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Integrated Care for Migrant Populations: A Scoping Review

RESEARCH AND THEORY

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ABSTRACT

Introduction: Migrants often encounter major health challenges upon arrival, including language barriers, unfamiliar healthcare systems, and lack of insurance. Addressing their needs require a clear understanding of integrated care. This scoping review synthesizes current literature on migrant healthcare needs within integrated care programs, highlighting effective strategies and persistent challenges.

Methods: A systematic search was conducted across five databases using predefined inclusion criteria. Seventeen eligible studies were analyzed following Arksey and O'Malley's scoping review framework. A narrative synthesis was performed to identify key findings.

Results: Four categories of migrant needs emerged: 1) access to care and administrative support, 2) communication, 3) relational, and 4) systemic and professional. Effective programs featured strong interpersonal and intersectoral collaboration, culturally safe services, access to multiple services, and emotional/administrative support. Challenges faced by patients included language and literacy barriers, geographic obstacles, limited-service access, and issues of distrust, reluctance, and dissatisfaction.

Discussion: Findings emphasize the importance of improving interpreting services, staff training, and implementing remuneration systems to support integrated care delivery.

Conclusion: Future research should include representative samples and could explore approaches that enhance cultural safety to address the complex and multifaceted backgrounds of these communities.

RÉSUMÉ

Introduction : Les migrants sont souvent confrontés à d'importants défis en matière de santé lors de leur arrivée dans leur pays d'accueil, notamment en raison des barrières linguistiques, de leur méconnaissance du système de santé et de l'absence de couverture d'assurance. Répondre adéquatement à leurs besoins nécessite une compréhension approfondie des soins intégrés. Cette revue de la portée vise à

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MOTS-CLÉS :
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synthétiser les connaissances actuelles sur les besoins de santé des migrants dans le contexte des programmes de soins intégrés, tout en mettant en lumière les stratégies les plus efficaces ainsi que les défis qui persistent.

Méthodes : Une recherche systématique a été menée dans cinq bases de données en utilisant des critères d'inclusion prédéfinis. Dix-sept études admissibles ont été analysées selon le cadre méthodologique de revue de la portée d'Arksey et O'Malley. Une synthèse narrative a été réalisée afin d'identifier les principaux résultats.

Résultats : Quatre catégories de besoins des migrants ont émergé : 1) l'accès aux soins et le soutien administratif, 2) la communication, 3) les besoins relationnels et 4) les besoins systémiques et professionnels. Les programmes efficaces se caractérisaient par une forte collaboration interpersonnelle et intersectorielle, des services culturellement sécuritaires, un accès à une diversité de services ainsi qu'un soutien émotionnel et administratif. Les principaux défis rencontrés par les patients comprenaient les barrières linguistiques, les faibles niveaux de littératie en santé, les contraintes géographiques, l'accès limité aux services ainsi que des enjeux de méfiance, de réticence et d'insatisfaction.

Discussion : Les résultats mettent en évidence la nécessité d'améliorer les services d'interprétation, de renforcer la formation du personnel et de mettre en place des mécanismes de rémunération soutenant la prestation de soins intégrés.

Conclusion : Les recherches futures devraient inclure des échantillons plus représentatifs et explorer des approches favorisant la sécurisation culturelle afin de mieux répondre à la complexité et à la diversité des réalités vécues par ces communautés.

INTRODUCTION

In developed countries, the long-term well-being and mental health of migrants —including immigrants (a term that encompasses permanent residents [1] and refugees [2]), as well as temporary residents such as asylum seekers and visa holders [1] — are closely linked to their societal inclusion and settlement processes [3, 4]. Migration also plays a key role in shaping demographics [5]. For example, between January 1 and April 1, 2025, Canada's population grew by just 20,107 — the lowest since 2020 [1]— yet this growth was entirely due to migration [1]. This trend underscores both a declining birth rate and an ageing population. In this context, successful migrant integration is vital not only for economic sustainability but also for fostering social cohesion in an increasingly diverse society. Such integration must be pursued with full respect for migrants' fundamental rights and dignity [6].

However, migrant integration remains a major challenge, particularly due to persistent barriers in accessing employment, housing, and—most critically—healthcare [7]. Limited access to healthcare services, often caused by language barriers, unfamiliarity with the health system, and lack of insurance, [8] contributes to poorer health outcomes, including elevated morbidity and mortality [9]. These issues are further exacerbated by pre-existing vulnerabilities such as migration-related stress, trauma, and inadequate care for chronic conditions prior to or during migration [10]. Barriers to healthcare thus represent a major obstacle to migrants' successful integration, as the well-being of an individual is a fundamental prerequisite for adaptation and flourishing in a new environment [11, 12].

This persistent issue of unmet healthcare needs has raised questions about the potential of integrated care to support migrants' health and well-being, especially in light of the low quality of care often received upon arrival [13–15] and the demonstrated effectiveness of this approach within the general population [16]. Broadly, integrated care seeks to address the fragmentation of healthcare services by ensuring that care is coordinated and responsive to individuals' needs across providers, sectors and stages of care. Accordingly, the World Health Organization defines integrated care as:

> 'Health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.' [17, p. 2].

Despite its promising outcomes, the current literature indicates that integrated care models remain underdeveloped and insufficiently evaluated, especially

for refugee populations. For example, mental health screening is often not routinely incorporated into initial health assessments, despite the high prevalence of mental health concerns among refugees [18].

Currently, important gaps remain in the literature regarding the breadth, nature, and extent of migrants' needs, the characteristics of successful integrated care programs, and the challenges associated with their implementation. To our knowledge, no scoping reviews have specifically addressed this topic. However, we identified a few reviews that address relevant aspects. Esala et al.'s systematic review [19] focussed on collaborative care for refugees and torture survivors, analyzing articles published between 2000 and 2016. While findings suggested that collaborative care was associated with improved access and use of health resources, the authors deemed the results inconclusive due to a lack of experimental studies and insufficient detail regarding the coordination programs. Collaborative care interventions included psychotherapy, pharmacotherapy, social counseling and/or physiotherapy [20, 21]. Moreover, the scoping review of Batista et al. [22] identified multiple barriers related to migrants' healthcare needs, including insurance eligibility, cultural differences, and language barriers, as well as strategies to address these challenges, such as attention to cultural norms and the use of interpreters and cultural brokers. These findings were derived from an examination of two healthcare models—Primary Medical Care and Primary Health Care. However, these findings were reported in the context of primary care and did not specifically address integrated care settings. Finally, Martinez et al. [23] reviewed randomized controlled trials (RCT) on integrating behavioural health and primary care for people of colour, but the scarcity of RCTs limited the identification of effective integrated care characteristics.

Thus, a broader, more inclusive and up-to-date literature review of the literature is relevant to better understand the role of integrated care in supporting migrants' health, and to promote their well-being and successful integration into host societies. Recent findings could inform system renewal and guide the development of policies that are fully responsive to migrants' needs, while also offering practical recommendations for healthcare professionals to deliver appropriate and equitable care to this population. This scoping review aims to synthesize current evidence on the specific needs of migrant populations within the context of integrated care, as well as the positive characteristics of programs, and the challenges encountered by both healthcare providers and migrant patients.

METHODS

This scoping review was conducted following the five-stage methodological framework proposed by Arksey & O'Malley [24], and subsequently refined by Levac et al. [25]. In addition, the PRISMA-ScR checklist [26] and associated guidelines [27] were followed to ensure methodological rigour and transparency. This methodological approach was particularly well suited to the objectives of this review, as it facilitated the comprehensive mapping of available evidence and the identification of knowledge gaps related to integrated care for migrant populations [28].

STAGE 1: IDENTIFYING THE RESEARCH QUESTION

The research question guiding this scoping review was: What is the current state of knowledge in the literature regarding the specific needs of migrant populations within the context of integrated care, including the positive characteristics of programs and the challenges faced by both professionals and patients?

STAGE 2: IDENTIFYING RELEVANT STUDIES

Relevant studies were identified across five electronic databases: CINAHL, Medline, Scopus, Embase and SocIndex with Full Text. A medical librarian was consulted to develop a conceptual search strategy based on keywords previously selected by the specialized research team, namely *integrated care* and *migrant*. Medical Subject Headings (MeSH) and Embase subject headings (Emtree) were incorporated according to the indexing standards of each database. To ensure relevance to the current needs of migrant populations, the search was limited to studies published within the last 10 years (2015–2025). Only studies published in English or French were included, in accordance with the language proficiency of the research team. The search strategy is described in Appendix 1.

STAGE 3: STUDY SELECTION

To be included, studies had to meet the following criteria: 1) focus on adult migrants (aged 18 years and older, immigrants (a term that encompasses permanent residents and refugees), as well as temporary residents such as asylum seekers and visa holders); 2) be conducted in a developed country listed by the Organization for Economic Co-operation and Development [29], to ensure consistency in identified needs and relevance to the North American context—given that developing countries may present major and persistent adverse health conditions that could influence findings; 3) report empirical results (qualitative, quantitative, mixed-methods); and 4) have integrated care as a central objective.

Studies were excluded based on the following criteria: 1) availability of abstract only; 2) focus on one or more specific diseases; 3) targeting overly specific subpopulations (e.g., migrant farm workers, migrants with hearing disabilities, pregnant migrants); and 4) addressing socioeconomically vulnerable or disadvantaged populations, where migrants were often considered a subcategory rather than the primary focus.

Following the identification of relevant studies, duplicates were removed using the systematic review management tool Covidence. Titles and abstracts were screened by the lead author (MP), permitting the exclusion of articles that did not meet the inclusion criteria. Subsequently, two team members (MP and ALC) independently reviewed the full texts of the selected articles. In rare cases where consensus could not be reached, a third team member (CH) was consulted to resolve discrepancies.

STAGE 4: CHARTING THE DATA

A data extraction template was developed in Covidence and subsequently exported to Excel by one team member (MP). To enhance accuracy, a second author (ALC) reviewed the extracted data for three studies. The template included the following variables: authorship, country of study, year of publication, study aim, study design, methodological summary, type of integrated care provided, population description, identified needs, and study limitations.

STAGE 5: COLLATING, SUMMARIZING AND REPORTING THE RESULTS

The results were collated, summarized, and reported by the lead author (MP), following the narrative synthesis approach outlined by Popay et al. to systematically summarise and explain findings across the included studies [30]. A second author (ALC) contributed to the narrative synthesis and interpretation of the data using an inductive approach. Patterns, similarities, and differences across the included studies were examined to identify and organize key findings. The second author (ALC) also participated in the validation and interpretation of the findings [30].

RESULTS

RESULTS OF THE SEARCH STRATEGY

A total of 6,057 studies were initially identified across five databases. Following the removal of 2,434 duplicates, 3,623 studies were retained for title and abstract screening. Of these, 89 were assessed for eligibility through full-text review, resulting in the inclusion of 17 studies. A manual search of reference lists from selected articles and previously identified scoping and systematic reviews was also conducted, but no additional relevant studies were found (Figure 1).

CHARACTERISTICS OF INCLUDED STUDIES

The 17 included studies were conducted across four countries: the United States (n = 9), Australia (n = 4), Canada (n = 2), and Germany (n = 2). Publication years ranged from 2015 to 2024 (Figure 2). Most studies employed quantitative designs (n = 7), followed by qualitative (n = 6) and mixed-method approaches (n = 4). While one study focused exclusively on healthcare professionals working in an integrated care setting, the remaining 16 included migrant populations (immigrants and temporary residents). Migrants originated from a diverse range of countries, including Afghanistan, Sri Lanka, Iran, Myanmar, Iraq, Burundi, the Democratic Republic of Congo, Sudan, Eritrea, Pakistan, and Syria. Three studies incorporated staff perspectives, and two included viewpoints from white Medicare beneficiaries. Full characteristics of included studies is available in Appendix 2.

NEEDS IDENTIFIED

Across the reviewed studies, identified needs in the context of integrated care were categorized into four main areas: 1) Access to care and administrative support, 2) Communication, 3) Relational needs of patients, and 4) Needs of the healthcare system and professionals. A complete description of these categories is available in Appendix 3.

Access to care and administrative support

Needs related to access to care and administrative support were identified across five studies, and referred to difficulties navigating, coordinating, and physically accessing integrated care services. In White et al. study [44], participants emphasized the critical role of nurses and social workers in facilitating connections with general practitioners, thereby improving care accessibility. Transportation barriers were frequently mentioned, with many participants lacking personal vehicles and being unfamiliar with public transit systems. Similarly, Esala et al. [36] reported that patients frequently required assistance with administrative tasks, such as completing complex paperwork. Bockey et al. [38] proposed that implementing a structured appointment schedule could significantly enhance care coordination. Furthermore, Huminuik et al. and Peer et al. [41, 43] emphasized the need for highly specialized and long-term care, especially for refugees with complex backgrounds who require extended support. Finally, participants from White et al.'s study [44] reported that phone call reminders were more effective than SMS or mail for managing appointments.

Communication

Communication needs regarding access to and use of interpreter services in integrated care programs were identified in four studies. Three of these [43, 44, 47] explicitly emphasized the importance of interpreter services, with a preference for in-person interpretation, although telephone-based options were also considered acceptable. In contrast, Huminuik et al. [41] reported that some participants were reluctant to use interpreter services due to concerns about confidentiality. In such cases, individuals expressed a preference for communicating directly with trained professional counsellors.

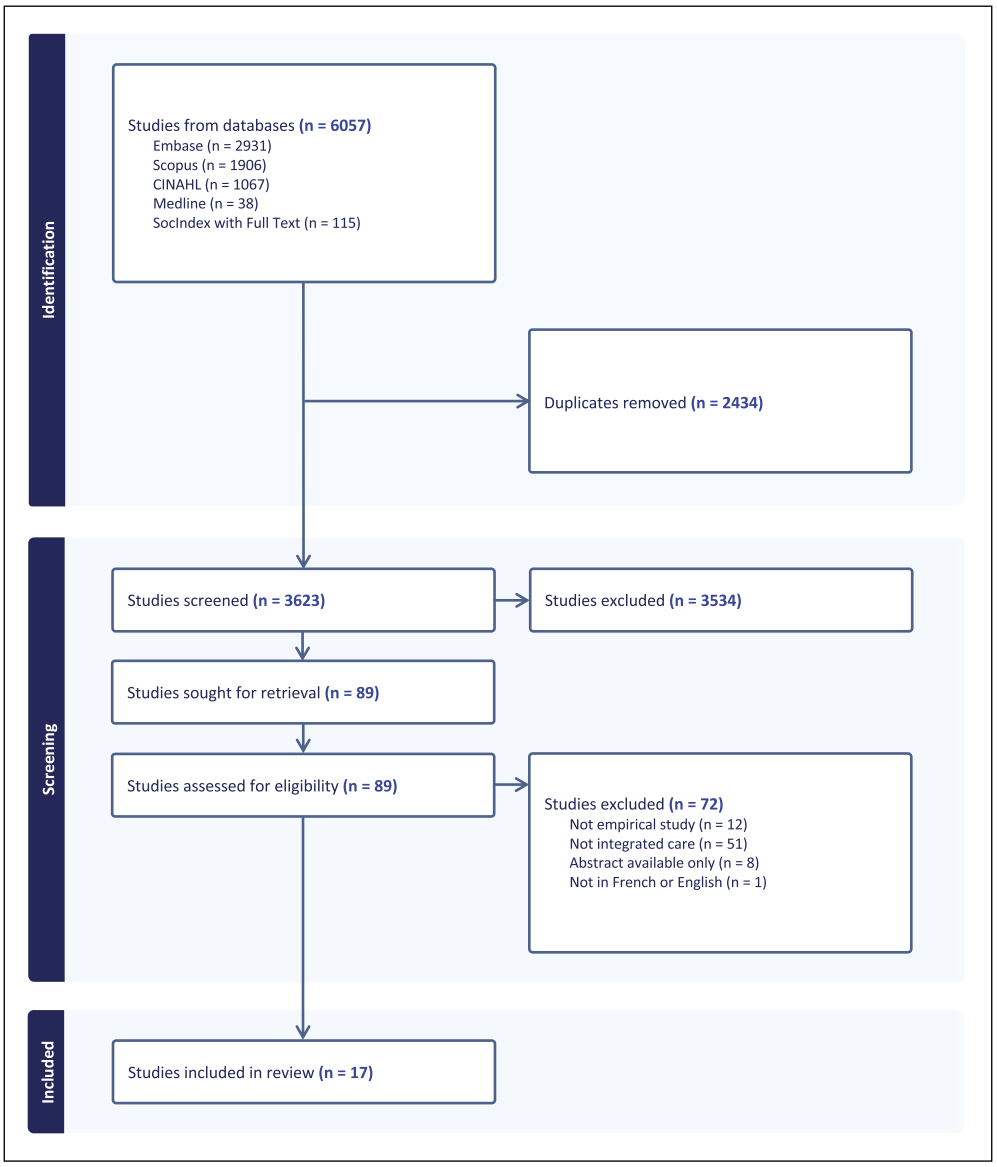


Figure 1 Flowchart.

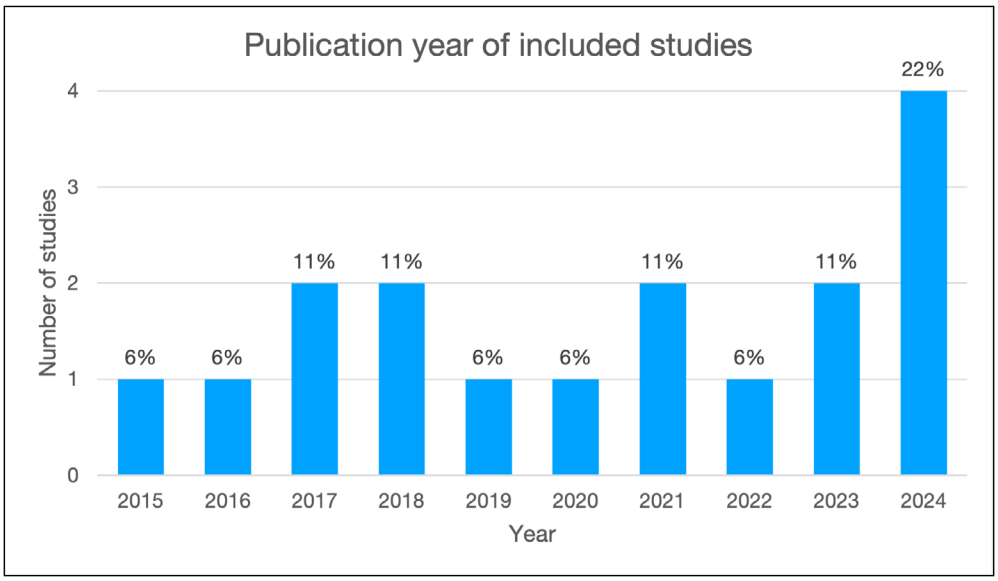


Figure 2 Publication year of included studies.

Relational needs of patients

Relational needs regarding the patient-provider relationship in integrated care settings were discussed in three studies. Bockey et al. [38] emphasized the importance of gender-appropriate care. Many participants from Huminuik et al.'s study [41] expressed greater comfort when receiving therapy from professionals who were outside the political, religious, and social contexts of their country of origin. This distancing was perceived as essential for fostering trust and openness. Additionally, participants from Reboe-Benjamin et al.'s study [45] highlighted the need for more supportive and empathetic family physicians.

Needs of the healthcare system and professionals

Needs of the healthcare system and professionals were explicitly identified in three studies. This category encompasses needs related to integrated care program implementation, interdisciplinary team functioning, and the organizational resources necessary for effective service delivery. From the perspective of healthcare workers, interprofessional trust was highlighted as a key requirement for the successful implementation of integrated care programs [43]. The presence of a facilitator—such as a community health worker—was also deemed essential. This role was seen as pivotal in engaging patients in their care, guiding access and follow-up, promoting integrated care, and addressing social determinants by connecting individuals with community resources. A lack of training across disciplines (including medicine, nursing, and social work) regarding the integration of behavioral health into primary care was reported in two studies [35, 43]. Additionally, staff cited insufficient resources to overcome linguistic and cultural barriers, which hindered the delivery of appropriate care [35]. Healthcare professionals in Ma and Saw's study [35] also emphasized the need for a reimbursement system to account for the additional time and training required to effectively serve migrant populations within the context of integrated care. The need for private consultations—without the presence of family members—was raised in Peer et al.'s study [43], particularly in cases involving Iraqi women who were restricted from discussing personal issues outside the family context. Finally, the importance of connecting patients with community-based resources was reiterated (Peer et al. 2023) [43], and Bockey et al. [38] identified the need to increase staffing levels to meet care demands.

CHARACTERISTICS LINKED TO POSITIVE OUTCOMES AND CHALLENGES ENCOUNTERED

Characteristics associated with positive outcomes and challenges encountered were analyzed and categorized to provide insights into the implied needs across all selected studies. Additional characteristics and challenges not discussed in the main text are presented in Table 1, providing further context to the findings.

Although Table 1 summarizes the impacts of the reviewed programs, these are not discussed in detail, as this scoping review does not assess the methodological quality of the included studies.

Characteristics linked to positive outcomes

Interpersonal and intersectoral communication and collaboration

Interpersonal and intersectoral communication and collaboration were identified in six studies as key characteristics associated with positive outcomes. Cheng et al. and Reboe-Benjamin et al. [37, 45] emphasized the

Characteristics linked to positive outcomes	Interpersonal and intersectoral communication and collaboration	- Formal (*e.g.,* case management meetings, regular team meetings) and informal (*e.g.,* meetings between staff conducted as needed) communication system [34, 35] - Close contact between case manager and PCP for better access to medication and fulfill the needs [36]
	Services culturally securing for patients	- Services oriented towards patients and delivered with respect and in a culturally appropriate way [33, 34] - Use of a strengths-based approach by counsellors [41], normalizing traumatic stress reactions and conversations about the interrelation of physical and mental wellbeing [46] - Friendly and helpful staff/trusting and respectful relationships between health professionals and patients [33, 41, 45]
	Access to multiple services	- Integrated physical and mental health services (*e.g.,* free services, accessible psychological education, health systems navigation information, logistical, financial and legal support, trained bicultural health workers) [31, 40, 41, 44] - Early access and avoiding travelling long distances to unfamiliar cities by the program negotiating visits with specialists [44] - Access to essential services (pharmacy, laboratory, x-ray, referrals) [45] - An hour per week reserved for clients to focus on themselves [41]
	Access to emotional and administrative support or guidance to access care	- Access to an existing Ezidi community for advice (explain the health care process, provide support by attending appointments, help with transportation) [44] - Help of staff to manage insurance and paperwork [44] - Health advice given to participants from doctors [45]

(Contd.)

Challenges encountered	By integrated care providers		- Telephonic interpreters not being able to consider body language (resulting in cancelled appointments and delays) [44] - Creating a continuum between organizations regarding roles (behavioural health vs. primary care providers), administrative procedures and vision of integrated care [35] - Gender mismatch affecting patients' engagement [43]
	By patients	Language and literacy	- Language restriction of staff and no permanent interpreter [38, 44, 45] - Feelings of distress, confusion and vulnerability by participants (*e.g.,* overwhelmed and disoriented regarding access to health services when unable to speak English, even when transport was arranged) [44, 45] - Difficulty of participants to understand the role of each team member and services available and needed (enhanced when poor health literacy) [44]
		Geographical	- Practice being too far from home, limited transport, unfamiliarity with transportation services [33, 44, 45]
		Access to services	- Treatment not able to be provided (dental, eye or ear care) [38, 45], no change or worse health status [45] - Waiting time, referrals, opening hours and multiple transfers between reception centres causing missed specialist appointments [38] - Insufficient number of sessions (10) [41] - Difficulty accessing insurance and advocating for services needed, concerns about the delays of accessing insurance and accessing permanent housing [44] - Difficulty with the booking system and management of health care appointments [44] - Persistent symptoms (though significantly reduced and more manageable) and unresolved concerns [41]
Impacts of programs	Better access and care coordination for improved health outcomes		- Health concerns adequately addressed, information well explained and increased understanding and control of health [33, 36, 37, 41, 42, 45] - Better redirection of refugees to specialized mental health services [42] - Better adjustment to new physician, particularly for participants with good English proficency [45] - Easy access to appointments [41, 45] or specialists [45], early access to treatment [44], better follow-ups [35, 42, 45] - Increased connection with a community general practice after leaving the program [33] - More time with care providers [36, 45], including physicians learning about their patients' mental health conditions [35] - Improvement of health status and management of complex health issues [41, 44, 45] - More healthcare utilization [31, 47]
	Positive outcomes on health care team		- Mutual respect and collaboration in staff's working relationships [34, 35]
	Positive experiences, empowerment and better self-management of patients		- Feeling understood, better coping skills, increased acceptance, self-knowledge, confidence and optimism for the future [41, 45] - Increased self-efficacy, sense of responsibility, and motivation for individual behavioural change of patients [35] - Increased knowledge of patients regarding health services available, better independence to seek help [36, 41, 44, 45] - Satisfaction and appreciation of the program [33, 38, 41, 44, 45] - Better perception of integrated care (*e.g.,* home health management, specialist awareness of medical history, assistance with self-directed care) among Black and Hispanic individuals compared to white individuals [39] - Improvement of relationships as couples and parents [41] - Better reporting of trauma events [31]

Table 1 Characteristics linked to positive outcomes, challenges encountered and impacts of programs.

value of formal collaborative planning and partnerships with external agencies—such as those providing health services beyond general practice—where clearly defined roles contributed to improved patient satisfaction, enhanced access to care, and greater awareness of available services. In Ma and Saw's study [35], providers noted that involving patients through transparent communication of health data, shared decision-making, and informal peer support was particularly effective in increasing patient motivation and engagement in their own health. Peer involvement was similarly highlighted by Ma and Saw and Griswold et al. [35, 40]. For example, participants in Ma and Saw's study [35] reporting that volunteering within the integrated care program—such

as by recruiting other patients, helping in wellness activities or assisting care as an interpreter—was a motivating and empowering experience.

Services culturally securing for patients

Thirteen studies identified that delivering services culturally securing for patients was a key factor contributing to positive patient outcomes. Cultural safety extends beyond cultural awareness, sensitivity and competence by emphasizing client-driven care and critically examining 'power imbalances, institutional discrimination, colonization, and colonial relationships as they apply to health care' [48, 49]. Three studies [41, 43, 44] emphasized the role of multilingual, culturally responsive, and sensitive settlement workers and counsellors in providing supported referrals and mental health counselling. For instance, Peer et al. [43] reported that providers received targeted training to ensure care was appropriately tailored to the specific needs and backgrounds of refugee populations. Patients in Huminuik et al.'s study [41] noted that having a counsellor or case manager who spoke their first language significantly facilitated their adaptation to life in a new country. Similarly, patients from Ma and Saw's study [35] found that language-concordant care helped reduce discomfort when discussing mental health concerns with providers. Onsite interpretation services were also widely appreciated, as reported in multiple studies [31, 33, 37, 42, 43, 45, 47]. Participants valued clear explanations of medical terminology and health conditions, which improved understanding and engagement. Peer et al. [43] specifically noted that some Iraqi refugees would only schedule appointments if an interpreter was available, highlighting the critical role of language accessibility. Moreover, the presence of interpreters was associated with increased patient satisfaction and repeat visits to integrated care facilities [47].

Access to multiple services

Access to multiple services within a single location was associated with positive outcomes in eight studies. Specifically, four studies [33, 36, 42, 45] reported that co-locating services—such as those addressing mental health, physical health, and social needs—was beneficial for patients. In one study [36], 33% of participants indicated that having services available in one place significantly improved convenience and ease of access, particularly given the common need to visit multiple providers across different locations.

Access to emotional and administrative support or guidance to access care

Access to emotional and administrative support, as well as guidance to access care, was identified as a positive program characteristic across five studies. Three studies [33, 40, 41] specifically highlighted the value of assistance in reaching healthcare services. In McBride et al.'s study [33], 74% of participants recognized the role of bicultural workers in providing practical support, such as directions for using public transportation, walking routes, or driving. Similarly, Huminuik et al. [41] reported that 87% of patients experienced improved access to appointments due to flexible scheduling by counsellors and the provision of bus tickets.

Challenges encountered

By integrated care providers

Challenges encountered by integrated care providers were reported in four studies. In one study [45], patients highlighted difficulties with staff respecting cultural beliefs and parental rights, which negatively impacted the patient-provider relationship. Clinicians in another study [43] expressed concerns regarding the use of telephonic interpreter services. Although interpreters were trained in medical terminology, clinicians were uncomfortable with the interpreter services offered, noting that interpreters lacked adequate preparation to understand cultural nuances and were often unfamiliar with both the patient and the provider.

By patients

Language and literacy

Challenges related to language and literacy were reported by patients in five studies, with limited English proficiency emerging as the most frequently cited challenge [33, 44, 45, 47]. In White et al.'s study [44], some participants described difficulties accessing care due to their inability to speak English. This study, along with Reboe-Benjamin et al.'s article [45], also highlighted that limited health literacy contributed to reduced patient engagement, resulting in persistent concerns and unanswered questions. Additionally, low English proficiency was associated with suboptimal interpersonal relationships and continuity of care, as well as difficulties in effectively engaging with healthcare professionals.

Access to services

Challenges related to accessing services were identified in four studies. In Reboe-Benjamin et al.'s study [45], some patients reported feeling pressured to exit the program within 12 months of settlement, even when they were not ready, due to clinic policies. This premature transition heightened feelings of vulnerability and fear. Participants from one article [44] also noted that appointment reminders sent via SMS or mail were often confusing, particularly for those with limited English proficiency.

Distrust, reluctance and dissatisfaction

Challenges related to distrust, reluctance, and dissatisfaction were reported in four studies. In two studies [41, 43], participants expressed reluctance to disclose the extent of their suffering and reported

stigmatizing beliefs toward counselling, noting that seeking mental healthcare was not culturally normative. A lack of trust in counsellors and dissatisfaction with therapy—particularly when expected outcomes were not achieved—were also highlighted in two studies [41, 44]. For example, participants in Huminuik et al.'s study [41] reported difficulty trusting counsellors who spoke their first language and originated from the same country.

DISCUSSION

KEY FINDINGS

To date, this is the first scoping review to synthesize the literature on the needs, characteristics linked to positive outcomes, and challenges in integrated care for large and diverse migrant populations. The review identified four key categories of needs: 1) Access to care and administrative support, 2) Communication, 3) Relational needs of patients, and 4) Needs of the healthcare system and professionals. Furthermore, the review highlights several characteristics of programs that are positively associated with improved outcomes. These include effective interpersonal and intersectoral communication and collaboration, the provision of services culturally securing, access to multiple services, and the access to emotional and administrative support or guidance to access care. Finally, the review identifies persistent challenges faced by both migrants and healthcare providers. For patients, these challenges fall into four primary categories: language and literacy, geographical, access to services, and issues related to distrust, reluctance, and dissatisfaction with care.

RELEVANCE TO CURRENT LITERATURE

Access to high-quality interpreter services emerged as a critical facilitator of appropriate integrated care for migrant populations. Several studies included in this review identified interpretation services as an essential need among migrant patients [43, 44, 47], consistent with previous reviews highlighting their role in supporting effective cross-cultural communication within integrated and interdisciplinary care settings [50–52]. However, Huminuik et al. [41] reported that some participants preferred not to use interpreters when discussing sensitive issues, citing concerns related to confidentiality and privacy. Similar concerns regarding trust, confidentiality, and perceived quality of interpreter services have also been reported in the broader literature [52]. Healthcare providers have also expressed concerns about the use of informal interpreters, such as family members or friends, particularly regarding confidentiality and the accuracy of communication [53].

Consistent with these concerns, three studies in this scoping review identified language and literacy challenges as barriers to navigating integrated care programs [38, 44, 45]. These challenges were partly attributed to limited language proficiency among healthcare staff and insufficient access to professional interpreter services in integrated care settings. Similar findings have been reported in Vange et al.'s review [52], where barriers to interpreter use have been linked to healthcare professionals' limited awareness of patients' rights to interpreter services, as well as from practical and organizational constraints within healthcare systems. Taken together, these findings suggest that interpreter services are essential for effective integrated care, but their impact depends on their availability, quality, and the trust established between patients and providers. Future integrated care programs should establish sustainable access to professional interpreters trained to work within multidisciplinary teams and ensure that migrant communities are aware of and able to access interpretation and culturally tailored services.

This review also provides insights into the needs of healthcare professionals within integrated care settings. Two included studies highlighted a need for enhanced training in behavioural health integration [35, 43]. Specifically, gaps in curriculum coverage—such as the management of somatic symptoms—were noted as areas requiring improvement [43]. These findings are consistent with Lu et al.'s systematic review [51], which underscored the importance of trauma-informed care in integrated care, while also showing that many providers felt inadequately prepared to deliver such care. Beyond training-related challenges, providers expressed concerns regarding the lack of financial support for the additional workload associated with integrated care programs [35]. Together, these findings suggest that future integrated care programs should incorporate thoughtfully designed financial incentive structures that are responsive to the specific contextual factors of each healthcare setting. Additionally, allocating sufficient time and resources for provider training is essential to ensure the delivery of high-quality, comprehensive care.

FUTURE RESEARCH

The limited number of relevant studies identified in this scoping review (n = 17) underscores the need for further research into the needs of migrant populations within integrated care programs. Future studies should aim to provide detailed protocols of implemented integrated care programs to facilitate the identification of specific components that most significantly influence patient outcomes in integrated care settings. The inclusion of control groups should also be considered to strengthen the validity and generalizability of findings. Moreover, future research should prioritize the recruitment of more representative samples to ensure that integrated care approaches are appropriately tailored to the diverse characteristics of migrant populations, including variations in background, country of origin, gender, and age. Such efforts are essential to inform the development of equitable and context-sensitive integrated care programs. Lastly, the reluctance of

participants to disclose the full extent of their suffering and past traumas [41, 43] must be carefully considered in the design and implementation of integrated care programs. To enhance the effectiveness and cultural sensitivity of such interventions, future research should investigate innovative strategies that promote trust and ensure that integrated care programs are responsive to the complex and diverse backgrounds of migrant populations.

STRENGTHS AND LIMITATIONS

A key strength of this scoping review lies in its adherence to a standardized methodology, strictly following the five-stage framework proposed by Arksey and O'Malley [24]. The search strategy was developed collaboratively by two team members (MP and ALC) and supervised by a trained medical librarian, thereby enhancing the reliability of the literature search. Additionally, full-text screening was conducted jointly by the same team members (MP and ALC), ensuring that no relevant studies were erroneously excluded and that selection decisions were consistently applied. Among its limitations, this scoping review did not involve individuals with lived experience, as it was based solely on existing literature and did not include primary data collection or partner consultation. Consistent with the nature of most scoping reviews, no protocol was registered, and the quality of included studies was not assessed, which may limit reproducibility and introduce bias. Furthermore, title and abstract screening was conducted by a single reviewer. However, to minimize the risk of erroneous exclusion, only records that were clearly ineligible were excluded at this stage, while any records with uncertain eligibility were retained for full-text review. These methodological limitations should be considered when interpreting the findings of this review. Common limitations in the selected studies included lack of control groups [31, 41, 47], confounding variables [32, 41], and non-representative samples (e.g., participants came from a limited number of countries, the sample was small, there were varied genders, ages and backgrounds, etc.) [33, 35, 36, 38–40, 43, 44]. Potential biases such as self-reporting, recall bias, and misinterpretation by participants or interpreters were also noted [33, 35, 40, 43–45].

CONCLUSION

The findings of this scoping review underscore the importance of fostering strong patient-provider relationships grounded in trust, respect, and effective communication in integrated care interventions. Strategies that enhance patient comfort—such as improved access to high-quality interpreting services—are essential to culturally responsive care. In addition, strengthening staff training and implementing a structured remuneration system may support clinicians in addressing the specific needs of migrant populations more effectively. Future studies should include representative samples and control groups to ensure that integrated care programs are appropriately tailored to diverse migrant populations. In addition, further research could explore approaches that enhance.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

Portions of the abstract and manuscript were drafted with the assistance of Microsoft Copilot to enhance clarity and conciseness. After using this tool, the authors reviewed and edited the content as needed and took full responsibility for the content of the published article.

ADDITIONAL FILES

The additional files for this article can be found as follows:

- **Appendix 1.** Research strategy. DOI: https://doi.org/10.5334/ijic.10180.s1
- **Appendix 2.** Characteristics of included studies. DOI: https://doi.org/10.5334/ijic.10180.s2
- **Appendix 3.** Identified needs. DOI: https://doi.org/10.5334/ijic.10180.s3

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COMPETING INTERESTS

The authors have no competing interests to declare.

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