The Global Mental Health Assessment Tool (GMHAT) pilot evaluation: Final report

Research report 108

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Acronyms

CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive behavioural therapy
CCG	Clinical Commissioning Group
CNAT	Client Needs Assessment Test
DA	Devolved administrations
DH	Department of Health
ESOL	English for speakers of other languages
GMHAT	Global Mental Health Assessment Tool
GP	General Practitioner
HCA	Healthcare assistant
HO	Home Office
IAPT	Improving Access to Psychological Therapies
ICD-10	International Classification of Diseases – 10th revision
IOM	International Organization for Migration
LA	Local authority
MENA	Middle East and North Africa
MHA	Migration Health Assessment
OCD	Obsessive-compulsive disorder
PHE	Public Health England
PHQ-9	Patient Health Questionnaire – module 9 (Depression)
PTSD	Post-traumatic stress disorder
SMP	Strategic Migration Partnerships
SVPRS	Syrian Vulnerable Persons Resettlement Scheme
UK	United Kingdom
UNHCR	United Nations High Commissioner for Refugees
VCRS	Vulnerable Children's Resettlement Scheme
VPRS	Vulnerable Persons Resettlement Scheme
WHO	World Health Organization

Executive summary

In December 2016, the Home Office and Public Health England in collaboration with the International Organization for Migration (IOM) began a pilot of the Global Mental Health Assessment Tool (GMHAT) among Syrian refugees who have been accepted for resettlement to the United Kingdom (UK). The GMHAT is a computerised clinical assessment tool developed to rapidly assess and identify mental health problems in a range of settings. This report summarises the findings of the evaluation around how this tool worked in practice at identifying immediate mental health needs that require urgent attention during the pre-departure stage and in facilitating diagnoses, referrals and treatment once in the UK.

The pilot was conducted from December 2016 to July 2017. The tool was tested in one clinic in Beirut, Lebanon with 200 Syrian refugees aged 18 years and above who were being processed for resettlement to the UK as part of the Vulnerable Persons Resettlement Scheme (VPRS).

The evaluation was mixed method by design including both quantitative and qualitative analysis. Quantitative analysis was conducted on participant data provided by IOM. Researchers also conducted qualitative analysis on refugee feedback forms, written feedback and interviews with five health practitioners involved in administering the tool in Lebanon, and 11 local authority (LA) caseworkers and 17 general practitioners (GPs) in the UK.

Key findings

The findings suggest that a pre-departure mental health assessment could be a useful and valuable tool to facilitate LAs in matching and preparing for new refugee arrivals, and a valuable resource for GPs during the initial consultation. LA caseworkers and particularly GPs valued having access to concise clinical information regarding a refugee's mental health prior to their arrival in the UK. The GMHAT is one option for such a tool, which the pilot findings suggest would require modifications (along with the accompanying training) to make it suitable for use in the resettlement context. If it is modified, the revised version will need to be validated (including an independent mechanism for collecting refugee feedback) and robust information flow processes established before it can be implemented. Concerns raised about a lack of appropriate services to support mental healthcare suggest additional guidance and training with LA caseworkers and GPs may be required on existing referral pathways. There may also be a need to expand the provision of culturally-appropriate mental health services for refugees for the pre-departure mental health assessment to have maximum impact.

Practitioners administering the tool had a largely positive experience, however they highlighted the need to adapt the tool to fit the context

Practitioners found the GMHAT tool easy to use for making rapid assessments, valued the opportunity to gain a greater insight into refugees' experiences, and appreciated its ability to distinguish between those with psychosocial stressors versus those with medical conditions.

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However, practitioners also found a need to both adapt the tool to fit the cultural context and were each required to translate it into the local dialect. This resulted in inconsistent application which means that we are unable to assess the accuracy of the estimates of likely diagnoses of mental health issues based on this pilot alone.

The tool identified 9% of pilot participants with a likely diagnosis of mental illness but 1.5% additional referrals were made based on clinical judgement, highlighting the importance of not relying upon this tool in isolation

During the GMHAT assessments, all participants reported a high level of psychosocial stressors, however most were able to continue their daily activities and cope with this level of distress. Eighteen out of 200 (9%) presented with a likely diagnosis of mental health issues with an impact on functioning and significant subjective distress as identified by the GMHAT assessment. All those were subsequently confirmed by further psychiatric evaluation as having a diagnosable mental health condition, most commonly depression and anxiety.

Practitioners highlighted that the tool's accuracy may depend upon a refugee being willing to discuss their problems, which may be hindered by factors such as different cultural perceptions of mental health (including stigma around mental health issues) and the gender of the practitioner. Indeed, despite not screening positive on the GMHAT tool, three additional participants were referred to the psychiatrist based on the practitioner's clinical judgement. This highlights the importance of not relying upon this tool in isolation, and its administration by a trained healthcare professional who can use their professional expertise to pick up on any missed diagnoses.

There were mixed views on the appropriateness of the tool for the population of concern

Practitioners administering the tool were required to make various adaptations to fit the cultural context and aid the comprehension of refugees. Some also adapted the tool to make a clearer distinction between refugee's mental health needs before and after their displacement. Refugee feedback was generally positive; however, the mechanism for collecting this feedback (through the practitioner administering the tool) may have contributed towards more positive responses. Among the minority who did voice discomfort following the assessment, their responses highlighted there was a potential risk of re-traumatisation and stigma surrounding mental ill health within their community. Such concerns may have also contributed to three in ten declining to participate in the pilot, although this was also attributed to time constraints. There were also suggestions for the tool to focus more on daily stresses in Lebanon, and some participants also used it as an opportunity to request counselling to prepare them for life in the UK.

Pilot participants' cases took longer to process but the reasons for this are unclear

GMHAT participants' cases took longer on average to process than those who had not been assessed (1.5 to 2.2 months longer). While it is not possible to distinguish whether the GMHAT was the cause of the delay or whether it was down to external factors, this is an important consideration in deciding whether to (and to who) roll out the tool across resettlement processing countries. Additional information will be required to estimate the future costs and impact on case processing times to try and understand the reasons for this delay.

There were critical operational issues with the information flow process during the pilot which need to be investigated and addressed

While from an IOM perspective the information sharing between IOM and the Home Office (HO) worked well and no issues in the sharing of GMHAT reports and Migration Health Assessments (MHAs) between IOM and HO were observed, feedback from LA caseworkers and GPs highlighted critical operational issues with the information flow process which need to be addressed: forms did not reach the majority of caseworkers (reaching 10 out of 26) and almost no GPs (3 out of 17). Feedback suggested a wide variation in pre-established processes for sharing resettlement information more generally with GPs, and some caseworkers were not clear on how the information was intended to be used and with whom it could be shared. This meant that we were unable to evaluate how well the tool fulfilled its main purpose of facilitating diagnoses, referrals and treatment for pilot participants once they reached the UK.

LA caseworkers and GPs valued receiving an 'initial snapshot' of an individual's mental health, with potential benefits of facilitating provision of timely and informed care

The majority of LA caseworkers and healthcare practitioners felt that the GMHAT had the potential to be a useful tool for informing their actions and role in supporting resettled refugees. Many commented on the value of receiving information in advance about a refugee's mental health, given the limited information typically available and the time it can take to overcome barriers such as trust and language on first arrival.

Both LA caseworkers and GPs felt that the tool was useful in its current form, but had suggestions for how it could be improved to make it more appropriate for their needs.

The tool was recognised for its value in providing an initial snapshot of mental health and wellbeing, and for flagging particularly vulnerable individuals. Potential benefits include:

- expedited referral and treatment;

- increased awareness of mental health issues (particularly for practices and/or individual practitioners with limited experience of working with refugees);

- improved support for the integration of the refugee into society by proactively addressing issues affecting their wellbeing;

- informing the commissioning of specialist mental health services if the tool demonstrated demand.

However, respondents stressed that a pre-departure mental health assessment should not replace a routine psychological assessment on arrival or ongoing monitoring, particularly given the longer latency of mental health conditions which can present at any time.

The impact of introducing the tool would be limited if there is a lack of appropriate services to support mental healthcare

The most frequently cited concern about the tool was that its impact would be diminished by the lack of appropriate resources and services to support referral and care, and there is a risk that incorporating a mental health element into the pre-departure assessment could raise expectations of post-arrival service delivery that local healthcare providers will struggle to meet with existing resources. Others suggested that a tool like the GMHAT could generate evidence to inform commissioning of specialist mental health services.

Receiving the report in advance could help LAs determine whether they have the services in place to support a refugee's resettlement, which in turn may lead to more appropriate matching and dispersal. However, the risk that cases could be rejected based on mental health needs if services are not available, and the longer-term impact of this on the refugee and their family, should also be carefully considered.

The findings suggest that it may be necessary to expand the provision of culturally-appropriate mental health services for refugees for the pre-departure mental health assessment to have maximum impact. Recent work by the Home Office to map the coverage of mental health services for refugees and asylum seekers in England may be helpful in addressing some of these gaps.

1   Introduction

The UK Government announced the establishment of the Vulnerable Persons Resettlement Scheme (VPRS) in January 2014, in response to the ongoing war in Syria and mass displacement of Syrians. Between March 2014 and June 2015, 216 refugees were resettled with prioritisation given to those requiring urgent medical treatment, survivors of violence and torture, and women and children at risk. In September 2015, the then prime minister announced the scheme would be expanded to resettle up to 20,000 vulnerable people from Syria by 2020. In 2017, the scheme was further expanded to include other refugees who have fled the conflict in the Syrian region but who do not have Syrian nationality. Since the scheme's expansion in 2015, 11,397 people have been granted protection under the scheme. This includes 67% in England, 19% in Scotland, 8% in Northern Ireland and 6% in Wales.[1]

The Office of the United Nations High Commissioner for Refugees (UNHCR) is responsible for identifying and referring vulnerable refugees who would benefit from resettlement. The referral is then processed by the Home Office (HO) resettlement casework team, who assesses case eligibility and commission relevant screening and security checks to determine whether the case should be accepted for resettlement to the United Kingdom (UK).

All refugees accepted onto the VPRS undergo a Migration Health Assessment (MHA) undertaken by the International Organization for Migration (IOM) to identify any health issues, including public health concerns, and future treatment needs. The aim of the MHA is to facilitate early integration of the refugee, promoting individual health, protecting public health where relevant, and linking individual needs with appropriate health and social services in the UK. It includes a general assessment, testing for specific conditions and infectious diseases, immunisations, and additional clinical assessments relating to other chronic, physical, psychosocial or mental health issues as appropriate. MHAs are provided to local authorities (LAs) in order that appropriate care can be arranged for the refugees concerned on arrival; they may also inform where an individual is resettled, for example if they have mobility issues or have a health condition which requires specialist treatment. At present the MHA does not include any systematic screening of mental health conditions.

Upon arrival to the UK, individuals who are resettled through the VPRS are provided with initial reception arrangements, casework and orientation support by the receiving LA (or community sponsor). The LA will assign a caseworker to every resettled family or individual who maintains close contact with the family for the first 12 months to support their wellbeing and integration. This caseworker support includes helping the family register with a local general practitioner (GP), providing advice around and referral to appropriate mental health services and to specialist services for victims of torture. GPs would normally be the first point of contact for assessing physical and mental health and signposting or arranging referrals as required.

In 2016, Public Health England (PHE) and the Home Office undertook a review of the protocol that informs the MHA. One of the findings of this review was that mental health assessments

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[1]   Home Office, Immigration Statistics, year ending 31 March 2018, Volume 4, as_19q.

should be informed by a validated clinical tool, rather than exclusively on clinical judgement. PHE consulted with mental health experts internally and in the Royal College of Psychiatrists, who recommended the GMHAT tool for adults. In December 2016, the Home Office and PHE in collaboration with IOM began a pilot of the Global Mental Health Assessment Tool (GMHAT) among Syrian refugees who have been accepted for resettlement to the UK. This report summarises the findings of the evaluation around how this tool worked in practice in identifying immediate mental health needs requiring urgent attention during the pre-departure stage and in facilitating diagnoses, referrals and treatment once in the UK.

What is the Global Mental Health Assessment Tool (GMHAT)?
The GMHAT is a computerised clinical assessment tool developed to assess and identify mental health problems in a range of settings. It is clinically validated and consistent with the World Health Organization's (WHO) diagnostic classification standard, the International Classification of Diseases – 10th revision (ICD-10). One of its aims is to help in overcoming the shortage of trained mental health practitioners, as it can be employed by nurses following a short training workshop.   The GMHAT asks a series of questions focusing sequentially on the following symptoms or problems: worries, anxiety and panic attacks, concentration, depressed mood, sleep, appetite, eating disorders, hypochondriasis, obsessions and compulsions, phobia, mania/hypomania, thought disorder, psychotic symptoms, disorientation, memory impairment, alcohol and drug misuse, personality problems and stressors.   Based on the responses to these questions, the GMHAT will produce a final assessment which outlines any mental health problems, scores against a range of mental health concerns, and an assessment of the severity of symptoms. The tool takes approximately 15 to 20 minutes to complete.

2 Literature review

WHO estimates anxiety affects 3.6% and depression affects 4.4% of the global population. For the Syrian Arab Republic, WHO estimates anxiety affects 4.3% and depression affects 3.9% of the population (WHO, 2017).

Refugees tend to be more vulnerable compared to both the general population and other migrant groups. Experiences along the migration trajectory – fleeing conflict, persecution and abuse; exploitation and torture; poor living conditions; poverty; lack of employment; family separation and bereavement; and challenges integrating with the host society – can all contribute to poorer mental health outcomes (Acarturk *et al.*, 2015; Mollica *et al.*, 1998; Rousseau *et al.*, 2001; Teodorescu *et al.*, 2012; Trautman *et al.*, 2002). Prevalence rates of common mental disorders have been shown to be twice as high in refugee populations in comparison with economic migrants (Lindert *et al.*, 2009), while refugees resettled in Western countries have been estimated to be roughly ten times more likely to have post-traumatic stress disorder (PTSD) than age-matched general populations in those countries (Fazel *et al.*, 2005). Meta-analytic reviews found a two to threefold increased risk of psychosis in migrants compared with the host population (Cantor-Graae and Selten, 2005; Bourque *et al.*, 2011). The outcomes suggest that the risk of developing psychosis varies by country of origin and host country and is higher for second-generation migrants. Typically, high incidence rates are not found in the country of origin, suggesting that the experiences preceding, during and following the migration process may play a role in the aetiology of psychotic disorders.

There is, however, also considerable variation of prevalence estimates in the literature, which likely reflects the heterogeneity of migrant groups and contexts as well as the different diagnostic tools and assessment criteria used (Turrini *et al.*, 2017). A systematic review of psychiatric disorders in refugees and internally displaced persons after forced displacement found prevalence varied from 3% to 88% for PTSD, from 5% to 80% for depression and from 1% to 81% for anxiety disorders (Morina *et al.*, 2018). Larger, more rigorous surveys have been shown to yield lower prevalence rates, and Fazel *et al.* (2005) estimated that around 5% of refugees in Western countries were thought to have major depression, 4% had generalised anxiety disorder and 10% had PTSD.

Among Syrian refugees, reported prevalence of mental illness in the literature tends to be considerably higher than among the general Syrian population (pre-conflict). One study found anxiety affected 31.7% of a sample of Syrian refugees resettled in Sweden (Tinghög *et al.*, 2017), while depression was found to affect 37.4% of Syrian refugees living in a Turkish refugee camp (Acarturk *et al.*, 2018) and 40.2% of Syrian refugees resettled in Sweden (Tinghög *et al.*, 2017). PTSD estimates ranged from 27.2% prevalence among Syrian refugees living in Lebanese refugee camps (Kazour *et al.*, 2017), 29.9% among Syrian refugees resettled in Sweden (Tinghög *et al.*, 2017) and up to 83.4% among Syrian refugees living in a Turkish refugee camp (Acarturk *et al.*, 2018). Of UK-bound refugees who underwent a migration health assessment at the IOM clinic in Lebanon in 2017 and 2018, 3.22% and 1.15% were referred for further psychiatric evaluation, respectively (unpublished data, IOM). These

findings highlight the need for continual assessment at different stages of the migration cycle, as some mental health conditions triggered by displacement may not emerge immediately. For example, Smid et al. (2009) found 24.8% of PTSD cases had delayed onset (defined as more than six months after the initial trauma). It is worth noting, however, that these studies may measure symptoms suggestive of mental health issues and not full diagnosis of syndromes.

A range of mental health screening tools exist and have been trialled for use in research and clinical practice among different population groups. Many are designed to be administered through self-assessment, which is less resource intensive, and based on evidence that self-rated health scores can accurately predict future morbidity and mortality (Dowling et al., 2017; Idler et al., 1997; Kaplan et al., 1996; Miilunpalo et al., 1997; Fylkesnes et al., 1993; Dowd et al., 2007; Idler et al., 1991). However, these tools may have limited application to clinical practice by covering only a limited range of clinical problems and requiring extensive training prior to use (Sharma et al., 2004).

Other clinical tools have been developed more specifically for primary care physicians, such as the Primary Care Evaluation of Mental Disorders (Spitzer et al., 1994) and the Symptom Driven Diagnostic System for Primary Care (SDDS/PC) (Broadhead et al., 1995). These tools can be used to detect common mental disorders but are generally not suitable for detecting more serious psychotic or organic disorders (Sharma et al., 2004). Structured questionnaires administered by GPs to monitor patients' mental health have not been found to be feasible to implement in routine surgery appointments (Kendrick et al., 1995). On a larger scale, WHO has developed the Mental Health Gap Action Programme (mhGAP), which aims to build capacity among non-specialist healthcare providers in the assessment of people with mental, neurological and substance use disorders in low resource settings. It is possible that mhGAP could be adapted to fit other contexts (such as the refugee context), but it has been designed with the goal of strengthening health system capacity in low- to middle-income countries in mind. WHO mhGap has a secondary set of tools (mhGap HI), which are specifically tailored for humanitarian-refugee settings. It is a simplified version of the tool which includes questions specifically on PTSD which is relevant to this population.

Evidence suggests that screening is more efficient when the prevalence of mental illness is high and, in particular, when prior detection is low (Martin et al., 2016). It is therefore likely that refugees represent a suitable population for mental health screening, although limited reliability and validity data is publicly available. A systematic review by Dowling et al. (2017) identified 45 self-measurement tools which had been used to assess the mental health of refugees, such as the Hopkins Symptom Checklist-25, the Harvard Trauma Questionnaire, the Vietnamese Depression Scale and the Refugee Health Screener-15. In this review, a third of tools had been designed specifically for use within refugee populations, but less than half had published reliability and validity data among the same population.

The variation in methods, application of assessment tools and screened populations makes selection of a robust and appropriate tool difficult. The GMHAT has been designed to address these gaps. It is a clinically validated tool which is easy to use, can be administered by a range of healthcare staff (and therefore less resource intensive), is designed to detect common psychiatric disorders as well as more serious conditions, and automatically produces a summary report for onward referral (Sharma et al., 2004). Previous validation studies of the GMHAT in various settings have found sensitivity ranges from 0.73 to 0.84 and specificity from 0.90 to 0.96 (Sharma et al., 2010; 2008, Krishna et al., 2009). It has also been clinically validated in other languages, including Arabic (Sharma et al., 2013).

3 Aims and objectives

The Home Office Resettlement Team's objectives for piloting the GMHAT were to assess the process and utility of introducing the screening tool for the following purposes:

- To identify immediate mental health needs requiring urgent attention during the pre-departure stage.
- To facilitate caseworker referrals and GP assessment, any subsequent diagnoses and referrals to specialist service provision once in the UK.

These overarching objectives were translated into an evaluation framework designed to address the following research questions:

- How does the GMHAT operate in situ as part of the pre-departure health assessment checks?
  - What mental health issues does the GMHAT identify in the sample population of concern?
  - Does the GMHAT facilitate the identification of immediate mental health needs of refugees requiring urgent pre-departure attention?
  - How appropriate is use of the tool for the population of concern?
- What is the impact of introducing the GMHAT on case flow?
- How useful is the GMHAT for LA caseworker referrals and GP health assessments?
  - Does this information reach caseworkers and/or GPs?
  - If so, to what extent do these stakeholders find the provided information useful (does it provide sufficient information for LAs and GPs in the UK to put support in place and refer appropriately)?

The outcome of this evaluation will feed into the decision of whether or not to permanently incorporate the screening tool into UK refugee resettlement operations across the Middle East and North Africa (MENA) region.

4 Methodology

4.1 Overview of pilot

The first stage of the pilot was conducted in December 2016, followed by a second stage from April until July 2017. The tool was tested in one clinic in Beirut, Lebanon with 200 Syrian refugees aged 18 years and above who were being processed for resettlement to the UK as part of the VPRS. This sample size was considered operationally feasible to answer the research aims and objectives (outlined in section 3), given the average number of UK resettlement cases being processed through the clinic and the timescale of the evaluation.

While the GMHAT has now been validated in Arabic (Sharma *et al.*, 2013), the English version of the tool was used during the pilot. Healthcare practitioners in Lebanon reported that they were more comfortable using the English version of the GMHAT as they were trained using English medical vocabulary. Using the English version of the tool was also chosen to facilitate comprehension of diagnoses by UK-based LA caseworkers and GPs, as there are free-text entry boxes (capturing background and clinical judgement) which if completed in Arabic would have needed to be translated manually into English.

The evaluation was mixed method by design and focused on two distinct stages of the resettlement operations:

- Pre-departure health assessments
- Post-arrival medical and social services and referrals.

Table 1 outlines the methodological approach used to assess each intended outcome.

Table 1: Methodological approach

Stage	Intended outcome	Methodology
Pre-departure health assessments	A range of mental health needs are identified pre-departure.	Quantitative analysis of GMHAT participant data.
	Immediate mental health needs are identified and urgent needs are addressed.	Quantitative analysis of GMHAT participant referral rates and telephone interviews with IOM health professionals administering the tool in Beirut.
	No detrimental impact on case flow (measured by average processing time).	Quantitative analysis of average processing times (from UNHCR referral date to arrival in UK) for GMHAT participants versus average of non-participant Lebanese caseload / entire VPRS caseload referred by UNHCR during the same time

Stage	Intended outcome	Methodology
		period.
	The tool is acceptable for use among refugees.	Qualitative telephone interviews with five IOM health professionals who administered the tool in Beirut (see Appendix A for topic guide). Findings from refugee feedback forms completed by IOM healthcare practitioners on behalf of participating refugees in situ (see Appendix B).
Post-arrival medical services and referrals	The information reaches caseworkers and assists with the provision of referrals to required services.	Qualitative telephone interviews with a sample of 11 LA caseworkers who have received refugees both pre- and post-introduction of GMHAT (see Appendix C for the LA caseworker topic guide).
	The information reaches GPs and assists with the provision of referrals to required services.	Qualitative telephone interviews with a sample of 17 GPs who have received refugees, both pre- and post-introduction of GMHAT, to determine whether they received the GMHAT information, how they interpreted the results, and to what extent they felt it necessary to / were able to act upon results. See Appendix D for the GP topic guide and Appendix E for the amended GP feedback form.

4.2   Sampling approach and methodology

4.2.1   Refugee pilot participants

The pilot was undertaken between December 2016 and July 2017 at the IOM's Migration Health Assessment Center in Achrafieh, Beirut, Lebanon. This location was chosen because at the time of the pilot, IOM Beirut was receiving the largest number of medical referrals from the UK and also employed a psychiatrist who was able to provide training, supervision and oversight.

Syrian refugees aged 18 years or above[2] who were being resettled to the UK through the VPRS were eligible to take part in the pilot. Although there had been an original intention to randomise selection of participants, this component was removed following discussion with the IOM chief medical officer and regional officer in order to avoid any perception of discrimination among refugees receiving and not receiving the assessment. Instead, all eligible applicants attending the clinic for the MHA from the start date of the pilot were offered the GMHAT assessment on a voluntary basis. This was continued until the target of 200 participants was reached.

Overall, 284 individuals were approached to take part in the pilot. Of these, 200 agreed to participate, with an equal 50/50 split between men and women, which reflects the gender ratio across those aged 18 years and above who have been processed for resettlement in Lebanon and across all VPRS-processing countries. A total of 84 individuals declined to participate

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[2] The tool was piloted with adults over 18 only for ethical reasons.

(30% refusal rate), and women were slightly more likely to decline than men (32% vs. 28%). The refusal rate was higher among those aged 50 to 64 years (50%). The refusal rate could have introduced a selection bias due to certain demographics being more likely to refuse to participate.

Table 2 shows the age and gender breakdown of participants.

Table 2: Age and gender of refugee participants (n=200)

Age group	Gender		Total
	Female	Male	
18-24	21	9	30
25-34	44	35	79
35-49	31	49	80
50-64	4	7	11
Total	**100**	**100**	**200**

Information on all refugee participants was compared to a programme-level dataset capturing all individuals resettled through the VPRS. Refugee participant demographic characteristics were compared to those of individuals resettled from Lebanon and those resettled from across the MENA region (Jordan, Lebanon, Turkey, Egypt and Iraq).[3] Psychiatric referral rates in this pilot were calculated as an indicator of whether immediate mental health needs had been identified and urgent needs addressed.

In order to calculate the impact of the GMHAT on case flow, we calculated the average processing time from UNHCR referral date until an individual's arrival in the UK for GMHAT participants who had arrived as of 31 May 2018. This was compared to the average processing time for all non-participants referred by UNHCR during the same time period who were processed in Lebanon and those processed across the MENA region.[4]

Qualitative forms captured immediate feedback from all refugees following the GMHAT assessment (see Appendix B). These contained three questions:

1. Do you think this assessment covered all aspects of your mental health?
2. If not, what else do you think it should cover?
3. Was there any issue, topic or aspect of the tool that made you feel uncomfortable? If yes please describe or point to it?

While self-completion forms were considered as an alternative, these were deemed unviable due to variability in refugee literacy rates. Instead, the IOM healthcare practitioner who administered the GMHAT tool translated the above three questions from English to Arabic at

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[3] Based on unpublished programme management information, reflecting VPRS arrivals to the UK as of 31 May 2018.
[4] *Ibid*.

the end of the assessment and recorded the responses (translating them from Arabic to English). Limitations of this approach will be covered below.[5]

These responses were anonymised, collated, coded (as to whether they were positive or negative in sentiment) and a combination of content and thematic analysis was undertaken, including consideration of whether response patterns varied by gender, age, family size and whether the individual was referred for further support.

4.2.2   IOM healthcare practitioners

Five IOM healthcare professionals were involved in administering the GMHAT in Beirut, Lebanon including a psychiatrist (who oversaw the pilot, conducted the first 29 assessments, and received psychiatric referrals), general physician, paediatrician and two nurses. All were interviewed as part of the evaluation to explore their views on the training sessions for using the tool, their experience of administering the tool, its strengths, weaknesses, challenges, and any suggested improvements to the tool.

Practitioners had between two to five years of clinical experience, and most had been working with IOM for the past two years. There was a range of prior experience among participants from those with no prior experience of conducting mental health assessments, to having conducted mental health assessments as part of wider medical assessments, to those who had experience using similar screening tools.[6]

Five semi-structured telephone interviews lasting between 30 to 60 minutes were conducted by a Home Office researcher with the IOM healthcare practitioners based in Beirut shortly after the pilot concluded. The interview was guided by a semi-structured topic guide which can be found in Appendix A. These interviews were recorded with the participants' consent, transcribed and analysed thematically.

4.2.3   LA caseworkers and GPs

Eleven LA caseworkers and 17 GPs participated in the evaluation.

All LAs where GMHAT participants had been resettled were informed of the evaluation (37 caseworkers covering 46 LAs). Those who had worked with VPRS refugees were invited to participate, although preference was given to those who had seen or handled the GMHAT report. The characteristics of the final sample of 11 LA caseworkers were as follows:

- Participants came from England (9), Scotland (1) and Wales (1).

- Most were based in local councils (9), while 2 worked in charities.

- More worked in an urban (5) compared to a rural setting (3) or a mixture of both (3).

- Most (9) had received the GMHAT as part of the pre-departure paperwork (which formed part of the original sampling criteria); Table 3 outlines the level of sample engagement with the GMHAT.

- All LA caseworkers had prior experience working with asylum seekers and refugees.

    - The majority (6) had moderate to extensive experience, citing involvement in the

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[5]   Interviewing participants after their arrival to the UK was discounted due to the recall issues arising from the time lag between the assessment and their departure to the UK.

[6]   Including the WHO Mental Health Gap Action Programme (mhGAP).

VPRS, other resettlement programmes, such as the Gateway Protection Programme, and asylum dispersal, as well as volunteering experience.

– The caseworkers with more limited experience were generally newer to their role.

GPs were identified using snowball and convenience sampling and selected if they had experience in supporting VPRS refugees. As for LA caseworkers, preference was given to those who had seen or handled the GMHAT report. Snowball sampling was used to identify GP participants from within LA networks. Convenience sampling was also used to identify GPs with a special interest or expertise in refugee health. Where possible, GPs were interviewed by telephone but, to facilitate engagement, the topic guide (Appendix D) was adapted into a short feedback form (Appendix E) and GPs were given the option to fill the form instead of being interviewed.

Seventeen GPs engaged with the study and their characteristics were as follows:

- The majority were based in England (15), with the other two participants in Scotland and Northern Ireland (1 each).

- Very few (3) had an opportunity to engage with the GMHAT prior to the evaluation. Table 3 outlines the level of sample engagement with the GMHAT.

- Most (13) had worked with asylum seekers and/or refugees before. Some had held clinical roles in a health inclusion team, were trained in mental healthcare for torture victims or had been involved in volunteering work.

- Approximately 5 GPs worked (or had worked) for a service that specialised in care for vulnerable people, including refugees and asylum seekers; the remainder worked in GP practices (partnership or group practices) in a variety of settings.

- Five worked for a small practice (1 to 3 GPs), 3 worked for a medium practice (4 to 6 GPs) and 4 worked for a large practice (6+ GPs).[7]

- The majority (11) worked in an urban setting, 3 worked in a suburban setting and 2 worked in a rural/semi-rural setting.[8]

- Those who said they worked in a more ethnically diverse area generally described having greater access to services and resources to support the asylum seeker and refugee population.

Original inclusion criteria excluded LA caseworkers and GPs who had not seen or handled a GMHAT report. However, because of the low number of potential participants identified, inclusion criteria were changed during recruitment to include LA caseworkers and GPs who had not handled the GMHAT, but had experience in working with VPRS refugees. These participants instead reviewed a sample GMHAT report – see Appendix F.

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[7] The remaining five were either not working in a GP practice or did not respond.
[8] The remaining person did not respond.

Table 3: Sample engagement with GMHAT reports

No. of times engaged with a GMHAT report	LA caseworkers	GPs
0	2	14
1-3	6	3
4-6	1	0
7-10	1	0
No response	1	0
Total	**11**	**17**

LA caseworkers and GPs who met the selection criteria were invited to take part in a semi-structured telephone interview using a pre-developed topic guide (Appendices C and D). Eleven interviews were conducted overall with LA caseworkers by a PHE researcher. Where GPs were unavailable for interview, they were instead invited to complete a feedback form (Appendix E). Overall, responses were gathered from 17 GPs, including through 4 semi-structured telephone interviews, 11 written feedback forms and 3 informal email responses.[9]

Interviews were digitally recorded and records destroyed immediately after data entry and verification. Transcripts and feedback forms were anonymised at the time of write-up. A combination of thematic and content analysis was used to identify patterns, similarities and differences between strata and samples (LAs and GPs) before being contextualised by theme. Findings were further stratified using participant details, such as geographic area, experience level and type of organisation/practice, to identify additional patterns and trends. While fewer LA caseworkers were engaged than originally intended, and the research approach was adapted to boost the response from GPs, later responses raised similar themes to earlier responses. This suggested that the evaluation reached the point of thematic saturation.

4.2.4   Ethics and consent

Participation was voluntary. Verbal and written consent (including consent to record) was obtained from all interview participants prior to taking part in the interview but only written consent was obtained from GPs returning feedback forms. All participants were also provided with an information sheet (Appendix G) about the pilot and the evaluation prior to the interview and given the chance to ask questions.

Ethical approval was obtained from the PHE Research Ethics and Governance Group.

4.3   Limitations

The main limitations are outlined in Table 4.

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9   One GP provided both an informal email response and participated in a telephone interview.

Table 4: Study limitations

Evaluation element	Limitations
Quantitative analysis	The tool was not implemented at random and there was no control group. However, we did compare case processing times between pilot participants and non-participants in order to estimate the impact of introducing the GMHAT on case processing times against a counterfactual group who had not been assessed. The tool was not used in a systematic way (due to questions being skipped and each practitioner translating the questions independently), therefore its results cannot be relied upon as a robust prevalence estimate (as may have resulted in either under- or over-reporting of mental health issues). The tool was administered during the pre-departure stage of resettlement (where some participants may have had concerns about how their responses might affect their resettlement prospects despite reassurances). This may have resulted in under- or over-reporting of mental health issues. Additionally, the refusal rate could have introduced a selection bias due to certain demographics being more likely to refuse to participate. Refugees' understanding of the terminology used in the tool may in some cases be limited due to educational levels, language barriers and cultural differences surrounding narratives about mental illness.
Refugee feedback forms	The same healthcare practitioner administering the tool asked the feedback questions and recorded the responses – this may have resulted in social desirability bias, discouraging refugees from providing negative responses. Each health professional was responsible for translating the questions and recording responses – there may have been inconsistencies in the way that the information was elicited and subsequently captured.
LA caseworker interviews	Although only the LAs recorded as having received GMHAT pilot participants were contacted, many had not seen or received the GMHAT results. These LAs were excluded under original eligibility criteria (although these criteria were subsequently dropped in order to boost the response rate), which may have introduced selection bias towards LAs with superior information flow processes and arrangements in place. While engagement efforts were targeted equally across nations, there was a much higher response rate from English LAs resulting in a slight under-representation of devolved administrations (DAs) when compared to the proportion of VPRS refugees they have received.
GP feedback	As we had difficulty identifying GPs who had had contact with the GMHAT report, feedback on an example rather than a real-life report was sought instead. Some GPs commented on the basis of a sample report rather than based upon their practical experience using the tool, which could weaken the conclusions that we were able to draw from the pilot. There were a few discrepancies between the sample report (which was taken from the GMHAT training manual) and the piloted report (which was adapted by IOM). The sample report did not categorise PTSD and did not reflect two free-

Evaluation element	Limitations
	text sections (capturing background detail and clinical judgement),[10] resulting in the suggestion to add aspects of the form already included in the piloted version.
	We sought to engage equally across the DAs but had higher levels of engagement with English-based GPs – this was largely due to making use of PHE's prior networks with GPs (in England) with a known interest or expertise in refugee health in order to boost the response rate.

Evaluation element	Limitations

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[10]   IOM have noted that their clinical staff were actively encouraged to always fill out these sections, which often highlighted important information including psychosocial stressors, key traumatic events pre-and post-conflict, concerns about other family members' mental wellbeing, among others.

5   Findings

5.1   How does the GMHAT operate in situ as part of the pre-departure health assessment checks?

5.1.1   GMHAT training

The IOM healthcare professionals completed three days of training on the GMHAT in September 2016 (three months prior to the start of the first stage of the pilot). This was provided by two academic professors specialising in refugee mental health and the use of GMHAT. The training consisted of: background to mental health conditions, an introduction to the GMHAT, and role play on how to perform an assessment. Refresher training was held in March 2017, just prior to the second stage of the pilot which resumed in April 2017.

Most practitioners considered the training to be good, though two felt they would benefit from additional refresher training every six months. The training was considered easy and straightforward, and there was a clear understanding of the tool's aims to identify mental health conditions among patients and facilitate referral if needed.

All practitioners felt confident in using the tool either immediately following the training, or after assessing one or two cases with supervision. Two practitioners mentioned the benefit of having access to an Arabic speaking psychiatrist during the first week for any further support such as asking questions on how to adapt and approach some of the more sensitive questions in the tool, and how to translate some of the questions from English into Arabic.

5.1.2   Time and setting of the GMHAT

The GMHAT assessments were carried out in a private setting, whether in the GP's office or in the nurse's clinic on the same day as the Migration Health Assessment. The assessments were conducted one-to-one unless they were with women who had a child under the age of two. This was in line with recommendations within the literature of delivering mental health assessments in the same location as other medical facilities for this population: Hassan *et al*. (2015) suggests that many Syrians, especially men feel more comfortable attending a general medical facility rather than a specific psychiatric outpatients department, due to the stigma surrounding mental health and the belief that the causes of mental illness are physical.

All medical practitioners agreed they had enough time to complete the assessments. However, one practitioner suggested that there would not be sufficient time to perform the GMHAT on all refugees, and another reported that it would depend on the number of cases processed per day as, due to other responsibilities, they would be able to assess fewer cases per day if the GMHAT were to be incorporated into the standard assessment for all refugees.

While time was not a great impediment for practitioners, three highlighted that the length of the GMHAT was an issue for the patients. This was corroborated by findings among refugees who refused to take part in the pilot. Among these refugees, 43 out of 84 refusals explained that

they would rather return home early than take the assessment as it was not mandatory. Of the 84, 13% who declined to participate had initially signed the consent form and then changed their mind because it was getting late and they preferred to return home. It was suggested by the practitioners that some refugees lived far from Beirut and had great distances to travel to return home.

IOM reported that medical practitioners attempted to overcome the issue of time constraints by placing the GMHAT earlier in the patient's day. This succeeded in raising consent rates but was logistically hard to do. One suggestion by a healthcare practitioner was to reduce the length of the assessment to overcome the issue of time.

Asides from time constraints, other reasons for refugee refusal included: children crying (due to hunger or length of time in clinic), a perceived lack of any mental health issues, and an increased number of refusals were noted during Ramadan.

5.1.3   Obtaining consent from refugees

The nurses obtained initial consent from all refugees prior to conducting the assessment which included outlining:

- Participation in the GMHAT is not mandatory.

- The refugee can stop the assessment at any time.

- The assessment will take 20 minutes.

- It may be beneficial to the refugees in terms of referral and access to mental healthcare in Lebanon and the UK.

- The result will not affect travel to the UK.

Participants were asked to read the Arabic consent form (which summarised the above) and sign it.[11]

Some refugees refused to take part as their participation would not have any additional benefits on their resettlement. Medical practitioners reported that consent was not affected by family member participation in the pilot. For example, if a husband refused to participate, this did not appear to affect the wife's participation.

5.1.4   Adapting the tool to the context

Practitioners described several challenges involved in using the tool, including the need to adapt the questions to make them acceptable and relevant within the Syrian cultural context. For example, the question on libido was not considered to be culturally acceptable by some practitioners. Practitioners mentioned that many refugees had low educational levels and so direct translations of the terms were not understood by refugees, requiring adaptation and simplification. It was also noted that the use of idioms in questions may not necessarily translate – for example, the idea of 'mixed-up thoughts' included in the assessment question 'Do your thoughts get mixed (muddled)?' also translates to an Arabic idiom, but it does not have any connotations with psychosis in that context. 'Mania' was another term that caused confusion. Practitioners also described how they would adapt questions depending on how long the refugee had been displaced in Lebanon, as an individual who had been displaced for

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[11]   Only 1 out of 200 was illiterate and consented to be assessed upon verbal explanation of the full content of the forms.

longer may have normalised their psychosocial stressors more than someone who had newly arrived.

> *"When you first start the GMHAT the first questions say, 'How have you been recently?' This might refer to the last few month...the last year, but they have been displaced, they have suffered from war for 4 or 5 years or more...they will say, 'I'm good, I'm feeling fine', so there should be more questions about how they have been before war, did they have any conditions, how they used to live and how they are now living...before war and after war, before displacement and after displacement, what they have been through, casualty or loss, about their daily life."*
> (Healthcare Practitioner)

The tool was adapted by practitioners in varied ways, including rephrasing and simplifying questions. Only one practitioner skipped some questions entirely (such as those relating to libido and eating disorders) as they regarded them as uncomfortable or insensitive.

Most other practitioners reported rephrasing questions – including asking refugees to consider their responses in relation to how they were prior to displacement – and adding explanation to aid the refugees' comprehension, including adding examples to encourage more detailed responses.

Other adaptations included simplifying or combining questions (on mania) to make them easier for the refugees to understand. One practitioner reported deliberately avoiding, adding or amending questions as they did not want to turn the tool into a psychiatric evaluation.

Healthcare practitioners were also each responsible for translating from the English version of the tool into spoken Arabic, which added another layer of variation to how the tool was applied across pilot participants.[12] All clinicians who administered the tool were bilingual and appropriate translation of the different questions into Arabic was discussed during training and supervision with the consultant psychiatrist, who also observed the first assessments the clinicians carried out.

While the tool was adapted to tailor it to the participants' context, the variation in its use will have introduced bias which makes it difficult to make comparisons across the findings. The implications of these adaptations on the estimates of likely diagnoses of mental illness are discussed below.

5.1.5 Overall practitioner views

IOM healthcare practitioners were largely positive about the tool as they found it:

- easy to use to make rapid assessments covering a range of conditions;

- able to differentiate between those with psychosocial stressors versus those with medical issues (although it was also noted that the tool did not flag mild anxiety and depression, and there were some cases of individuals assessed with depression who in the practitioner's judgement actually had adjustment disorder);[13]

- adaptable to the context and individual;

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[12] Healthcare practitioners in Lebanon reported that they were more comfortable using the English version of the GMHAT as they were educated in English and French, and were trained using the English medical vocabulary.

[13] Note, however, that three individuals with clinical symptoms of a mental health condition were missed by the tool.

- acceptable to refugees;

- provided practitioners with an opportunity to learn about refugees' experiences;

- effective in reaching marginalised groups such as women.

However, they also identified several limitations affecting the current version of the tool.

Practitioners needed to adapt the questions to the context and individual, and were also required to translate from English to Arabic. There were some issues with the tool which the participants could not overcome through local adaptation, such as when conditions were not given sufficient attention. For example, one practitioner suggested there were not enough questions asked on stress, schizophrenia and psychosis. Moreover, even with these adaptations, the tool is still reliant on the refugees being open and willing to talk about their problems to make accurate assessments. The gender of the practitioner may have affected responses – two practitioners felt that this was an issue when male practitioners were assessing female patients.

All practitioners were prepared to administer the tool in the future, with one having already incorporated some of the questions in other assessments they were conducting. One practitioner thought the tool would need to be adapted first and re-validated before they would be prepared to administer it again.

All practitioners agreed that doctors would be best placed to administer the tool as they have better medical and patient knowledge, patients have greater trust in them, and their offices may offer greater privacy than healthcare workers administering the tool in a clinic. However, all but one practitioner felt that nurses and social workers could also administer the tool with training.

5.1.6   Suggested improvements

Practitioners suggested the following amendments to the tool and training in order to improve its relevance for their context:

- More support adapting the tool to the specific context of refugees (including tailoring the training video to the circumstances of their patients).

- Translating the tool from English to the local Arabic dialect.

- Include the following:

  – More practical elements within the GMHAT training (e.g. more role play and observing a psychiatrist perform an assessment using the tool).

  – Shorten the gap between training and implementation (all practitioners took part in the initial training but four out of five practitioners were involved only in the second stage of the pilot, meaning a six-month delay from initial training to implementation – although this was mitigated by the refresher training).

  – Increase the number of refresher training sessions (e.g. every six months).

- Most agreed that the displacement period should be considered within the questions by asking refugees how they felt prior to the conflict.

- Practitioners had different views on which questions to retain and remove, which included suggestions to:

- remove the question on libido vs. increase questions on sex;

- remove the question on eating disorders;

- remove the question on obsessive-compulsive disorder (OCD);

- increase the number of questions on stress-related disorders, including PTSD;

- increase the number of questions on personality disorders.

Note that including additional questions without removing an equivalent number will mean that the time required to administer the assessment is likely to increase.

- Allowing more time for practitioners to complete the assessment.

5.1.7 What mental health issues does the GMHAT identify in the population of concern?

The pilot evaluation provided a unique opportunity to understand the range of mental health issues identified as likely diagnoses among pilot participants. Note that the GMHAT is designed to assist the practitioner in assessing clinical symptoms. It is not designed for the purpose of estimating prevalence levels as in an epidemiological study.

Out of the 200 participants, 18 (9%) presented with likely diagnoses of mental health issues with an impact on functioning and significant subjective distress according to the GMHAT assessment. All were referred to the psychiatrist for further psychiatric evaluation and all were found to have a mental health condition.

Among pilot participants, the GMHAT flagged symptoms indicative of a range of mental health issues including anxiety, depression, PTSD, personality disorder, psychotic disorder and OCD. The most commonly identified issues were anxiety and depression.[14]

Two of the healthcare professionals responsible for administering the tool believed its accuracy could depend on whether the patient under or over emphasised their symptoms, which might be partly affected by time constraints.[15] In three instances, the GMHAT tool did not identify mental health issues but clinical judgement suggested additional support would be required.

It was also noted that while the tool was generally considered by the practitioners administering it to be accurate in detecting a mental health issue, it did not always correctly diagnose *which* mental health issue. For example, although some refugees were diagnosed by the tool as having depression, in one professional's judgement some in fact had adjustment disorder (though this was not a major concern as they require the same treatment). This is consistent with the tool's aim of providing a *preliminary assessment* of mental health for consideration by a healthcare professional alongside their own clinical judgement. It will be important to clearly communicate this purpose to stakeholders to manage expectations and ensure the information provided in the report is realistically interpreted.

The evaluation highlighted that the tool was deployed flexibly by healthcare practitioners (as outlined in section 5.1.4), who reported that they adapted the tool in several ways. While this flexibility in application was considered one of the tool's strengths, the unsystematic approach to using the tool (alongside an individual's willingness to disclose symptoms) may have resulted in

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[14] Note that these figures are based upon both main and other possible diagnoses identified using the GMHAT tool.
[15] Although not mentioned directly by healthcare professionals who were interviewed, the literature suggests that stigma and cultural-linguistic issues may have also contributed towards under or over emphasis of symptoms.

an under- or over-estimation of those identified as having a likely diagnosis of mental illness. However, practitioners involved in developing the GMHAT tool have emphasised that this flexibility is built into its design (which involves semi-structured questions) and the training (which encourages the assessor to adapt the questions to the situation). As a clinical assessment tool, the GMHAT's aim is to assist the practitioner in assessing clinical symptoms with the ultimate aim of protecting the individual and linking them to appropriate care.

5.1.8 Does the GMHAT facilitate the identification of immediate mental health needs of refugees requiring urgent pre-departure attention?

All of the participants who were assessed reported a high level of psychosocial stressors including poor housing, difficulty paying rent, difficulty accessing child healthcare, cost of schooling, unemployment, bullying and harassment, family separation, discrimination and insecurity due to the perceived risk of being arrested by the Lebanese police. However, the majority of participants assessed were currently able to manage their daily functioning and cope with distress.

Out of the 200 participants, 18 (9%) presented with mental health issues with an impact on functioning and significant subjective distress according to the GMHAT assessment. All were referred to the psychiatrist for further psychiatric evaluation/management and were found to have a mental health condition. None of the participants had suicidal thoughts nor reported prior attempts.

A further three participants assessed by the healthcare practitioner administering the tool presented with some anxiety or depressive symptoms and were referred to the psychiatrist, despite these symptoms not having been flagged by the GMHAT report.

These findings highlight the importance of the tool not being relied upon in isolation and being administered by a trained healthcare professional who can use their professional expertise to pick up on any missed diagnoses. It is also important to note that some mental health issues may not emerge until after an individual's arrival to the UK, highlighting the importance of continued follow-up post arrival.

5.1.9 How appropriate is use of the tool for the population of concern?

At the end of the GMHAT assessment, pilot participants were asked three questions by the healthcare practitioners administering the tool to gather their views on whether the GMHAT covered all aspects of their mental health, what else they would add, and whether there were any parts which made them feel uncomfortable.

Nine refugee participants (5%) reported that the tool did not cover all aspects of their mental health; however, the majority (94%) agreed that the tool covered all aspects of their mental health. Though many did not elaborate on their response, 11 refugees expressed that it was good to talk about their problems. For some, this was the first time they had ever been asked about their mental health or had the opportunity to speak to a professional for this purpose.

Of the 94%, 13 (7%) had suggestions for additional areas that it could cover. Nine refugees suggested that the tool should focus more on the daily stresses they are experiencing in Lebanon and this was reported by both genders. The other main area that a small number of participants felt was not addressed by the tool was counselling for life in the UK, mentioned by

eight participants (including two of those who asked for a greater focus on daily stresses).[16] Three participants also expressed a desire for counselling on their relationship problems. Some of the male participants also listed anxiety towards family members left behind and sexual issues.

A similarly high percentage (95%) reported that they were comfortable with the questions asked by the tool. Some refugees mentioned that they would have liked the assessment to last longer as they enjoyed the experience.

Of the 200 people interviewed, ten reported discomfort with some of the questions. Reasons for discomfort included that some of the questions brought back painful memories, as well as cultural differences on questions related to drugs, alcohol and suicide. For some participants, the question on hallucinations was associated with stigmatised perceptions of being 'crazy', and one participant feared that the results of the tool would be shared with her husband. While efforts are made to protect patient confidentiality, information security was a risk that was identified during the course of the pilot. In particular, a risk emerged around the practice of providing refugees with a copy of their IOM medical records on the departure day, as each case is provided with an IOM bag containing all members' medical documentation. There is therefore a risk that an individual's medical documentation (including this mental health assessment) will be accessible to other members of their family.

Some of this discomfort may be due to cultural stigma surrounding mental ill health. Within the Syrian context, researchers have found that while the thoughts and feelings attached to conditions such as anxiety, depression and PTSD are acknowledged and recognised as an aspect of life, labelling them as psychiatric disorders with the connotation of 'madness' can be widely perceived as negative (Hassan *et al.*, 2015).

Overall, refugees gave positive feedback on the tool. This echoed healthcare practitioners' views on how the tool was received by pilot participants, reporting that they were largely positive towards and comfortable with the tool, and for some it had a therapeutic use as it became an outlet for their grief. However, two practitioners suggested some refugees were dissatisfied with the experience as they felt the tool was stigmatising, it reminded them of distress in their past and some of the questions were culturally insensitive (such as the question on alcohol usage). One patient became upset when the tool identified a condition which she did not believe that she had.

There are a number of limitations in the way in which this information was gathered (outlined in full above). In particular, the fact that these questions were asked by the same healthcare professional administering the tool and that the feedback was collected during the pre-departure stage of resettlement, may have both contributed to a bias towards more positive responses as participants may have (mistakenly) feared any negative responses might jeopardise their resettlement process.

5.2   What is the impact of introducing the GMHAT on case flow?

During the pilot period, IOM Beirut conducted 648 VPRS medicals (including 200 GMHAT participants and 448 non-GMHAT participants), with an approximate average of 11 medicals conducted per working day. IOM did not observe any slow down to case flow and the number

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[16]   Note that at the time of the GMHAT assessment, participants had not yet been invited to attend the two-day pre-departure cultural orientation sessions (sometimes referred to as 'counselling') that is offered to all refugees aged above 14 years who are accepted for resettlement to the UK.

of medicals completed due to the introduction of GMHAT. It is worth noting that the number of participants in the pilot was overall relatively small. However, additional resources would be needed if the pilot was to be rolled out for all VPRS and VCRS (Vulnerable Children's Resettlement Scheme) cases.

The average time from UNHCR referral to arrival in the UK was 7.7 months for GMHAT participants who had arrived in the UK at the time that the evaluation concluded (164 individuals). This is higher than the average case processing time for non-participant cases referred by UNHCR during the same time period from both Lebanon (5.5 months) and for VPRS-processing countries as a whole (6.2 months).

Whether the GMHAT was the cause of this delay, however, remains unknown as pilot participants were not randomly selected and so the influence of other factors not captured as part of this evaluation cannot be assessed. HO is not aware of any reason why participation in the GMHAT pilot would have had an impact on the length of time for resettlement.

5.3   How useful is the GMHAT for LA caseworker referrals and GP health assessments?

5.3.1   What are the existing arrangements for mental health screenings in the UK?

Most LAs reported that they do not conduct mental health screenings but take preparatory steps to prepare for each arrival and facilitate GP referrals and consultations. These steps included reviewing the UNHCR case files and IOM MHAs in advance of arrival to flag anything requiring immediate medical action and making a 'quick assessment' of mental and physical health on arrival. A more remotely situated LA described how they had developed their own initial needs assessment form to help pinpoint issues needing a referral shortly after arrival:

> *"Within a few days of arrival the refugees get a full GP and nurse assessment, and mental health and wellbeing are discussed or introduced during these assessments."* (Caseworker, Scotland)

Arrangements for initial consultations varied between LAs. Some LAs commission Inclusion Health Teams to conduct the initial health assessment while others are linked to local GP practices.[17] All LA respondents said that the refugees they had supported received an initial consultation with either a GP or nurse.

Onward referral to secondary or specialist care is done by the GP. However, some LAs described well-established links with local organisations to support adult and child mental health and wellbeing which they could refer to directly without a GP.

There was a wide range of mental health screening arrangements across the sample of GPs, which depended on where a refugee is placed and to which healthcare professional they were assigned.

All five GPs from specialist services said they had existing mental health screening for refugees in place, which was more comprehensive and longer in duration (30 to 60 minutes)

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[17]   Some services and local areas have established an Inclusion Health agenda which provides a framework for driving improvements in health outcomes for socially excluded groups. HM Government supports delivery of the Inclusion Health agenda through the National Inclusion Health Board.

than that offered to a non-refugee patient. This 'enhanced check' was done by a GP or nurse and would include an assessment of psychological health/history through verbal questioning and discussion. A few GPs mentioned that they would also use a simple screening tool to guide a discussion about sleeping, eating, mood, social contact and daily functional living. Some GPs mentioned that they reviewed the UNHCR/IOM medical records with their patients as part of the assessment.

Among the other GP practices, existing mental health screening was comparably simpler and the initial assessment could be done by a healthcare assistant (HCA), a nurse or GP. These practices were more likely to report using a screening tool such as a PHQ-9, or to have no specific screening measures in place. One GP described their practice's approach to detecting mental health issues as *"very passive"*, while another mentioned that, as a practice, they are *"very alert to mental health problems in asylum seekers and refugees"*, suggesting that approaches and expertise varies widely by practice, locality, and even by individual healthcare professionals.

> *"The onus is on the person to declare it, I would say, rather than the person really hunting."* (GP, England)

This variation in mental health screening practices and the reliance (in some practices) on the individual being willing and/or able to articulate their mental health needs may not work well in practice for groups (such as Syrian refugees) where there is cultural stigma associated with acknowledging a mental health issue or a lack of awareness of mental illness.

5.3.2 Does GMHAT information reach caseworkers and/or GPs?

From an IOM perspective, the information sharing between IOM and HO worked well and no issues in the sharing of GMHAT reports and MHAs between IOM and HO were observed; however, LA caseworker and GP responses highlighted significant operational issues with the information flow process.

LA caseworkers

Of 37 LA caseworkers who were initially engaged (out of a list of LAs who had received participants in the GMHAT pilot), ten reported that they had seen or handled the GMHAT report, nine of whom were interviewed. A large number (16 out of 26) who were invited to participate reported that they had heard about the pilot from the Home Office and were willing to engage but had not received any GMHAT reports and were therefore excluded from the evaluation under the original eligibility criteria. Due to the challenge of finding eligible caseworkers, two more were recruited and interviewed who had not previously seen a GMHAT report (instead reviewing a sample report).

Of respondents who had seen a GMHAT report, most had received it six to eight weeks in advance of the refugee's arrival, along with the UNHCR case file and MHA. This timing was considered helpful, as it allowed the GMHAT report to be reviewed in tandem with the case file and could function as an 'early warning' to help the LA prepare for individuals needing additional support on arrival.

One caseworker in Scotland said that they received the GMHAT report separately from the MHA, around two weeks prior to arrival and after the LA had made the decision to accept the family. This was less favourable timing, as the GMHAT report could not be used to inform the acceptance decision based on whether the LA could support those needs. This suggests that it

will be important to ensure the GMHAT and MHA reports are always combined together in one file and transmitted at the same time to the LA, to support their decision-making process.

A number of respondents commented on the fact that the GMHAT report they received was uploaded as part of a separate file containing the medical declaration and consent forms (a 30-page document), rather than as part of the MHA, which made it easy to miss. This may also explain why so few of the LAs contacted had seen the report. A couple of respondents suggested the GMHAT could be made more visible by being flagged on the UNHCR documentation or the front cover of the MHA, as part of a summary or contents page.

> *"The GMHAT was not provided as a separate report but instead tagged onto the end of the normal medical document... you may not be aware you had been sent it unless you scrolled all the way down to the bottom. So there'd be the potential to miss if you were in a bit of a rush."* (Caseworker, England)

GPs

Only 3 out of 17 (18%) GPs reported having come into contact with the GMHAT report prior to being interviewed. In order to address this, a sample report (see Appendix F) was shared with all in advance of the interview / completing the feedback form.

This may reflect variation in pre-established information flow processes to GPs. More GPs had come into contact with the UNHCR documentation; however, the nature of contact varied widely. For example, one GP reported they always received hard copies of the UNHCR documentation, which would form the initial part of the patient's computer record (this clinic had a special arrangement with the VPRS, which could explain the smooth information flow process). Another GP said they rarely received the UNHCR documentation unless the patient brought it in themselves, and they did not have an arrangement with the LA to facilitate the transfer of documents. This highlights a potentially wider issue around the information flow of medical documentation more broadly to health professionals.

Of the three GPs who had engaged with the GMHAT, two had received the report when the patient was registered with their practice. The other had viewed the report during a Client Needs Assessment Test (CNAT) at a local charity, separate from their GP practice.

5.3.3   Where it reached them, do stakeholders find the information useful?

LA caseworkers and GPs were asked a series of questions around how useful they found the tool. This included consideration of how well they understood the report, how they used it in practice, the value of the tool, perceived impacts of introducing the tool, and any suggestions for how it could be improved. The majority of LA caseworkers (9 out of 11) had seen at least one participant's GMHAT report; however, this applied to only 3 out of the 17 GPs, meaning that the majority therefore responded hypothetically.

Understanding the report

In general, the 11 LA respondents felt the report was relatively clear, well summarised and easy to understand. Many noted that this was because the reports they received indicated low needs and did not require much further interpretation or follow-up action. Confidence in using and understanding the information tended to be associated with level of previous experience working with refugees. More experienced caseworkers tended to like the report's brevity, while

those who were less experienced felt overwhelmed – one commented that the amount of information *"provided in one go"* could be *"quite daunting to look at"*.

Opinion among the 17 GPs, however, was more split. They were more likely to find it confusing or unclear and highlighted that, in its current form, the GMHAT report was impractical for a busy GP. They suggested that a shortened and simplified report (that worked 'at a glance') would be more appropriate for their needs.

> *"I thought it was complex...despite the fact that I'm very experienced...So I think it needs to be simpler...and this sense of handing over, and quickly communicating severity and complexity."* (GP, England)

LA caseworkers and GPs who we spoke to identified a range of potential barriers to understanding the information contained within the report. Table 5 summarises the main barriers.

Table 5: Summary of potential barriers

Topic	Barrier
Language and terminology	The use of outdated terminology e.g. hyperchondriasis would usually now be referred to as health anxiety. Muddling symptoms and diagnoses, making interpretation more difficult: *"It says symptoms, but some of them are diagnoses… concentration is a symptom and memory's a symptom, but depression is a diagnosis. So that's a little bit confusing… the score seems to be a combination of diagnoses and symptoms, so it makes it difficult for a clinician to interpret."* (GP, England)
Layout	The current report layout presents the findings cumulatively, with the diagnosis featured last. *"It's a very long form and the information that you want the professionals to look at is right at the end, rather than at the beginning. I think having the results first would be more what the practitioners would want to see and a better way of organising it."* (Caseworker, England) *"You just want the most important stuff to stand out... Imagine you've got three seconds to look at a document. You need something in it somewhere that just catches your eye…"* (GP, England) Both groups commented that the formatting could be improved, through the use of larger text boxes, more spacing between objects and bolded text, to highlight and draw attention to the most important information.
Level of detail	Some GPs suggested that the report could be simplified and made more appropriate for their clinical needs by focusing on the conditions that tend to be most prevalent in the refugee population, i.e. depression, anxiety and PTSD. There were a few areas where GPs highlighted that the report could be more detailed, particularly around symptoms of PTSD: *"There is no specific mention of traumatic stress. In my experience this is very common in the asylum seeker and refugee population and not well recognised in general practice in any group...many of the primary care mental health services are not able to respond to traumatic stress and the particular symptomatology can affect a person's ability to take advantage of the services*

Topic	Barrier
	and systems that others can." (GP, England)
	This is partly due to the reliance on the sample report which did not mention PTSD (in contrast to some of the actual participant reports); however, IOM health practitioners also suggested that more attention could be paid to symptoms of PTSD in the piloted tool.
	One GP also recommended that the report should look at *"resilience and protective factors as well as risk factors"*, taking a more holistic view of the individual's mental health.
	"It is useful to have a picture of their mental health before arrival, but if more information was provided, for instance about a certain environment that triggers behaviour, then this information might be used to inform the local authority's resettlement work." (Caseworker, England)
Symptom ratings	The concept of the symptom rating itself was felt to be useful; however, both GPs and LA caseworkers unanimously highlighted the absence of a key to explain scores, making interpretation difficult.
	A lack of detail about positive-rated symptoms; for example, drug misuse was a 'yes/no' response without any indication of the severity of the issue.
	'Personality issues' was not felt to be precise or clear enough.
	Certain measures of symptoms were felt to be inappropriate for quantifying severity or risk. For example, alcohol is scored as a 'yes/no' answer, whereas GPs felt the level of consumption would be more meaningful.
	The risk assessment was lacking in detail:
	"Just writing ''risk assessment' doesn't really tell you…risk of what? Is it a risk of self-harm? Risk to others? Risk of neglect? Risk of abuse? It's very, very unclear." (GP, England)
	One caseworker also commented that discrepancies between the symptom ratings and the psychological history provided in the MHA led to confusion:
	"The GMHAT gives a low score, but their history of abuse or torture would suggest they have a bigger mental health need than is described." (Caseworker, England).
	This may reflect when and how the GMHAT and MHA were conducted, and highlights the advantage of integrating a mental health assessment tool within the psychological assessment of the MHA in future.
Information to add to report	Both LA caseworkers and GPs suggested that adding a narrative element to the report would be helpful. Some LA respondents questioned whether the quantitative scoring system risked being too reductive in providing a picture of mental health, whereas narrative accounts and observations could convey lived experience more powerfully, and be more appropriate for caseworkers' needs.
	Many GPs agreed that a narrative or observational summary from the GMHAT practitioner would aid their understanding, given the complexity of diagnosing mental health conditions. One GP felt the report should function as a clear and concise handover between professionals to minimise additional work and potential re-traumatisation of the patient:
	"Something that's...a very clear handover to the next practitioner about, 'this person's been through this, this is their story, they're struggling, they've been

Topic	Barrier
	tortured…' ...something that makes it really accessible to the person that's reading it. I think that would transform it into something that would be really useful." (GP, England) *"People don't come in and say 'hey, I've been tortured' […] it would take two hours of meeting with them before they told me about it. So, if somebody already knows […] what they've been through, passing it on to the next person who can then say... 'I understand that you've been imprisoned and tortured...that must be very difficult…' it starts you off on the front foot and engages really quickly."* (GP, England) It was also suggested that current medications should be listed on the report, and a space to name a caretaker, supporter or mental health advocate (if applicable) to promote their welfare in the UK.
Supplementary information	Many LA respondents desired additional information regarding how the GMHAT was conducted and how the reports should be used (e.g. practical guidance on caring for somebody identified with complex needs). Guidance notes for GPs and LA providing this information were developed as part of the pilot study, but the findings of this evaluation suggest that these documents are not being widely shared and/or read. A couple of respondents said that they would like to have more information about the way in which the assessment was conducted, including how trust and rapport were established. They felt it was important to know what participants had understood about the purpose of the assessment: *"I'd want more clarity around when the assessment took place as it is likely to affect the way they answered the questions, if they thought it would affect their application or resettlement process. There's no information about what the doctor has told them about the process before it starts or consideration about how the timing of the assessment may influence their responses."* (Caseworker, England) A couple of GPs mentioned that it would be useful to understand how the scores compared to other commonly used tools (e.g. PHQ-9 and GAD-7), given the GMHAT's unfamiliarity: *"I think the format is something we wouldn't be used to looking at in general practice... We wouldn't know what it was out of and what it meant."* (GP, England) One GP also suggested that the report could include links to resources and further information, such as PHE's Migrant Health Guide (Public Health England, 2014), to support GPs with less expertise in refugee care.

How did they use it in practice?

A majority of the 11 LA respondents who had downloaded the GMHAT reports had passed them onto the GP directly, or to the relevant health contact, such as their Clinical Commissioning Group (CCG) lead. Most respondents reported having an existing arrangement in place to do this; however, feedback from GPs suggested that this information did not always reach GPs across the different areas where pilot participants were placed.

LA caseworkers explained that as their role was non-medical, further action was minimal and it was the role of the GP to follow up. Most also stated that the reports they had seen showed

low needs and further action was not required, but they might consult other colleagues, such as adult social care, if appropriate.

A few caseworkers said their action had been limited due to uncertainty about the process and data sharing permissions. They said that they would want more information about how the data should be used and who it could be shared with, particularly if the intention was to facilitate referrals or put provisions in place before arrival.

> *"It probably needs to be clearer what the intention is for LAs in terms of receiving information…. It needs to be made clear that the information is allowed to be released to social care and not just GPs."* (Caseworker, England)

> *"The tool hasn't necessarily prompted me to take action as there is not much information on what to do with this information so you can put provisions in place from the outset and refer [onwards for care]. […] If the Home Office do want the tool to be used to facilitate [referrals], I'm not sure that is happening."* (Caseworker, England)

Some also mentioned that they felt unable to trust or rely on the information provided in the report because they had received inaccurate MHAs in the past.

> *"What we've often found is that the information [in the MHA] is not always accurate so we have learnt that it is worth waiting until the clients [refugees] have arrived before doing a thorough assessment."* (Caseworker, Scotland)

> *"My use of the GMHAT in informing my decisions [around housing provisions, etc] has been limited because I'm not sure how much I can trust the minimal information provided in the report – it is a brief snapshot with only limited description of any previous trauma…there is not much information about what the refugees get told when they undergo the GMHAT, like whether they are told that it will be beneficial to them and help them get the right support when they are resettled, or whether they perceive it as just another test that they have to pass so that they get accepted."* (Caseworker, England)

Most of the 17 GPs had not received a copy of a real-life GMHAT report and were therefore unable to comment on how they had used it in practice. Among the three GPs who had engaged with the GMHAT report, one did not comment, one said that no action was required and one said that the report had been *"Scanned on and viewed by GP"*, and would have been reviewed during the new patient check with the GP.

Value of the tool

Pre-departure timing of the assessment

All LA caseworkers and most GPs agreed that the pre-departure timing of the assessment was appropriate as it could help identify significant, pre-existing mental health needs in advance, which might require medical attention and could help with LA preparations. However, it was recognised that some mental health conditions may not present until later and some may not be picked up by the GMHAT tool, therefore follow-up assessments after arrival were recommended.

> *"You must recognise that for many or most people, mental health issues do not present until about six months after arrival. Therefore, the GMHAT is likely to reflect*

a low level of need at the time, apart from the few who have pre-existing acute mental health needs. So it is important to still identify and address mental health needs as they present post-arrival." (Caseworker, England)

"The report helped me to recognise that there were not likely to be any major issues with the individual on arrival due to relatively low symptom ratings…however, mental health conditions may not present until later on, once they have settled down in the community, so the GMHAT provides an initial snapshot but we continue to monitor them over time as well...We routinely monitor individuals over time for any mental health conditions such as PTSD or difficulties integrating, as these may present later on, well after arrival. We speak to the other services which we have linked the refugees with, e.g. ESOL [English for speakers of other languages], the advice centre...and community groups so that if any issues flare up, like a change in their attitude or behaviour, we are aware and able to look into this further."
(Caseworker, Scotland)

GPs recommended follow ups at a number of points: on arrival if conditions had been identified pre-departure; within the first 1 to 2 months, and at 6 to 12 months post-arrival. Longer-term monitoring was also suggested (e.g. five years after arrival), recognising the changes in mental health that can take place over time.

A few GPs said they felt the timing of the assessment was not as important as recognising and addressing how the different stages of migration (in their home country, on their journey and in the destination country) may impact on a refugee's mental health and their readiness to speak about personal and emotional experiences. This echoed a point raised by IOM practitioners about the need to consider the displacement period as part of the assessment. Recording the timing of the assessment, as a reference point, was felt to be more important than the timing itself.

"There's lots of evidence that... people's mental health changes massively...in their home country, on their journey and then once they've settled. And there's this theory that we should address health in those three separate [periods]….so pre-migration, during the migration, and then post. And that potentially the things that are bothering them before they're settled, can sometimes completely disappear off the earth's face, for example. So I think actually, the timing, I don't know whether it's that important. As long as it's documented when it was." (GP, England)

Providing an initial snapshot

Both LA respondents and GPs considered the information in the report to be very valuable in providing an 'initial snapshot' of an individual's health and wellbeing on arrival, and informing their actions.

"…the fact that it was there for me to read was helpful - it gave an idea of questions I might need to ask, for instance if it highlighted any health problems or previous problems, and that helped facilitate referrals and signposting." (Caseworker, Wales)

LA respondents said the report could help them to determine whether they were equipped to accept and support an individual's needs, and prepare for their arrival. This was felt to be particularly important in rural or remote areas where services are more limited or difficult to access.

The feedback suggests that it would be beneficial to receive the GMHAT report together with the UNHCR paperwork, to give a richer overall picture of an individual case.

> *"It is quite good, but it does not give much narrative. It would be more useful to read together with the narrative – family history, experiences, special needs, you know, provided in the refugee resettlement form and in the UNHCR documentation. Combined gives a good picture."* (Caseworker, England)

LA respondents also highlighted the report's potential to overcome initial communication barriers and expedite referral to secondary care.

> *"It gives me a platform to work with mental health services that we can offer them, it gives them an idea of maybe things that have been diagnosed in the past…you know, there's a language barrier so, you know, if they can't voice what their conditions were in the past but we've got it on paper ready to go, it's going to make things quicker, they're going to be seen quicker, they're going to be treated quicker."* (Caseworker, Wales)

Although most of the GPs had not used the GMHAT in practice, many said they felt it would be valuable to receive clinical information about a new refugee patient on arrival, noting the usually limited sources of information. Most saw the report as a 'starting point', which could help to guide an initial consultation and prompt a discussion about mental health and wellbeing.

> *"Generally speaking when they first come in, they're quite nervous, a lot goes through the interpreter, so it is all incredibly valuable information and it forms a very, very important part of their assessment."* (GP, England)

While most GPs were able to describe an existing procedure for evaluating a patient's mental health, and felt comfortable relying on their experience and existing tools, one added that they felt *"Certainly [the] GMHAT tool would increase awareness of mental health issues."* One GP said they felt it would probably make them more likely to discuss mental health issues or invite a patient in for a discussion. Another said they could see how such a tool could be of particular use to a GP with less experience working with refugee patients.

> *"It is helpful in that it addresses the issue and can then lead to a discussion based on the information provided."* (GP, England)

> *"I'm not sure that I would behave much differently, but I can definitely see that if you're not used to this kind of work, then it would be really helpful."* (GP, England)

Flagging vulnerable patients

GPs also highlighted how the tool could be used to flag vulnerable patients who needed to be prioritised for care. While this would mostly benefit those with significant, complex needs, GPs said it could also help detect those with lower grade needs, who might otherwise be missed or overlooked in a routine appointment.[18]

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[18] However, feedback from IOM practitioners suggested that in practice this was not always the case, with one commenting that the tool did not always pick up on mild anxiety or depression.

"It would be useful for flagging up people who are vulnerable because they've got complex needs...traumatic stress and depression often go together and once you've got both of those operating you're not functioning very well…" (GP, England)

"This is probably going to be more useful for those low grade things that might get missed in, say patients that come and go and see their GP as routine […], it's people who might not really realise that they are feeling low, or depressed or anxious, who might not realise they're drinking too much…" (GP, England)

Useful monitoring and reference tool

The tool's focus on mental health was seen as positive. Its clinical validation and delivery by a mental health professional were considered additional bonuses according to GPs.

"It is great that their mental health is being proactively attended to." (GP, England)

LA respondents said that the GMHAT was complementary to measures they already had in place and could be used as a reference document to monitor how an individual was coping and integrating. One caseworker mentioned how they felt the tool could have longer-term applications and be used to monitor an individual's progress over time from baseline, and to inform needs assessments.

"We are currently conducting needs assessments with the families around health and wellbeing and mental health issues, so the tool would be really great for this and for the assessors to use… if it is possible to replicate the test from time to time to monitor the progress of certain individuals from baseline." (Caseworker, England)

Potential benefits and risks

LA caseworkers and GPs identified a number of potential benefits offered by the GMHAT.

Facilitating provision of timely and informed care

Refugees may experience better and more appropriate access to care as a result of being matched to a LA that can better support their needs (provided the MHA is received far enough in advance to be reviewed with the case file).

The tool could increase awareness of mental health issues among this population, particularly among those GPs less experienced in refugee health; for example, it could assist GPs who are less experienced in working with refugees or with trauma patients to start a dialogue around their mental health and put support in place.

As the report provides valuable information which is usually either not available on arrival, or takes time and trust to elicit from a patient, the GMHAT may help a GP to save time and take appropriate action more proactively, for instance around safeguarding. This has the potential to expedite referral and provision of care.

Support integration into society by proactively addressing mental health needs

The GMHAT could help refugees integrate more quickly into society by starting a dialogue about their mental health and addressing issues that are affecting their wellbeing. Many GPs commented that it was positive that refugees' mental health was being proactively attended to.

Informed commissioning of specialist mental health services

In the longer term, LA caseworkers who had voiced concerns around resource availability suggested that a tool like the GMHAT could generate evidence to inform commissioning of specialist mental health services by CCGs and funding bodies:

> *"It could be used to provide evidence to support the case for commissioning these bespoke services, particularly when the funding from the Home Office stops. […] There are many people who would benefit from trauma-related interventions but as the services are so limited, many do not meet the threshold to be eligible for these services (currently provided by Freedom from Torture)."* (Caseworker, England)

This was weighed against the reality that the shortage in mental health services is not limited to refugees but also felt by the wider population:

> *"There is already a huge need across the country for all groups/everybody, not just asylum seekers and refugees, so it may just be added to a big pile."* (Caseworker, Scotland)

LA caseworkers and GPs also identified the following potential risks involved in introducing the GMHAT.

Risk of raising expectations

A few GPs raised concerns with the 'tone of language' used in some past MHA reports which risked raising patient expectations, and raised this as a potential risk that could affect future GMHAT reports. In their experience, past MHAs had sometimes prescribed specific courses of action without recognition that health systems may differ between the processing and receiving countries. For example, one GP had a patient who was told pre-departure that he needed a liver transplant as soon as he arrived; in the UK, they performed more tests and found he needed a different form of treatment rather than a liver transplant:

> *"We had a huge difficulty then in altering people's expectations... and it damaged relationships and trust enormously for somebody over there to say what should happen".* (GP, England)

No or inappropriate referral due to lack of services

A number of the LA caseworkers and GPs felt that the tool's impact, at least in the short term, was likely to be limited by resource availability and access to specialist mental health services. They explained that general mental health services such as social care, Improving Access to Psychological Therapies (IAPT) and Child and Adolescent Mental Health Services (CAMHS) are often not appropriate for the specific mental health needs of refugees who have fled conflict or experienced violence, torture or trauma.

> *"The tool may identify issues which we do not have the services in place to refer to."* (Caseworker, England)

> *"The local mental health services are limited generally but particularly for the specific needs that many of the refugees may be experiencing."* (Caseworker, England)

Given the already limited access to mental health services for the general population, a tool that identifies a need for follow-up and referral may have a limited impact on a refugee's ability

to access those services, and a potentially negative impact on their overall wellbeing in the long-term.[19]

> *"We find it very difficult to get help for our traumatised patients. Our mental health services are over-stretched and CBT [cognitive behavioural therapy] suitable for PTSD is difficult to come by. Also they have to feel secure enough to engage in the process."* (GP, England, suburban setting)

Risk of re-traumatisation

A few concerns were raised around possible re-traumatisation as a result of the tool. This included pre-departure, if the GMHAT assessment was poorly executed; or in the UK, where referral to an inappropriate mental health service could be detrimental to the patient's wellbeing and condition.

> *"From my service people might wait for quite a while to see an IAPT practitioner, who was not able to work with traumatised people, often adding to the individuals' sense of alienation and burden of trauma."* (GP, England)

A patient's mental health condition could also be compounded if the GMHAT paperwork did not reach the UK practitioner, and the refugee was required to undergo another in-depth assessment on arrival.

> *"If the person has to tell their story again they get disengaged, they get freaked out, it's too difficult, they don't want to go, to come here and have to tell their story to all these different people."* (GP, England)

Risks hindering integration into society if diagnosis is stigmatising

If the tool were found to over-medicalise distress, this could be at a detriment to the refugee's wellbeing and social integration in the long-term.

> *"One thing I have learned is not to over-medicalise distress. This can increase a feeling of helplessness in a group of people who tend to be very resilient and resourceful, and who are disempowered at every turn through the asylum process. Bereavement, grief, cultural loss, adjustment are all natural processes that need time to unfold, security and support. Over-medicalisation can also lead to labels that may disadvantage people when trying to integrate/get jobs etc in the future."* (GP, England)

Suggested improvements

Suggestions for how the tool could be improved to make it more user-friendly and relevant for caseworkers' and GPs' needs are outlined in Table 6.

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[19] This echoes the point raised by the study by Martin *et al.* (2016) comparing different mental health screening tools; they highlighted that the effectiveness of screening depends on provision of appropriate follow-up of individuals with elevated scores.

Table 6: Suggested improvements to the GMHAT

Topic	Suggestions for improvement
Language and terminology	• Avoid using jargon and complex terminology. • Revise classifications of symptoms and diagnoses where they are currently misleading.
Tone	• Ensure report functions as a 'clear and concise handover' between professionals. • Ensure practitioners acknowledge potential differences in health systems and referral mechanisms when providing recommendations for further care. GPs suggested that it would be more helpful for the report to flag up the symptoms and needs as part of the narrative summary.
Layout	• Use text formatting (e.g. larger or bold font; text boxes and tables) and layout (e.g. present information in order of importance with main diagnosis and medication first) to highlight the most important information. • Flag diagnoses, vulnerabilities and essential information on the front cover of the MHA, where they would be more likely to catch the attention of a GP or HCA reviewing the paperwork. This would be particularly important where non-clinical staff are tasked with this work, common in some GP practices.
Level of detail	• Simplify the tool to focus on conditions most relevant to the population, e.g. anxiety, depression and PTSD. • For PTSD, report risk factors and possible symptoms (e.g. nightmares, difficulty sleeping, phobias, flashbacks) along with a narrative description. • Consider removing symptoms that are less relevant to the population, e.g. obsession, eating disorder,[20] hyperchondriasis. • Look at resilience and protective factors as well as risk factors.

Symptom ratings	• Provide parameters or a key for symptom ratings and consider using simple visual aids, such as traffic light guidance, to illustrate the scale or severity of the condition.
	• Provide more detail about positive-rated symptoms (e.g. if drug misuse, list the names of drugs).
	• Add a symptom rating for risk of PTSD.
	• Revise sections on:
	  – 'personality issues': more appropriate to term 'personality disorder' and score as yes/no;
	  – alcohol: quantify amount rather than score as yes/no;
	  – risk assessment: elaborate on current risk and quantify the level of risk. Include forensic information if available.
	• Incorporate the GMHAT within the MHA if not already doing so.

Information to add to report	• A free-text section for narrative/observational information (to act as a 'handover' note). • A space to list medications. • A space to name a caretaker, supporter or mental health advocate for the patient.

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[20] Eating disorder was not included in the piloted version of the tool.

Topic	Suggestions for improvement
Supplementary information	- Ensure that pre-developed guidance materials reach LA caseworkers and GPs. These already include explanations of: – the GMHAT tool, including clinical validation; – interpretation of the data; – assessment process/methodology; – correlation with other commonly used tools. - Suggestions for additional information they could cover include: – Information on how the assessment is explained to the participant. – Qualifications and mental health expertise of the assessing practitioner.

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6 Discussion

The evaluation sought to explore how the GMHAT worked in practice at identifying immediate mental health needs requiring urgent attention during the pre-departure stage and in facilitating diagnoses, referrals and treatment once in the UK.

Practitioners administering the tool had a largely positive experience, but highlighted the need to adapt the tool to fit the cultural context

Feedback from the practitioners who administered the tool suggested that they had a largely positive experience. In particular, they found the GMHAT tool easy to use for making rapid assessments, valued the opportunity to gain a greater insight into refugees' experiences, and appreciated its ability to distinguish between those with psychosocial stressors versus those with medical conditions. However, practitioners also found a need to both adapt the tool to fit the cultural context and to translate it into the local dialect. This resulted in inconsistent application which has implications for the estimates of likely diagnoses of mental health issues.

The tool identified 9% of pilot participants with a likely diagnosis of mental illness, but 1.5% additional referrals were made on the basis of clinical judgement, highlighting the importance of not relying upon this tool in isolation

During the GMHAT assessments, all participants reported a high level of psychosocial stressors, as is commonly found among Syrian refugees, but most were able to continue their daily activities and cope with this level of distress. Eighteen out of 200 (9%) presented with a likely diagnosis of mental health issues with an impact on functioning and significant subjective distress as identified by the GMHAT assessment. All those were subsequently confirmed by further psychiatric evaluation as having a diagnosable mental health condition, most commonly depression and anxiety.

Practitioners highlighted that the tool's accuracy may depend upon a refugee being willing to discuss their problems, which may be hindered by factors such as different cultural perceptions of mental health (including stigma around mental health issues) and the gender of the practitioner. Indeed, despite not screening positive on the GMHAT tool, three additional participants were referred to the psychiatrist on the basis of the practitioner's clinical judgement. This highlights the importance of not relying upon this tool in isolation and its administration by a trained healthcare professional who can use their professional expertise to pick up on any missed diagnoses.

There were mixed views on the appropriateness of the tool for the population of concern

Practitioners administering the GMHAT tool were required to make various adaptations to fit the cultural context and aid the comprehension of refugees. Some also adapted the tool to make a clearer distinction between refugees' mental health needs before and after their displacement. Refugee feedback was generally positive; however, the mechanism for collecting this feedback may have contributed towards more positive responses. Among the minority who did voice discomfort following the assessment, their responses highlighted the

potential risk of re-traumatisation and stigma surrounding mental ill health within their community. Such concerns may have also contributed to three in ten declining to participate in the pilot, although this was mainly attributed to time constraints. There were also suggestions for the tool to focus more on daily stresses in Lebanon, and some participants also used it as an opportunity to request counselling to prepare them for life in the UK.

Pilot participants cases took longer to process, but the reasons for this are unclear

GMHAT participants' cases took longer on average to process than those who had not been assessed (1.5 to 2.2 months longer). While it is not possible to distinguish whether the GMHAT was the cause of the delay or whether it was down to external factors, this is an important consideration in deciding whether or not (and to who) to roll out the tool across resettlement processing countries. Additional information will be required to estimate the future costs and impact on case processing times to try and understand the reasons for this delay.

There were critical operational issues with the information flow process during the pilot which need to be investigated and addressed

From an IOM perspective, the information sharing between IOM and HO worked well and no issues in the sharing of GMHAT reports and MHAs between IOM and HO were observed. However, feedback from LA caseworkers and GPs highlighted critical operational issues with the information flow process which substantially threaten the utility of the tool. Only 10 out of 26 contacted caseworkers who had received pilot participants reported having seen or handled their GMHAT report. Some caseworkers were not clear on how the information was intended to be used and with whom it could be shared. Only 3 out of 17 engaged GPs reported having encountered the GMHAT report, and their feedback suggested a wide variation in pre-established processes for sharing resettlement information more generally with GPs. We were therefore unable to evaluate how well the tool fulfilled its main aims of facilitating diagnoses, referrals and treatment for pilot participants in the UK.

LA caseworkers and GPs valued receiving an 'initial snapshot' of an individual's mental health, with potential benefits of facilitating provision of timely and informed care

The majority of LA caseworkers and healthcare practitioners felt that the GMHAT had the potential to be a useful tool for informing their actions in supporting resettled refugees. Many commented on the value of receiving mental health information in advance, given the limited information typically available and the time it can take to overcome barriers such as trust and language on first arrival.

Both LA caseworkers and GPs felt that the tool was useful in its current form, but had suggestions for how it could be improved to make it more appropriate for their needs.

The tool was recognised for its value in providing an initial snapshot of mental health and wellbeing, and for flagging particularly vulnerable individuals. Potential benefits include:

- expedited referral and treatment;
- increased awareness of mental health issues (particularly for practices and/or individual practitioners with limited experience of working with refugees);
- better integration of the refugee into society;
- informing the commissioning of specialist mental health services if the tool demonstrated demand.

However, respondents stressed that a pre-departure mental health assessment should not replace a routine psychological assessment on arrival or ongoing monitoring, particularly given the longer latency of mental health conditions which can present at any time.

The impact of introducing the tool would be limited if there is a lack of appropriate services to support mental healthcare

The most frequently cited concern about the tool was that its impact would be diminished by the lack of appropriate resources and services to support referral and care. There is a risk that incorporating a mental health element into the pre-departure assessment could raise expectations of post-arrival services that local healthcare providers will struggle to meet with existing resources. Others suggested that a tool like the GMHAT could generate evidence to inform commissioning of specialist mental health services.

Receiving the report in advance could help LAs determine whether they have the services in place to support a refugee's resettlement, which in turn may lead to more appropriate matching and dispersal. However, the risk that cases could be rejected on the basis of mental health needs if services are not available, and the longer-term impact of this on the refugee and their family, should also be carefully considered.

The findings suggest that a pre-departure mental health assessment could be a useful and valuable tool to facilitate LAs in matching and preparing for new refugee arrivals and a valuable resource for GPs during the initial consultation. LA caseworkers and particularly GPs valued having access to concise clinical information regarding a refugee's mental health prior to their arrival in the UK. The GMHAT is one option for such a tool, which the pilot findings suggest would require modifications (along with the accompanying training) to make it suitable for use in the resettlement context. If it is modified, the revised version will need to be validated (including an independent mechanism for collecting refugee feedback) and robust information flow processes established before it can be implemented.

Concerns raised about a lack of appropriate services to support mental healthcare suggest additional guidance and training with LA caseworkers and GPs may be required on existing referral pathways. There may also be a need to expand the provision of culturally-appropriate mental health services for refugees for the tool to have maximum impact. Recent work by the Home Office to map the coverage of mental health services for refugees and asylum seekers in England may be helpful in addressing some of these gaps (ICF, 2018).

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Appendix A: IOM health practitioner topic guide

I am _____, a researcher from the Home Office in the UK contacting you for your interview as part of the evaluation of the Global Mental Health Assessment Tool (GMHAT).

Thank you for agreeing to be interviewed today.

Introduction

The purpose of this interview is to get your views on how the GMHAT has been working with refugees who will be resettled in the UK. This forms part of the evaluation (along with data collection and interviews in the UK with practitioners) to inform a decision about whether to incorporate the tool into pre-departure medical checks for UK resettlement cases across the Middle East and North Africa (MENA) region.

Recording

We would like to record your answers, in order to allow us to have an accurate record of what you have said. All your answers will be confidential and any reporting that we do will be done at a level where people cannot be identified. Is that ok?

We expect the interview to last between 30 minutes to 1 hour.

1. Background

- Are you a doctor/nurse/psychiatrist? For how long?
- How long have you worked in this post (yrs)?
- How long have you worked in a resettlement context?
- What is your day-to-day job like?
- Do you conduct any physical health assessments?
- Before using GMHAT, did you have any experience conducting mental health assessments?
  - *Probe* – Where was this experience? What groups did you assess? (refugees/men/women/age etc.)
  - Have you ever used this tool before? *If yes* – Can you give more details?

2. Training for using the tool

- What training did you have, how many sessions, what did they cover, how long?

- When did you receive training (how long before you started administering the tool?)
- What are your views on the content and duration of the training? (e.g. long enough, detailed enough)
- What do you understand to be the aims of the tool?
- How confident did you feel using the tool after the training?
  – Would you say you felt: Not at all confident / Not very confident / Neutral / Confident / Very confident?
- Was there anything you were not sure of? Did you need further support and supervision?
  – *Probe* – Needed further advice? Who from?
- Is there any way the training could be improved?

3. Administering tool

Setting and time:

- Where did you conduct the assessments?
  – *Probe* – Private space, quiet, office etc? Same place as general medical assessments? Same for all refugees that you have done assessment with?
  – If done in different spaces – what works well?
- Have the assessments been done privately or were other people present (e.g. families)?
  – If yes, who was present?
  – Does this make a difference to how you administer the tool and how refugees answer?
  – Any particular examples?
  – What are your views on having other people present?
- Did you have enough time to do the assessments?

4. Obtaining consent from refugees

To nurses only:

- How have you obtained consent from refugees to participate in the GMHAT trial?
- Have you experienced any challenges in obtaining consent? If so, please can you describe what these were?
- Have any refugees refused consent?
  – *Probe* – Are refugees concerned that it will affect their resettlement chances? Stigma of mental illness? Anxiety about the process, the questions?
  – Role of relatives/spouses influencing decision to take part.
  – Other reasons given?

- What kind of reassurances did you offer?
- What advice would you give to another practitioner around obtaining consent for using the tool with a similar population?

To all:

- *Once conducting interview* – Have you offered any reassurance that it is not related to resettlement possibilities / any other reassurances?
  - *Probe* – Was this in response to a question/concern of refugees or proactive?

5. Adapting the tool to specific context

- Did you change/adapt the tool in any way? Was it changed by anyone else in the team?
  - *Probe if changed* – What questions were added/omitted/changed and why?
  - Is this the same across all participants or did you adapt for only some?
  - If some, who and why (e.g. men, women, individual characteristics...)?

6. Acceptability of the tool for refugee participants

- What was the range of conditions picked up by the GMHAT tool?
- Did you explain the results of assessment to people and how they will be used?
- How comfortable did you feel explaining results to refugee?
- In your opinion, to what extent did they understand how the results would be used?
- Did any refugees tell you how they felt about completing the survey? Please describe.
- Were there any questions they didn't want to answer?
  - If so, which questions?
  - Did that differ for particular groups (e.g. patterns)? If so, who?

7. Value of GMHAT tool

- To what extent do you think it gives you an accurate picture of mental health problems?
  - *Probe* – If not, does it over- or under-diagnose any particular conditions?
- Have you used the tool to make recommendation or referral?

8. Strengths

- What has worked well and why?
- What is good about the tool? And how has it been used?
  - *Probe* – E.g. picking up different problems, easy to use etc?

9. Weaknesses of the tool

- What are the limitations of the tool?

- What could or should have been done differently and why?

    - *Probe* – Appropriateness / ease of use with different populations / value in assessing different conditions?

10. What have been the main challenges in implementing the tool and how have you addressed these?

- *Probe* – E.g. time, space, willingness to participate; what to do with the result; any particularly difficult situations?

11. Were there any unanticipated or unintended consequences (both positive and negative) to using the tool?

12. Is there anything you would like to change about the tool (content or delivery)? Improvements that could be made?

13. Future roll-out of the tool (FUTURE USE OF GMHAT)

- Would you feel comfortable administering the tool in the future?
- Who do you think is best placed to administer the tool?

    - *Probe* – E.g. could anyone administer it (i.e. non-medical professional)? Or do they need to be a qualified professional/doctor/nurse etc. – *be specific*)

14. Any other issues you would like to comment on? (concerns, benefits, ideas etc.)

Thank you for your participation!

Appendix B: Refugee feedback form

1) Do you find that this mental health assessment covered all aspects of your mental health? (Emotional wellbeing, stressors, etc.)

2) If not, what do you think it should also be covering?

3) Was there any issue, topic or aspect in the tool that made you feel uncomfortable? If yes, please describe or point to it.

Appendix C: Local authority (LA) caseworker topic guide

Vulnerable Persons Resettlement Programme: Mental Health Pilot Evaluation

LA Caseworker Topic Guide

Background

The Resettlement Programme is piloting the Global Mental Health Assessment Tool (GMHAT) among refugees who have been affected by the conflict in Syria and have been accepted for resettlement to the UK.

At present, all refugees who are accepted onto the programme undergo a health assessment carried out by the International Organization for Migration (IOM) in order to ensure that refugees are fit to travel, receive appropriate assistance when required, and do not pose a hazard to other travellers or receiving communities. The assessment typically includes conditions of public health significance, the need for pre-departure treatment and medical referrals, pre- and post-assessment counselling, fitness-to-travel assessments and medical escorts when required. It does not currently include any systematic screening of mental health conditions.

In December 2016, the programme began a pilot of the GMHAT tool for a cohort of 200 refugees processed in one clinic in Lebanon for UK resettlement. The programme team is interested in evaluating the utility of this tool for improving aspects of the programme's operations. The outcome of the evaluation will feed into the decision of whether or not to roll the screening tool out across the remaining process.

Research aims

The programme team's objectives and intended outcomes are to facilitate caseworker referrals and GP assessment, any subsequent diagnoses and referrals to specialist service provision once in the UK.

The aim of this research is to understand how useful the GMHAT is for LA caseworker referrals and GP health assessments – more specifically:

- Does this information reach caseworkers and/or GPs?
- If so, to what extent do these stakeholders find the provided information useful?

Note to moderators

Please note, this guide is not a script and is intended to be used flexibly, with participant responses guiding the flow of the conversation, topics covered in the order that they naturally arise and probes used only when needed.

1. Introduction (2 minutes)

Introduce research, reassure about confidentiality and set tone of discussion.

- **Warm up and introduction**

    – *Introduce moderator* – This research is being conducted on behalf of Public Health England (PHE), NHS, IOM, Department of Health (DH) and the Refugee Resettlement Programme operating out of the Home Office.

    – The purpose of this discussion is to understand if and how you have been using the information from the GMHAT and how useful you have found it.

    – The information you give us forms part of the evaluation of the tool (alongside interviews with caseworkers, practitioners administering the tool in Lebanon, refugee feedback and quantitative data) to inform a decision about whether to incorporate the tool into pre-departure medical checks for UK resettlement cases across the Middle East and North Africa (MENA) region.

    – Interview length ~ 30 minutes.

    – Research is confidential and voluntary – your personal details will not be shared with PHE, NHS, IOM, DH or the Home Office, and participation will not affect your current or future relationship with PHE, NHS, IOM, DH or the Home Office.

    – This research study has received ethical approval from the PHE Research Ethics and Governance Group.

    – Any questions before we start?

- **Recording**

    – We would like to record your answers, in order to allow us to have an accurate record of what you have said for analysis purposes. All your answers will be confidential and any reporting that we do will be anonymous, where people cannot be identified. Is that OK?

2. Background (5 minutes)

Warm up participant and establish context and participant background.

- **LA characteristics:**

    – Location

    – Size of LA

    – Areas covered

- Number of staff
- Rural/urban

- **Participant role:**
  - Current role
  - Day-to-day responsibilities
  - Length of time in role

- **Prior experience working with refugees and asylum seekers:**
  - How long ago
  - When/where
  - Extent of experience (e.g. number of refugees/asylum seekers they have engaged with/supported)

3.   Use of the tool   (7 minutes)

To understand if the participant has received GMHAT data and how they have been using the results in their day-to-day work.

LA characteristics

Explain to participant that you are now going to be discussing their use of the GMHAT.

- **Check whether the participant has come into contact with the GMHAT following a refugee's arrival to the UK**
  - Whether they received the report of results following the GMHAT assessment.
    - If so, at what stage they received the report in the resettlement process.
    - If not, why they did not receive it (if known to participant), e.g. any difficulties obtaining the data?

- **Timeliness of the GMHAT report**
  - How they feel about the appropriateness of the time they received the data from the GMHAT assessment.
  - Any changes they would make to the timing of receipt.

- **Understanding the data**
  - How clear was the report/information?
  - Were they able to understand?
    - Why / why not?
    - What facilitated/prevented understanding?
  - Did they receive a guidance note accompanying the data?
    - If so, how clear was it?
    - Did they understand it? Why / why not?

- o How useful was it?

- **Use of the data/ results**

  – What have they done with the data once they have received it? Has the tool prompted them to take any action?

  - o How have they used it? Any examples of action taken and how the tool has helped them to do this?

  – How confident did they feel using the data? Why?

4. Value of the tool   (8 minutes)

To assess the usefulness of the GMHAT tool and whether it provides sufficient information to put support in place of refer appropriately.

- **Usefulness of the GMHAT**

  – How useful have they found the tool and the report?

  - o Are there any sections that are more useful than others?

  - o If so, which sections are more useful and why?

  - o Which sections are less useful and why?

  – How comprehensive are the results for caseworker needs?

  – How useful is the timing of when the GMHAT assessment is done?

  - o Is it done at the right time?

  - o When would be the most appropriate time for the assessment to take place? E.g. pre-departure, X days/months/years following arrival to the UK.

  - o Why is that time most appropriate?

- **What would happen if they didn't have the tool?**

  – How would they prepare for and provide support for a refugee that has not undergone a GMHAT assessment?

  – Is there any value in having data from tool?

5. Impact of tool and improvements   (5 minutes)

To understand the impact the tool has had on different stakeholders and identify any improvements that could be made.

- **Impacts of GMHAT**

  – Impacts of the tool on different stakeholders:
    - o Refugees
    - o Caseworkers/LAs
    - o GPs
    - o Other wider stakeholders

- – Explore any differences in short-term vs. long-term impacts

- **Improvements to the tool**

  - – Any improvements to the tool and report they receive and why.

6. Wrap up (3 minutes)

To wind down the interview and come to a close, thanking the participant for their time.

- **Participant to sum up whether they would they support, oppose or feel indifferent about the future use of the tool more widely**

  - – Why / why not?

- **Final messages for PHE, NHS, IOM, DH and HO**

- **(IF NOT ALREADY ASKED AS PART OF SCREENING/ RECRUITMENT)** – As part of the evaluation, we are also speaking to GPs who have received copies of the summary GMHAT reports. Are you aware of any GPs in your local authority who have received this documentation or who have worked with refugees who have participated in the GMHAT pilot assessments?

   NAME OF GP:

   GP PRACTICE:

   PHONE NUMBER (IF AVAILABLE):

- **Thank you and close**

Appendix D: GP topic guide

Vulnerable Persons Resettlement Programme: Mental Health Pilot Evaluation

GP Topic Guide

Background

The Resettlement Programme is piloting the Global Mental Health Assessment Tool (GMHAT) among refugees who have been affected by the conflict in Syria and have been accepted for resettlement to the UK.

At present, all refugees who are accepted onto the programme undergo a health assessment carried out by the International Organization for Migration (IOM) in order to ensure that refugees are fit to travel, receive appropriate assistance when required, and do not pose a hazard to other travellers or receiving communities. The assessment typically includes conditions of public health significance, the need for pre-departure treatment and medical referrals, pre- and post-assessment counselling, fitness-to-travel assessments and medical escorts when required. It does not currently include any systematic screening of mental health conditions.

In December 2016, the programme began a pilot of the GMHAT for a cohort of 200 refugees processed in one clinic in Lebanon for UK resettlement. The programme team is interested in evaluating the utility of this tool for improving aspects of the programme's operations. The outcome of the evaluation will feed into the decision of whether or not to roll the screening tool out across the remaining process.

Research aims

The programme team's objectives and intended outcomes are to facilitate caseworker referrals and GP assessment, any subsequent diagnoses and referrals to specialist service provision once in the UK.

The aim of this research is to understand how useful the GMHAT is for LA caseworker referrals and GP health assessments – more specifically:

- Does this information reach caseworkers and/or GPs?
- If so, to what extent do these stakeholders find the provided information useful?

Note to moderators

Please note, this guide is not a script and is intended to be used flexibly, with participant responses guiding the flow of the conversation, topics covered in the order that they naturally arise and probes used only when needed.

1. Introduction   (2 minutes)

Introduce research, reassure about confidentiality and set tone of discussion.

- **Warm up and introduction**
  - Introduce moderator – researcher for PHE.
  - This research is being conducted on behalf of Public Health England (PHE), NHS, IOM, Department of Health (DH) and the Refugee Resettlement Programme operating out of the Home Office.
  - The purpose of this discussion is to understand if and how you have been using the information from the GMHAT and how useful you have found it.
  - The information you give us forms part of the evaluation of the tool (alongside interviews with caseworkers, practitioners administering the tool in Lebanon, refugee feedback and quantitative data) to inform a decision about whether to incorporate the tool into pre-departure medical checks for UK resettlement cases across the Middle East and North Africa (MENA) region.
  - Interview length ~ 30 minutes.
  - Research is confidential and voluntary – your personal details will not be shared with PHE, NHS, IOM, DH or the Home Office, and participation will not affect your current or future relationship with PHE, NHS, IOM, DH or the Home Office.
  - This research study has received ethical approval from the PHE Research Ethics and Governance Group.
  - Any questions before we start?

- **Recording**

  We would like to record your answers, in order to allow us to have an accurate record of what you have said for analysis purposes. All your answers will be confidential and any reporting that we do will be anonymous, where people cannot be identified. Is that OK?

2. Background   (5 minutes)

Warm up participant and establish context and participant background.

- **GP practice characteristics:**
  - Type of GP practice e.g. solo practice, group practice, partnership
  - Size of business
    - Number of staff
    - Number of patients

- – Location
- – Rural/urban

- **Participant role:**
  - – Current role
  - – Day-to-day responsibilities
  - – Length of time in role

- **Prior experience working with refugees and asylum seekers:**
  - – How long ago
  - – When/where
  - – Extent of experience e.g. approximate number of refugee / asylum seeker cases dealt with

- **Before introduction of the tool, did they have any mental health screening in place?**
  - – If so, how would they screen for mental health issues
  - – For refugees and asylum seekers
  - – For wider population

3. Use of the tool   (7 minutes)

To understand if the participant has received GMHAT data and how they have been using the results in their day-to-day work.

LA characteristics

Explain to participant that you are now going to be discussing their use of the GMHAT.

- **Check whether the participant has come into contact with the GMHAT following a refugee's arrival to the UK**
  - – Whether they received the report of results following the GMHAT assessment.
    - o If so, at what stage they received the report in the resettlement process.
    - o If not, why they did not receive it (if known to participant) e.g. any difficulties obtaining the data?

- **Timeliness of the GMHAT report**
  - – How they feel about the appropriateness of the time they received the data from the GMHAT assessment.
  - – Any changes they would make to the timing of receipt.

- **Understanding the data**
  - – How clear was the report/ information?
  - – Were they able to understand?
    - o Why / why not?
    - o What facilitated/prevented understanding?

- Did they receive a guidance note accompanying the data?

- If so, how clear was it?

- Did they understand it? Why / why not?

- How useful was it?

- **Use of the data/results**

  - What have they done with the data once they have received it? Has the tool prompted them to take any action?

  - How have they used it? Any examples of action taken and how the tool has helped them to do this?

  - How confident did they feel using the data? Why?

4.   Value of the tool   (8 minutes)

To assess the usefulness of the GMHAT tool and whether it provides sufficient information to put support in place of refer appropriately.

- **Usefulness of the GMHAT**

  - How useful have they found the tool and the report?
    - Are there any sections that are more useful than others?
    - If so, what sections are more useful and why?
    - What sections are less useful and why?

  - How comprehensive are the results for GP requirements?

  - How accurate did they find the results?
    - Did it match with their own assessments of the patient?

  - How valuable is the data from the tool for those who screened positively, and those who screened negatively?

  - How useful is the timing of when the GMHAT assessment is done?
    - Is it done at the right time?
    - When would be the most appropriate time for the assessment to take place? E.g. pre-departure, X days/months/years following arrival to the UK.
    - Why is that time most appropriate?

- **What would happen if they didn't have the tool?**

  - How would they check for MH issues?

  - Are there any systematic mental health screenings in place?

  - Is there any value in having data from tool?

5. Impact of tool and improvements   (5 minutes)

To understand the impact the tool has had on different stakeholders and identify any improvements that could be made.

- **Impacts of GMHAT**

    – Impacts of the tool on different stakeholders:

        o Refugees

        o Caseworkers/ LA's

        o GPs

        o Other wider stakeholders

    – Explore any differences in short-term vs. long-term impacts

- **Improvements to the tool**

    – Any improvements to the tool/report and why

6. Wrap up   (3 minutes)

To wind down the interview and come to a close, thanking the participant for their time.

- **Participant to sum up whether they would they support, oppose or feel indifferent about the future use of the tool more widely**

    – Why / why not?

- **Final messages for PHE, NHS, IOM, DH and HO**

- **Thank** y**ou and close**

Appendix E: GP feedback form

Vulnerable Persons Resettlement Programme: Mental Health Pilot Evaluation

Thank you very much for agreeing to give feedback on the Global Mental Health Assessment Tool (GMHAT) in writing. We appreciate you taking the time to complete the attached form as your input is valuable to the overall evaluation of the tool.

This research is being conducted on behalf of Public Health England (PHE), NHS, International Organization for Migration (IOM), Department of Health (DH) and the Refugee Resettlement Programme operating out of the Home Office.

The purpose of this discussion is to understand if and how you have been using the information from the GMHAT and how useful you have found it.

The information you give us forms part of the evaluation of the tool (alongside interviews with caseworkers, practitioners administering the tool in Lebanon, refugee feedback and quantitative data) to inform a decision about whether to incorporate the tool into pre-departure medical checks for UK resettlement cases across the Middle East and North Africa (MENA) region.

Research is confidential and voluntary – your personal details will not be shared by the interviewer with NHS, IOM, DH or the Home Office and participation will not affect your current or future relationship with PHE, NHS, IOM, DH or the Home Office.

This research study has received ethical approval from the PHE Research Ethics and Governance Group.

There are 11 questions on this form which should take you no longer than 15 minutes to complete.

Feedback form

Question	Feedback *Please type your answers in the spaces below*
1 Please tell us a little bit about the practice you work for, including size (number of staff and patients) and location (urban or rural).	
2 Please tell us a little bit about your current role, including your day-to-day responsibilities, length of time in role and your prior experience of working with refugees and asylum seekers.	

	Question	Feedback *Please type your answers in the spaces below*
3	Before introduction of the tool (GMHAT), did you have any mental health screening in place, for both refugees and asylum seekers and the wider population? Please describe.	
4	Have you come into contact with the GMHAT for any of your refugee patients and if so, at what stage (i.e. before or after they arrived to the UK)? An example GMHAT report is attached to this form.	
	If you have come into contact with the GMHAT for any of your patients, please complete the following questions on the basis of your experience to date. If you have not come into contact with the GMHAT before, please feel free to provide your views on the basis of the attached example report.	
5	How useful have you found the tool and the report? Including: - How clear was the GMHAT report/ information? - How comprehensive are the results for GP requirements? - How accurate did you find the results?	
6	How did you use the data? What did you do with the data once you received it? Did the tool prompt you to take any action? *Please include any examples where possible*	
7	When do you think would be the most appropriate time for a mental health assessment to take place for a refugee patient and why? E.g. before arriving to the UK, X days/months/years following arrival to the UK.	
8	What would happen if you didn't have the GMHAT tool? How would you check for mental health issues?	

Question	Feedback *Please type your answers in the spaces below*

9 Has the tool had any impacts on the following stakeholders:
    • Refugees
    • GPs
    • Other wider stakeholders
If so, how? If not, why not?
	65

10 Are there any improvements you would make to the tool/report, and why?	
11 Would you support, oppose or feel indifferent about the future use of the tool more widely with resettled refugee populations? Why / why not?	

Appendix F: Sample GMHAT report

GMHAT Interview Report

If you need to refer your patient, please attach this to your normal referral letter which should include any additional details about the patient's presenting symptoms, their current medication and a summary of their key medical history including any past psychiatric history.
GMHAT is presented as an aid to healthcare professionals only and is not a substitute for a satisfactory clinical assessment.

Client Details   **c.s.,tiwari [29/10/1974]**

Interviewed by[Dr. Vimal Sharma] on 27/05/2008

Symptoms based on GMHAT Interview
       Anxiety : Moderate
       Depression : Severe
       Manic symptoms : Mild
       Memory impairment : Mild
       Alcohol : Yes
       Drug misuse : No
       Personality issues : No
       Level of stress : Moderate
       Risk assessment : Mild

Symptom ratings

Anxiety (0-12)	6	Obsession (0-3)	0	Disorientation (0-9)	0
Concentration (0-3)	0	Phobia (0-9)	0	Memory (0-6)	4
Depression (0-36)	11	Mania (0-6)	2	Eating disorder (0-18)	0
Psychosis (0-9)	0	Hypochondriasis (0-3)	0		

GMHAT main diagnosis   **Depression**

Other possible diagnosis   Mania, Anxiety, Alcohol abuse

Appendix G: Information sheet

The Global Mental Health Assessment Tool (GMHAT) Evaluation information sheet and consent form

You are invited to take part in a research study evaluating the Global Mental Health Assessment Tool (GMHAT).

We are contacting you because a small number of the refugees who have been received in your local authority (LA) are known to have participated in the GMHAT pilot assessment during their resettlement to the UK, as part of their standardised pre-entry health assessment.

What is the GMHAT?

The GMHAT is a computerised clinical interview tool developed to assess and identify a wide range of mental health problems in primary healthcare settings. The tool was developed to help staff in any primary care setting make a standardised and convenient, yet comprehensive mental health assessment and to provide a means to address the specific mental health needs of this population.

What is the evaluation about?

The tool is being piloted by the Home Office, International Organization for Migration (IOM) and Public Health England (PHE) to test whether it is a useful inclusion in the pre-departure health assessment for refugees accepted on to the Vulnerable Persons Resettlement Scheme (VPRS), providing sufficient information for local authorities (LAs) and general practitioners (GPs) to put support in place or refer appropriately. We are also testing how feasible it is to implement. Since December 2016, 200 adult refugees processed in one clinic in Lebanon have received a GMHAT assessment. Following the evaluation, a decision will be taken on whether to roll out the use of the GMHAT more widely, either in its current format or using a revised version.

The evaluation involves various activities. The first stage of the evaluation involved: interviews with healthcare practitioners in Lebanon who administered the tool; refugee feedback forms; and quantitative analysis of patient demographics. This email is to inform you of the second stage of the evaluation activities – interviews with LA caseworkers and GPs in the UK who have received copies of the summary GMHAT reports as part of their case documentation.

What will taking part involve?

Confidential telephone interviews

As part of the second stage of the evaluation, we will be seeking views from LAs who have received pilot participants to date to understand if and how they have been using the information gathered by the tool. From early February, a researcher from PHE will

be contacting a small number of LAs who have received pilot participants to invite them to take part in a short telephone interview, followed by interviews with the relevant GPs.

Please note that this study is separate from the Ipsos MORI evaluation and will be focused specifically on those LAs who have received GMHAT assessments as part of their pre-arrival documentation. The number of LAs who have so far received pilot participants is small, so we would be extremely grateful for your participation as your views and experience will be instrumental in informing whether the tool should be rolled out more widely.

By consenting to take part, you understand that:

- The discussion will last approximately 30 minutes and will involve discussing how you have used the data obtained from the GMHAT, how useful it was and if there have been any impacts.

- Participation in this study is **voluntary** and you are free to withdraw at any time without facing any negative consequences and can request that all the data that you have provided is destroyed. This study is being conducted independently from the Home Office and IOM and your decision whether or not to participate will not affect your current or future relationship with the Home Office and IOM.

- Everything you say will be treated **confidentially** and the findings will be **anonymised**. No information written in the final report will make it possible to identify you and no one in the Home Office and IOM will know who has said what.

- The discussion will be recorded using a digital voice recorder. The audio recording will be transcribed by the researcher and used only for analysis purposes and will be destroyed once transcripts are checked for accuracy. Transcripts will be anonymised and any extracts from the interview may be used in any report, presentation or publication developed as a result of the research. No other use will be made of the recording without written permission and no one outside the research team will be allowed to access the original recording.

- The information you give us forms part of the evaluation of the tool (alongside interviews with caseworkers, practitioners administering the tool in Lebanon, refugee feedback and quantitative data) to inform a decision about whether to incorporate the tool into pre-departure medical checks for UK resettlement cases across the Middle East and North Africa (MENA) region.

When is the evaluation happening?

The second and final stage of the evaluation is taking place from the beginning of February until March 2018.

Where can I learn more about the evaluation?

If you have any questions or would like to learn more about the evaluation, please contact _____.

Statement of consent

I have read the above information and I consent to participate in the study.

Signature of participant: _____

Date: _____

Signature of researcher: _____

Date: _____

Appendix H: GMHAT guidance for local authorities

Global Mental Health Assessment Tool (GMHAT)

Guidance notes

What is the Global Mental Health Assessment Tool (GMHAT)?
The GMHAT is a computerised clinical interview tool developed to assess and identify a wide range of mental health problems in primary healthcare settings. It consists of a series of questions that leads to a comprehensive yet quick mental state assessment.

The tool was developed to help staff in any primary care setting make a standardised and convenient, yet comprehensive mental health assessment and to provide a means to help people in bringing relief from the sufferings of their mental health problems.

Why is the tool being piloted?

A validated version of the GMHAT tool is being piloted to evaluate its usefulness as a component of the pre-entry health assessment for those accepted on to the Vulnerable Persons Resettlement Scheme (VPRS) and how feasible it is to implement. The pilot commenced on 5 December 2016 and the tool will be tested in one clinic in Lebanon with 200 adults aged 18 and above who are being processed for resettlement in the UK.

At present, all those who are accepted onto the programme undergo a health assessment carried out by the International Organization for Migration (IOM) on behalf of the UK Government. This does not currently include any systematic screening of mental health conditions. The purpose of the pilot is to test whether the GMHAT is a useful tool for inclusion in the health assessment, providing sufficient information for local authorities (LAs) and general practitioners (GPs) to put support in place or refer appropriately, and whether the tool can be implemented, both in terms of its impact on case flow and departure schedules and of whether those who are assessed find it acceptable. The pilot will also provide an indication of the prevalence of certain mental health conditions in this cohort.

What additional information will LAs receive?

The GMHAT tool generates a summary report that sets out the result of the assessment, including a symptom rating and a self-harm assessment. It contains a rating of either mild, moderate, severe or yes/no against nine symptoms, such as stress, anxiety, depression etc. (please see accompanying Annex A[21] – an example interview report taken from the GMHAT training manual). For those individuals participating in the pilot, the GMHAT report will be

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[21] Appendix F of this report

included together with their Migration Health Assessment. You will also find attached *Guidance for GPs* (including two Annexes)[22] to support in interpreting the report.

How will we know if a GMHAT has been conducted on adults referred to us?

Not everyone will have a mental health assessment during the pilot period, only those eligible and who agree to participate at the one clinic in Lebanon where the pilot is being implemented. If the Home Office does not upload a GMHAT report for someone, you can assume that that person was not part of the pilot and did not undergo a mental health assessment.

How should this additional information be used by the LA to support the resettled individual?

The content of the GMHAT report should be treated in the same way as the Migration Health Assessment. However, it is strongly recommended that the report and the GP guidance documents are shared with the resettled individual's GP once they are registered at a practice, to support in the timely and appropriate referral to relevant services.

Where a high level of need for mental health support is identified among those resettled in your area, you may wish to consider evaluating the current provision of suitable mental health services for this population group in your area. In addition, it would also be of value to ensure an awareness of mental health among the caseworkers supporting those individuals being resettled in your area.

How do I read and interpret the GMHAT report?

The GMHAT report is a very brief document (see example at Annex A[23]), which is automatically generated based on the answers to the questions. It lists nine symptoms: anxiety, depression, manic symptoms, memory impairment, alcohol misuse, drug misuse, personality issues, level of stress and risk assessment, with a rating of no/mild/moderate/severe against each. It includes a main diagnosis (e.g. depression) and possible other diagnoses (e.g. alcohol misuse) that, again, are automatically generated. It will also include a very brief observation from the clinician who administered the assessment.

In all cases it is recommended that the GMHAT report and GP guidance documents are shared with the individual's GP.

Who can I contact if I have further questions about anything included in the GMHAT?

Any further questions should be referred through your Strategic Migration Partnership regional co-ordinator or, in London, your contact officer.

Will there be any evaluation of how a LA supports people who have had a GMHAT assessment?

The Home Office intends to conduct qualitative interviews with a number of LAs who have received the GMHAT reports. This will form part of the overall evaluation of the pilot. Following the evaluation, a decision will be taken on whether to roll out the use of the GMHAT more widely, either in its current format or a revised version. LAs will be notified of any decision to roll out.

Will the individuals know that this information is going to be shared with LAs and GPs?

Yes, the individual will sign a specific informed consent form before participating in the pilot.

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[22] Appendix I of this report
[23] Appendix F of this report

Appendix I: GMHAT guidance notes for GPs

What is the Global Mental Health Assessment Tool (GMHAT)?

The GMHAT is a computerised clinical interview tool developed to assess and identify a wide range of mental health problems in primary healthcare settings. It consists of a series of questions (see Annex 1)[24] that leads to a comprehensive yet quick mental state assessment.

The tool was developed to help staff in any primary care setting make a standardised and convenient, yet comprehensive mental health assessment and to provide a means to help people in bringing relief from the sufferings of their mental health problems.

The tool has been validated in primary care and specialist settings and across cultures, with consistent correlation between the GMHAT diagnosis and the International Standard Classification of Diseases and Related Health Problems 10th Revision (ICD-10) code-based diagnosis by independent psychiatrists.

Why is the tool being piloted?

A validated version of the GMHAT tool is being piloted to evaluate its usefulness as a component of the pre-entry health assessment for those accepted on to the Syrian Vulnerable Persons Resettlement Scheme (SVPRS) and how feasible it is to implement. The pilot commenced on 5 December 2016 and the tool will be tested in one clinic in Lebanon with 200 adults aged 18 and above who are being processed for resettlement in the UK. All participants are vulnerable Syrian refugees who are being resettled in the UK as part of the scheme.

At present, all those who are accepted onto the SVPRS undergo a health assessment carried out by the International Organization for Migration (IOM) on behalf of the UK Government. This does not currently include any systematic screening of mental health conditions. The purpose of the pilot is to test whether the GMHAT is a useful tool for inclusion in the health assessment, providing sufficient information for local authorities (LAs) and general practitioners (GPs) to put support in place or refer appropriately, and whether the tool can be implemented, both in terms of its impact on case flow and departure schedules and of whether those who are assessed find it acceptable. It is hoped that the pilot will also provide an indication of the prevalence of certain mental health conditions in this cohort.

What is the GMHAT report?

The GMHAT report is a very brief summary document (see Annex 2),[25] which is automatically generated based on the answers to the questions. It contains five sections: background descriptive details, symptoms and their severity, symptom scores, main diagnosis and other possible diagnoses, and a statement of clinical judgement from the administering clinician.

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[24] Appendix K of this report
[25] Appendix F of this report

How do I read and interpret the GMHAT report?

The report clearly lists and ranks nine symptoms: anxiety, depression, manic symptoms, memory impairment, alcohol misuse, drug misuse, personality issues, level of stress and risk assessment, with a rating of no/mild/moderate/severe against each. This descriptive rating is automatically generated from a numerical scoring system which rates symptoms based on responses to the questionnaire (see table: Symptom ratings).[26]

The report includes a main diagnosis (e.g. depression) and possible other diagnoses (e.g. alcohol misuse) that, again, are automatically generated based on the numerical ratings. The additional diagnoses or co-morbid states are based on the presence of other mental illness symptoms and disorders. It will also include a very brief observation from the clinician who administered the assessment. The report is intended to act as a preliminary assessment of mental health, and not a clinical diagnosis.

What action should I (the GP) take on the basis of this report?

You will receive these GMHAT/PC reports on people who are being resettled in your local area as part of the SVPRS, have participated in the pilot and are being registered with your surgery. Please take this is a preliminary assessment of their mental health to assist you in making your decision on whether they need any further help from specialist mental services or other agencies.

The following key, while not exhaustive, may be used to support your own clinical judgement and guide you in determining further action for managing the patient. To see the specific questions used to assess symptoms and arrive at a diagnosis, please refer to the relevant section(s) in the questionnaire (Annex 1).[27]

GMHAT/PC diagnosis	Suggested action for management
• Anxiety • Mild to moderate depression • Obsessive-compulsive disorder (OCD) • Phobias • Stress-related disorders	Support from primary care mental health services
• Severe depression with risk of moderate to severe self-harm	Referral to secondary care mental health services
• Psychosis • Organic disorders (dementia)	Referral to appropriate specialist services, e.g. Early Intervention of Psychosis Services or Memory Clinics
• Alcohol and substance misuse disorders	Support from respective specialist services

Other information

More information on the GMHAT can be found at: http://www.gmhat.org/?page=main

Annexes

Annex 1: GMHAT questionnaire
Annex 2: GMHAT sample summary report[28]

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[26] Appendix J of this report
[27] Appendix K of this report
[28] Appendix F of this report

Appendix J: GMHAT scoring system

Diagnosis	Mild	Moderate	Severe
Anxiety	1-4	5-8	>8
Depression	1-7	8-16	>17
Others, where range = 1-3	1	2	3
Others, where range = 1-6	1-2	3-4	5-6
Others, where range = 1-9	1-3	4-6	7-9

Please note that GMHAT is a clinical interview and helps in arriving at a possible clinical diagnosis.

The scores are just indicative of symptom presence.

Appendix K: GMHAT essential questions

The GMHAT questionnaire comprised a set of 'essential' questions, tailored to the target population, which are listed below. In addition, further, optional questions may have been administered, dependent on the participant's responses. The full set of questions are available on request.

The questionnaire was administered through face-to-face interviews between a trained healthcare professional and patient, and results were recorded directly into the questionnaire on a computer or smartphone device.

Ratings:

0 = No evidence of presence of symptom

1 = Symptom present and mildly distressing or disabling

2 = Symptom present and moderately distressing or disabling

3 = Symptom present and severely distressing or disabling

8 = When interviewer is unsure about the presence or absence of symptom

9 = Not applicable or not asked

Worries

Do you tend to worry a lot?

Does this worrying bother you a lot?

Rate worries if bothersome

Anxiety

Do you get frightened or nervous?

Rate anxiety

Panic attack

Have you had attacks of fear or panic?

Rate panic attack

Concentration

How is your concentration?

Can you concentrate on talking to someone, or listening to radio, or watching TV, or reading newspapers or books?

Rate impaired concentration

Depressed mood

Have you been sad (depressed) recently?

Have you cried at all or felt like crying?

Is the depression there most of the time or just a few hours at a time?

Rate depressed mood

Loss of interests

How is your interest in things? (Have you lost interest in things?)

Rate loss of interests

Hopelessness

How do you see the future?

Do you feel hopeless?

Rate hopelessness

Recent suicidal tendencies

Have you felt that life wasn't worth living?

Have you thought of ending it all?

Have you actually done anything to harm yourself?

Rate recent suicidal tendencies

Present suicidal tendencies

Do you still think that way?

Do you have any plans to end your life?

Rate present suicidal tendencies

Sleep

Have you had trouble sleeping recently?

Rate sleep difficulties

Hypochondriasis

Do you worry about your health or any illness?

Rate hypochondriasis

Obsessions/compulsions

Do you have to check things over and over again; for example, whether you have turned off the taps (faucets), gas or lights?

Rate obsessions/compulsions

Phobias

People sometimes have fears they know don't make sense, like being afraid of crowds or going out alone. Do you have such fears or do you have any other fears? (Agoraphobia)

Rate agoraphobia/ other fears

Thought disorder – ideas of reference and delusions

Do you believe that people talk about you (laugh at you)?

Do you believe that the TV/radio/newspaper is referring to you?

Do you have any other unusual (strange) ideas or beliefs (e.g. people are going to harm you)?

(Explore if the person has any other delusions)

Rate delusions (of reference or any other delusions)

Psychotic symptoms – auditory symptoms

Do you hear things other people cannot hear?

Rate auditory hallucinations

Alcohol misuse

May I ask you about your drinking habits (alcohol)? How much do you drink?

Do you have strong desire to drink alcohol every day?

Rate alcohol misuse

Drug misuse

Do you take any other drugs not prescribed by a doctor (illicit drugs)?

Rate drug misuse

Personality problems

Have you had psychological/emotional difficulties for a long time?

Is it since teenage years?

Has that continued throughout your life without getting significantly better or worse?

(Note to assessor: please don't include psychological/emotional difficulties due to stress, mental or physical illness.)

Rate if persistent problems

Stressors

Have you been in any kind of stress before your problems started?

For example, anyone close to you died, break-up of a relationship, or any other kind of stress?

Rate significant stress

Post-traumatic stress disorder (PTSD)

What happened after the (stressful event)? Did you suffer from nightmares (about the event?)

Rate evidence of PTSD

Clinical judgment

Enter clinical judgement (free text)

After completing the assessment, the assessor makes his/her own clinical judgement before submitting the GMHAT scores for processing. A report is then produced (the GMHAT 'output'). The combination of the assessor's clinical judgment and the GMHAT output are used to determine the appropriate course of action for the patient.