Barriers to accessing appropriate mental health services

The problem

Focus group participants working in arrival camps reported that they meet a huge number of refugees with mental health problems in need of psychosocial assistance and support. Rates of post-traumatic stress disorder, anxiety and depression in these groups are especially high. This is due to the situation and traumatic experiences they encountered before and during their journey, for example, many females seeking asylum from war-torn countries have been raped. Wider problems also include concerns about confidentiality, racism and xenophobia. To make it worse, repressive police and army actions (unexpected replacement of people, officers carrying weapons, police helicopter flights etc.) further stimulate re-traumatization among refugees, which resulted in the need for many interventions of health care workers and volunteers that could be have been avoided.

Furthermore, extended asylum procedures, particularly when involving detention or the threat of detention or deportation often lead to psychiatric disorders. Literature shows that fear of jeopardizing an asylum application and social taboos can inhibit the disclosure of psychological symptoms. Even where permission to remain is granted, general stressors in the post-migration environment linked to social determinants of health, such as poverty, violence and threats, racism, acculturation stress and loss of family and friends, can damage health. In particular, structural features, such as insecure asylum status, financial difficulties and discrimination affect children and unaccompanied refugee minors (Bradby, Humphris, Newall, & Phillimore, 2015).

In spite of all this, it has been reported that there are no appropriate professionals (psychologists, psychiatrists, therapists etc.) in arrival camps who can adequately address refugees' needs. When there are, however, these professionals are not always able to perform their activities due to a repressive police approach, which is at the forefront of work organization in arrival camps. As a result many people waiting to get medical help do not actually need it, but are in extremely hard circumstances only looking for support, human contact, information, food, water or dry clothes and shoes.

Similarly, there is no adequate care addressing the mental health needs of asylum seekers that are transferred to the asylum centre. Special care, including psychotherapeutic care, can in some countries be covered, but only within a limited range to so-called vulnerable persons with special needs (disabled people, the elderly, pregnant women, single parents with minor children, victims of trafficking, persons with mental health problems and victims of rape, torture or other serious forms of psychological, physical and sexual violence) and on condition that a special commission approves it. Despite the fact that there are psychologists employed in some centres for asylum seekers, there are no generally accessible specialist therapies for traumatized refugees. They may be able to access them only if a general practitioner writes them a referral, which is conditioned by many barriers (long waiting periods, lack of translators/intercultural mediators, lack of cultural competent specialists etc.).

Evidence on the barrier

The available literature suggests that one of the main themes in the delivery of mental care to refugees is communication (Jensen, Norredam, Priebe, & Krasnik, 2013). Language especially in the context of mental health represents one of the main barriers: emotions, fears and feelings are more difficult to explain compared to other types of clinical symptomatology particularly when the language is lacking. This theme includes considerations related to the use of interpreters, but also that communication with patients entails more than simply speaking the same language.

From a linguistic and cultural point of view, mental diseases represent a taboo for many communities and cause stigma and humiliation; in some contexts it's not even clear what mental health care involves, and there are different perceptions about the meaning of mental diseases. The stigma of mental illness within many refugee communities may provide a barrier to seeking mental health services, as in some cultures, mental illness is considered a taboo topic and is not openly discussed (Ellis, Miller, Baldwin, & Abdi, 2011).

Cultural factors have been reported as potential barriers in mental health service provision, many studies have shown that not being able to recognize mental health problems acts as a significant barrier to accessing mental health resources and lead to underutilization of mental health services. Cultural dissonance between refugee patients and service providers, for example, may create a barrier to access mental health services. Medical practitioners may be perceived as inflexible and insensitive to patients' needs, rushing through the consultation, thus preventing the development of trust and a rapport between doctor and patient (Thomson, Chaze, George, & Guruge, 2015; Wohler & Dantas, 2016).

The organization of mental health care interventions suffers because of the lack of knowledge concerning referral options, difficulties with transport, rigid appointment systems, lengthy waiting lists and delays before accessing specialists represent a common hindrance to accessing these services (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015; Wohler & Dantas, 2016).

Mental health service systems and refugee resettlement services typically are delivered by different agencies and with relatively little connection. Limited continuity of care and fragmented service delivery are identified as barriers to engagement: referrals to mental health services were seen as problematic and this reflects in the drop out ratio from care. Patients with psychological problems are often bounced between inpatient and outpatient services, but the lack of coordination in referral systems causes interruptions in care. In addition to this, refugee clients may not understand why they have been referred to a specialist service (Colucci et al., 2015). Lack of flexibility and responsiveness in the system, transfer of information between units, detachment between the patient and treatment initiatives, and coordination with social services is reflected in discontinuity of care.(Jensen, Johansen, Kastrup, Krasnik, & Norredam, 2014)

Measures to address the barrier

The negotiation of a shared understanding of the concepts of mental health, illness, and treatment has emerged as being essential in various studies. For this reason, clinicians should work with the patient, his/her family, and intercultural mediators to develop a shared understanding of the present difficulty and the meaning of symptoms (Colucci, Szwarc, Minas, Paxton, & Guerra, 2014). Some authors (Colucci et al., 2015; Ellis et al., 2011) observed that partnerships between mental health service providers, communities, and religious organisations can open pathways to mental health care, and improved service relationships between physical and mental health services has also been found to be important.

Research suggests the need for linguistically and culturally sensitive services and this means changes in the training of practitioners, practitioner behaviours as well as changes in service delivery (Thomson et al., 2015). Mental health workers should be trained in cultural and language competency, with a more sensitive approach in order to be able to reach migrant perspective. Providers of mental health to migrants require cross-cultural communication skills to work with culturally different immigrants across age groups and considering migration experiences (Thomson et al., 2015). Alternative approaches to traditional mental health services, such as the employment of a strength based narrative methodology, being youth-friendly, approachable, non-judgemental, respectful, and compassionate and taking an "informal" approach have proved to successfully overcome barriers due to perceived stigma and lack of knowledge about what is on offer (Colucci et al., 2015).

Working with interpreters and cultural mediators is necessary to be able to offer mental services, however, problems may arise when these professionals belong to the same ethnic or cultural group, as patients may be particularly concerned about confidentiality (Ellis et al., 2011; Thomson et al., 2015). Therefore, in selecting interpreters, mental health professionals should consider gender, age, dialect, and cultural factors such as dynamics between different ethnic groups. Asking migrants for their preferences for interpreter use at the outset and considering the need for professionally qualified interpreters and defining interpreter confidentiality are key elements to ensure trust and confidentiality, especially in the context of mental health.(Colucci et al., 2015)

In order to reduce organisational barriers, literature and experience suggest that mental health services should be accessible by public transport, preferably be discreet and "out of sight", user-friendly environments, including drop-in and outreach services. Furthermore a flexible approach to appointments is indicated to be successful with new migrants who have difficulty understanding boundaries and systems in formal settings (Colucci et al., 2015). Other authors have suggested the involvement of intercultural mediators, advocates, or brokers to ensure appropriate referrals and access. Similarly effective are strategies aimed at taking services out of the clinic to places that people are familiar and comfortable with, and that do not carry the stigma of mental health settings (Hughes, 2014). Locating services within service systems that are trusted and highly accessed by refugee families and youth, such as schools, is a powerful approach to diminishing the stigma associated with mental health services (Ellis et al., 2011).

An integrated approach to mental health service delivery has been suggested by multiple authors arguing that mental health services should build direct relationships with refugee communities and the wider social service system, including settlement programs (Colucci et al., 2015). Strengthening the collaboration and co-ordination between different services by disseminating information on services both to the marginalised groups themselves and to health care practitioners in the area has also proved to be successful (Priebe et al., 2012). Establishing partnership between mental health services, local schools and refugee serving agencies and marketing clinical services, for example, has proved to be an effective strategy to overcome the numerous access barriers. Finally, by creating a system-wide, collaborative, integrated model that recognises and addresses critical clinical and economic aspects in the delivery of services, high quality, evidence-based care can be made available to groups susceptible to the burdens of mental illness(Grazier, 2008).

Successful example

Psychological intervention guide for direct assistance to migrants and refugees
(Seville, Spain)

Service/department in charge of the measure:
University of Sevilla**;** University Complutense of Madrid; Psychologist of the World organization; Official College of Psychologist in Spain

Description of the measure
A guide was created to illustrate psychological issues present in migratory processes by involving health providers and different institutions.

Expected outcomes:
To contribute through a psychological perspective to the current humanitarian crisis.

Achieved outcomes:
It was introduced during the current year, thus it has not yet been evaluated.

Available at: https://www.ucm.es/data/cont/docs/315-2016-06-02-g.refugiados_PDF.pdf

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