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Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review☆

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ABSTRACT

Background: Refugees and asylum seekers often have increased mental health needs, yet may face barriers in accessing mental health and psychosocial support (MHPSS) services in destination countries. The aim of this systematic review is to examine evidence on MHPSS service utilisation and access among refugees and asylum seekers in European Union Single Market countries.
Methods: Four peer-reviewed and eight grey literature databases were searched for quantitative and qualitative literature from 2007 to 2017. Access was categorised according to Penchansky and Thomas' framework and descriptive analyses were conducted. Quality of studies was assessed by the Newcastle-Ottawa scale and the Critical Appraisal Skills Programme checklist.
Results: Twenty-seven articles were included. The findings suggest inadequate MHPSS utilisation. Major barriers to accessing care included language, help-seeking behaviours, lack of awareness, stigma, and negative attitudes towards and by providers.
Conclusions: Refugees and asylum seekers have high mental health needs but under-utilise services in European host countries. This underutilisation may be explained by cultural-specific barriers which need to be tackled to increase treatment demand. Training health providers on cultural models of mental illness may facilitate appropriate identification, referral, and care. Based on these findings, it is crucial to review policies regarding MHPSS provision across the EU.

1. Introduction

In 2014/15, Europe began experiencing a dramatic increase in the number of migrants arriving in search of asylum [1], principally as a result of the war in Syria but also from countries such as Afghanistan, Iraq and Eritrea. These refugees came primarily via the Eastern Mediterranean route through Turkey and Greece or the Central Mediterranean route through Libya and Italy [2]. The EU received nearly 1.26 million asylum claims in 2015 alone, double the number from 2014 [2].

Asylum seekers' experiences of war and persecution, and the ensuing flight, are major risk-factors for poor mental health [3,4]. In the post-migration period, living conditions, uncertainty, loss of livelihoods, impoverishment, and disrupted social and cultural networks can increase the risk of mental health problems such as depression, anxiety, post-traumatic stress disorder (PTSD), and psychosis [4–6]. A meta-analysis indicated that common mental disorders were twice as likely in refugees as in economic migrants [7].

Given the elevated levels of mental disorders commonly observed among refugees and asylum seekers, the provision and use of Mental Health and Psychosocial Support (MHPSS) services is recommended [8]. MHPSS services are local and external support activities that aim to protect or promote psychosocial well-being and/or prevent or treat mental disorders [8]. These include basic psychosocial interventions such as child-friendly safe spaces, community activities, or low-intensity psychological interventions delivered by lay health care providers. MHPSS services also include specialist psychological counselling such as cognitive behaviour therapy (CBT), including the use of psychotropic drugs for more severe cases [8].

Understanding the utilisation of and access to health services, including barriers and facilitators, is vital to ensuring that services maximise their potential benefits and respond to the needs of

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health care users. This is particularly the case for MHPSS services for refugees given potentially low awareness of services, linguistic barriers, and different cultural perspectives and preferences towards MHPSS services. While a recent WHO report provided a synthesis of MHPSS services for refugees in Europe [9], to date, there has been no systematic review specifically examining the evidence on access to mental health care and the respective barriers and facilitators for refugees and asylum seekers in Europe. This systematic review builds on the evidence of available MHPSS services for refugees and asylum seekers, as described by the WHO [9], by incorporating an assessment of contact coverage and ease of access.

The aim of this systematic review was to examine evidence on MHPSS service utilisation and access among refugees and asylum seekers in the countries of the European Union and Single Market. The specific objectives were: (i) to systematically review evidence on MHPSS utilisation rates among refugees and asylum seekers; (ii) to describe and summarise barriers and facilitators to MHPSS care for refugees and asylum seekers using a tailored conceptual framework; and (iii) to assess the quality and strength of the evidence.

2. Methods

This systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) approach [10] (see online Appendix A for the completed PRIMSA checklist).

2.1. Eligibility criteria

The populations of interest were refugees and asylum seekers (all ages) who migrated and resettled in the 28 countries of the European Union (EU) and those in the EU's Single Market (Norway, Iceland, and Liechtenstein, Switzerland). The EU Single Market countries were included to yield additional evidence and insights.

A refugee was defined as "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" [11]. Asylum seekers are individuals whose requests for refugee sanctuary have not yet been processed [12]. Adults, accompanied minors (AMs), and unaccompanied minors (UAMs) were included. Undocumented migrants were not included. Where studies included other types of immigrants or marginalised populations along with refugees and asylum seekers, only the data on refugees and asylum seekers were used.

The outcomes of interest included mental, neurological, or substance use disorders including: PTSD, depression, anxiety disorders, alcohol and drug dependence, schizophrenia, bipolar, and psychosis. Broader outcomes, such as psychological distress, were also included, as were culturally-specific mental health-related outcomes and somatoform disorders.

The interventions of interest were MHPSS services. MHPSS services were defined as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" [8].

We conceptualized utilisation as an estimate of contact coverage rather than of effective coverage [13]. Contact coverage describes the proportion of individuals who receive an appropriate intervention for their respective condition [13], whereas effective coverage includes an assessment of whether those receiving the service gain the intended health benefit.

We conceptualized access based on Penchansky and Thomas's five elements of access: affordability, availability, accessibility, accommodation, and acceptability [14]. Three additional barriers to accessing care were identified in the literature and included: awareness, stigma, and help-seeking. These eight elements are described in Box 1.

Box 1: Elements of Access to care

Affordability concerns patients' perceptions of service worth relative to cost and their ability to pay for services.
Availability addresses whether the provider has the personnel, technology, and other resources to meet the clients' needs. It also refers to the availability, or lack thereof, of clinics, hospitals, and specialised services.
Accessibility refers to the geographic accessibility of the service. Accessibility determines whether the client has the resources to meet the provider (financial, transportation, time).
Accommodation evaluates whether the provider operates their service to best meet the patient's constraints. This includes hours of operation, walk-in-facilities, telephone services, appointment systems, and referrals. Additionally, it assesses the client's perceptions of service appropriateness.
Acceptability assesses the patient's attitudes and comfortability with the personal characteristics of the provider: age, sex, ethnicity, social class, diagnosis, and type of coverage. This can also work in reverse, measuring the extent to which the provider is comfortable with the clients' personal characteristics.
Awareness of mental health and information about available MHPSS services
S*tigma* towards mental health and MHPSS services (with stigma defined as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination, encompassing many statuses and characteristics [15])
Help seeking refers to an adaptive coping process in which the client attempts to obtain external MHPSS [16].

Primary quantitative and qualitative research studies from published peer-reviewed and grey literature in English were eligible. The time-period was limited to between January 2007 and August 2017 to assess more recent patterns in access to MHPSS services.

2.2. Search strategy and data extraction

Four bibliographic databases were searched (MEDLINE, Global Health, Embase, and the International Bibliography of the Social Sciences (IBSS)) using: (i) mental health terms; AND refugee and asylum seeker terms; AND EU terms and names of EU and EU Single Market member states; AND access terms based on the Penchansky and Thomas framework [14]. The list of search terms is included in online appendix B. Grey literature was examined through searches on eight web-based grey literature sources: United Nations High Commissioner for Refugees (UNHCR), Mental Health and Psychosocial Support Network, World Health Organization, United Nations International Children's Emergency Fund (UNICEF), Médecins Sans Frontières, International Rescue Committee, International Committee of the Red Cross, and Google. Reference lists from included articles and reports were hand-searched to ensure no other relevant studies were missed.

Following the eligibility criteria provided above, article titles and abstracts were screened and studies not meeting eligibility requirements were excluded. This was followed by a full-text review to identify articles included in the final systematic review. A data extraction sheet listing relevant articles and grey literature was created. Key extraction variables included: author, date of publication, geographic setting, study population characteristics, study design and objectives, MHPSS outcomes, MHPSS services (service categories based on the Inter-Agency Standing Committee (IASC) health service pyramid (8)), elements of access, MHPSS service utilisation rates, results, limitations and quality appraisal criteria. All

data and quality appraisal criteria have been double data extracted (ES and DF).

2.3. Analysis and synthesis

When assessing for utilisation of MHPSS services, the analysis was limited to a synthesis of contact coverage [13]. Since articles lacked evidence on effective coverage, service quality and effectiveness of interventions was not assessed. Due to the heterogeneity of the included studies, results were described using narrative synthesis. When describing articles on barriers and facilitators to accessing MHPSS services, this narrative synthesis followed the adapted Penchansky and Thomas conceptual framework [14].

2.4. Quality and risk of bias assessment

The quality of quantitative studies was assessed using the Newcastle-Ottawa scale (NOS) adapted for cross-sectional studies [17] and the respective NOS scales for case control and cohort studies [18]. Using a star system, the NOS assesses the quality of participant selection, comparability, and ascertainment of exposures and outcomes. Each study was given a final score after assessment. Studies rated a 7 or above were considered "good" quality, studies rated 5 or 6 were "fair" quality, and studies rated below 5 were "poor" quality [19]. Qualitative studies were appraised using the Critical Appraisal Skills Programme (CASP) qualitative checklist which assesses appropriateness of study design, recruitment strategy, data collection, and analysis [20]. For each of the ten questions, articles were recorded as a "yes", "no", or "can't tell." Since the checklist was designed as an educational pedagogic tool, a scoring system was not recommended [20]. Mixed method articles employing both quantitative and qualitative designs were evaluated with both scales.

3. Results

Of the initial 6527 records identified through the database search, a total of 27 articles were included for full-text review [21–47]. The mean publication year was 2012 (Fig. 1).

Seventeen studies used quantitative designs [21–25,31–38,41,43–47]: 13 were cross-sectional, 3 were cohort, and 1 was case-control. Nine studies used qualitative methods [26–30,33,39,40,42]. One study used mixed methods [36]. While participants in most studies were refugees or asylum seekers, five studies assessed either mental health services, mental health workers, or other healthcare providers working on MHPSS for refugees and asylum seekers [23,27,30,41,42].

Out of the 32 EU/Single Market countries, the studies took place in 18 countries, namely in the UK [26,28,33,38–43], Germany [24,28,41,42,45], the Netherlands [31,32,41,42], Norway [22,36,44,47], Ireland [37,41,42,46], Denmark [21,29,30], Sweden [25,35,42], Austria [41,42], Belgium [41,42], France [41,42], Italy [27,42], Poland [41,42], Switzerland [23,34], Croatia [28], the Czech Republic [42], Hungary [42], Portugal [42], and Spain [42].

The most frequently represented countries of origin for the refugee and asylum seeker research participants included Somalia [21,22,25,26,32,35–40,44], Iran [22,24,25,32,35,40,45,46] (29, 39), Iraq [22,24–26,29,31,35,37,40,44–46], Afghanistan [24–26,32,37–39,45,46], and the Former Yugoslavia [21,22,24,28,35,37,38,40,43,45,46].

The majority of studies assessed MHPSS services targeting a range of mental, neurological, and substance use disorders but four targeted single disorders: two focused on PTSD [28,32], one

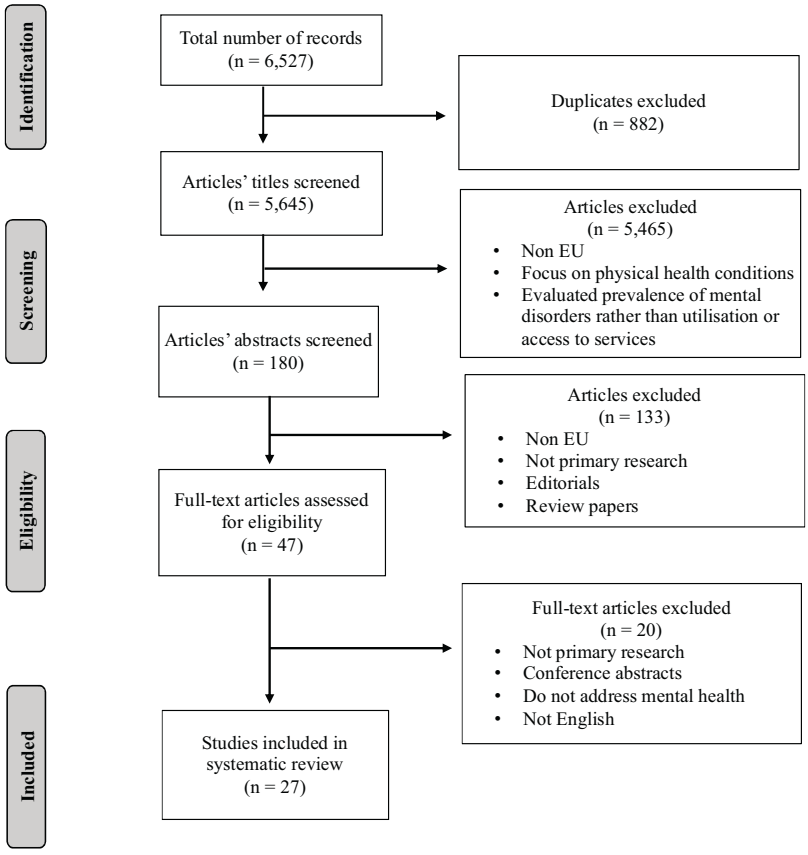

Fig. 1. Flow chart.

on psychosis [33], and one on depression [36]. Of the 27 studies, six focused on children and adolescents or on refugees and asylum seekers who arrived as teenagers [21,26,35,38,43,47]. Of these, four assessed both AMs and UAMs [21,26,35,38].

3.1. MHPSS utilisation

Fifteen articles [21,22,24,25,31,32,34,35,37,38,43–47] (all quantitative) assessed rates of mental health service utilisation among refugees and asylum seekers (Table 1). Despite presenting data on contact coverage, these studies did not evaluate reasons behind service utilisation patterns or the adequacy or effectiveness of services. Included articles discussed a range of MHPSS and general health service use. Seven articles focused primarily on general health care utilisation in primary care and emergency settings [24,31,34,37,44–46]; however, in addition to service use for physical conditions, these included utilisation of these services for mental health outcomes. Seven articles focused more specifically on MHPSS services [21,22,32,35,38,43,47], and one study assessed utilisation of psychotropic drug use in addition to face-to-face MHPSS care [25].

Among the 15 studies which looked at rates of MHPSS service utilisation, ten demonstrated that despite high mental health morbidity among refugees and asylum seekers, rates of MHPSS use were low. For example, only 20% of refugees with PTSD in the Netherlands accessed care [32]. In Sweden, psychotropic drugs, including anxiolytics, antidepressants and neuroleptics, were utilised less frequently among refugees than among the general population, despite higher rates of mental health problems among refugees [25] who migrated from the Horn of Africa during the past three years (Odds Ratios (OR) of psychotropic drug use compared to Swedish-born peers were 0.50 (95% CI 0.42-0.61) for men and 0.36 (95% CI 0.30-0.41) for women). While this study did not provide information on specific diagnoses, the mhGAP for humanitarian settings recommends antidepressants for PTSD if CBT, Eye Movement Desensitization and Reprocessing (EMDR), and stress management are ineffective [48].

While mental health service utilisation rates were generally low among refugees and asylum seekers [21,32,43,44], one study found that access to services, particularly outpatient services, increased the longer individuals lived in the country of resettlement [35]. The Hazard Ratios (HR) among refugees who arrived over 11 years ago was 1.22 (95% CI 1.05–1.41) (compared to those who arrived in Sweden less than 10 years ago) [35]. A study in Germany evaluated sociodemographic differences in utilisation and found that utilisation of MHPSS services among asylum seekers increased with higher MHPSS needs and higher educational attainment [24].

Studies conducted with child and adolescent populations found notable differences in engagement with care between AMs, UAMs, and children from the host countries. A study conducted in the UK found that UAMs were more likely than AMs to have experienced traumatic events prior to resettlement ($p < 0.01$); yet despite higher levels of subsequent PTSD, they attended fewer appointments and missed more treatment sessions than AMs ($p < 0.01$) [38]. Refugee children in Denmark had fewer first-time contacts with psychiatric services compared to Danish-born peers [21]. In a study in Norway, Norwegian children were more likely than refugee children to be referred to MHPSS by medical services ($p = 0.006$) while refugee children were more likely to be referred by non-medical professionals, such as social workers, personnel working at asylum centres, or teachers [47].

A study conducted in Switzerland, assessing both mental and physical health care, found that asylum seekers incurred higher annual healthcare costs (1.8 times, $p = 0.022$), and more visits to general practitioners (GPs) and hospitals than the resident population (over 2.0 times, $p < 0.001$) [34]. However, while utilisation of GP and emergency services was high, utilisation of psychiatric care among refugees and asylum seekers was low relative to need; while 41% of asylum seekers in the sample had clinically relevant mental disorders, only 26% had received MHPSS [34]. Sandvik, Hunskaar, and Diaz [44], in a study of Iraqi and Somali asylum seekers in Norway, and Laban and colleagues [31], in a study of Iraqi asylum seekers in the Netherlands, both demonstrated a trend among asylum seekers to present with non-specific pain attributable to somatic distress, rather than mental complaints.

Conversely, two studies demonstrated higher rates of access to MHPSS among refugees and asylum seekers. Schneider, Joos, and Bozorgmehr [45] found that a higher percentage of asylum seekers used psychotherapy compared to a German comparison population (15.5% vs. 4.3%; OR = 4.07 [95% CI 2.48–6.43]). Research also reported that within two Irish practices, asylum seekers were five times as likely to be diagnosed with a psychiatric condition (OR = 3.17 [95% CI 1.1, 8.68]), were two times as likely to be prescribed psychiatric medications, and exhibited higher consultation rates than Irish peers [37].

3.2. Access to care

Twelve articles assessed access to mental health care. The findings on access to care are described below based on the access framework (Box 1), and are summarised in Table 2.

3.2.1. Availability

All studies assessing barriers and facilitators to access (n = 12) reported sufficient numbers of services, with 8/12 explicitly discussing availability [26,27,29,33,39–42]. Refugees stressed the importance of having staff regularly available to build trusting relationships [29]. Additionally, long wait times were mentioned as being problematic among forced migrants in the UK [40] and among refugees from the former Yugoslavia in Germany and the UK [28]. Three studies—one from Denmark [29], one from the UK [40], and one which assessed 14 countries throughout the EU (42)—demonstrated the need for better collaboration and knowledge exchange between physical and mental health services in order to promote supportive and dedicated centres and MHPSS care [29,40,42].

3.2.2. Accessibility

Two studies reported physical accessibility as a barrier or facilitator to accessing MHPSS. In Jankovic and colleague's [28] study, refugees from the former Yugoslavia did not receive treatment for PTSD because they could not afford transportation costs. Conversely, a study of refugee adolescents in the UK showed that school-based mental health services were particularly accessible to students as they allowed on-site counselling. While these school-based services were better utilised, there were still barriers to care as students found it difficult to fit appointments into the school day without missing classes [26].

3.2.3. Accommodation

Nine studies, [26–30,33,39–42], covering the UK [26,28,39,40], Denmark [29,30], Italy [27], Germany [28], and 14 European capital cities [41,42], discussed accommodation as a barrier or facilitator to accessing MHPSS services. The most common access concern regarding accommodation was a lack of interpreters and appropriate language services [30,39,40]. The PROMO study, a review of services in European capital cities providing mental health care for marginalised groups, found that among services for refugees and asylum seekers, only 53% had interpreters available [41]. Likewise, participants from the former Yugoslavia reported that language barriers stood in the way of them accessing services [28]. In Denmark, children or other family members frequently attended

Table 1
Mental health service utilisation, by study (N = 15).

Author/Date	Study design and sample size	Population	Mental Health Outcome	Case Determination	MHPSS service being utilised	Key findings
Abebe, Lien & Elstad, 2017 [22]	Cross-Sectional (N = 39,110 refugees)	Refugees and asylum seekers from Iraq, Iran, Pakistan, Somalia, Vietnam, Bosnia, and Sri Lanka in Norway	Unspecified - all mental health disorders requiring specialist MHPSS services were included	Diagnostic interview with specialist mental health provider	Specialist mental health services (secondary and tertiary care)	14.98% of refugees from Iran and 11.44% of refugees from Iraq utilised specialist mental health services in past 4 years, compared to 8.58% of Norwegian-born population
Barghadouch et al, 2016 [21]	Cohort (N = 24,427 refugee children)	Accompanied and unaccompanied refugee children from Asia, the Middle East, sub-Saharan Africa, and former Yugoslavia in Denmark	Unspecified - all mental health disorders requiring specialist MHPSS services were included	Unspecified; referrals based on screening by health professionals	Specialist mental health services (psychiatrist; secondary and tertiary care)	12,218 first-time contacts with psychiatric healthcare services; 3.5% of refugee children utilised services compared with 7.7% of Danish-born peers
Bozorgmehr, Schneider & Joos, 2015 [24]	Cross-Sectional (N = 156 asylum seekers)	Asylum seekers in Baden-Wurttemberg, Germany	Unspecified	Unspecified	Specialist mental health services (psychotherapist; secondary and tertiary care)	15.5% of asylum seekers had seen psychotherapists in past 12 months
Brendler-Lindqvist, Norredam & Hjern, 2014 [25]	Cross-Sectional (N = 43,403 refugees and their families)	Refugees from Iraq, Iran, Eritrea, Ethiopia, Somalia, and Afghanistan in Sweden	Depression, anxiety, epilepsy (anti-depressants, anxiolytics/hypnotics, neuroleptics)	Unspecified	Specialist mental health services (psychotropic drugs; tertiary care)	Refugees had lower gender stratified ORs for having psychotropic drug dispensed than Swedish-born population: (0.83 (95% CI 0.77-090) for men from Iraq/Iran; 0.5 (95% CI 0.42-0.61) for refugee men from Horn of Africa; 0.48 (95% CI 0.44-0.53) for refugee women from Iraq/Iran; 0.36 (95% CI 0.30-0.41) for refugee women from Horn of Africa); psychotropic drugs dispensed increased with duration of time refugees spent in Sweden (e.g., OR for refugee women from Iraq/Iran went up from 0.48 for 0-3 years to 0.72 (95% CI 0.65-0.80) for 7-10 years in Sweden)
Laban et al, 2007 [31]	Cross-Sectional (N = 143 asylum seekers living in Netherlands less than 6 months; N = 151 asylum seekers living in Netherlands over 2 years)	Iraqi asylum seekers in the Netherlands	Unspecified	Structured questionnaires – WHO-CIDI 2.1 (Composite International Diagnostic Interview)	Specialised, focused non-specialised, and preventive MHPSS services (primary, secondary, and tertiary care)	Over 80% of asylum seekers with psychiatric disorders used primary care services for any condition and 8.8% used mental health services; 5.4% of combined sample used specialised mental health services and 16.7% used hypnotics or anxiolytics
Lamkaddem et al, 2014 [32]	Cohort (N = 172 refugees and asylum seekers)	Refugees and asylum seekers from Iran, Afghanistan, and Somalia in the Netherlands	PTSD	Part IV of Harvard Trauma Questionnaire	Specialised and focused non-specialised MHPSS services (psychiatrists, psychologists, psychotherapists, social workers; secondary and tertiary care)	At baseline (T1) 16.3% had PTSD and 21% of these individuals had contacted mental health providers; at second wave (T2 (7 years later)), 15% had PTSD and 53.8% had contacted mental health providers
Maier, Schmidt & Mueller, 2010 [34]	Cross-Sectional (N = 78 asylum seekers)	Asylum seekers in Zurich, Switzerland	Major depression (MD), PTSD, pain disorder, anxiety disorder, alcohol abuse	Psychologist-delivered diagnostic interviews (Mini-International Neuropsychiatric Interview; MINI)	Specialised and focused non-specialised MHPSS services (psychiatrists, psychosocial counselling with GPs, psychotropic drugs; secondary and tertiary care)	41% of asylum seekers had at least one psychiatric disorder and 26% had received psychiatric treatment since residing in Switzerland; overall healthcare costs for asylum seekers were 1.8 times higher than those of the average resident population

Table 1 (*Continued*)

Author/Date	Study design and sample size	Population	Mental Health Outcome	Case Determination	MHPSS service being utilised	Key findings
Manhica et al, 2016 [35]	Cohort (N = 35,547)	Unaccompanied and accompanied refugees who came to Sweden as teenagers	Schizophrenia and other psychotic disorders, affective disorders and depression, PTSD, neurotic and somatoform disorders, behavioural, mental health and physiological disorders, and emotional disorders (based on ICD-10)	Diagnostic interview with specialist mental health provider	Specialist mental health services (compulsory, inpatient, and outpatient care; secondary and tertiary care)	UAMS and AMS more likely to experience compulsory-admission to psychiatric hospital compared to native peers (Hazard Ratio (HR) 2.76 (1.86-4.10) compared to 1.89 (1.53-2.34)); highest rate of compulsory admission among refugees from Horn of Africa and Iran (HR 3.98 (2.12-7.46) and 3.07 (1.52-6.19))
McMahon et al, 2007 [37]	Cross-Sectional (N = 171 asylum seekers)	Asylum seekers in Ireland	Unspecified	Diagnoses made by GP (not further specified)	Focused non-specialised MHPSS services (primary health care)	Asylum seekers 5 times as likely as Irish-natives to attend with psychiatric concern (p = 0.0001); 2 times as likely to be prescribed antibiotics and psychiatric medications; 2 times as likely to be referred as outpatients
Michelson & Sclare, 2009 [38]	Cross-Sectional (N = 49 unaccompanied minors, N = 29 accompanied minors)	Accompanied and unaccompanied refugee children in London	PTSD, anxiety, depression, family and/or peer relationship problems	Clinician-rated symptomology of mental health disorders	Specialised and focused non-specialised MHPSS services (psychologists, family therapist, social development worker; secondary and tertiary care)	76% of UAMs and 66% of AMs had depression, 85% of UAMs and 86% of AMs had anxiety, and 85% of UAMs and 66% of AMs had PTSD; trauma-focused interventions did not vary between groups (30% vs. 31%); AMs had higher rates of cognitive therapy (41% vs. 19%), systemic therapy (38% vs. 22%, parent/carer training (71% vs. 16%), and psychoeducation (72% vs. 53%)
Sanchez-Cao, Kramer & Hodes, 2013 [43]	Cross-Sectional (N = 71 unaccompanied asylum-seeking children)	Unaccompanied asylum-seeking children in the UK	PTSD and depressive disorder	Self-administered screening instruments: Birleson Depression Self-Rating Scale, Impact of Events Scale, Harvard Trauma Questionnaire, Strengths and Difficulties Questionnaire	Specialist mental health services (secondary and tertiary care)	66.2% at high risk for PTSD and 12.7% at high risk for depressive disorder and 17% in contact with mental health services
Sandvik, Hunskaar & Diaz, 2012 [44]	Cross-Sectional (N = 4793 Somali asylum seekers, N = 5382 Iraqi asylum seekers)	Iraqi and Somali asylum seekers in Norway	Non-specific pain and psychiatric illness	Diagnoses made in primary care according to ICPC-2 (International Classification of Primary Care)	Focused non-specialised MHPSS services (emergency primary health care)	27.4% Norwegians contacted EPHC compared with 31.8% Somalis and 33.6% Iraqis; over half of Somali and Iraqi contacts were for non-specific pain
Schneider, Joos & Bozorgmehr, 2015 [45]	Cross-Sectional (N = 156 asylum seekers)	Asylum seekers in Germany	Unspecified	Self-report based on three health questions	Specialised and focused non-specialised MHPSS services (secondary and tertiary care)	15.5% of asylum seekers had at least one visit to psychotherapist in past year, compared with 4.3% of German reference population
Toar, O'Brien & Fahey, 2009 [46]	Cross-Sectional (N = 60 asylum seekers, N = 28 refugees)	Refugees and asylum seekers in Ireland	PTSD, depression, anxiety	Self-administered screening instruments: Harvard Trauma Questionnaire, Hopkins Symptom Checklist-25	Specialised and focused non-specialised MHPSS services (secondary and tertiary care)	Asylum seekers significantly more likely than refugees to report PTSD (OR 6.3, 95% CI: 2.2-17.9) and depression/anxiety (OR 5.8, 95% CI 2.2-15.4); no significant differences in mental health service utilisation
Vaage et al, 2007 [47]	Case-Control (N = 61 refugee children and N = 61 Norwegian children)	Accompanied refugee children in Southwestern Norway	Psychoses, affective and emotional disorders, including mood disorders, neurotic and stress-related disorders, somatoform disorders, eating and feeding disorders, pervasive developmental disorders, hyperkinetic and tic disorders, conduct disorders and disorders of social functioning specific to childhood, mixed conduct and emotional disorders (based on ICD-10)	Diagnostic interview with specialist mental health provider in line with ICD-10 criteria	Specialist mental health services (secondary and tertiary care)	90.2% of refugee children and 83.6% of Norwegian children had a mental health diagnosis. Refugee children outnumbered Norwegian children 4 to 1 in PTSD diagnoses; approximately same number of refugee and Norwegian children were treated as outpatients (53 vs. 51)

PTSD = Post-traumatic stress disorder, ICD-10=International Classification of Disease, CI = Confidence Interval, OR = Odds Ratio, HR=Hazards Ratio, MD = Major depression, AM = Accompanied minor; UAM = Unaccompanied minor.

Table 2
Access to MHPSS services, by study (N = 12).

Author/Date	Population, Outcome and Method	MHPSS Service Being Utilised	Elements of Access Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Attitudes and Stigma	Help-Seeking
Qualitative Studies										
Fazel, Garcia & Stein, 2016 [37]	Population: AMs and UAMs* in Oxford, Glasgow, and Cardiff, UK; Outcome: unspecified; Method: semi-structured interviews (n = 40)	Specialist mental health care (school-based mental health services for refugee children; secondary and tertiary care)	Not discussed	School-based mental health services have required space and staff to provide mental health care; teachers available to make referrals to specialist services	School-based mental health services are convenient and accessible (pupils can go straight from their classes to appointments)	School day can be too busy to attend mental health services (hard for students to find time to schedule appointments without missing classes)	Students preferred school-based to hospital-based services	Not discussed	Concerns over stigma/privacy; negative perceptions of attending mental health services at school (ñot sick)	Not discussed
Griffiths & Tarricone, 2017 [38]	Population: mental health providers working with refugees and immigrants in Bologna, Italy; Outcome: somatisation disorder, PTSD, psychotic disorder, anxiety disorder, depression; Method: semi-structured interviews (n = 14)	Specialised and focused non-specialised MHPSS care (secondary and tertiary care)	Not discussed	Good collaboration with Local Health Authority	Not discussed	Ethnic community services and interpreters helped accommodate needs of patients, however some inaccurately interpreted responses; good registration and appointment systems	Refugees have different expectations of the psychiatrist. This leads to frustration and difficult doctor-patient relationships	No cultural training among staff; patient misconceptions of mental health and mental health worker's role	Some refugees see depression as 'punishment of gods'	Not discussed
Jankovic et al, 2011 [39]	Population: refugees from former Yugoslavia in Germany and UK; Outcome: PTSD; Method: structured interviews (n = 212)	No MHPSS services utilised	Some refugees could not afford transportation costs to attend a specialist	Not discussed	Not discussed	Some MHPSS services unable to accommodate languages (language barriers between patient and provider); MHPSS services in the UK had long wait lists	Many refugees uncomfortable or distrusting of psychiatrists; concerned about confidentiality	Different explanatory models of illness; lack of information and awareness of services	PTSD symptoms as 'normal' response to war; negative attitudes towards treatment; concerns over stigmatisation and trust	Other methods of coping such as by staying busy, working hard, or spending time with family and friends (did not think doctors could help)
Jensen et al, 2014 [40]	Population: refugees from Iran, Bosnia, Iraq, and Turkey in Copenhagen, Denmark; Outcome: depression and postnatal depression, PTSD, schizophrenia and paranoid schizophrenia, ADHD, brain damage; Method: narrative interviews (n = 19 with 15 patients, some interviewing twice)	Specialist mental health care (community psychiatric centre; secondary and tertiary care)	Some experienced cost concerns when making appointments with psychologists (but costs covered in Denmark)	Need better service coordination; staff need to be available to talk to patients (otherwise, experience feelings of neglect)	Distance to services was not a barrier for patients	System flexibility is important to patients; need to regularly stay in touch with health professional; phone contact important; need childcare options	Acceptability most important factor; need to build trusting relationships with providers; need to feel respected	Patients lack awareness of mental illness and potential for relapse	Mental illness taboo and not accepted in refugees' cultures	Not discussed

Table 2 (*Continued*)

Author/Date	Population, Outcome and Method	MHPSS Service Being Utilised	Elements of Access Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Attitudes and Stigma	Help-Seeking
Jensen et al, 2013 [41]	Population: GPs working with refugees in Copenhagen, Denmark; Outcome: anxiety and other psychological/ physical symptoms; Method: semi-structured interviews (n = 15)	Focused non-specialised MHPSS support (GPs)	Not discussed	Not discussed	Not discussed	GPs may be reluctant to start certain treatments because of language and communication barriers between patients and providers; inadequate language services or interpreters -> providers do not accept family interpreters	Patients perceived to have high expectations (they expect to be treated and given medicine immediately) with providers often unable to fulfil their expectations, causing frustration and resignation on both sides	Not discussed	Not discussed	Not discussed
Leavey et al, 2007 [42]	Population: Kurdish refugees in London; Outcome: psychosis; Method: narratives of illness (n = 9)	Varied, including specialised, focused non-specialised, and traditional MHPSS services	Not discussed	Patients primarily attend hocas (traditional healers)	Not discussed	Not discussed	Patients and families more comfortable seeing Turkish doctors	Families do not know where to send family members with psychosis	Stigma against mental illness; supernatural beliefs	Families often send client to hocas (traditional healer) instead of Western doctors; patients resist formal care
O'Donnell et al, 2007 [43]	Population: asylum seekers in Glasgow, Scotland; Outcome: unspecified; Method: focus groups (n = 6) and group and individual interviews (n = 16)	Focused non-specialised MHPSS support (general practi-tioners)	Affordability is not a barrier	Long wait times	Not discussed	Difficult to make appointments (lack of interpreters)	Generally satisfied with providers once an appointment is made; uncomfortable discussing mental health with GP due to fears that interpreters may not keep information confidential	Most participants received information on available MHPSS services, but some did not receive information at all and others did not receive information on most accessible services	Not discussed	Not discussed
Palmer & Ward, 2007 [44]	Population: refugees and asylum seekers in London; Outcome: PTSD and depressive and anxiety disorders; Method: semi-structured interviews (n = 21)	Specialised and focused non-specialised MHPSS care (secondary and tertiary care)	Not discussed	Lack of service coordination; long wait times	Not discussed	Difficult to schedule appointments due to language barriers	Participants stressed cultural differences and a preference for someone from their own culture to help in navigating and accessing services	Insufficient knowledge of services	Not discussed	Not discussed

Table 2 (*Continued*)

Author/Date	Population, Outcome and Method	MHPSS Service Being Utilised	Elements of Access Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Attitudes and Stigma	Help-Seeking
Priebe et al, 2012 [45]	Population: mental health professionals working with marginalised populations in European capital cities; Outcome: depression and psychosis; Method: semi-structured interviews (n = 154)	Social care services, general health care services, mental health management and coordination (primary, secondary and tertiary care)	Providers found it important to keep services free of charge to facilitate access	Providers suggested coordination with physical health services	Not discussed	Services need to keep office hours open and increase trust among clients; refugees and asylum seekers often have administrative barriers which they need support with	Providers asserted that building trust with patients through community outreach is essential	Providers explained that outreach and education should be conducted in churches and community centres to increase patient awareness; providers advocated for increased education and training on client's needs and specific mental health concerns	Providers explained the importance of going out into the community to reduce stigma among patients and advocated for integrating mental health care into places where individuals typically access services (to improve attitudes)	Not discussed
Quantitative Studies										
Bartolomei et al, 2016 [35]	Population: caregivers and primary care workers working with asylum seekers in Switzerland; Outcome: unspecified; Method: cross-sectional surveys (n = 135)	Specialised and focused non-specialised MHPSS care (secondary and tertiary care)	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	66.2% of all respondents believed asylum seekers' lack of information on existing mental health services was a major barrier to access	66.4% of all respondents believed asylum seekers' fear of being stigmatised by own community was a major barrier to access	Not discussed
Priebe et al, 2013 [36]	Sample: mental health services for marginalised populations in European capital cities; Outcome: unspecified; Method: surveys on service characteristics, staff and programmes (n = 516)	Individual and group psychotherapy, occupational therapy, alcohol and substance abuse treatment, outreach, social support, legal advice, befriending, coaching (primary, secondary, tertiary, and community care)	13% of mental health services serving marginalised populations required 'out-of-pocket' payment	13% had psychiatrists available, 54% had social workers, 37% had counsellors, and 39% had psychologists or psychotherapists	Not discussed	30% of services open outside normal office hours and 13% open on weekends; 76% of mental health services serving marginalised populations accepted self-referral from asylum seekers and refugees; 53% of services always had interpreters available	Not discussed	Not discussed	Not discussed	Not discussed

Table 2 (*Continued*)

Author/Date	Population, Outcome and Method	MHPSS Service Being Utilised	Elements of Access Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Attitudes and Stigma	Help-Seeking
Mixed Methods Studies										
Markova & Sandal, 2016 [46]	Population: Somali refugees in Norway; Outcome: depression; Method: cross-sectional surveys (n = 101) and focus group discussions (n = 10)	Community care, specialised and focused non-specialised MHPSS care (religious leaders, friends/family, traditional healers, alternative medicine, GPs, social worker, psychiatrist/psychologist)	Not discussed	Not discussed	Not discussed	Not discussed	Not discussed	Somali refugees generally believe that depression is caused by possession from the Jinn and accordingly need to be dispossessed; refugees confused medical doctors with psychologists during qualitative phase	During qualitative portion, participants reported that the only people who get psychiatric disorders are those who do not believe in a higher power (good Muslims do not)	Qualitative findings revealed refugees prefer to seek social support or turn to religious or spiritual healing for depression and coping strategies

* AMs: accompanied minor; UAMs: unaccompanied minors.

appointments with their relatives to serve as interpreters when health services did not have professional interpreters available [28]. However, contrary to refugee patients, GPs expressed that they may not be comfortable with family interpreters as intimate relationships could lead to discrepancies in interpretation [28]. A lack of child care options [29] and difficulties scheduling appointments were also mentioned as barriers to care in the UK, Germany, and Denmark [39,40]. Specifically, a study across six European capital cities found that only 30% of refugee and asylum seeker-specific services were open outside normal office hours and 13% were open on weekends [41]. Research with refugees in Denmark also documented the importance of responsive services, whereby participants could stay in touch with providers between appointments or after being discharged from the hospital [29].

3.2.4. *Affordability*

Affordability did not appear to be an issue and was only mentioned as a barrier in one study. In Denmark, prolonged and specialist care services need to be submitted for approval. While almost all cases are approved, those not approved could present affordability barriers [29].

3.2.5. *Acceptability*

Acceptability of MHPSS services was listed as a salient factor in access in 10 studies [23,26–30,33,39,40,42] covering the UK [26,28,33,39,40], Denmark [29,30], Italy [27], Germany [28], Switzerland [23], and 14 European capital cities [42]. All but two of these studies [29,42] described MHPSS services as unacceptable for refugees and asylum seekers. For example, Kurdish refugees in UK were more comfortable seeing Turkish-speaking doctors [33] and frequently visited *hocas* (traditional healers) in the UK. Refugees and asylum seekers in the UK mentioned desires for more ethnic minority staff in psychiatric services in order to build trusting, culturally acceptable and positive relationships [40]. A qualitative study of mental health professionals working with refugees and asylum seekers throughout European capital cities stressed the importance of building trust with clients [42]. Reflecting this, asylum seekers in Scotland mentioned discomfort with discussing certain mental health-related topics with their GP due to a lack of trust [39].

3.2.6. *Awareness*

Nine studies reported refugees and asylum seekers' lack of awareness of mental health and available MHPSS services as a major barrier to receiving appropriate care [23,26–29,33,36,39,40,42]. These studies covered the UK [28,33,39,40], Denmark [29], Italy [27], Germany [28], Norway [36], Switzerland [23], and 14 European capital cities [42]. Sixty-six percent of mental health caregivers and primary care workers in Switzerland mentioned lack of information on available MHPSS services as a barrier [23]. Another study found that Kurdish refugees in the UK were unsure where to seek support for family members struggling with psychosis [33]. In the UK, refugee participants mentioned that they lacked knowledge of available MHPSS services, were hesitant to discuss emotional concerns with a doctor, and were unaware that disorders such as anxiety could be treated [39]. Lack of awareness was not limited to refugees and asylum seekers. A study of GPs working with refugees in Denmark revealed that some practitioners did not realise that certain physical symptoms, such as somatoform disorders, could indicate mental illness [30].

3.2.7. *Stigma*

Stigma towards mental illness, help-seeking, and MHPSS services and providers emerged as a significant barrier to MHPSS service access in six studies covering Italy [26,27,33], the UK [28],

Germany [28], Switzerland [23], and Denmark [29]. In a study in Germany and the UK, refugees from the former Yugoslavia exhibited negative attitudes towards treatment and discussed concerns over stigmatisation of help-seeking [28]. Another study of caregivers and primary care workers working with asylum seekers in Switzerland found that 66.4% of the asylum-seeking population feared being stigmatised by their community for attending MHPSS services [23]. Refugee and asylum-seeking children in the UK felt they would be stigmatised by their classmates for attending MHPSS services at school [26]. In a study from the UK, Kurdish refugees noted how the Kurdish community attributed poor mental health to religious and supernatural beliefs [33]. Similarly, Somali refugees in Norway stressed that mental illness can be owed to possession by the 'Jinn,' or supernatural creatures from the Islamic tradition [36].

3.2.8. Help-seeking

Refugees and asylum seekers in three studies, based in Norway [36], Germany [28], and the UK [28,33], were reluctant to seek formal care for mental health problems due to differences in the understanding of causes of mental illness and coping patterns. For example, Somali refugees in Norway stressed the need to first seek social support from the Somali community or to visit a sheikh for help with de-possession [36]. Families of Kurdish refugees with psychosis in the UK similarly preferred to send the individual to traditional healers, while the clients themselves resisted care [33]. In the study assessing MHPSS access among former Yugoslavian refugees in Germany and the UK, individuals preferred to seek help elsewhere, often because of a belief that Western doctors would be unable to help [28].

3.3. Quality appraisal and strength of evidence

Of the 17 quantitative studies, 11 were of "good" quality, 4 were of "fair" quality, and 2 were rated "poor" quality according to the NOS scale (see online appendix C for details). Four studies received full marks for an appropriate selection of study groups. However, many studies lacked representativeness and adequate sample sizes. Eleven achieved high ratings for comparability of intervention groups. Generally, outcome assessment was adequate with studies using validated tools for the assessment of mental disorders, and using appropriate statistical methods for outcome assessment between refugee and host population (comparison) groups. Quality of quantitative studies was adequate. Since most studies relied on cross-sectional methods, access of MHPSS and adherence to treatment could not be tracked over time [14].

Overall, the 9 qualitative studies clearly defined the aims of the research, employed appropriate methodology, and adequately specified methods of data collection and analysis (see online appendix D for details). All studies considered ethical issues and provided value to the field. The sampling strategy was defined and justified for all but three studies [27,29,33]. Three articles did not appear to consider the relationship between the researchers and the participants [39,40,42].

4. Discussion

This is the first systematic review to examine the evidence base on MHPSS utilisation and access in Europe. The review identified 27 eligible studies assessing MHPSS service utilisation and access by refugees and asylum seekers' in the EU and EU's Single Market. The review findings suggest that there remains a discrepancy between mental health need and the amount of MHPSS received.

Despite under utilisation of MHPSS services, there is some evidence that refugees and asylum seekers with mental health needs are proportionally more likely to utilise services for physical health complaints, including emergency care [31]. This may be partly attributable to somatic distress which is linked to disorders such as PTSD [49,50]. The evidence on possible role of somatic distress suggests that practitioners in primary care or hospital settings may misdiagnose refugees and asylum seekers and delay mental health treatment onset [51]. Diagnosis of mental health problems is particularly difficult with refugee populations due to language barriers and the added communication barrier associated with working through interpreters. Therefore, it is particularly important that providers understand somatic distress as a common response to trauma across cultures. If providers have a clear grasp on somatic distress or non-specific pain in relation to mental illness, they can better navigate language barriers and provide early and appropriate mental health diagnosis.

There is also initial evidence that refugees may seek treatment for mental health problems in hospitals more frequently than their reference population, without referral by general health care services [26]. This could be due to a number of reasons: lack of awareness of mental health and MHPSS services outside of hospitals; differences in help-seeking behaviours leading to delayed help-seeking and greater severity of symptoms requiring immediate hospital care [49]; or coming from countries where preferences are to seek hospital care rather than local primary/community care services.

This review provides initial evidence that refugees and asylum seekers utilise more mental health services the longer they live in their country of resettlement [22,35]. This indicates that the longer individuals spend in a country, the more they adapt to the host-country's MHPSS services, knowledge, and attitudes [52]. Thus, acculturation to the host country's values and help-seeking practices through integration and assimilation could lead to increased use of MHPSS over time.

Of the studies exploring access to MHPSS services, the most frequently discussed elements were acceptability, language, awareness, and help-seeking. Concerns with acceptability were common, with patients preferring practitioners from the same ethnic background and who spoke the same language. For some refugees, telepsychiatry or similar online services which allow refugees and asylum seekers to talk with professionals in their mother tongue, could be more acceptable [53–55]. Health systems can further facilitate access through integrating care in the community and primary health care, engaging in outreach, collaborating with and hiring interpreters, accepting self-referrals, and extending operational hours.

There is evidence to suggest that stigma is a major barrier in refugees seeking and accessing MHPSS in the EU. Mental illness is still taboo in several countries. Improving awareness on MHPSS services among refugee populations and cultural sensitivity among providers is paramount. Activities are required to reduce stigma towards mental illness among refugees and asylum seekers, and integrate MHPSS services into community and health care services [56]. Stigma and discrimination towards refugees and asylum seekers may further marginalise them from seeking MHPSS services. Therefore, community education and support programmes are crucial to bridging cross-cultural connections and breaking down stigma. Programmes to reduce stigma are especially important for UAMs. As this population has inadequate contact with mental health services relative to their needs [43], UAMs could benefit from increased mental health education among social workers, teachers and community pediatricians.

Currently, research illustrates widespread challenges among refugees and asylum seekers in accessing mental health care; however, no evaluation studies were identified on efforts to improve utilisation or access to MHPSS services by refugees and asylum seekers. Therefore, implementation research is needed to help understand what practices increase utilisation and access to care.

There is also a need to evaluate determinants of differences in access in order to inform practice and create culturally-competent interventions and services. For example, refugees arriving with higher educational attainment may be more likely to utilise mental health services [24]. Moreover, refugees from different ethnic backgrounds may also have different levels of awareness and perceptions of mental health, and thereby stigma, which may impact their service use [57]. Research has demonstrated increased mental health risk among refugee women as compared to refugee men [58]–clinicians and policy-makers should increase efforts to provide tailored MHPSS for female migrants, and address barriers hindering women from seeking services. We note that studies in this review rarely explored underlying determinants such as gender, age, economic status, and social exclusion. Further studies should assess these determinants in relationship to MHPSS service use.

Finally, this review highlighted the importance of supporting mental ill-health among refugees and asylum seekers and allowing primary health care to serve as a gateway to appropriate mental health services. Future studies should also consider policy analysis to better understand the responsiveness of health policies and systems in encouraging access to care [59].

4.1. Limitations

There are some weaknesses in the evidence. Most studies (15/27) were conducted between 2012 and 2013. As this time period falls before dramatic migration patterns starting in 2014, notably to Germany and Greece, the research may not reflect current trends in MHPSS service utilisation and access. Furthermore, Syria [39] and Eritrea [25], major host countries in migration to Europe, are under-represented, with only one study including refugees from each respective host country.

Although the aim of this review was to assess patterns of MHPSS service utilisation broadly, studies assessing utilisation described contact coverage rather than effective coverage. Thus, a synthesis of the evidence does not allow valid conclusions as to the quality or adequacy of treatment. Accordingly, the literature does not delineate whether refugee and asylum seeker patients received adequate or recommended treatment for their given diagnoses. In addition to evaluating MHPSS contact coverage, future studies need to also assess for the quality of the intervention [60].When assessing for quality of treatment, it is important to assess if an appropriate evidence-based intervention is used for the given disorder and if the provider is appropriately trained in providing the respective treatment. If MHPSS care is provided by non-specialists, supervision and quality control measures needs to be discussed as well.

Similarly, qualitative studies in this review primarily reported on barriers to MHPSS from the subjective perspective of the respondents. While the aim of this review was to assess barriers to access more broadly, these studies are unable to provide insight as to the frequency of each barrier or the association between indicators and MHPSS utilisation and access. There is a clear absence of quantitative studies assessing for barriers to access.

None of the 27 studies employed or evaluated interventions to assess the effectiveness of improving utilisation or access to MHPSS services for refugees. Furthermore, in terms of MHPSS outcomes, only two articles specifically focused on PTSD. This lack of trauma-informed responses, as well as a lack of focus on severe conditions such as psychosis, is concerning given that such conditions can be exacerbated by exposure to the stressors of conflict and forced migration. Additionally, all but one study [26] focused on MHPSS in primary health care or in more specialised services—there was a notable lack of evidence from psychosocial community-based interventions. Only two studies discussed geographic accessibility as a barrier or facilitator. However, distance and time may have been additional limiting factors to accessing MHPSS.

This review is limited by its restriction to studies published from 2007 onward. This timeframe was used as it addresses recent patterns in refugee flows and access to MHPSS in Europe, and so is of current relevance. Second, only articles written in English were included. However, after full-text screening, this only excluded 5 articles published in other languages.

4.2. Conclusions

Based on a systematic review of 27 studies assessing utilisation and access to MHPSS services in Europe, it is evident that refugees and asylum seekers receive inadequate MHPSS relative to need. This underutilisation can be explained by several factors including language barriers, differences in symptom expression, discrepancies between patient and provider service expectations, lack of awareness of services, stigma, and cultural differences in help seeking. Future research needs to assess more recent utilisation and barriers to access among refugees and asylum seekers arriving from Syria and other recently-conflict-affected countries and need to assess the effects of MHPSS service reforms on utilisation. Based on these findings, it is crucial to review policies regarding mental health service provision and MHPSS across the EU.

Conflict of interests

There are no conflicts of interest.

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