational domains and strategies used are presented in Chart 3.

DISCUSSION

AS&R experience mental health challenges that reduce their well-being not only related to the experiences in their country of origin but also when in transit and with the reception on arrival, including accesses to housing or healthcare. The contact made between AS&R and the healthcare system is often crisis-driven and mediated through NGOs, whose staff lack knowledge and skills in the management of distress[4,43].

To respond to the shortage of health professionals in the world[49], especially in low- and middle-income countries where conflicts, disasters, and poverty is more common, thereby leading to an increase in AS&R, the WHO proposes professional training of lay counsellors to provide mental health interventions[50]. Additionally, the Inter-Agency Standing Committee recommended guidelines for emergency relief efforts and proposed that mental health interventions could be delivered by trained,

Chart 3 – Studies included in the scoping review – Porto, Portugal, 2022.

ID	Study characteristics				
	Program name, intervention	Participants	Trainers	Domains included	Strategies used
1	Handbook for Teachers, a guidebook suggesting approaches to specific problems, habits and culture of Vietnamese refugee students[33].	Teachers working with Vietnamese refugees in American schools.	Self-guidebook.	Religious beliefs and practices, cultural values, personal characteristics, holiday customs, traditional expectations for children's behavior at home and at school, Vietnamese educational institutions, pupil orientations, cultural awareness.	The book includes seven short case studies illustrate problems with coeducation, food habits, climate and clothing, illnesses and medication, adjustment, motivation, and the language barrier of Vietnamese refugees' students to help teachers to understand the cultural differences. The book also presents a culture-sensitive assessment practices for determining grade placements.
2	Mind-Spring, a community-based intervention to provide psychoeducation and psychosocial support[34].	People with background as a refugee or asylum seekers, who spoke at least Dutch and/or English, and an education background in (para)medics, psychology, social work, teaching, or education, living in Netherlands.	Coach from the Dutch mental health care system trains the refugee trainers who will implement the intervention with other refugees and asylum seekers.	The training of trainers consists in 2 parts. The 1st part (10sessions of 4h) includes theory and exercise focused on mental health issues as trauma, stress, mourning, feelings of guilt, depression, somatic complains, identity, and acculturation. The second part is a short intern- ship at a local mental health institute in the Netherlands.	1st part: Trainees are shown exercises to learn about coping strategies (cognitive approach), relaxation exercises, how to empower people, developing a helping attitude, how to stay healthy themselves and most the skills and tools of a good trainer. These subjects and exercises are learnt in the Mind-Spring manual for trainers, and they use regularly the role playing to exemplify. 2nd part: The internship, requires completing one psycho-education course for asylum seekers or refugees which consists in 8 sessions of 2 hours each. In the internship, the trainee works with a mental health professional who also receive a Mind-Spring training.
3	PFA, a manual for people in a position to help others in ways that respect their dignity, culture, and abilities[35].	Field workers.	Self-guide manual.	Understand PFA (crisis situation, implementation of PFA), how to help responsibly (cultural knowledge and awareness), providing PFA (communication, preparation, action, refer), caring for themselves and colleagues.	The guide presents each chapter with full description of the domains included including images and several examples who to apply the instructions. At the end presents 3 case scenarios to intervene in disaster, violence and displacement and accidents.
4	Psychosocial Support of volunteers (Toolkit), a manual to prepare and support volunteers for their work during and after disasters, conflicts, and other crisis events[36].	Field workers.	Self-guide manual.	Five contents: Resilience, risk, and responsibility; Communicating the Message; Response Cycle and Volunteer Psychosocial Support: Before, During and after; Psychological first Aid for Volunteers; and Monitoring and evaluation of Volunteer support.	The toolkit present support activities to intervene in several emergency situations, different worksheets regarding the training; strategies and tips for peer support and collect useful information; indicators to evaluated complex emergencies.
5	PFA, a manual for orienting field workers[37].	Field workers.	Self-guide manual.	Step-by-step orientation to implement PFA (definition and framework; applying PFA; and PFA role plays and wrap-up, self and teams care, evaluation).	The guidebook contains orientation modules to implement the PFA and presents supporting materials to implement PFA as: PFA pocket guide, option pre/posttest, simulation instructions, case scenario instructions, communication exercises, exercises to help children and vulnerable populations, evaluation form, self-relaxation exercise and an example of full-day of orientation agenda.
6	Psychosocial support of volunteers[38], a 2-day training program that complements the toolkit presented in Study ID nº 4.	Field workers, staff or volunteers who are responsible for other volunteers. This program can be manage by people that who participate in the Training of Trainers (ToT). For this specific training should have a back- ground in health, mental health, social welfare, or human resources and have a good understanding of psychosocial support.	Master Trainer in psychosocial support minister the ToT program and then the ToT trainer can manage the psychosocial support for volunteers.	3-day training: 1st day: Understanding psychosocial support; Risks, resilience, and protective factors; Self-care; Peer support and Psychological first aid for volunteers. 2nd day: Setting up psychosocial support systems for volunteers; Monitoring and evaluation of volunteer support; Communicating the message; Developing an action plan and Evaluation.	The manual sets out a basic training in the psychosocial support of volunteers. The manual is also used for the ToT together with a separate set of training notes. The TOT do a 3-day training program using the basic program supplemented by half a day on facilitation techniques and half a day for preparing practice training activities. The Psychosocial support training manual includes: Icebreakers, check-in and check-out activities and energizers, Evaluation questionnaire, Handouts, Self-care scenarios and a Workshop planner.

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ID	Study characteristics				
	Program name, intervention	Participants	Trainers	Domains included	Strategies used
7	MHFA, an 8-hour training course performed in one full day[39].	Bhutanese refugees (n=120) from 26 cities in USA' 13 states participated in the MHFA program (classes with 30 participants each.	Eight qualified instructors from the National Council for Behavioral Health (2 instructors and 1 bilingual interpreter per class).	Risk factors, warning signs and common treatments for depression, anxiety, trauma, psychosis, eating disorders, substance use disorders, self-injury, and suicidal behaviors. They also learn a five-step action plan to help people who may be developing a problem or who are already in a crisis.	The course used role-playing and simulations to demonstrate how to assess a mental health crisis, select interventions, provide initial help, and connect persons to professional, peer and social supports as well as self-help resources.
8	CBT for Community and Religious Leaders, a 4-session of 12-hours training program[40].	Community leaders (n=38) from Burma in North Carolina (Refugee Resource Center and Five Oaks Seventh-Day Adventist Church)	One psychologist and two facilitators (one Karen-speaking and one Burmese-speaking)	Signs and symptoms of depression and related problems, including intergenerational conflicts, substance abuse, domestic violence, and suicide; CBT skills, Awareness of stigma toward treatment-seeking for depression and its related risk factors.	As an interactive training program, presents exercises to support the skills development, several examples of homework for the participants, several quizzes, techniques to implement the program and promote the participants involve and a program evaluation form.
9	CBP & MHPSS, a guide to help community-based protection actors and MHPSS practitioners work together to contribute to the wellbeing and protection of forced displacement people[41].	Field workers.	Self-guide manual.	MHPSS: Definition, approach, and intervention. Intervention pyramid: social considerations in basic services and security, strengthening community and family supports, focused psychosocial supports and clinical services. Linkages between MHPSS and Community-based intervention.	Several examples about social inclusion and participation are present to the readers to promote reflexive thinking. Also, some case studies and activities are shown to strengthen community and family support.
10	PM+, a Protocol for a program implementation with 5 weekly face-to-face sessions of 90 minutes[42].	PM+' facilitators are men and women refugees who speak Arabic, with a background in education, social work, health, or a related field, fluent in German and English.	Licensed mental health care professionals.	Common mental disorders, basic counselling skills, delivery of intervention strategies and self-care.	The facilitator received 8 days of training, follow by 2 practice cases, with close supervision of trained PM+ trainers and supervisors who also received training to supervise.
11	PM+, a protocol for a randomised controlled trial implemented in local NGOs delivering the PM+ for AS&R by lay people (PROSPER pilot)[43].	Two Wellbeing Mentors appointed by the of the Person Shaped Support – a health and social car charity – (group 1) and 15 people with asylum experience (group 2).	PM+ Master Trainers	Group 1: delivery of the PM+ intervention strategies in both individual and group modalities, skills in training and supervising lay therapists Group 2: education in mental disorders, basic helping skills, delivery of intervention strategies and self-care.	Group 1: 5 days of intensive training from two PM+ Master Trainers and monthly supervision to became Wellbeing Mentors and supervise the lay therapists. Group 2: 8 days of training to trained to deliver either individual or group PM+. This was followed by training cases and a competency assessment.
12	EmpaTeach – a self-guided teacher training intervention designed to reduce and prevent teachers' use of corporal punishment in the classroom, learned in 12 sessions[44].	85 Teacher from fourteen schools of Nyarugusu Refugee Camp.	Three persons: 1 from the Behavioural Insights Team, 1 from the International Rescue Committee education technical unit staff and 1 local refugee.	Self- regulation, alternative discipline techniques, and classroom management strategies.	EmpaTeach inter- vention used empathy-building exercises and group work. Some of the sessions have videos that were produced locally as part of the intervention, in other sessions is necessary to play to apply learned concepts and they learn how to co-create classroom rules with students.
13	Suicide Prevention Education, a 2-day training program for people working with AS&R[45].	Staff, volunteers, and students from NGOs who provide case management, support, or counselling to AS&R across Australia, primarily in the community, but also in held detention.	Members of Australian Red Cross and an asylum seeker.	Evidence concerning suicide and suicide prevention, the development of the asylum seeker suicidal mind, trauma-informed practice, risk and protective factors, ideation to action theories of suicide, cultural considerations, compassion, and hope when engaging with suicidal persons, safety planning, postvention, and self- care.	2-day training program (15h): lecture-style presentations (3 h), interactive discussions (4.5 h), small group activities/role plays (1.5. hr), and case studies (2 h). All attendees received a take-home workbook, including the presentation slides, worksheets, and literature. Questionnaire pre-training, post training and 4-6 months follow-up.

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ID	Study characteristics				
	Program name, intervention	Participants	Trainers	Domains included	Strategies used
14	Islamic Trauma Healing, a 6-session of 2-hours, lay-led group intervention developed within a Somali Muslim community that integrates evidence-based trauma-focused cognitive-behavioral therapy principles[46].	Adults who practice Islam.	2 Lay leaders of the same gender facilitate each group of 5-7 people members, and they must have knowledge of the Qur'an but need no prior training in mental health	Sessions contents: Trauma, post-traumatic growth, reconciliation with others using prophets' narratives. Structure: i) Community and spiritual preparation; psychoeducation, describing programs, prophet narratives, and turning to Allah (informal prayer).	The lay-leaders also receive a two 4-hour sessions, including motivational stage setting, didactic and competence components. The Islamic Trauma Healing is carried out in mosques and formal diagnostic labels are not used.
15	PM+, reflections and recommendations to deliver the PM+ for AS&R by lay people (PROSPER)[47].	Peer Lay therapists (n=12)	PM+ Master trainer and two Well- being Mentors	PM+ ToT which includes basic helping skills and the PM+ sessions.	The skills in training others were possible conducting role plays and providing feedback and leading supportive supervision. Wellbeing Mentors each completed three individual PM+ practice cases with volunteers. Wellbeing Mentors have received monthly supportive supervision with one master trainer and the Person Shaped Support team leader lasting between 1.5 and 2 hours, complemented by e-mail and telephone discussions The Peer Lay Therapist Training was separated into Group PM+, and Individual PM+, and were carried out once a week for 8 weeks. The supervision of Peer Lay Therapist Training was led by the Wellbeing Mentors. Collective informal engagement such as shared lunches during training and sightseeing tours helped build intervention team cohesion within and beyond PM+ roles.
16	TRT[48], a community-based intervention utilizing trained lay counsellors in a stepped model of care for refugee youth experiencing trauma symptoms, one a week for 7 weeks.	TRT trained lay counsellors with experience working with unaccompanied refugee minors: Professionals, such as teachers, nurses, or social workers (n=50).	Swedish non-governmental organisation Children's Rights in Society (n=2).	TRT comprises 2 sessions for caregivers and 5 sessions for youth including: psychoeducation, affective modulation skills, cognitive coping and processing, in vivo mastery of trauma reminders, guided exposure and exploring plans and hopes for the future.	Techniques like positive self-talk, dual attention and relaxation are used. The focus is on symptoms and tools rather than trauma narrative and processing. The intervention tries to normalize the trauma' symptoms in the group environment as this is assumed to relieve youth from shame and fear.

nonprofessional community members[51]. In light of the results of this review, the number of scientific studies researching on programs and/or interventions to train mental health competencies of the volunteers, which includes community members, and NGO staff, with no health or mental health background to work with AS&R is insufficient. Most are protocols focused on specific mental health problems or cultural and religious backgrounds, incapable of being used in several contexts or self-administrated without control of the acquired knowledge. However, the number of articles about the topic has been increasing, especially since 2015. This increment might be related to the exponential increase of forcibly displaced people since 2015, the highest since World War II[52]. Altogether these situations led to a forced exodus of populations to neighbouring countries.

The investment in mental health training of community workers or volunteers and staff with no background in the health domain is aligned with the principle that non-specialists can help to increase access and effectively provide mental health interventions in low-resource communities[53]. As shown, all the included studies in this review aimed to guide the volunteers on how to provide humane, supportive, and practical help to adults and children AS&R experiencing crisis events. Most of the articles are designed for lay providers regarding their educational backgrounds. Two articles are specific for teachers, one is a handbook to guide American teachers to deal with Vietnamese refugee children[33], and another one is a self-guided teacher training intervention designed to reduce and prevent teachers' use of corporal punishment in the refugee camps' classrooms in Tanzania[44]. The manuals of WHO[35,37], IFRC[36,38], and UNHCR[41] are designed for field workers, i.e., people who support others during or immediately after extremely stressful events. The remaining studies published in the

scientific databases focused mainly on training people with refugee[34,39,40,42,43,47] or asylum seekers' backgrounds[34], NGO volunteers, and professionals working in the incoming countries[43,44,46]. Although lacking specifications regarding the educational background, some of the studies indicated that participants should preferably be psychologists, social workers, teachers, nurses, leaders, volunteers' managers, or workers in related fields.

Regarding the domains included, the WHO[35,37], IFRC[36,38], and UNHCR[41] manuals focused essentially on PFA[35,37] and MHPSS[41] to help people in crises and psychosocial support for volunteers approaching resilience, risks, and self-care[36,38]. The articles from the databases focused mainly on common mental health disorders[42,43] such as trauma[34,40,45,46,48], stress, mourning, feelings of guilt, somatic complaints, identity and acculturation[34], depression[34,39,40], psychosis, eating disorders, substance use disorders[38,40], self-injury, and suicidal behaviours[39,40,45]. The PM+, which is an individual psychological help for adults developed by the WHO, was modified to be an evidence-based psychosocial intervention delivered by lay staff to help AS&R with basic counselling skills, delivery of intervention strategies and self-care[43,47]. All articles and documents included in this review broadly agree that psychological support can be facilitated by lay people for vulnerable populations, such as AR&R, which in most cases can be people with previous asylum experience or people with high interest and willingness to help these populations. However, due to the cultural background of each population, they all agree that any programs that are considered a model need to be adapted appropriately to the local context and the culture of the people who will be assisted by volunteers. Although most lay facilitation programs address similar domains, the time devoted to training is quite diverse. Lay-facilitators' programs duration was found to last eight hours in a single day[39], to a two-day training of 15h[45], six-sessions of two hours[46], four-session of 12-hours[40], five weekly face-to-face sessions of 90 minutes[42], 10 sessions of four hours each, including internship[34], three-day training[38], and seven weeks without specification of hours[48].

The current findings may be important for health authorities, policymakers, and other stakeholders planning to provide mental health training to NGO volunteers and staff in the incoming countries or even in humanitarian settings. In particular, for people preparing others to work in humanitarian settings, which is increasing worldwide due to forced migrations, the use of lay mental health providers could be a valuable, first-tier psychological support service for people in underserved communities such as AS&R.

The heterogeneity of the interventions used in the included studies is both a strength and a weakness. On the one hand, the diversity in the type and length of training shows both the investment that is being made to respond to emerging local needs and a concern to train the volunteers and the staff of community helpers under supervision to make the provision of support to a greater number of people in need possible. On the other hand, this diversity challenges the results' interpretation regarding the training programs and their comparison. In some of the studies, the training is self-guided by manuals or handbooks with no facilitator, which could lead to a misunderstanding of contents. Other studies did not describe the supervision conditions as part of or after the training.

Further research is needed on mental health training of non-health professionals and volunteers that are in places where mental health needs outrun professional resources s (e.g., refugee camps, shelters, and reception centers), whether in humanitarian crisis contexts or the reception of refugees in host countries. Furthermore, research should explore the psychological impact of becoming a lay facilitator and the influence of the mental health training programs on their well-being and the well-being of the AS&R they assist. This is especially important in the case of interventions recruiting members from the same community that has been exposed to similar experiences. In addition, it would be interesting to evaluate the impact of mental health training programs on the relationships between staff or volunteers and AS&R and the acculturation process.

Regarding the limitations of the study, some articles or documents did not provide a satisfactory description of the intervention or the participants' characteristics. Furthermore, data about settings, hours, strategies of training sessions, and the kind of participants' supervision during or after the training was also absent. Additionally, the studies included did not specifically address work with AS&R; they were rather included as they presented training to work in the humanitarian field or crisis situations by using examples of scenarios with displaced people.

Although the programs in mental health competencies for non-health professionals or volunteers to work with AS&R are scarce, we identified eleven training programs or interventions with this purpose, some of them being self-guided sources of training. Even though lay people have a promising role to play in assisting the AS&R and referring them to specialized care, the number of mental health training programs to train the volunteers is insufficient. In addition, the fact that working with AS&R is often voluntary work means that prior training is not required, and this could be the reason why greater and better investment is not made in training those who take care of the AS&R. This review demonstrates the need to invest in the development and implementation of mental health training programs in which nurses can play a vital role. As the ICN highlights, nurses are the key to caring for migrant populations[27]. Nursing care is indispensable for the easement of human distress and for the promotion of comfort and coping. Nurses also have an essential role in advocating for policies that will enhance AS&R's access to health and mental health care and address barriers irrespective of AS&R status. By becoming aware of the existing challenges regarding access to mental health professionals and care, nurses' intervention, support, and training of those caring for AS&R can help in different ways. In mental health training of non-health professionals and volunteers working with AS&R, mental health nurses, as qualified mental health educators, stand out for their ability to develop, coordinate, and implement mental health training programs which are activities aligned with the mental health and psychiatric field of nursing[25]. Mental health training provided by mental health and psychiatric nurses encourages the empowerment of the non-health professionals and volunteers to deal with the AS&R's overwhelming life transitions; enhances the ability to refer people who need specialized mental health care; makes possible earlier care for

those who have the luck of having someone trained who can help and recognized their needs; and promotes the non-health professionals and volunteers' self-mental health care.

CONCLUSION

Sixteen articles aboard eleven training programs to promote mental health competencies training: Mind-Spring, PM+, MHFA, Cognitive-Behavioral Training for Community and Religious Leaders, EmpaTeach, Suicide Prevention Education Program, Teaching Recovery Techniques, Handbook for Teachers of Vietnamese Refugee Students, PFA, Psychosocial support of volunteers and CBP&MHPSS.

Training programs from scientific literature focus mainly on mental health disorders, while non-governmental organizations' documents focus on resilience and self-care. The eleven training programs included in this review might not be sufficient to meet the training needs of non-health professionals and volunteers working with AS&R. It is important to highlight that some studies are focused on specific cultural backgrounds or religious beliefs or based on the capacity of self-education of each person, which can contribute to lack of training to work in several countries, and to misinterpretation of the training concept as information available in the self-guided manuals. NGO volunteers and professionals with no educational background in the health domain need comprehensive training to deal with others' mental health suffering without jeopardizing their mental health. This implies recognizing signs and symptoms of mental health problems that allow them to refer people to specialized care, understand how cultural background influences the suffering manifestations, and acquire strategies to take better care of themselves.

To fill this gap, mental health nurses should be on the front line to help people improve their mental health competencies to work with AS&R attending their cultural backgrounds.

RESUMO

Objetivo: Identificar e descrever os programas de treino em saúde mental para profissionais, que não de saúde, e voluntários que trabalham, trabalharam ou gostariam de trabalhar com requerentes de asilo e/ou refugiados. **Método:** Revisão de escopo seguindo a metodologia JBI. Pesquisa realizada na MEDLINE, CINAHL, ERIC, SCOPUS, PsycINFO, Psychology & Behavioral Sciences Collection, RCAAP, ProQuest e sites do ClinicalTrials, ACNUR, Organização Internacional para as Migrações, OMS, Save the Children, Migração Internacional, Integração e Coesão Social na Europa e Federação Internacional das Sociedades da Cruz Vermelha e do Crescente Vermelho. Estudos escritos em inglês, português, francês, espanhol e sueco. **Resultados:** Dos 8.954 artigos identificados, 16 foram incluídos relatando 11 programas de treinamento: Mind-Spring, PM+, MHFA, Treinamento Cognitivo-Comportamental para Líderes Comunitários e Religiosos, EmpaTeach, Programa de Educação para Prevenção do Suicídio, Técnicas de Recuperação de Ensino, Manual para Professores de Estudantes refugiados vietnamitas, PFA, apoio psicossocial de voluntários e CBP&MHPSS. **Conclusão:** Os programas de treino na literatura científica focam nos transtornos de saúde mental, enquanto os documentos das organizações não governamentais focam na resiliência e no autocuidado. Os atuais programas de treino em saúde mental podem ser insuficientes.

DESCRITORES

Refugiados; Saúde mental; Educação; Enfermagem.

RESUMEN

Objetivo: Identificar y describir los programas de formación en salud mental para profesionales no sanitarios y voluntarios que trabajan, han trabajado o gustarían de trabajar con solicitantes de asilo y/o refugiados. **Método:** Revisión de alcance según la metodología JBI. Búsqueda realizada en MEDLINE, CINAHL, ERIC, SCOPUS, PsycINFO, Psychology & Behavioral Sciences Collection, RCAAP, ProQuest, y sitios web de ClinicalTrials, ACNUR, Organización Internacional para las Migraciones, OMS, Save the Children, Migración Internacional, Integración y Cohesión Social en Europa, y Federación Internacional de Sociedades de la Cruz Roja y de la Media Luna Roja. Estudios escritos en inglés, portugués, francés, español y sueco. **Resultados:** De los 8954 artículos identificados, se incluyeron 16 que informan sobre 11 programas de capacitación: Mind-Spring, PM+, MHFA, Capacitación cognitiva conductual para líderes comunitarios y religiosos, EmpaTeach, Programa de educación para la prevención del suicidio, Enseñanza de técnicas de recuperación, Manual para maestros de Estudiantes refugiados vietnamitas, PFA, apoyo psicosocial de voluntarios y CBP&MHPSS. **Conclusión:** Los programas de formación en la literatura científica se centran en los trastornos de salud mental, mientras que los documentos de las organizaciones no gubernamentales se centran en la resiliencia y el autocuidado. Los actuales programas de formación en salud mental pueden ser insuficientes.

DESCRIPTORES

Refugiados; Salud mental; Educación; Enfermería.

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