RESEARCH ARTICLE

Turkish Journal of Psychiatry 2024;35(2):87–94

https://doi.org/10.5080/u27044

Barriers to Accessing Mental Health Services Among Syrian Refugees: A Mixed-Method Study

Cengiz Kılıç[1,5], Edip Kaya[2], Özge Karadağ[3], Sarp Üner[4]

ABSTRACT

Objective: Although Syrian refugees have high rates of mental health problems due to war trauma, little is known on their degree of need for and contact with mental health services. Using a population sample of Syrian refugees living in Ankara, we assessed the perceived need for and contact with mental health services, as well as the barriers to access these services.

Method: This was a cross-sectional mixed-method study of 420 Syrian refugees living in Ankara city center, using face to face interviews administered at the respondents' home by trained, Arabic-speaking interviewers. PTSD and depression were assessed using Harvard Trauma Questionnaire and Beck Depression Inventory, respectively.

Results: Of all the refugees in our sample, 14,8% (N=62) stated that they felt the need for mental healthcare since arriving in Turkey. The actual number contacting any mental health service was very low (1,4%, N=6). The most important barriers to accessing mental health services were reported by the respondents to be language problems and lack of information on available mental health services. Service providers and policymakers also reported similar topics as the most important barriers: low awareness about mental health problems, daily living difficulties, and language and cultural barriers. Multivariate analyses revealed that presence of medical or mental disorders and female gender predicted the perceived need for contacting services.

Conclusion: Our results show that, although refugees report high rates of mental health problems, the perceived need for and actual contact with services are very low. To address this treatment gap, and to provide adequate care for refugees with mental health problems, common barriers (language and awareness) should be identified and dealt with.

Keywords: Refugee, Mental Health, Healthcare Utilization, Syria

INTRODUCTION

According to the data of the United Nations High Commissioner for Refugees (UNHCR 2021), 6.6 million refugees took shelter in other countries as a result of the war in Syria. As of today, Syria ranks first among the countries where refugees originate. Turkey, which hosts more than 3.6 million Syrian refugees, is still the country with the highest number of refugees in the world. Mental health problems, especially depression and posttraumatic stress disorder (PTSD), are common among Syrian refugees due to conflicts in their country (Tekeli-Yesil et al. 2018, Kaya et al. 2019). However, studies conducted in host countries show that 80-90 percent of refugees with PTSD and other mental disorders do not contact mental health services at all (Sijbrandij et al. 2017, El Chammay et al. 2013, Laban et al. 2007). In a study conducted among Syrian refugees living in Istanbul, Fuhr et al. (2019) showed that only 9% of those in need of mental help sought help. In a study conducted in Germany, it was found that only 5% of refugees who need mental health services can receive these services (Sijbrandij et al. 2017). Similarly, in the study conducted with Iraqi refugees in the Netherlands, it was found that only 8.8% of refugees with mental illness contacted mental health services (Laban et al. 2007). In the study conducted with Syrian refugees in Lebanon, the rate of refugees who could access mental health services was only 1% (Rabih El Chammay et al. 2013). Not being able to speak the language of the host country, lack of

Received: 13.12.2021, **Accepted:** 01.08.2022, **Available Online Date:** 07.01.2023

[1]Prof., Hacettepe University, Faculty of Medicine, Department of Psychiatry, [2]Stress Assessment and Research Center, Ankara; [3]Assoc. Prof., Ağrı İbrahim Çeçen University, Faculty of Health Sciences, Department of Disability Care and Rehabilitation, Ağrı; [4]Assoc. Prof., Columbia University, Department of Center for Sustainable Development, The Earth Institute, New York, USA; [5]Prof., Lokman Hekim University, Faculty of Medicine, Department of Public Heath, Ankara, Turkey.

e-mail: cengizk@hacettepe.edu.tr

information about available services, low awareness of mental health problems, fear of stigma, feeling unsafe, transportation problems, financial difficulties, and cultural factors were the most frequently mentioned obstacles in studies (Hassan et al. 2016, de Anstiss et al. 2009, Maier et al. 2011, M'Zah et al. 2019). Inadequacy or cost of mental health services in the host country, long waiting times, stigmatizing and discriminatory attitudes, and strict policies towards refugees were also reported to reduce access to mental health services (Satinsky et al. 2019, Hendrickx et al. 2020, Fenta et al. 2006, Nadeau and Measham 2006).

In our study, we aimed to investigate the subjective mental health service needs of Syrian refugees living in Ankara and the objective and perceived predictors of the barriers to contacting those services. Based on the existing literature, we predicted that the need for and contact with mental health services will be predicted by factors such as the severity of mental health problems, female gender, and education. A more detailed description of the results and methods regarding the prevalence and predictors of mental illness in refugees can be found in Kaya et al. (2019) and Karadağ et al. (2021).

METHOD

Our research is a cross-sectional, mixed-method study conducted with Syrian refugees living in the city center of Ankara. Quantitative data were collected in face-to-face interviews at participants' homes by trained Arabic-speaking interviewers using an assessment battery. Qualitative data were obtained from 10 health care providers (6 doctors, 2 midwives and 2 nurses) and 10 health administrators (9 doctors, 1 social worker) using an interview conducted by the second author (EK).

The Sample

In October-November 2016, 420 Syrian refugees over the age of 18 were interviewed face-to-face in two neighborhoods in Ankara where Syrian refugees are concentrated. At the time the data were collected, an estimated 88,000 Syrian refugees were living in Ankara, according to data from the Directorate of Migration Management (2016). Since there was no reliable sampling frame for refugees, we decided to visit the households in these neighborhoods and include all those who volunteered to participate in the study. The only exclusion criterion was the presence of any condition that impeded understanding or communication. Qualitative data were collected through in-depth interviews with 10 health service providers and 10 administrators. In-depth interviews were conducted with service providers at the health centers where they provide service, and with managers at their workplaces. The interviews were recorded using a voice recorder; they were recorded manually for two managers who did not agree to recording. Each interview lasted between 30-45 minutes. Service providers including five general practitioners, two midwives, two nurses, and a psychiatrist working at Ankara Training and Research Hospital were interviewed at Ulubey (Altındağ), Gülveren (Mamak) and Yenimahalle Immigrant Health Centers. Five of the 10 managers interviewed were from Ankara Provincial Public Health Directorate (current Public Health Services Directorate affiliated with Ankara Provincial Health Directorate), and five were from the Ministry of Health Turkish Public Health Institution (now General Directorate of Public Health). All of the managers from the General Directorate of Public Health were department heads. The administrators interviewed at the Provincial Directorate of Public Health were two Community Health Center heads, two branch managers, and a deputy director.

Measures

Services use: In this section, there were sociodemographic variables, perceived physical and mental health status, and factors preventing access to and contact with general and mental health services. Current or past physical and mental disorders, history of alcohol/drug use, and current psychotropic drug use were also evaluated.

Harvard Trauma Questionnaire (HTQ): The Arabic version of the self-report scale developed to evaluate DSM-IV PTSD symptoms was used (Mollica et al. 1992, Shoeb et al. 2007). The scale consists of five parts. The first part used in this study consists of a list of 43 different traumatic events that participants answered as "yes" or "no". In the fourth part, which measures traumatic stress, participants are asked to rate each item on a four-point Likert scale (1=not at all, 2=a little, 3=quite a lot, and 4=a lot). Since there is no cut-off point for the Arabic version, the probable prevalence of PTSD was calculated using the algorithm proposed in the original study (Mollica et al. 1992). The internal consistency (Cronbach alpha) value for 16 PTSD symptoms in this study was found to be 0.82.

Beck Depression Inventory (BDI): The BDI is a commonly used 21-item self-report scale; it measures the level of depressive symptoms in the previous week (Beck et al. 1961). All questions are coded from 0 to 3; higher scores indicate more severe depression. Its validity and reliability for Arabic has been demonstrated by West (1985) and Abdel-Khalek (1998). Both the BDI total score (range: 0-63) and probable depression prevalence (using 19 as cut-off) were used in the analyses. The Cronbach's alpha value for the present sample was found to be 0.85.

Qualitative Interviewing Guide: A qualitative interview guide prepared by the researchers was used to collect qualitative data. Two types of interview guides have been prepared: for service providers and for health managers. The interview guide

prepared for service providers consisted of 12 questions, and the one for health administrators consisted of nine questions. Interview guides included the descriptive characteristics of the participants (age, gender, occupation, education level, years of experience with refugees, etc.), mental health services provided to refugees at the country and provincial level, mental health problems of refugees, their views on the adequacy and accessibility of mental health services provided to refugees, as well as their views on refugees. It covered topics such as suggestions for removing barriers to accessing mental health services and for improving mental health services.

Analyses

Marital status (married=1, unmarried=0) and education (primary school graduate or less=0, secondary school or higher=1) were recoded as binary variables. The frequency of those with possible depression or possible PTSD was calculated to be used in the analyses. In the results that describe the general sample, those who need and do not need psychological help were compared using t-test for continuous variables and chi-square test for categorical variables. SPSS 23.0 statistical software package was used for data analyses.

For qualitative data analysis, audio recordings of the interviews were transcribed, and then a content analysis was carried out in which themes and sub-themes were determined. Qualitative findings were given under the main themes, and relevant quotations were presented in a way that would protect the anonymity of the participants. After the analysis of the qualitative data, the findings were evaluated and interpreted together with the quantitative analysis findings.

Procedure

A convenience sample was used to recruit participants. The households in two neighborhoods of Ankara densely populated by Syrian refugees were visited by six interviewers who speak Turkish and Arabic. Every household visited was asked if there were other Syrian families around that they knew of, and the households indicated by the family were visited. If the visited household did not know of any other household of Syrian origin, a random household was visited, and in case they were of Syrian origin, the purpose of the study was explained and they were invited to participate in the study. This was continued until a new suitable household was reached. A sampling frame or a sample size could not be computed; we tried to reach as many refugees as possible during the two-month study period. 15 of the visited households who refused to participate were not included in the study. Contact was made with 431 people from 229 households who agreed to participate in the study. Eleven out of those 431 refused to participate in the study, and interviews were completed with 420 people. All interviewers were trained in the use of study scales, and the performance of the interview battery and of interviewers was tested by conducting a pilot study before the main study. Each household was visited by teams of two interviewers. In order to reduce the rejection rates, the interviewers and the participants were matched by gender. Since the majority of the respondents had a low level of education, the interviewers were asked to read out the items and record the responses. Ethical approval was obtained from Hacettepe University Ethics Committee, and institutional permissions were obtained from the Ministry of Interior, General Directorate of Migration Management and the Ministry of Health, General Directorate of Public Health for the study; and written informed consent was obtained from the participants.

RESULTS

Sample description: The mean age of the participants in the study was 35.4 (Range: 18-80, SD: 13.0). 56.4% of the participants were women and 84.7% were married. The education level of 70.1% of the participants was primary school level or lower. The rate of those who stated that they work in an income-generating job was 28.2%. Of the participants, 24.1% had at least one Turkish friend, and 11.7% spoke Turkish well. The percentage of participants who reported that they had been diagnosed with a mental disorder in the past was 2.9% and 2.1% reported that they still use medication for their mental problems. Reported need for their mental problems during their stay in Turkey was 14.8% (N=62). The ratio of those who had any physical disease was 43.9%, and the ratio of those who contacted any carer with a general health problem in the last year was 46.3%. The average number of traumatic events experienced by refugees was found to be 13.8, out of 43 traumatic events asked to the participants. 88.8% of the refugees stated that they were in a war and conflict environment, 44.0% of them reported that they lost a family member (child, spouse, etc.) due to war or violence, and 31.0% of them witnessed murder. The prevalence of probable PTSD and depression, measured by the cut-off point of the scores obtained from the HTQ and BDI scales, was 36.5% (N=152) and 47.7% (N=198), respectively. Presence of either possible PTSD or probable depression was also calculated (56.7%, N=238).

Need for mental treatment and contact with services: Need for mental health services was higher in women (p=0.009), those who contacted mental health services (p=0,001), and those who contacted general health services (p=0.03). On the other hand, the need for mental health services was not found to be associated with age, length of stay in Turkey, marital status, employment status or education (Table 1).

Table 1. Factors Associated with the Subjective Need for Mental Health Care (n=420)

Sociodemographic Variables		Need present N (%)	Need absent N (%)	Total N (%)
Gender**	Male	17 (9.3)	165	182
	Female	45 (19.0)	192 (81.0)	237
Education	Primary school or lower	45 (15.4)	248 (84.6)	293
	Middle school or higher	16 (12.9)	108 (87.1)	124
Marital status	Married	50 (14.1)	305 (85.9)	355
	Not married	12 (18.8)	52 (81.2)	64
Paid job	Present	12 (10.2)	106 (89.8)	118
	Absent	50 (16.6)	251 (83.4)	301
General health care contact in the last year*	Present	37 (19.1)	157 (80.9)	194
	Absent	25 (11.1)	200 (88.9)	225
Mental health care contact in the last year**	Present	6 (100)	0	6
	Absent	56 (13.6)	357 (86.4)	413
		Mean (s.d)	**Mean (s.d)**	
Age		34.84 (11.2)	35.55(13.35)	
Years in Turkey		2.37 (1.11)	2.15 (1.1)	

* P<0.05; ** P<0.01

There were 6 people in total who contacted mental health services in the whole group (9.7% of those who felt they needed help; 1.4% of the total sample). All six people stated that they needed psychological help. Detailed analyses were not carried out because the number of contacts with mental health services was very low.

Regression analyses: Logistic regression analyses were used to determine the independent factors that predicted the need for psychological help in the last year. Literature knowledge was used to determine which variables to include in the analyses; variables that were found to be significant in univariate analyses were also included. Being female, and having a known physical or mental illness (diagnosed by a doctor) predicted the need for psychological help. None of the demographic variables such as age, education, marital status, income level, or length of stay in Turkey were associated with the need for psychological help (Table 2).

Reason for non-contact: Figure 1 compares the most common barriers to accessing general health and mental health services reported by respondents. It is understood that language barrier and lack of information about services were seen as the most important obstacles based on responses to the instruction: "To what extent have the following factors prevented your access to healthcare? Rate using the scale 0=none 5=a lot". Interestingly, lack of knowledge was perceived as a more important barrier for mental health services than general health services (4.77 vs. 3.28). Another finding was that the fear of stigma was seen as the least obstructing factor in contacting mental health services. Stigma as a barrier was scored even lower for mental health than for general health (2.03 vs. 2.7).

Results of Qualitative Analyses

In-depth interviews were held with the health professionals who provide services to refugees and the managers involved in the provision of these services in order to reveal the mental health service needs of refugees, the obstacles to their access to services, and to develop solution proposals. Recommendations of service providers and health administrators regarding service needs, possible barriers to accessing services and solving problems were similar. Both groups reported that mental health problems were very common, but contact was very low.

K7 (Female, 33): "I do not think that refugees with mental health needs contact services. Rate of contact is around 5%. Because many do not even know that this is a reason to contact health care services. There may be domestic violence in general, and there may be complaints related to psychological problems such as incontinence in children. Women complain about lack of support… Insomnia, many have this complaint. They complain of too many diseases. When I start to question those diseases, we see that there are actually psychological reasons behind them. Revealing more through inquiry…."

Service providers and administrators identify barriers to refugees' access to mental health services as: priorities such as accommodation, nutrition, clinging to life, language barrier and lack of interpreters, low awareness of mental problems and not knowing the system about how and where they will receive mental health services.

Table 2. Predictors of Subjective Need for Mental Health Care (Logistic Regression)

Variables	Subjective Need For Mental Health Care			
	p	OR	(95% CI)	
Gender				
Male	Ref.			
Female	0.026	2.065	1.090	3.913
Education				
Primary school or lower	Ref.			
Middle school or higher	0.973	0.989	0.509	1.922
Marital status				
Not married	Ref.			
Married	0.271	1.548	0.711	3.372
Medical illness diagnosis				
Absent	Ref.			
Present	0.021	2.166	1.126	4.167
Mental illness diagnosis				
Absent	Ref.			
Present	0.000	13.104	3.257	52.728
Health care contact in the last year				
Absent	Ref.			
Present	0.093	1.686	0.917	3.097
Age (years)	0.127	0.980	0.955	1.006
Monthly family income (TL)	0.986	1.000	0.999	1.001
Years in Turkey	0.116	1.244	0.948	1.634

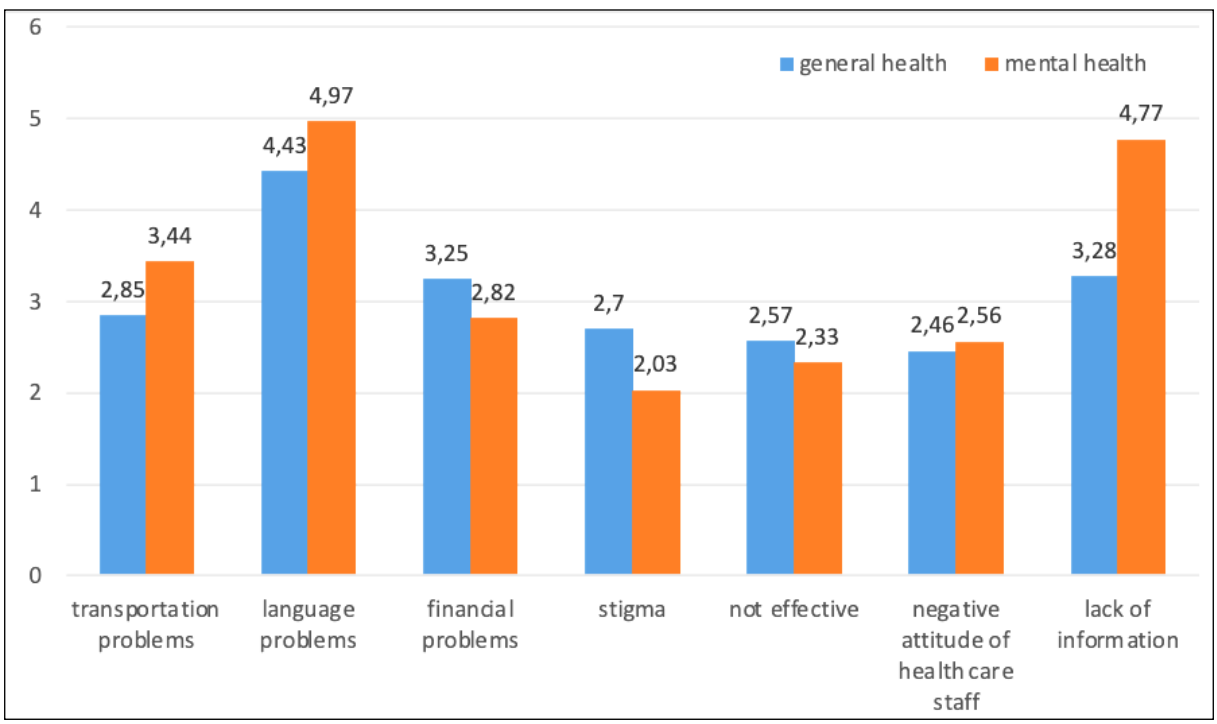

Figure 1. Barriers to accessing general and mental health services (participants' own views)

*To what extent did the above factors hinder your access to health services? (0=none 5=a lot)

K13 (F, 46): …First, they don't know the system very well. Where to start, where to go… Plus, it is not easy for them to reach someone who can understand them, help them, speak the language, but also know the system in this country. …I mean, at this point, they have postponed the previous trauma right now, or they put their depression aside and because they struggle to survive, I think their mental health has been postponed for now. But I think that this will come before us as a much bigger problem in three or five years.…"

In line with their observations, both groups emphasized that the communication problem should be solved urgently in order to improve the mental health of refugees. For this purpose, they recommended employing Arabic-speaking doctors, having more translators in hospitals, providing training to increase mental health awareness, and screening refugees for the presence of mental disorders.

K3 (F, 29): So it is necessary to educate. In other words, awareness should be raised in groups about mental problems and coping. Hospitals only have one translator. Not enough at all. So, this is a main problem; the number of translators should be increased.

K14 (Male, 51): "My suggestion is: First, overcoming the language problem is very important. The second is the need to make use, in the best way possible, of communication resources such as Facebook, WhatsApp, television, and radio; especially the TV channels Syrians watch and the radio they listen to. Another thing is getting support from non-governmental organizations.…

DISCUSSION

Our findings show that, similar to previous research with Syrian refugees and other refugee groups, many refugees need mental health support, but few make use of these services (Bartolomei et al. 2016, Fuhr et al. 2019, Hawkes et al. 2021, Jack- Ide and Uys 2013, Kirmayer et al. 2011). Although the study designs were different, our results on rates of contact with health care services were strikingly similar to those reported by Fuhr et al. (2019) for Syrian refugees in Istanbul. The rate of contact with mental health services of refugees is much lower than it is for the Turkish population (approximately 20%-Turkish Mental Health Profile - Kılıç 1998). Although all of those who contacted mental health services did have mental problems, the vast majority of those with mental problems have never contacted such services. One reason for the low contact with services may be the insufficient awareness of mental health or that mental health does not have priority for participants over general health. Our qualitative data support our conclusions: both service providers and health administrators stated that refugees' awareness of mental health problems was low and that mental problems have lower priority compared to more pressing problems such as loss of relatives, property loss and other socioeconomic difficulties. On the other hand, the prevalence of depression and PTSD may be over diagnosed because the measurement tools (BDI and HTA) we used were not diagnostic interviews. In a systematic review and meta-analysis study, it was reported that a higher prevalence of depression and PTSD was found in studies using self-rating scales (Steel et al. 2009). There is a need to conduct qualitative studies with refugees in order to better understand the reasons why the need for mental health services remains very low given the high prevalence of mental problems.

Refugees' subjective reports of what they see as the main barriers preventing access to mental health services have been strikingly similar in many studies. The most frequently reported ones are language problems (Doğan et al. 2019, Sijbrandij et al. 2017, Derr 2016, Guarnaccia et al. 2005, Guruge et al. 2018) and lack of information about where and how to reach mental health services (Al-Soleiti et al. . 2021, Bartolomei et al. 2016, Fauk et al. 2021, Jack-Ide and Uys 2013, Kiselev et al. 2020, Maconick et al. 2020); Our findings in this study are also in this direction. The language barrier is particularly important: Except for the study by Fuhr et al. (2019), all studies on the use of mental health services by Syrian refugees have shown that refugees see language barriers as the biggest barrier preventing access to services (Hassan et al. 2016, M'Zah et al. 2019, Kiselev et al. 2020). Many refugees stated that they would go to the hospital if they knew that there was an interpreter or an Arabic speaking doctor/psychologist at the facility. Many stated that they could not read the signs on buses or buildings, indicating that the problem was not only related with a different language but also with a different alphabet. An interesting finding was that stigma was not perceived as a major barrier preventing access to mental health services. This is a welcome finding, because stigma is known to reduce access to mental health care, even in under-resourced countries. However, this may also be due to the fact that refugees are not aware of stigmatization due to their low awareness of mental illness and services. Although we couldn't do further analyses due to the small number of people who contacted services, the role of women needs to be examined in detail. In univariate analyses, both the psychological symptom levels and the need for treatment in women were found to be higher than it is in men. Refugee status may affect female refugees more than men and prevent them from seeking treatment. Finally, it is known that the vast majority of refugees experience serious financial difficulties and have difficulty meeting even their most basic needs (Kirmayer et al. 2011). In our study, the majority of refugees reported their economic situation as bad or very bad. Refugees cite financial and transportation problems as the leading reasons for not seeking treatment; therefore, it is possible that contact with mental health services

is not a priority. In qualitative interviews, both administrators and health service providers emphasized this situation.

Our study has some limitations. Since random sampling was not possible (lack of recorded data and refugee mobility), a conveniency sampling method was used. The very low number of treatment contact significantly limited the power of the analyses. For example, mental health service needs were examined in multivariate analyses, but contact with mental health services could not be examined. Finally, although the measurement tools used in the study are clinically valid, the lack of interview tools to provide clinical diagnosis limits the power of the study.

CONCLUSIONS

This study supports the findings of previous studies showing that Syrian refugees rarely contact mental health services despite the presence of many war traumas and common mental problems. The most important barriers preventing access to mental health services are language problems and lack of information about available mental health services. It is understood that the application for mental problems is not a priority for refugees, and the main reason for this is the lack of awareness. Our findings show that there is an urgent need to increase knowledge and awareness about mental health problems and available services in refugees. Finally, future studies on barriers preventing access to mental health services should focus on gender differences in the use of services. While the unmet mental health needs of refugees are generally very high, our findings suggest that this need is even higher among female refugees.

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Acknowledgements: *We thank the members of our field team Reshed Abohalaka, Sanaa Ishag, Raghad Kurdi, Heba Salama, Arwa Bayraktar and Mohamed Sryh for their support in data collection. We also thank Hacettepe University and the Ministry of Interior, General Directorate of Migration Management and Ministry of Health for approving the fieldwork.*

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