REVIEW

Providing mental healthcare to immigrants: current challenges and new strategies

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Purpose of review
The article reviews recent evidence on improving access to mental healthcare for immigrants and best practice of care provision.

Recent findings
Language barriers, different beliefs and explanatory models of illness, confidentiality concerns, stigma, reluctance to seek psychological help outside families, and social deprivation may prevent immigrants from accessing mental healthcare. Pathways are influenced by families, primary care practitioners, voluntary organizations, and social services. Interpreting services are often not available, and data documentation on immigrants' use of services is inconsistent. Nonmedical specific services for immigrants can be effective in outreach activities. Cultural training of staff can improve clinicians' attitudes and patients' satisfaction with care. Integrative approaches between primary and mental healthcare, psychoeducational programs, and technological innovations have been developed to improve access to care.

Summary
Immigrants can face significant barriers in accessing mental healthcare. Strategies to overcome these barriers are as follows: increased coordination and communication between voluntary organizations, social services and mental health services; training of staff on cross-cultural issues; integration of mental healthcare with primary care; psychoeducational initiatives focused on families and broader social groups; and technology-based interventions.

Keywords
barriers, immigrants, mental healthcare, pathways to care

INTRODUCTION

Immigrants, that is, people who were born outside the country of residence [1], show higher rates of mental disorders, such as psychosis, mood disorders, anxiety disorders, and particularly posttraumatic stress disorder, compared with indigenous populations [2,3].

Various factors can influence their higher psychiatric morbidity, that is, premigration, migration, and postmigration stressors, long-term adjustment difficulties in another country, and poor living conditions [4].

In the last 50 years, immigration has almost doubled, with currently 191 million immigrants worldwide. Targeted mental healthcare strategies for these populations may be needed [5]. Understanding barriers to care for immigrants and identifying their pathways may help to develop strategies to meet the cultural, religious, and linguistic needs of different immigrant groups [5,6].

WHAT IS ALREADY KNOWN?

Immigrants face substantial obstacles in accessing healthcare services. Previous studies identified language and literacy issues, cultural differences in explanatory models of illness, restricted legal entitlements, social deprivation, and traumatic experiences as the main barriers to accessing and receiving healthcare [1,7,8]. Immigrants often have specific needs and treatment preferences [9,10]. Good practice recommendations have emphasized the need for organizational flexibility, provision of

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KEY POINTS

- Access to mental healthcare in immigrants may be hindered by language barriers; different beliefs and explanatory models of mental illness; confidentiality concerns; influence of stigma and reluctance to seek help outside immediate social networks; and social deprivation.
- Immigrants often follow nonmedical pathways to care through self-referral, social services, voluntary not-for-profit or religious organizations.
- Interpreting services and cultural competence training for staff are rarely available in mainstream health services, and information on service use by immigrants is scarce.
- Collaboration and sharing of information between mental health services and nonmedical services (voluntary organizations and social services), integration of mental healthcare with physical care, and psychoeducational family programs may increase help-seeking and engagement with services in immigrant populations.
- Technology-based interventions may help support translation of information, reach underserved populations, and deliver culturally tailored psychosocial programs.

good professional interpreting services, raising cultural awareness of staff, delivery of psychoeducational programs, collaboration with families, communities and social services, building positive and stable relationships with patients, and clear guidelines on care entitlements of migrants [1,9,11,12]. Sound research evidence on how mental healthcare should be delivered to benefit immigrants is still scarce.

PURPOSE OF THE REVIEW

In this article, we review the evidence published between June 2012 and November 2013 on the barriers encountered by immigrants when accessing mental healthcare; their pathways to care; the current state-of-care provision for immigrant groups; and newly developed interventions to improve access to and quality of care provided to immigrants. The included studies were carried out in European countries, the United States, Canada, and Australia, and encompass both economic and political immigrants.

BARRIERS TO MENTAL HEALTHCARE FOR IMMIGRANTS

Barriers to mental healthcare fall into five categories: language barriers, different beliefs and explanatory models of mental illness, confidentiality concerns, influence of stigma and reluctance to seek help outside immediate social networks, and social deprivation. These barriers are similar to those in general healthcare, which have been well documented [1,7]. However, the specific nature and social significance of mental disorders can lead to additional problems in accessing care.

Language barriers

Good communication between clinicians and patients is particularly important in mental healthcare in which diagnostic procedures are based on verbal communication rather than on physical and objective examinations. Mental health practitioners qualitatively assessed in 16 major European cities in the EUGATE study reported language difficulties as a major hindrance to assessing symptoms, establishing a diagnosis, and developing a relationship with immigrant patients [13▪▪]. Language problems were also the most prominent barriers to accessing treatment among Latin-American immigrants in the USA, in both community samples and patient groups with depression and PTSD [14▪,15▪,16▪]. Patients reported difficulties in expressing their symptoms and needs to English-speaking clinicians and in understanding their instructions [15▪,16▪,17,18▪]. A preference for bilingual clinicians was a major concern for trauma-exposed Latin-American women [15▪]. Insufficient language skills may also limit access to specific treatments such as psychotherapy. General practitioners in Denmark were sometimes reluctant to refer immigrants to such treatments because of the lack of bilingual therapists and skilled interpreters [19]. Forty-three percent of psychotherapists surveyed in Hamburg ($N = 485$) refused treatment to immigrant patients because of language problems [20▪▪]. Patients' difficulties in expressing themselves in a psychotherapeutic setting may be frustrating for both patients and clinicians, with negative effects on therapeutic alliances, while the presence of interpreters introduces further challenges in establishing trust and a therapeutic rapport [15▪,21▪▪].

Explanatory models of mental illness and expectations of care

Mental health practitioners surveyed across Europe reported that divergent explanatory models of mental illness, such as beliefs in supernatural causes and preferences for physiological interpretations were commonly encountered in non-western immigrant patients [13▪▪]. They were perceived as a potential barrier to the diagnostic procedure, making it difficult to assess psychosocial functioning and

distinguish between culturally accepted beliefs and actual symptoms [13▪▪,18▪,20▪▪]. Patients' views and values may clash with those of clinicians, resulting in distrust and difficulties in establishing therapeutic alliances. Subsequently, engagement with both psychopharmacological and psychotherapeutic treatment may be poor [13▪▪,21▪▪,22]. Adherence to antipsychotic medication was poorer among immigrant patients in Spain than indigenous patients (19 vs. 40%), with particularly low rates among sub-Saharan Africans [23▪]. However, Danish general practitioners reported that immigrant patients sometimes demanded medication when clinicians themselves believed psychological treatment was more suitable [19]. Different views and expectations may also be linked to a lack of a perceived need for mental healthcare and poor knowledge of services, as found in studies on Latin, Korean, and African-American immigrants in the USA [15▪,24–26].

Stigma and reluctance to seek help outside immediate social networks

Stigma and negative views of mental disorder can influence treatment seeking in Latin-American immigrant patients with depression and PTSD [15▪,16▪], and may explain their concerns about receiving medication. Mental health practitioners providing care for Asian-Americans also reported stigma as an important obstacle to these patients [17]. The significance of families and their role as a source of psychological support for Latin-American and Asian immigrants has been highlighted by both patients and professionals in the USA and Australia [16▪,17,27]. However, the presence of this support may also lead to reluctance to seek help outside the family. Immigrant patients may prefer self-reliance and have concerns about the family's reputation [16▪,17,27].

Social deprivation

Specific problems arise when immigrants live in poor socioeconomic conditions. Mental health professionals in European urban settings emphasized the risk of marginalization for immigrant patients [13▪▪]. They suggested engaging with social services and communities to increase the social integration. The self-reported need for interpreters in GP consultations among Danish immigrants was linked to modest income levels, poor health, and unemployment [28▪]. Economic factors such as costs, lack of health insurance, and unemployment were the main barriers to utilizing mental healthcare among Latin-American immigrants in the USA, particularly in low-income groups [14▪,15▪,18▪]. Homelessness was the most significant risk factor for dropping out of substance abuse treatment in the same population [29▪].

PATHWAYS TO MENTAL HEALTHCARE

Immigrants in both USA and Europe often follow nonmedical pathways to care through self-referral, social services, voluntary not-for-profit or religious organizations [14▪,16▪,30▪]. Thirty-nine percent of immigrant patients in Italian community mental health centers were referred through such routes [30▪]. The community outreach activities of these agencies seem to be key in promoting access to care, particularly for marginalized groups of immigrants [30▪,31▪▪]. For example, language assistance programs increased access of Spanish-speaking people to mental health services in California, but only when implemented by community-based organizations [32▪▪]. Emergency departments were a primary source of care for low-income Latin-American groups and treatment was offered to patients who screened positive for depression in this setting [18▪]. Those who dropped out of the subsequent intervention were concerned about receiving medication, but valued counseling delivered by a social worker, particularly over the phone.

CURRENT STATE OF MENTAL HEALTHCARE PROVISION

Information on immigrants' use of mental healthcare and on provision of relevant staff and services is scarce. Several studies published in the period considered in this review have explored this issue.

Service use registers

The EUGATE study assessed emergency, primary care, and mental healthcare services in 16 European cities [33▪▪] and found that 48% of all services kept a database of information on patients' service use. However, immigration status was recorded by only 25% of mental health services, which is still higher than that in other investigated services (19 and 10%).

Provision of interpreting services and bilingual staff

The EUGATE study also explored the provision of interpreting services in different settings [33▪▪]. Many surveyed organizations (42%) did not provide any language assistance; 53% never provided any face-to-face interpreting, and 59% never had any

telephone interpreting. Face-to-face interpreting was most often provided by mental health services (35%), followed by emergency (23%) and primary care services (20%). In California, the presence of language assistance programs was associated with improved access to mental healthcare for Spanish-speaking patients [30▪]. The provision of interpreters increased completion rates in substance abuse treatment for patients from Central and South America [29▪].

Seventy-six percent of mental health services assessed in the EUGATE study reported having members of staff with migrant background [33▪▪], and practitioners frequently regarded this as an effective way to improve the attitude toward immigrants in the service. A survey of public outpatient psychotherapists in Hamburg found that only 14% of them were immigrants, whereas 27% of the population in the area was of such background [20▪▪]. Almost all bilingual professionals were from the EU countries, although the largest immigrant groups were from outside Europe. Community-based mental health providers in California reported a significantly higher number of Spanish-speaking bilingual staff in comparison to Medi-Cal county providers (180 vs. 17); however, this was not associated with improved treatment access [32▪▪].

Cultural competence

Cultural competence training for mental health staff was viewed as important for improving the knowledge, attitudes, and skills of mental health professionals [13▪▪]. Ninety-one percent of psychotherapists in Hamburg considered culturally sensitive attitudes necessary for conducting psychotherapy with immigrants, although cultural beliefs and rituals informed the therapeutic approach of just 29% [20▪▪]. Seventy-two percent of therapists agreed that advanced training in cross-cultural competence would be helpful, whereas 9% had already completed some form of such training.

Bilingual and bicultural Latin-American therapists in the USA reported using culturally preferred communication styles, language, and self-disclosure to engage with patients of the same immigrant background [34▪].

Asylum seekers, refugees, and undocumented migrants

Providing care to asylum seekers, refugees, and undocumented migrants poses specific challenges. Restricted legal entitlements to care and lack of required documents may prevent these patients from accessing healthcare in both Europe and the USA [15▪,18▪,30▪]. Addressing confidentiality concerns is particularly important as patients may fear being reported to the authorities in the host country or their countries of origin [15▪,21▪▪,35▪]. Concerns about the ethnic and political background of interpreters can inhibit information sharing and the development of trust [13▪▪]. An uncertain immigration status and a fear of repatriation undermine the motivation for psychotherapeutic treatment [21▪▪,36▪], although some refugee patients appear to benefit despite precarious circumstances [36▪].

Traumatic experiences are frequent in these populations and disclosing them may in itself be a challenge to a therapeutic relationship [36▪]. Refugee interpreters may feel overwhelmed by the emotional impact of interpreting, particularly for patients with shared histories, and require professional guidance and training in self-care [37▪]. Developing trust and good therapeutic alliance among trauma-affected patients, psychotherapists, and interpreters was seen as an essential curative factor by all three groups [21▪▪].

A study exploring mental healthcare provision for refugees, asylum seekers, and undocumented migrants in eight European capitals [31▪▪] identified differences in service provision between generic services and those with a specific focus on these groups, frequently found in not-for-profit and voluntary sectors. The latter tend to offer more outreach programs and social support, whereas medical interventions were mostly provided by generic services. The activities of specific and generic services overlapped substantially, highlighting the need for good collaboration and information sharing.

MENTAL HEALTH INTERVENTIONS FOR IMMIGRANTS

A number of studies in the present review assessed mental health interventions designed to meet the needs of immigrants, with particular emphasis on integrating mental and physical healthcare, developing community and family-oriented approaches, and using new technologies.

Integrating mental and physical care

General practitioners and primary care services can promote immigrants' access to and engagement with mental healthcare, as they care for a large number of such patients and are able to build trusting relationships [14▪,16▪]. A survey of Latin-American immigrant patients in the USA who received mental health treatment at community healthcare clinics, found that 77% originally made an appointment because of physical ailments [26]. Trauma-exposed

Latin-American women expressed a preference for treatment, and in particular individual psychotherapy, delivered by mental health specialists in primary care settings [15▪].

Approaches to integrate mental health and primary care services have shown positive results in immigrant populations. They successfully reduced depressive symptoms in Asian-Americans [38,39▪] in both general community health centers and culturally sensitive clinics [39▪].

Community-focused and family-focused psychoeducational approaches

Providing information on physical and mental health in community settings and utilizing family support are being increasingly used in psychoeducational approaches for immigrants.

Workshops on mental health and physical diseases were effective in increasing knowledge and utilization of services amongst African immigrants in the USA [25].

Culturally tailored approaches for promoting a healthy lifestyle for pregnant and early postpartum Latin-American women in the USA also reduced the risk of depression [40]. Parenting interventions combined with practical and emotional support by befrienders were experienced as psychologically beneficial by asylum-seeking mothers in the UK [41].

A 12-week multifamily group intervention with bilingual facilitators delivered to women with perinatal depression showed good feasibility (13 out of 16 families attended more than 90% of sessions), and improved the psychosocial functioning and support in the families [42▪].

Family-oriented, culturally tailored psychoeducation intervention for Chinese-American patients with schizophrenia improved symptom levels and quality of life, knowledge of the illness, and social support for the caregivers [43▪]. Flexibility in delivering the intervention to accommodate the specific needs of families was found to be particularly helpful.

Technology-based interventions

Technology-based interventions have been developed to overcome language barriers, ensure a detailed and valid mental health assessment of immigrants, reach underserved populations, and provide tailored psychosocial approaches.

An iPad-assisted psychosocial risk-assessment was tested on a population of Afghani refugees in Canada [35▪]. The assessment tool increased the reported intention to visit a psychosocial counselor (72% of experimental vs. 46% of usual care group).

Using Internet videoconferencing (Webcam intervention) for online consultations between psychiatrists and immigrants with depression was found to be more effective than standard primary care in reducing depressive symptoms and improving quality of life [44▪].

A culturally tailored, problem-solving, web-based intervention was tested in Turkish immigrants with depression [45▪]. The study had high attrition rates and failed to show a significant effect on depressive symptoms. However, a completers-only analysis suggested better recovery from depression in the experimental group.

CONCLUSION

Research on mental healthcare for immigrants is still inconsistent and has methodological shortcomings. Yet, a number of common barriers preventing access to mental healthcare have been identified in very different immigrant populations. Immigrants, particularly those with poorer socioeconomic status, may share similar pathways to mental healthcare that are different from those of indigenous populations and often involve non-medical agencies. Recent evidence suggests that several strategies should be implemented and tested to improve access to mental healthcare in immigrants:

(1) Sharing of information between mental health services and existing networks of voluntary organizations and social services, which are in a better position to carry out outreach activities, develop trusting relationships, and direct patients to mental health services.
(2) Improving the collaboration between 'migrant-specific' (voluntary organizations, charities) and generic mental health services, with regular communication and protocols to avoid overlap of activities.
(3) Training of mental health professionals on cultural beliefs and explanatory models of mental disorders may improve attitudes to immigrant patients, and help reassure patients about their confidentiality concerns.
(4) Integrating mental healthcare with physical healthcare can help to engage immigrants, in particular, but not exclusively, when significant physical health and mental health needs are present at the same time.
(5) Psychoeducational family programs may increase knowledge about mental health problems. Considering the family-centered culture of many immigrant groups, such programs can influence help-seeking.

(6) Technology-based interventions can support a translation of information, enable same-language clinicians to access underserved populations, and support a cost-effective implementation of culturally tailored psychosocial programs.

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Conflicts of interest

The authors declare no conflicts of interest.

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- ■ of special interest
- ■■ of outstanding interest

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This study evaluated the effectiveness of culturally sensitive, self-help, problem-solving intervention delivered via the Internet to Turkish immigrants with depression. There was no significant effect on depressive symptoms compared to a waiting list control groups, but a completers-only analysis indicated possible effectiveness of the intervention when assessed in a larger sample.

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QUERY NO.	QUERY DETAILS	RESPONSE
<AQ1>	Please provide the expanded form of EUGATE.	
<AQ2>	Please provide the expanded forms of PTSD, GP, RCT.	
<AQ3>	Please check whether the intended meaning of the following sentence is retained after making the edits. 'A survey of public outpatient psychotherapists in Hamburg found that only 14% of them were immigrants, whereas 27% of the population in the area was of such background'.	
<AQ4>	Please check whether the intended meaning of the following sentence is retained after making the edits. 'Seventy-two percent of therapists agreed that advanced training in cross-cultural competence would be helpful, whereas 9% had already completed some form of such training'.	
<AQ5>	Please check whether the intended meaning of the following sentence is retained after making the edits. 'The latter tend to offer more outreach programs and social support, whereas medical interventions were mostly provided by generic services'.	
<AQ6>	Please check the author names in Refs.[1,3,9,13,18,23,24,25,30,31,33,38,40,41,43,45].	
<AQ7>	The page range appearing in Ref.[7] is invalid. Please check.	
<AQ8>	Please update Refs. [15,22], if possible, by providing complete publication details such as volume, year of publication, and page range.	
<AQ9>	The intended meaning of the following sentence is not clear. Please check. 'The findings highlighted scarcity of data on immigrants, patients' service use,	

	and a high number of services, which did not provide any interpreting and did not employ any members of staff with immigrant background'.
<AQ10>	Please provide the year of publication in Ref.[37].
<AQ11>	Please check the page range in Ref.[44].