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Review

Core competencies for physiotherapists working with refugees: a scoping review

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Abstract

Objective To summarise the existing knowledge base that can inform the development of a core competency profile for physiotherapists to support and deliver rehabilitation services to refugees.

Method In this scoping review, a comprehensive search of peer-reviewed and grey literature was conducted. The search parameters included studies relevant to the physiotherapy profession and published between 2000 and 2019. MEDLINE, EMBASE, CINAHL, PEDro, and Ovid PsycINFO databases were searched. Grey literature was accessed through website searches, Google Scholar, and direct requests.

Findings Three themes were identified in the literature. The first theme encompassed the physical and mental health of refugees. The second theme explored the cultural competence physiotherapists need to work with refugees. This theme included the cultural influences on health and healthcare and communication strategies that could be used to optimise healthcare for refugees. The last theme described refugees and the healthcare system which encompassed the challenges that refugees face in accessing healthcare and navigating the healthcare system. The main physiotherapy competencies detected in the literature were an understanding of refugee health, the administration of culturally competent care and knowledge of healthcare systems as they relate to refugees.

Conclusion This comprehensive search identified three themes that can be used to inform the development of a competency profile for physiotherapists working with refugees. These themes are, however, rather vague and non-specific and signal the need for research to further examine the physiotherapy competencies necessary to provide the highest quality of care for this growing population.

Keywords: Refugees; Rehabilitation; Physiotherapy; Competencies

Introduction

In recent years, there has been a steady increase in the global number of refugees and migrants [1]. The United Nations High Commissioner for Refugees (UNHCR) reported that at the end of 2018 there were over 29 million refugees and asylum seekers across the globe [2]. The large and increasing numbers of refugees call for the development of appropriate knowledge and skills to facilitate effective healthcare delivery in their receiving countries. Many refugees arrive with complex health needs, both physical and mental, signifying the important role of rehabilitation [3]. Competency profiles, which detail the knowledge, activities, tasks, behaviours and skills required to provide optimal care for this population, have been developed for some health professions, e.g. public health professionals [4], and for health professionals in general [5]. However, there is no clear definition of the competencies needed by physiotherapists to optimally serve this population. This review aims to summarise the existing knowledge base, considering both peer-reviewed and grey literature that can inform the development of a competency profile for physiotherapists to support and deliver rehabilitation services to refugees.

The definitions used for this review are displayed in Table 1. When discussing the articles included in this review, the terms refugee or migrant are used depending on which

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Table 1
Definitions used in this review.

Term	Definition
Refugee	According to the UNHCR a refugee is someone who: "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it" (UNHCR-Refugee Convention).
Migrant	A 'migrant' is fundamentally different from a refugee. Refugees are forced to flee to save their lives or preserve their freedom, but 'migrant' describes any person who moves, usually across an international border, to join family members already abroad, to search for a livelihood, to escape a natural disaster, or for a range of other purposes. However, refugees and migrants often employ the same routes, modes of transport, and networks. Movements of both refugees and migrants are commonly referred to as 'mixed movements'. It is important to distinguish the different categories of person in mixed migratory movements and apply the appropriate framework of rights, responsibilities, and protection (UNHCR-Emergency Handbook).

was used in the specific study. However, when the results of the articles are being discussed more generally, the term refugee is used consistently. As noted by the UNHCR [6], the large numbers of people arriving by boat to Europe in recent years comprise both refugees and migrants but the majority are refugees and the term migrant would only be correct for a small proportion.

Methods

A scoping review was conducted between November 2018 and February 2019. This review was informed by Arksey and O'Malley's [7] methodological framework and other recommendations from Levac *et al.* [8] and Peters *et al.* [9] and consisted of four steps. First, a search strategy was implemented to find relevant publications, next publications were screened and selected using our predetermined inclusion/exclusion criteria. Thirdly, the authors extracted the data from the included publications and grey literature, and lastly, the authors organised, summarised, and presented the results [7,9]. This review aimed to explore the extent and range of knowledge of this particular area, and therefore in keeping with the guidelines for conducting scoping reviews, the retrieved literature was not systematically appraised.

The search parameters included studies from peer-reviewed and grey literature relevant to the physiotherapy profession and published between 2000 and 2019. The start date of 2000 was chosen to reflect current physiotherapy practices. To locate peer-reviewed literature the following electronic bibliographic databases were searched: MEDLINE, EMBASE, CINAHL, PEDro and Ovid PsycINFO. Hand searching and reference list searching were also employed to locate peer-reviewed literature [9]. Grey literature was accessed through website searches, Google Scholar and direct requests to the following organisations: International Committee of the Red Cross, Humanity and Inclusion, Health Volunteers Overseas, Health Policy & Administration of the American Physical Therapy Association, Global Health Division of the Canadian Physiotherapy Association, Australian Physiotherapy Association, WCPT (World Confederation for Physical Therapy) and ADAPT (Chartered Physiotherapists in International Health and Development).

To ensure a comprehensive search, a health science librarian was consulted to develop the search terms and to ensure search terms were tailored for each database. An example of our search term strategy can be found in Table 2 (See Appendix 1 for the full electronic search strategy). Publications were excluded if: (1) the article was published prior to 2000, (2) the reviewers were unable to obtain an English translation of the article, (3) the article did not address refugees or migrants and the physiotherapy profession or physiotherapists' knowledge, activities, tasks, behaviours or skills.

Covidence Online Software (www.covidence.org) was used to manage the retrieved items, to perform the abstract/title review, and to extract the data from the studies included in the review. First, two reviewers independently screened articles for relevance based on their titles/abstracts. Any disagreements were resolved by a consensus discussion and/or consultation with two other researchers. When it was unclear if the research involved physiotherapy and/or refugees, the abstract was included in the full-text review. Full-text reviews and charting of the data were performed independently by two researchers. The research group developed a data extraction form to record essential information (study details, aims, population, methods, characteristics relating to physiotherapy and refugee health and potential implications for physical therapy), from each article. Patterns and common topics or findings in the data were identified by the reviewers and then discussed using a consensus approach to form the initial themes and subthemes. Using a thematic analysis approach the extracted data from the articles were then coded by each reviewer. Reviewers identified the predominant theme(s) in each article independently. A consensus approach was then used to refine the themes and to inform the directed content analysis of the data [10]. Key themes were identified and agreed upon by the two reviewers with any discrepancies resolved by a consensus discussion with a third reviewer.

Table 2
Ovid MEDLINE search strategy.

To encompass the term Physiotherapy or Physical therapy or Rehabilitation
- exp Physical Therapy Modalities
- Physical Therapists
- (physiotherap* or physical therap*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- (physiotherap* or physical therap*).jw.
- [OR] rehabilitat*.mp,jw
[AND]
To encompass the term Refugee
- "emigrants and immigrants"/or undocumented immigrants/or refugees/
- (emigra* immigra* or migrant*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
- (displaced adj3 (people or person* or group* or population*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

Results

Peer-reviewed literature

The search of the peer-reviewed literature returned 1365 articles. The stages of the peer-reviewed literature search are displayed in Fig. 1.

The ten included articles are summarised in Table 3. All the studies were conducted in Europe with the majority ($n = 8$) coming from Nordic countries. Five of the studies were interview-based, qualitative studies. The other methodologies employed were qualitative questionnaires, qualitative multiple case studies, Delphi method, longitudinal-single cohort, and controlled descriptive studies. Participants were migrants or refugees in four of the studies, health professionals in five of the studies and one study included both health professionals and refugees/migrants.

Grey literature

The exploration of grey literature returned nineteen documents. All documents went through full-text eligibility assessment. Documents were excluded if they were not specifically about physiotherapy practice; this resulted in thirteen documents being excluded. The six included grey literature articles are summarised in Table 4.

Key themes identified

The analysis of peer-reviewed and grey literature identified three key themes with five sub-themes:

1. Refugee health
   a. determinants of health
   b. physical health
   c. mental health
2. Cultural competence
   a. cultural sensitivity
   b. communication
3. Refugees and the healthcare system

Discussion

This comprehensive search of peer-reviewed and grey literature identified three themes that can be used to inform the development of competencies needed by physiotherapists working with refugees. It also highlights a lack of research in this area and the limited evidence for physiotherapy interventions for refugees. Only ten relevant peer-reviewed articles were found which emphasises the need for further research and education in this area. Furthermore, no articles specifically outlined the competencies needed by physiotherapists working with this population. However, the studies in this review do provide useful findings which could be used to inform the development of a competency profile for physiotherapists working with refugees. The sample sizes in these studies were generally small and the studies were published between 2002 and 2017. Consequently, they may not accurately reflect the situation for refugees today. This may limit the generalizability of the results to the current circumstance for refugees and should be considered when interpreting the results of this review.

Theme 1: Refugee health

As displayed in Tables 3 and 4, many of the articles discussed the mental and physical health of refugees and the factors that can influence these aspects of health. This data constituted the first theme, refugee health, which focused on the physical and mental health issues exhibited by refugees and also encompassed the determinants of health for refugees. An individual's health is determined by the social and economic environment, the physical environment, and a person's characteristics and behaviours [27]. In the literature, many determinants have been identified that can affect refugees'

Table 3
Summary of the relevant findings from the peer-reviewed literature.

Author	Key aims and objectives	Methods	Summary of relevant findings	Themes[a]
Dogan *et al*. [11]	To describe the problems Turkish immigrants and German healthcare personnel faced and the ethical implications of these problems.	Qualitative–survey	Highlighted the importance of good communication and an understanding of culture-based expressions of illness. Provided recommendations for the education of healthcare professionals to improve practice.	Cultural Competence.
Dressler and Pils[12]	To examine how the staff of a postaccident, in-patient rehabilitation centre in Austria perceived cross-cultural communication between the staff and migrant and ethnic minority patients.	Qualitative - semi-structured interviews	Participants recognised that language barriers and cultural aspects influence rehabilitation outcomes. There was particular reference to attitudes concerning disease and disability, differing views on the role of health professionals, and pain behaviour. Provided suggestions for overcoming these barriers.	Cultural Competence; Refugees and the Healthcare System.
Fougner and Horntvedt [13]	To describe Norwegian physiotherapy students' experiences of cultural diversity in practice.	Qualitative - semi-structured interviews	Cultural competency training is important for physiotherapists to help prevent interactions based on myths and stereotypes, and is vital to raise physiotherapists' consciousness of these phenomena and the concepts associated with them. Suggested that there should be additional focus on cultural competency for healthcare professionals in a multicultural society.	Cultural Competence.
Gard [14]	To identify factors important for a good interaction between a physiotherapist and a patient who has been tortured.	Qualitative - multiple case study	Identified five prerequisites for a good interaction with persons who have undergone torture and five factors in the interaction situation that are important for a good interaction.	Refugee Health; Cultural Competence.
Möller [15]	To examine how physiotherapists in primary health care experience encounters with migrant refugee patients.	Qualitative - semi-structured interviews	Highlighted that the collision of cultures between physiotherapist and refugee patient can be a challenge. Identified that cultural communication differences and language barriers exist and it is important to use a trained interpreter. Suggested physiotherapists need more knowledge to manage psychosomatic problems.	Refugee Health; Cultural Competence; Refugees and the Healthcare System.
Müllersdorf *et al*. [16]	To examine the experience of living with musculoskeletal pain and experiences of health care among dispersed ethnic populations of Muslim women.	Qualitative - semi-structured interviews	Discussed the association between refugee status and pain. Highlighted the need for physiotherapists to use good communication skills and cultural sensitivity for effective and patient centred rehabilitation outcomes.	Refugee Health; Cultural Competence; Refugees and the Healthcare System.

Table 3 (*Continued*)

Author	Key aims and objectives	Methods	Summary of relevant findings	Themes[a]
Nyboe *et al*. [17]	To compare bodily symptoms in traumatised refugees and Danish war veterans with post-traumatic stress disorder (PTSD) with healthy controls.	Controlled, descriptive study	Traumatised refugees have poorer movement function and more bodily complaints than healthy individuals. The Body Awareness Movement Quality and Experience scale (BAS MQ-E) may be a useful outcome measure when working with people with PTSD.	Refugee Health.
Palic and Eiklit [18]	To describe a specific, culturally diverse population of refugees in terms of traumatisation and symptom levels as well as global functioning and social support; and assess the effectiveness of the multidisciplinary treatment offered.	Longitudinal, single cohort study	Found that there were high rates of physical and mental health problems (including PTSD) among refugee populations and described determinants of maintenance and severity of PTSD. Physiotherapy in combination with psychotherapy and pharmacotherapy can lead to improvement in symptoms. Suggested that cognitive behavioural therapy (CBT) and body awareness therapy (BAT) are effective interventions.	Refugee Health; Cultural Competence; Refugees and the Healthcare System.
Persson and Gard [19]	To explore tortured refugees' expectations of the multidisciplinary pain rehabilitation programme offered at a specialised rehabilitation centre for torture victims.	Qualitative – semi-structured interviews	The refugees who had survived torture had different, mostly positive, expectations of the multidisciplinary pain rehabilitation programme. General expectations of the rehabilitation content, as well as specific expectations of the professionals' treatment, were expressed. Mutual and active participation and communication between patients and therapists were important expectations.	Refugee Health; Cultural Competence; Refugees and the Healthcare System.
Zander [20]	To determine the perceptions of pain and pain rehabilitation directed to resettled women from the Middle East, from a variety of health care professionals.	Delphi method	Highlighted the need to support and increase knowledge among healthcare professionals to involve the patient, their beliefs and expectations, background and current life situation, and to involve family and relatives in rehabilitation.	Cultural Competence; Refugees and the Healthcare System.

[a] Themes written in bold indicate that the theme was a key aspect of the article, themes in normal font indicate that the themes was present in the article but not a central focus.

Table 4
Summary of the relevant findings from the grey literature.

Author	Key aims and objectives	Methods	Summary of relevant findings	Themes[a]
EASP [21]	To build capacity through training of trainers in affected communities who can implement training activities for health workers so that they can develop intercultural competencies and have a clear understanding of a migrant sensitive health care delivery model.	Course syllabus	Describes 5 modules (including learning objectives, learning activities, and related reading): Context; Strengthening institutional capacity to organise the response; Capacity building for migrant sensitive health systems; Specific health concerns; Vulnerable groups.	Refugee Health; Cultural Competence; Refugees and the Healthcare System.
CARE [22]	To provide a syllabus for a training course for healthcare professionals working with migrants and refugees.	Course syllabus	Suggests topics and approaches to topics to be covered in a training courses for healthcare professionals working with migrants and refugees. Lists competencies, knowledge and skills.	Refugee Health; Cultural Competence.
Chaudry [23]	To share strategies that physiotherapists can use at the organisational level and individual clinician level to assist in eliminating the language barrier between the physiotherapy professional and their patient with limited English proficiency.	Narrative	Describes organisational and clinician level strategies for physiotherapists to appropriately address a patient's limited English proficiency for best practice to effectively work with the linguistically diverse patient populations.	Cultural Competence; Refugees and the Healthcare System.
MEM-TP Team [24]	To improve access to and quality of health services for migrants and ethnic minorities. It focused on reviewing, developing, testing and evaluating training in migrant and ethnic minority health for front-line health professionals in primary care settings.	Course syllabus and report	Describes the development, pilot and evaluation of a training programme for healthcare professionals working with migrants and ethnic minorities. Module units include knowledge about migrants' health problems and health determinants, intercultural competence and diversity sensitivity, interpersonal skill development and strategies for people-centred health care services oriented towards cultural and ethnic diversity.	Refugee Health; Cultural Competence; Refugees and the Healthcare System.
Nielsen [25]	To describe physiotherapeutic tools that could be applied in practice for physiotherapists who work with torture survivors in third world countries with limited resources.	Guidelines	Gives detailed practical guidance for physiotherapists working with survivors of torture. Identifies 3 most important symptoms that may present: chronic pain, PTSD, sleep disturbance.	Refugee Health; Cultural Competence.
Vanstone *et al*. [26]	To provide a guide for doctors, nurses and other health care providers for promoting health when caring for people from refugee backgrounds.	Guidelines	Provides detailed advice on working with refugees to promote health with some aspects particular to the Australian context. Sections 2, 3, 4 and 5 provide valuable resources relevant to physiotherapy practice.	Refugee Health; Cultural Competence; Refugees and the Healthcare System.

[a] Themes written in bold indicate that the theme was a key aspect of the article, themes in normal font indicate that the themes was present in the article but not a central focus.

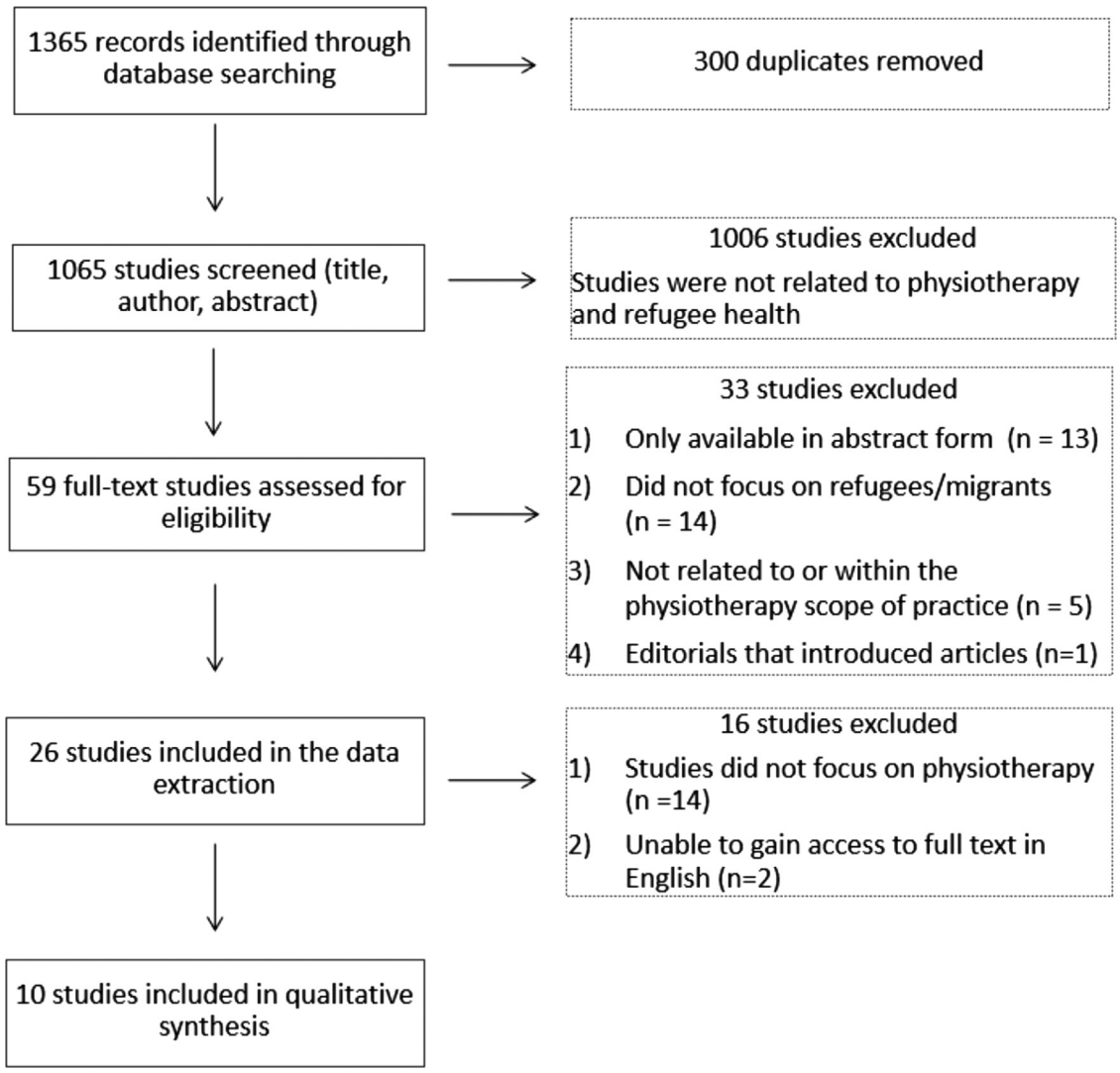

Fig. 1. Flowchart showing the article retrieval process of the articles to be included in the scoping review.

health during and after the migratory process. Examples of health determinants that should be considered when working with refugees include: uncertainty about civil status, unstable accommodation or homelessness, loss of social networks and isolation, anxiety about family and friends, poverty, racism in the host society and lower average socioeconomic status [15,16,18,21,22]. The literature indicates a significant proportion of refugees will have been subject to severe physical and/or psychological torture and that this exposure may have long-term physical and psychological consequences [18,19,26]. When working with survivors of torture, physiotherapists should take general health, torture, depression, stress, post-traumatic stress disorder, anxiety, migration history, social support, and socioeconomic status into consideration when developing treatment plans [14].

Several articles covered the physical and mental health of refugees. Refugees are known to have an increased risk of physical and mental health challenges because of the physical and mental strain they are likely to have experienced [18]. Common physical health problems reported in this population include infectious diseases, non-communicable diseases (NCDs), such as diabetes, hypertension, coronary heart disease, and musculoskeletal problems (e.g. injuries, backache, non-specific body pain) [3,22,26].

The risks to health are particularly high when migration is due to violent conflicts and associated with trauma, and it has been shown that pain is common in refugees who have experienced trauma [16,17,19,25] and can have a significant impact both physically and emotionally. The experience of pain can have a large impact on the individual's ability to participate in their daily activities [16].

When treating refugees, physiotherapists must be aware that they may be survivors of torture. There is a need to establish trust before inquiring about torture. Knowledge of the type of torture employed can, however, aid in evaluating injuries, scars, and other chronic sequelae [28]. For survivors of torture, pain is one of the most frequent complaints [19]. Physiotherapy is a key component of the multidisciplinary

approach to chronic pain management [29–31]. Managing chronic pain following torture is challenging due to the comorbid presence of somatic, psychiatric and social problems [28]. A biopsychosocial approach is needed to assess the total experience of pain and enable the development of multidisciplinary treatment plans for chronic pain [28,32]. These treatment plans should be tailored to the individual but may include: pain control, creating a realistic understanding of problems, graded steps to achieve short- and long-term goals for function and increased participation and focus on quality of life [14,28].

Additional physical impairments were found in the study by Nyboe *et al*. [17], where the bodily symptoms of traumatised refugees and war veterans were compared with healthy controls in Denmark. The refugees with post-traumatic stress disorder (PTSD) were found to have significantly poorer stability, balance, flexibility and coordination in movement, more muscular tension, more pain complaints, more restricted breathing, and greater limitations in activities of daily life compared to the healthy controls. Refugees can demonstrate acquired brain damage due to traumatic brain injury as a result of undernourishment or thirst for prolonged periods, or different forms of torture. Traumatic brain injury can easily be confounded with PTSD as the most common symptoms are memory and attention deficits, apathy, impaired social judgement, distractibility, and impulsivity [18].

The available literature recognised that refugees also have complex mental health needs [3,17,18]. These needs are a result of traumatic experiences, sociocultural variables and economic conditions that negatively affect one's health [14]. Refugees may present with PTSD, anxiety, and depression [3,17–19,21,25,26,32–34]. In their guideline for health professionals caring for people with refugee backgrounds, Vanstone *et al*. [26] explained the importance of knowledge of the psychological sequelae of trauma and torture. An individual's experiences of trauma and torture may impact their ability to participate in assessment and treatment [26]. When designing physiotherapy treatment plans for individuals that are suffering from PTSD, Nielsen [25] suggests that physiotherapists incorporate strategies that include: psychoeducation about PTSD, breathing exercises, grounding exercises, body awareness therapy, mindfulness training, physical training, relaxation massage and cognitive behavioural training [25]. Psychological recovery is assisted by attention to the individual's specific needs and, referrals should be made for counselling and other forms of specialised care when appropriate [26].

Theme 2: Cultural competence

A client-centred approach is central in providing culturally competent care [14,16,19,21,33]. Cultural competence is defined as: "a set of skills or processes that enable health professionals to provide services that are (culturally) appropriate for the diverse populations they serve" [35]. As displayed in Tables 3 and 4, cultural competence when treating refugees was a key aspect of most of the included articles. This data constituted the second theme, cultural competence.

The literature within the second theme presented two interrelated subthemes: cultural sensitivity and communication.

Refugees are a heterogeneous group of culturally, ethnically and linguistically diverse individuals with complex health needs. Consequently, they can face a range of cultural barriers to accessing care [3,36,37]. An understanding of these barriers is important when working with this population [22]. The impact of cultural differences between patient and therapist on assessment and treatment was highlighted and discussed in several papers. There was recognition that culture can influence attitudes concerning disease, disability and the role of health professionals [12,21,26] and cultural differences in beliefs about pain and disability may play a role in the expression of distress and help-seeking behaviour [12,15,18,32,36]. In a qualitative study investigating rehabilitation professionals' perceptions of cross-cultural communication, Dressler and Pils [12] found differing beliefs regarding taking an active role in rehabilitation and participating in activities of daily living were a source of frustration for the rehabilitation professionals.

Health professionals need to recognise the influence of cultural aspects on functional activities such as eating, hygiene and receiving visitors while in the hospital and be cognisant of these influences when delivering rehabilitation programmes [11]. In a study exploring the rehabilitation of women resettled from the Middle East in Sweden, Zander *et al*. [20] identified cultural differences relevant to healthcare between the women and the Swedish health professionals. The women in this study placed importance on the role of religion and spirituality in their recovery whereas this was not reported as relevant by the health professionals. The authors state that health professionals need to be conscious about their own cultural backgrounds and how their views affect their responses to the care of patients [20]. Similarly, Gard [13] advocated the importance of being sensitive to each individual's religious beliefs, norms and values. Additionally, health professionals need to consider cultural diversity when tailoring treatments to refugees' individual needs.

Fougner and Hornvedt [13] highlighted the importance of reflecting on preconceived ideas or biases when working with patients from different cultures. Physiotherapy students in the study were found to switch between two models when dealing with diversity. Depending on the context, students switched between the idea of "sameness" or "otherness." In one model, the students respected the otherness of the Muslim patients and their dress choices as integral to their culture. However, in the other model, the students perceived the women's dress choices as inhibiting integration into the majority culture. Dogan *et al*. [11] argued that it is a matter of ethical responsibility for health professionals to have the ability to explore the meaning of illness, understand patients' social and family contexts and provide culturally competent care. The literature

Table 5
Implications for practice and suggested competencies for physiotherapists working with refugees.

Implications for practice
Physiotherapists should be aware of the complex physical, mental and social problems which can contribute to poor health outcomes for refugees and impede their social integration.
A significant proportion of refugees have been subject to torture (physical or psychological) which can have long-term consequences for their physical and mental health.
When developing treatment plans for this cohort, physiotherapists should take general health, torture, depression, stress, post-traumatic stress disorder, anxiety, migration history, social support, and socioeconomic status into consideration.
Chronic pain is common in refugees, especially those who have experienced trauma and/or torture, and can have a significant impact on both physical and emotional well-being.
Treatment plans should be tailored to the individual and a biopsychosocial approach that includes physical, psychological and social-contextual factors is needed to assess the total experience of pain.
Refugees can have complex mental health needs and may present with PTSD, anxiety and/or depression.
Physiotherapists should be cognizant that health consultations can be a source of anxiety for refugees and employ appropriate strategies to mitigate for this.
Physiotherapy interventions for patients with mental health issues can include psychoeducation about PTSD, breathing exercises, grounding exercise, basic body awareness therapy, mindfulness training, physical training, relaxation massage and cognitive behavioural training.
Physiotherapists should be aware of the range of barriers that refugees can face to accessing care. Cultural barriers, stereotyping, communication difficulties and health professionals' lack of cultural awareness can be difficulties experienced by refugees.
Physiotherapists must be aware of the influence that culture can have on attitudes concerning health, disability and the role of health professionals. They should recognise the influence of culture on functional activities and be sensitive to each individual's religious beliefs, norms and values.
Physiotherapists should be conscious of their own cultural background and how it may affect their responses to and care of patients in pain.
To provide appropriate care for refugees, it is essential that physiotherapists have strong, culturally competent communication skills.
Professional interpreters should be used when there are language barriers.
Difficulties in understanding how to navigate foreign health systems, stereotyping, cultural issues, poor understanding/awareness of available services, practical considerations and communication difficulties are barriers commonly faced by refugees when trying to access healthcare.
Treatment interventions reported in the literature included physical activity, pain management, cognitive behavioural therapy (CBT) and body awareness therapy (BAT).

supports the use of training to develop cultural competence [24,26] and Fougner and Horntvedt [13] suggested that this topic should be included in the physiotherapy curriculum.

Communication and the difficulties that arise due to language barriers were prominent and recurring subjects in the literature [11,12,15,16,19,23]. Physiotherapists need strong, culturally competent communication skills to ensure that appropriate care is provided to their patients. Communication can be influenced by cultural and language barriers, and efforts should be made to cope with these barriers [11,15,21]. It was evident in the current literature that the care refugees receive can be improved by using professional interpreters when language barriers occur [11,12,15,20,23,26].

Major language barriers that affect the ability to communicate the importance and benefits of rehabilitation may have significant consequences and can lead to patient drop out. In a qualitative study, Turkish migrant patients were found to place importance on good communication, physical contact, and understanding of their culture-based expressions of illness, while the healthcare professionals expressed that they need resources and personnel to minimise language barriers as well as education and training in Turkish culture [11]. The authors recommended simulation activities, cross-cultural communication exercises, immersion programmes, and didactic materials as appropriate learning tools [11].

Theme 3: Refugees and the health care system

The final theme covered refugees' experiences of accessing healthcare and navigating the healthcare system in their host country. While refugees' experiences of healthcare were not a key concept in all of the included studies, it was explored in several of them (see Tables 3 and 4). Refugees can face many barriers when trying to access healthcare, including difficulties in understanding how to navigate foreign health systems [26], stereotyping, cultural issues, communication difficulties and practical considerations [12,37]. Many are either unaware of available services (such as primary healthcare) or specific health services (such as rehabilitation) [3,38].

Persson and Gard [19] found that expectations of a multidisciplinary pain rehabilitation programme were mainly positive and expressed in terms of trust and hope in the professionals as rehabilitation experts. Both positive and negative healthcare experiences were expressed by participants in a study of Muslim women from migrant backgrounds in Sweden [16]. Positively, there were reports of knowledgeable care providers who performed careful examinations. However, other participants reported negative experiences, including ineffective treatment and an impression of not having access to available treatment [16].

While this review focused on physiotherapy competencies, the need for a multidisciplinary approach to rehabilitation was recognised [19,20,28]. Persson and Gard [19] advocated that a multidisciplinary approach is key to the rehabilitation of survivors of torture. Similarly, Zander *et al.* [20] highlighted the importance of multidisciplinary collaboration with the patient to overcome difficulties identifying and meeting their needs. Treatment interventions reported in the literature included physical activity [19,20]; pain management [19,20,25]; cognitive behavioural therapy [16] and body awareness therapy [18,25]. Implications for practice drawn from the findings of this scoping review are displayed in Table 5. These practice points can be used to inform the development of a competency profile for physiotherapists working with refugees.

This review has highlighted the limited amount of literature describing competencies for physiotherapists working with refugees and the need for more studies in this area. To improve the evidence base, there is a need for experimental studies which evaluate treatment approaches and physiotherapy interventions for refugees. Studies are also needed which compare approaches and highlight the considerations needed for different cohorts of refugees. Both quantitative studies which measure the outcomes of interventions and qualitative studies that explore refugees' experiences of physiotherapy are warranted. There is also a need to evaluate educational programmes which aim to develop the competencies of physiotherapists working with refugees to investigate whether they have an effect on physiotherapists' behaviours and ultimately patient outcomes.

Limitations

There are some limitations of this scoping review that are worth noting. The authors were unable to access the full-text articles for 2 studies even though efforts were made to source the articles from other libraries and to contact the authors. The heterogeneity of the included studies made it challenging to draw universal themes from the data. Thus, the conclusions made in this article are at a high (rather than specific) level. The authors were unable to provide recommendations for physiotherapy competencies specific to different contexts and cohorts of refugees. The exclusion criteria for this study meant that studies related to professions other than physiotherapy or to cultural groups other than refugees or migrants were excluded. Thus, relevant information that may inform the competency profile for physiotherapists working with refugees may have been missed.

Scoping reviews have inherent limitations because the focus is to provide breadth rather than depth of information in a particular topic [39]. Only the reference lists of selected studies were reviewed therefore it is possible that relevant articles may have been missed. Additionally, because the aim of a scoping review is to map the evidence produced in a given area rather than seek out the best available evidence to answer a specific research question, there was no methodological quality assessment of the included articles [9,40]. However, care was taken to ensure that all relevant articles were included in the study. When studies published in another language were found these were translated (or analysed by other researchers) to allow them to be screened.

Conclusion

This paper aimed to summarise core competencies for physiotherapists working with refugees from peer-reviewed and grey literature. While this review focused on physiotherapy competencies, there was recognition of the importance of a multidisciplinary approach to rehabilitation for this cohort. The main competencies detected are: (1) an understanding of refugee health, (2) administration of culturally competent care, and (3) knowledge of healthcare systems as they relate to refugees. These are, however, rather vague and non-specific and signal the need for further examination of physiotherapy competencies to provide the highest quality of care to this growing population. The limited amount of literature describing competencies for physiotherapists working with refugees highlights a need to develop a competency profile for this profession and to explore how best to teach this in higher education institutes. It is our opinion that this review can be used to inform such a competency profile.

Contribution of paper

What does this paper add to the current literature?

This review summarises the existing knowledge base related to the provision and delivery of rehabilitation services to refugees.

Practical considerations for physiotherapists working with refugees are provided.

Key messages

The main competencies needed by physiotherapists working with refugees are an understanding of refugee health, administration of culturally competent care, and knowledge of healthcare systems as they relate to refugees.

Rehabilitation provided to refugees should take a multidisciplinary approach.

Further exploration of the physiotherapy competencies needed to provide the highest quality of care for refugees is warranted.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at https://doi.org/10.1016/j.physio.2020.04.004.

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