# Providing mental healthcare for refugees in primary care: a systematic literature review

Dr. Akker Bruneel, UGhent

Dr. Yoran Joseph, UGhent

Promotor: Prof. Dr. Stéphanie De Maesschalck,
Faculty of Medicine and Health Sciences > Department of Public Health and Primary Care, UGhent

Co-promotoren: Dr. Jessica Tilley
Faculty of Medicine and Health Sciences > Department of Public Health and Primary Care, UGhent

Master of Family Medicine

Masterproef Huisartsgeneeskunde
Academiejaar: [2024 – 2025]

Deze masterproef is een examendocument dat niet werd gecorrigeerd voor eventueel vastgestelde fouten. Zonder voorafgaande schriftelijke toestemming van zowel de promotor(en) als de auteur(s) is overnemen, kopiëren, gebruiken of realiseren van deze uitgave of gedeelten ervan verboden. Voor aanvragen tot of informatie i.v.m. het overnemen en/of gebruik en/of realisatie van gedeelten uit deze publicatie, wendt u tot de universiteit waaraan de auteur is ingeschreven.

Voorafgaande schriftelijke toestemming van de promotor(en) is eveneens vereist voor het aanwenden van de in dit afstudeerwerk beschreven (originele) methoden, producten, schakelingen en programma's voor industrieel of commercieel nut en voor de inzending van deze publicatie ter deelname aan wetenschappelijke prijzen of wedstrijden.

# Preface

This thesis represents a significant milestone in our journey as junior doctors. We are grateful for the opportunity to explore a topic of growing importance—improving access to mental healthcare for refugees in primary care—and we hope that our work can contribute, in some small way, to enhancing the quality and equity of care for this vulnerable population.

We extend our sincere gratitude to our promoter and co-promotor for their invaluable guidance, unwavering support, and insightful feedback throughout the course of this review. Their expertise and encouragement have been instrumental in shaping the quality and direction of this work. We remain committed to contributing to ongoing scholarly dialogue and further exploration of the critical issues addressed herein.

We are also profoundly thankful to our partners, families, and friends for their unwavering encouragement. Their support, patience, and belief in us provided strength during challenging moments and played an essential role in the completion of this thesis.

As we look ahead with curiosity and optimism, we are eager to embrace the next chapter of our professional lives as general practitioners and to continue engaging with the complex and meaningful challenges that lie ahead.

# Abstract

**Background:**
As of 2024, over 122 million people worldwide have been forcibly displaced due to conflict, persecution, and violence, with nearly 38 million recognized as refugees. Refugees are at high risk for psychiatric problems, particularly post-traumatic stress disorder (PTSD), depression, and anxiety. Despite these high mental health needs, refugees face substantial barriers to accessing care, including language difficulties, limited mental health literacy, cultural divergences, social stigma, systemic/structural barriers, limited awareness of available services, challenges in navigating healthcare systems, and a shortage of culturally competent providers. Since community health centres and primary care clinics serve as the main point of access to mental health services for refugees, they can play an important role in the early identification and treatment of mental disorders.

**Objective:**
This systematic review aims to identify and synthesize existing solution-oriented interventions that enhance mental health care access for adult refugees within European primary care settings.

**Methods:**
A systematic search was conducted in PubMed and Web of Science on August 8, 2024, targeting studies published from 2011 onward. The inclusion criteria focused on studies that examined barriers to, and solutions for, improving access to mental healthcare for adult refugees and asylum seekers resettled in Europe, specifically within primary care settings. Ultimately, 17 articles were included for qualitative synthesis using narrative methods.

**Results:**
Several solution domains were identified: (1) the use of professional, culturally competent interpreters; (2) the development and delivery of culturally sensitive care models; (3) cross-cultural training programs for healthcare providers; (4) peer-to-peer support interventions; (5) psychoeducational initiatives to reduce stigma and enhance mental health literacy; (6) the integration of trauma-informed care principles; (7) stepped care models to tailor intervention intensity to patient needs; and (8) digital mental health tools to overcome accessibility barriers. NGOs were highlighted as key actors in bridging service gaps.

**Conclusions:**
This systematic review highlights the urgent need for tailored, culturally sensitive, and trauma-informed strategies to improve mental healthcare access for refugees within primary care settings. While several promising interventions have been identified—such as interpreter services, psychoeducation, and cross-cultural training—broader structural challenges remain insufficiently addressed. The review underscores the importance of multi-sector collaboration and system-level reforms to ensure sustainable and equitable mental health support. Future research should prioritize the rigorous evaluation of the long-term cost-effectiveness and scalability, as well as the concrete implementation of these interventions within primary care settings.

# Table of contents

1. Introduction ..... 1

2. Methods ..... 5

2.1. Search strategy and eligibility criteria ..... 5

2.2. Study selection ..... 6

2.3. Data extraction / Data collection Process ..... 7

2.4. Data synthesis ..... 7

3. Results ..... 9

3.1. Point of interest in mental health care approaches for refugees ..... 18

*3.1.1.* Language ..... 18

*3.1.2.* Culture ..... 19

3.2. Organisation of mental healthcare for refugees ..... 25

*3.2.1.* Stepped care models ..... 25

*3.2.2.* The role of NGOs ..... 28

4. Discussion ..... 29

5. Conclusion ..... 34

6. References ..... 35

# 1. Introduction

As of the most recent estimates, over 122 million individuals globally have been forcibly displaced due to conflict, persecution, violence, human rights violations, and other crises, with nearly 38 million of them recognized as refugees (1).

Refugees' mental health is influenced by a range of factors that can be categorized into pre-migration, migration, and post-migration stages. Pre-migration experiences often include exposure to traumatic events such as conflict, violence, and persecution, which can lead to significant psychological distress. During migration, refugees may face additional challenges, including dangerous travel conditions, family separation, and exploitation, further exacerbating their mental health issues. After resettlement, they frequently encounter post-migration stressors, such as cultural adjustment, social isolation, legal uncertainties, and barriers to accessing appropriate healthcare services. These cumulative factors underline the complex nature of mental health challenges faced by refugees and the need for targeted support within primary care settings (2).

Taking these reasons into account, one would expect prevalence rates of mental health disorders in resettled refugees to be higher compared to the general population. However research has shown that this is not necessarily the case (3). A meta-analysis indicates that, overall, the prevalence of mental disorders is not significantly higher in refugees than observed in host populations (4). There is an exception to be made for PTSD. Due to a higher exposure to traumatic events, the prevalence of PTSD is seen to be elevated in refugee populations (3). Different studies agree that there is a wide variability to be noted across different refugee groups. This could be explained by different groups having different backgrounds, having different experiences in their country of origin, as well as during their migration or ending up in different contexts within the host countries. It is however important to note that the quality of methodology also shows to have an impact on the reported prevalence. Studies of higher quality tend to have more representative sampling, where people have been randomly selected from a larger population. These studies report lower prevalence than studies where an opportunistic or convenience sample (not randomly selected) has been used (3, 5). A last factor to be noted is that diagnostics of mental disorders are often sensitive to a certain level of subjectivity, since diagnostic systems often rely on the expression of emotions and the interpretation of reactions to psychological suffering. This could be influenced by cultural background or language barriers (5). These reasons suggest that accurately determining the prevalence of mental health disorders in refugees may be infeasible due to numerous influencing factors (3-5).

Despite these complexities, the prevalence of different mental disorders have been relatively well studied, although it is important to note that these studies focus on the world population, as to where this review focuses on studies published in Europe. When it comes to the prevalence of psychotic disorders, some studies suggest a similar prevalence in refugee populations as in the general population, about 1.3% – 2% (3, 5). While alternative sources suggest a higher prevalence within refugee populations, with estimates ranging from 3 to 4.5 times greater (6, 7). The first year of resettlement is thought to be a critical period in the development of a psychotic disorder (3, 5). When it comes to mood disorders different numbers are being called, but the World Health Organisation (WHO) states that when looking at the larger studies the prevalence of depression is similar in refugees as in host populations (3, 5). Recent studies show that 1.8% of refugees were

diagnosed with an anxiety disorder (5). When using the Hopkins Symptoms Checklist, both disorders show much higher numbers. 20% of refugees reported clinically significant symptoms of depression, while 19% - 20.3% reported significant symptoms of anxiety (5). Studies report a prevalence of PTSD of 9%, which is higher than host country populations, with prevalences ranging from 1-3%. PTSD is commonly seen together with depression (5). The prevalence of substance abuse disorder, more specific alcohol dependence ranges from 1 – 42% and harmful alcohol use ranges from 4% - 36% . The variety in these results are caused by different refugee backgrounds, as well as the host country's availability of alcohol or the social norms regarding alcohol (5).

However in these different prevalence numbers, some biases have to be taken into account. *The WHO Mental Health Action Plan 2013-2020* emphasizes the need for mental health services that are tailored to the specific needs of refugees (8). However, the reality is that many refugees do not have access to the care they require (9).

Several barriers are documented in the literature. A first barrier identified across multiple sources pertains to the social stigma associated with mental health conditions. Individuals experiencing mental health problems are often perceived as crazy or abnormal (9-14). Furthermore, even when mental health issues are recognized as such, seeking external professional assistance beyond the family is often discouraged. A cultural norm often prevails wherein mental health difficulties are expected to be resolved within the private sphere and concealed from the broader community (9-11, 13, 14). Refugees and asylum seekers often prefer informal support networks, such as family, social connections, and religious leaders, due to shared linguistic and cultural backgrounds (9, 10, 12, 15). Additionally, refugees reportedly exhibit a general mistrust and aversion towards authority figures, stemming from prior negative encounters with public institutions. Furthermore, concerns are articulated regarding the confidentiality obligations of healthcare professionals, with fears that sensitive personal information may be disclosed, potentially impacting for example decisions related to child custody or residency status by relevant authorities (3, 9, 10, 12, 13). Moreover, pre-existing perceptions regarding mental health and its interventions contribute to a diminished belief in the efficacy of such treatments, consequently discouraging help-seeking behaviours (3, 9, 10, 12, 15).

Related to this is a deficiency in mental health literacy. This knowledge gap influences both the individuals' appraisal of their care needs and their perceptions and experiences of treatment. Consequently, patients may attribute psychological symptoms to somatic origins rather than acknowledging their mental health ethology (3, 9, 10, 12-15). Moreover, cultural, spiritual, and religious values exert a significant influence on the conceptualization and experience of mental health. These perspectives can diverge substantially from those prevalent in high-income Western countries, potentially leading to a diminished perceived necessity for professional intervention (3, 9, 10, 12-16).

Moreover, there is a lack of awareness regarding available mental health services and difficulties in navigating the healthcare system (3, 9, 10, 13-15, 17). This knowledge deficit results in uncertainty about service availability, the scope of practice of various healthcare providers, and the nature of different treatment modalities. Furthermore, individuals often lack information regarding the healthcare entitlements associated with their specific legal status (3, 9, 14). These factors are compounded by language barriers, which further impede the acquisition of necessary information (9,

14). Consequently, this can lead to a reduced propensity to seek appropriate help or the utilization of unsuitable services, such as an increased reliance on emergency departments (3, 9).

There are several practical, structural, and political barriers described. Primarily, mirroring a broader trend in mental healthcare, a discernible insufficiency in the availability of services exists. This scarcity is exacerbated by the specialized nature of care required by refugees and asylum seekers, leading to protracted waiting lists and scheduling complexities (9, 10). Furthermore, the absence of a cohesive organizational framework among mental healthcare providers and services results in a fragmented service landscape (9, 15, 17). Physical accessibility to healthcare providers also frequently presents a challenge, since transportation brings certain difficulties. Finally, obtaining adequate care can entail financial implications, commencing with potential transportation expenses and extending to the direct costs of treatment. This can constitute a substantial barrier for this population, particularly those with limited financial resources and/or lacking insurance coverage, as well as those uncertain about their legal entitlements and the potential for reimbursement of healthcare costs (9, 10, 13, 14).

A next significant barrier addresses the attitudes of healthcare professionals towards refugee and asylum seeker populations, as well as their competence in addressing the unique needs of this group (9, 11, 13, 14, 16). Providers reportedly often lack adequate training and familiarity with these complex and specific requirements. This can lead to a reluctance to engage in treatment provision or result in suboptimal treatment quality (3, 9, 15-17). Furthermore, providers have expressed concerns regarding their own psychological well-being when exposed to the traumatic experiences encountered by this population (9, 16). Because of the cultural gap, it is often difficult to establish a connection between healthcare providers and refugees/asylum seekers (9, 16). This can manifest in a range of complications, from difficulties in establishing a shared understanding of mental health concepts to the occurrence of insensitive inquiries, judgmental or stereotypical assumptions, and even the expression of negative attitudes or discriminatory behaviours based on ethnicity, migration status, and gender (9, 11, 14).

Language presents a clear and substantial barrier to consider. Linguistic factors are paramount in the provision of mental healthcare, with effective communication being critical for the accurate diagnosis of mental health disorders, the delivery of various treatment modalities, and subsequent follow-up care (3, 9, 11). While interpreter services could facilitate this communication, their consistent availability and quality are frequently observed to be suboptimal (9, 11, 15, 17). Furthermore, healthcare providers may lack adequate training in working collaboratively with professional interpreters (9, 17). The absence of professional interpreters frequently leads refugees and asylum seekers to rely on informal interpreters, such as family members or friends. Consequently, this creates significant concerns regarding confidentiality. The accuracy of translation provided by such informal interpreters may also be compromised (9, 11, 14, 15).

Refugees frequently turn to their communities for emotional support instead of seeking professional care. After family and community members, general practitioners are the next most common source of assistance, followed by psychiatrists and psychologists (6). Since community health centres and primary care clinics serve as the main point of access to mental health services for refugees, they can play an important role in the early identification and treatment of mental disorders. The strategy of

equipping primary care practitioners with mental health training represents a cornerstone of mental health and psychosocial support (MHPSS) initiatives targeting refugee and migrant populations and is embedded within the policy frameworks of both the WHO and the United Nations High Commissioner for Refugees (UNHCR) .

As described, there is a substantial amount of evidence concerning the epidemiology of mental disorders in refugee populations, as well as a well-documented understanding of the barriers encountered (3, 9-17). The combination of these two thematic areas, as well as our own practical experience, indicates significant challenges. This ultimately led to the formulation of our research question. We hope that this review can contribute to the further concrete development of solutions, given the enduring nature of refugee flows, a phenomenon with which we will likely continue to be confronted, potentially with increasing frequency. Consequently, our professional obligations as healthcare providers necessitate adaptation to this reality.

Therefore, the aim of this systematic review is to identify and synthesize existing solutions aimed at addressing the barriers that hinder refugees' access to mental healthcare in Europe. This thesis specifically focuses on interventions and strategies that are applicable within primary care clinics, as these settings often serve as the main point of access to mental health services for refugee populations.

# 2. Methods

## *2.1.Search strategy and eligibility criteria*

On 08 august of the year 2024 a comprehensive systematic article search was carried out in the bibliographic databases Pubmed and Web of Science (WoS) to address the initial research question: "What are the challenges and solutions in providing mental health care for adult refugees in primary care in Europe?". Search terms included both controlled terms (MeSH in Pubmed) as well as free text words (in Pubmed and in WoS). The full search strategy for each database is provided in Appendixes A and B.

Studies were considered eligible for inclusion in this systematic review if they met the following criteria: (a) examined solutions to barriers that impede access to mental healthcare, (b) focused on an adult population (≥18 years) of refugees and asylum seekers, (c) involved individuals who had resettled in Europe, and (d) included participants seeking care at primary care facilities.

For the purposes of this review, refugees were defined in accordance with the UNHCR as “individuals who have fled their country of origin to escape conflict, violence, or persecution and have sought refuge in another country” (18). Asylum seekers were defined as “individuals who have applied for international protection and are awaiting a decision on their application” (19).

Primary care was defined as per WHO as “a model of care that provides first-contact, accessible, continuous, comprehensive, and coordinated person-centered services. This model aims to optimize population health and reduce health disparities by ensuring equitable access to services for all subgroups (20).

Mental health conditions were defined in accordance with the WHO, encompassing mental disorders, psychosocial disabilities, and other mental states that result in significant distress, functional impairment, or an increased risk of self-harm (21).

A geographic filter was applied to limit the scope of studies to those conducted in Europe and Turkey. Turkey was included due to its geographic proximity to Syria, making it a primary destination for many Syrian refugees. Additionally, depending on the definition used, Turkey is often considered part of Europe (22).

A publication date filter was also applied, restricting inclusion to studies published from 2011 onwards. This time frame was selected because it marks the beginning of the Syrian Civil War, which led to the Syrian refugee crisis, one of the largest refugee crises in modern history (23).

Articles were excluded if they did not meet the predefined inclusion criteria. Studies that focused on migrants rather than refugees were also excluded. The definition of "migrant" provided by the UNHCR was applied: "The term 'migrant' does not have an international legal definition. However, it is generally understood to refer to an individual who has voluntarily chosen to leave their home to seek a new life in another country. Unlike refugees, migrants can return to their country of origin without the risk of persecution, loss of life, or freedom." (24).

## 2.2.Study selection

The study selection process followed a three-step procedure. First, the results from the systematic search were imported into EndNote for the removal of duplicate records. In the second step, titles and abstracts were screened using Rayyan reference management software to exclude articles that did not meet the criteria for inclusion in the systematic review. Finally, full-text articles were assessed for eligibility. Both the second and third steps were performed independently and blindly by two researchers, with any discrepancies between the reviewers being resolved through discussion

A systematic literature search was conducted on August 8, 2024, using the final search string in both PubMed and Web of Science (WoS), yielding 1289 articles from PubMed and 1374 articles from WoS. All identified records (2663) were exported into EndNote, where duplicates (n = 430) were identified and removed. After this step 2233 articles remained. The remaining articles were imported into Rayyan software for title and abstract screening based on predefined inclusion and exclusion criteria, resulting in the exclusion of 2048 records.

Following this initial screening, 185 articles remained. At this stage, it became apparent that the initial research question had been too broad, as it was not possible for the researchers to process the 185 articles identified within the limited time and resources of a master thesis. Consequently, and in consultation with our promoter and co-promotor, we made the decision to refine the scope of the review by focusing exclusively on solution-oriented studies and excluding those addressing barriers and shift towards our current research question. While this adjustment deviates from standard systematic review procedures, it was deemed necessary to ensure the relevance and manageability of the included literature.

After applying this refined focus, a total of 42 articles were included for full-text screening. Finally, the remaining articles were assessed for eligibility based on the full text. In this final step, 17 articles were retrieved. The specific reasons for exclusion are summarized in figure 1.

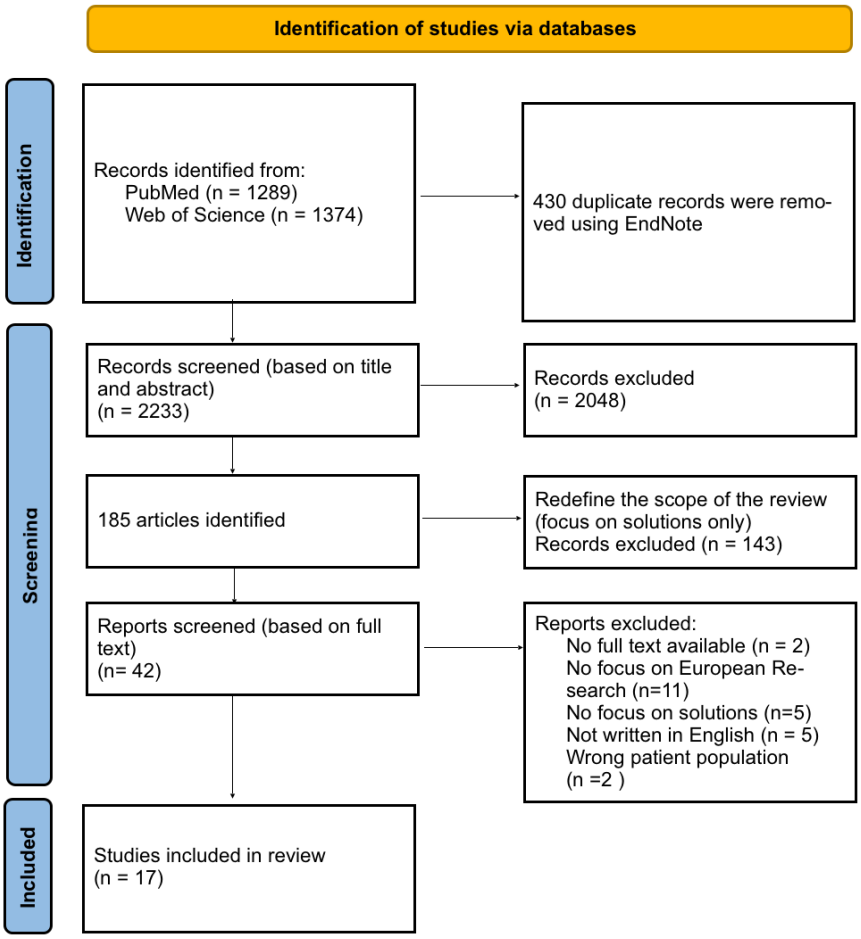



*Fig. 1 PRISMA flow diagram*

## 2.3.Data extraction / Data collection Process

A standardized data extraction was used to summarize relevant information from the included studies. This synthesis is presented in tabular format and included the following variables: [1] author(s) and year of publication, [2] study aim, [3] study design, [4] region/country of origin, [5] study setting, [6] population/participants, [7] type of healthcare providers involved and [8] main findings. Data extraction was performed together by the first and second authors. Any disagreements between the reviewers were resolved through discussion to reach a consensus. An overview of this summarized data, with all the variables, can be found in table 1.

## 2.4.Data synthesis

Data from the included studies were synthesized qualitatively using a narrative synthesis approach. The synthesis involved categorizing studies based on the type of solutions aimed at enhancing access to mental healthcare for refugees, such as culturally sensitive care, digital mental health interventions, stepped care models, and others. A descriptive summary was then provided for each

theme, highlighting specific interventions and solutions that can be feasibly implemented within primary care settings. ChatGPT (OpenAI) and Gemini (Google) were utilized to assist in ensuring the correct use of scientific language and the clarity of English throughout the synthesis process.

# 3. Results

*Table 1. Synthesis of included studies*

| ***Author, year*** | ***Aim of the review*** | ***Type of review*** | ***Region/ country of origin*** | ***Study setting*** | ***Population/participants*** | ***Type of healthcare providers*** | ***Main findings: solutions to accessing mental health care*** |
|---|---|---|---|---|---|---|---|
| *Bäärnhielm et al. – 2013 (25)* | "To present current examples from three European countries working to open up mental health care services to the cultural diversity of their populations" | | Germany, Norway, Sweden | three northern European countries | Migrants, refugees, minorities, asylum seekers | Primary care providers, psychiatrists, psychotherapists, nurses | Germany:<br>12 Sonnenberger Guidelines<br>- providing cross-cultural sensitivity and cross-culturally competent staff<br>- using interpreters with some psychology training<br>- providing information in migrants' native languages<br>- offering further education in cross-cultural psychotherapy for mental health care staff<br>- initiating research projects in the field of mental health and migration<br>- NGOs offer specialized social, psychological and medical treatment<br>Norway:<br>Focus on internally displaced people; outside of the scope of this review<br>Sweden:<br>- offering of free of charge interpreters<br>- Specific trauma clinics and programs<br>- Transcultural center<br>* expertise in transcultural psychiatry<br>* Different healthcare services<br>* training programs for healthcare workers<br>* Consultative support for professionals in the region<br>- Projects with health advisers: aim to familiarize refugees and migrants with the health and mental health care system |
| *Bäärnhielm et al. – 2014 (26)* | "To test the outcomes of cross-cultural mental health training given | Research article | Stockholm, Sweden | Local refugee reception services, mental health | Social workers, Swedish language teachers, employment officers, nurses, | Professionals in health care and refugee reception | Cross-cultural mental health training intervention for staff in refugee reception and mental health care resulted in:<br>- The cross-cultural mental health training led |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | to professionals in health care and refugee reception” | | | care (primary and psychiatric care) and representatives from two national patient associations | psychologists and physicians | | to a significant decrease in the hindering effect of lack of knowledge on participants' work.<br>- Participants shifted their focus from emphasizing communication barriers to showing more empathy towards refugees with mental health issues.<br>- The training resulted in an increased capacity among participants to understand the social vulnerability of newly-arrived refugees with mental distress.<br><br>Cross-cultural mental health training was not enough to overcome the lack of collaboration between different organizations. |
| *Böge et al. – 2020 (27)* | “To investigate the effects of a stepped an collaborative care model addressing systemic, organizational, cultural and socio-linguistic barriers in mental healthcare for refugees” | Multicentre RCT | Germany: Berlin, Aachen, Marburg, Mannheim, Munich, and Ulm | General practitioners, gynecologists, consultations in refugee facilities, central clearing clinics, residential care settings, etc. | Adult and adolescent refugees | Primary and secondary healthcare workers | - Peer-to-peer group interventions: train selected individuals from the refugee community (peers) in offering psychosocial support in the form of a group.<br>- Smartphone application: An app helping migrants and refugees better understand the underlying mechanisms of their stress and arms them with appropriate tools to cope with their struggles and psychological distress by using a visualized story-telling approach with videos and pictures (to also combat illiteracy).<br>- Gender-sensitive intervention: Using peer-to-peer group session, but with women's only groups to support vulnerable adult women and attempts to address their cultural needs.<br>- Empowerment group intervention: empower participants with the knowledge and resources to cope with psychological stressors and depressive symptoms.<br>- START adolescent group intervention: a standardized brief therapeutic program, focusing on stabilization, crisis management and recovery of self-regulation that build upon the basics of dialectical-behavioral therapy for adolescents up to the age of 21 with moderate depression.<br>- Psychiatrist/psychotherapist: individuals who suffer from the most severe and distressing |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | symptoms are to receive direct treatment from an expert clinician.<br><br>=> significant reduction in depressive symptoms<br>=> increase in effectiveness concerning response, remission and quality of life as well as efficiency in terms of cost-effectiveness<br>=> significant reduction in emotional stress experienced by traumatic events in adolescent refugees |
| *Chiarenzaet al. – 2019 (28)* | "To develop a "Resource Package" to support European Union (EU) member states in improving access to healthcare for refugees, asylum seekers and other migrants" | Research article | Europe: Greece, Italy, Spain (arrival countries); Slovenia, Hungary (transit countries); Austria, Belgium, Denmark, The Netherlands, United Kingdom (destination countries) | Reception centres | Not specified | Health care providers in reception centers: Medical doctor, Service manager, Nurse, Psychologist, Social worker, Intercultural mediator, Activist, Administrative staff | - Increase the presence of skilled professionals, particularly at initial reception stages.<br>- Implement alternative, person-centered, and non-judgmental approaches to mental health services, emphasizing informality and respect.<br>- Deliver services outside traditional mental health settings to reduce stigma.<br>- Foster collaboration between mental health services, schools, and refugee support organizations.<br>- Improve the provision of information about available services for both migrants and healthcare professionals. |
| *Denkinger et al. – 2022 (29)* | "To evaluate a newly developed 10 min film, 'Coping with Flight and Trauma', which explains PTSD symptoms and how these could be treated" | Clinical Research Article | Germany | Specific organizations and institutions in the field and asylum-specific Facebook groups | Adults with forced displacement experiences within the past 8 years who were literate in English, German, or Arabic | Psychologists and physicians | Directly after viewing the film:<br>- Demonstrated feasibility and high levels of acceptance for the short film intervention.<br>- Reduction in stigma and elevated receptiveness for mental health services.<br>- 50% of participants reported acquiring new information regarding mental health and available treatment options.<br>- 56% of participants report a better understanding of their symptoms<br>- Participants reported experiencing feelings of courage, understanding, motivation, hope, |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | relief, and a decrease in shame and desperation, alongside a desire for social connection upon recognizing shared experiences with others.<br><br>3.8 months after viewing the film:<br>- Changes observed immediately post-viewing were no longer statistically significant at long-term follow-up.<br>=> may be attributable to the reduced sample size at the later assessment.<br><br>Negative impact:<br>- 20% of participants experienced negative emotions (helplessness, fear)<br>- 4 participants discontinued the viewing due to these emotions |
| *Gruner et al. – 2020 (30)* | "To describe what factors determine the success or failure of community-based psychotherapy for trauma-affected refugees" | Realist informed systematic review | Researchers from Canada, Included papers out of Denmark, Egypt, Germany, Norway, Sweden, Thailand, Uganda and USA | High-income country outpatient settings as well as low-resource community settings like homes, huts, and community centers. Many of the settings were specialized for refugee populations or specific ethnic/cultural groups and provided migrant-sensitive | Male or female populations over the age of 18 years who participated in a psychotherapy delivered in any clinical or community setting | Primary care clinicians, psychiatrists, clinical psychologists, experienced mental health workers, social workers, nurse practitioners and nurses, settlement workers, cultural navigators, lay counselors, teachers, former refugees | - Factors that improved refugee mental health outcomes included culturally adapted care, task-shifting to other clinical staff, and sufficient intervention intensity.<br>- Precarious asylum status, program constraints, and diverse socio-cultural needs reduced the effectiveness of mental health programs.<br>- Primary care programs may enable community-based mental health care and reduce stigma for refugees. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | services<br>. | | | |
| *Jirovski et al. – 2018 (31)* | "To create a concise modular training program to strengthen Primary health care professionals in European countries in the provision of high-quality care for refugees and migrants, based on the EUR-HUMAN project + testing the effectiveness of the course" | Qualitive research article | Austria, Croatia, Greece, Hungary, Italy, The Netherlands, Slovenia | Primary health care | General practitioners, nurses, midwives, government officials, civil servants, local stakeholders (390 in total) | General practitioners, nurses, midwives, government officials, civil servants, local stakeholders | To evaluate participant progress in the EUR-HUMAN online course, both pre- and post-course knowledge assessments were conducted. Results showed a 17% improvement in mental health knowledge, with scores rising from 66% on the pre-test to 83% on the post-test. Additionally, 57.7% of participants expressed a positive appreciation for the online course. |
| *Larsen et al. – 2024 (32)* | "To outline how tailored digital interventions may address mental health needs among refugees by providing a platform for household-based digital mental health interventions that makes an intergenerational impact on the mental health of refugees across the life course" | Literature review | Not specified | Not specified | Refugees | Not specified | Digital mental health solutions offer promising avenues to enhance mental health care access for refugee populations through several key mechanisms:<br><br>- Reducing Access Barriers:<br>Digitally delivered, evidence-based interventions can offer more consistent and readily available care compared to traditional in-person services. These approaches—delivered via phone hotlines, SMS, websites, chatbots, or mobile applications—provide discreet access to support, which is especially important in overcrowded or communal living settings. Moreover, digital platforms help individuals avoid potentially stigmatizing physical spaces associated with mental health care.<br>- Family-Oriented Digital Interventions:<br>Digital platforms are well-suited for interventions targeting entire families, which can be particularly effective in multigenerational refugee households experiencing shared psychological burdens. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | These family-focused approaches also offer economic and logistical advantages, making them adaptable to the varied needs and contexts of refugee communities worldwide. |
| *Linney et al. – 2020 (33)* | "1. To explore community beliefs(Somali community) and views about the:<br>-causes of mental illness<br>-treatment options for mental illness<br>-access to medical services in general<br>+<br>2. To improve knowledge of mental health and access to mental health services by the Bristol Somali community." | Qualitative Research article | South West of England | Community centre | Somali community in Bristol in the South West of England | Not specified | Primary care providers may need targeted training to recognize how mental health issues appear across different cultural groups. Study participants highlighted the significance of religion, suggesting faith-based practices be included in care. Community workshops could help reduce stigma around mental illness in the Somali community in Bristol. Expanding services through social prescribing or Health Link workers may also strengthen trust between communities and mental health providers. |
| *McDonald et al. – 2021 (34)* | "To evaluate Comprehensive Cross-Cultural Training for mental health care professionals in Stockholm, and to assess training outcomes for participants' perceived knowledge regarding mental health and care for newly arrived refugee patients, asylum seekers and | Mixed method research article | Sweden | Not specified | Healthcare providers | psychologists, psychiatrists, social workers, nurses, nurses aide, administrative staff, some health workers from primary care and social and employment services in Stockholm | Post-training evaluation indicated that 77.6% of respondents (N = 160) found the training to be either useful or very useful.<br>Statistical analysis revealed a significant increase in self-reported knowledge across all assessed domains, including the health impacts of severe trauma and the psychological effects of the migration process on adults. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | undocumented refugees" | | | | | | |
| *Nagy et al. – 2023 (35)* | "To develop a culturally sensitive screening tool for primary care assessing the need and urgency for mental health care" | Research article | Heidelberg, Baden-Wurttemberg, Germany | Refugee state registration and reception centers | Refugee state registration and reception centers | psychologists, psychiatrists and psychosomatic experts, focused on primary care | - The RAS-MT-Screener is a valid and reliable tool for assessing the urgency and need for mental health treatment among refugees and asylum seekers, with good sensitivity and acceptable specificity.<br>- The RAS-MT-Screener was able to detect meaningful clinical differences, with patients of the psychosocial walk-in clinic scoring higher on the urgency and need for mental health treatment scales compared to other groups.<br>- The RAS-MT-Screener demonstrated cross-cultural validity, with measurement invariance shown across different countries of origin. |
| *Orang et al. – 2022 (36)* | "To measure the efficacy of value based counselling" | Research article | Berlin, Germany | Care center run by IPSO (NGO: International Psychosocial Organization) | Not specified | trained VBC counsellors | Implementing a specific counseling program as 'Value based counseling' can lead sustainable change like a reduction of psychological symptoms, including depression, PTSD, perceived stress, anxiety, somatic complaints, and daily functionality impairment at the posttest assessment. |
| *Spanhel et al. – 2019 (37)* | "To identify elements of Internet-based interventions that need cultural adaptation to be suitable for refugees (In the present study the user experience of an Internet-based intervention for refugees with sleeping problems was investigated)" | Qualitative study | Germany | Not specified | Six refugees from Syria, Iran, Eritrea, Algeria, and Iraq | 2 social workers, 2 psychologists, 1 physiotherapist, 1 physician | The findings underscore the importance of tailoring interventions to address the unique circumstances of refugee populations. Effective adaptation should center on a nuanced understanding of the distinct experiences and needs of refugees, which can be categorized into three core areas:<br><br>-Stressors and challenges commonly encountered by refugees<br>-Daily routines, cultural values, and social practices<br>-Perceptions of illness and approaches to treatment<br>Adaptation strategies should incorporate culturally relevant visuals, appropriate role models, accessible language, psychoeducational content, and consider both the structure and delivery format of the |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | intervention modules. |
| *Strassmayr – 2012 (38)* | "To identify barriers to mental health care for irregular migrants and to explore ways by which these barriers are overcome in practice" | Research article | capitals of 14 European countries: Austria, Belgium, Czech Republic, France, Germany, Hungary, Italy, Ireland, The Netherlands, Poland, Portugal, Spain, Sweden and UK | health care services, some type of social care service and research centers | experts in the field of mental health care for irregular migrants | experts in the field of mental health care for irregular migrants | - Experts reported a range of barriers to mental health care for irregular migrants, including lack of legal entitlements, administrative obstacles, shortage of culturally sensitive care, complex social needs, and fear of deportation.<br>- Despite these barriers, some mental health care is provided to irregular migrants through networks of committed professionals and supportive services, particularly NGOs.<br>- Providing mental health care to irregular migrants often involves ethical dilemmas for professionals and services, as they have to balance legal and administrative rules with the humanitarian need to provide care. |
| *Wenk-Ansohn et al. – 2011 (39)* | "To offer practical advice for diagnostics, counselling and treatment of patients from other cultures who are not speaking the language of the therapist" | Literature review | Not specified | Not specified | Persons traumatized by war or persecution | counsellors and psychotherapists | When supporting refugees—many of whom have endured significant trauma—interventions must be culturally sensitive and aligned with the individual's educational background. Interpreters play a vital role in this process, not only by facilitating language translation but also by providing essential cultural context to enhance mutual understanding. |
| *Wood et al. – 2022 (40)* | "To give recommendations towards a trauma-informed resettlement scheme" | Research article | United Kingdom | Resettlement scheme | Syrian refugees, adults or whole families | community teams, including clinicians, psychologists and interpreters | Applying principles of trauma-informed care<br>For example:<br>- Psychologist as part of the community team responsible for practical and essential support (housing, access to healthcare, education etc.)<br>- Overcoming the stigma by proactively reaching out<br>- re-establish a sense of security by supporting refugees in the application process for their legal entitlements<br>- integrating interpreters in the team, also to act as cultural mediator |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | - reassuring confidentiality<br>- longer-term funding of services, to not put time stress<br>- focusing on education or employment |
| *Wrede et al. – 2021 (41)* | "To investigate the effectiveness of the 'Hälsostöd' program (psycho-educative program) on participants' mental health status" | Research article | Västra Götaland, Sweden | public venues such as libraries and immigration centres | asylum seekers and newly arrived immigrants with milder mental health problems | Community health workers | The application of a focused counseling protocol, like "Value-Based Counseling," may result in long-term benefits, indicated by a decrease in reported psychological distress, encompassing depression, PTSD, perceived stress, anxiety, somatic symptoms, and enhanced daily functionality at the conclusion of the intervention. |

## *3.1.Point of interest in mental health care approaches for refugees*

### *3.1.1.* Language

Language represents a significant barrier to accessing mental health care for refugees. The employment of qualified interpreters offers an effective means of addressing this challenge by ensuring accurate and reliable communication between patients and healthcare providers (25, 28).

In the context of mental health care for refugees, several critical factors must be considered when utilizing interpreters to ensure effective communication and high-quality care. Firstly, the presence and personal characteristics of the interpreter inevitably influence the dynamics of the interaction, even when the interpreter strives for neutrality and accurate translation. Verbal and non-verbal communication styles, cultural background, and interpersonal demeanour can shape how messages are conveyed and perceived, potentially affecting the therapeutic or professional exchange. This dynamic often leads to transfer and countertransference reactions within the triadic relationship of the patient, interpreter, and therapist, making it essential for therapists to remain vigilant of these processes to mitigate distortions in the therapeutic relationship (39). The British psychological guidelines also highlight the necessity of recognizing interpreters as active participants in the working relationship, advising that factors such as gender, religious background, and political affiliations be considered during the interpreter selection process to ensure cultural appropriateness and effective communication (40).

Secondly, the importance of specific training for interpreters in mental health care is emphasized by professional guidelines. The Sonnenberger Guidelines, a national initiative in Germany aimed at improving health care services for migrants, advocate for interpreters with specialized training in psychology to address the nuanced psychological needs within mental health settings (25). In the past, and in some contexts still today, interpreting services have frequently been provided by volunteers, non-governmental organization (NGO) staff, or other migrants who lack formal professional training. This practice has often led to suboptimal communication quality, potentially compromising the efficacy of mental health interventions (28).

The psychological well-being of the interpreter is also a critical consideration. Interpreters, especially those with personal experience of trauma or concerns about the safety of their families, may be at risk of vicarious traumatization. Recognizing this risk and implementing support mechanisms are essential for mitigating the psychological burden on interpreters, which in turn supports the maintenance of high-quality care (39, 40).

Finally, policy decisions regarding the funding and availability of language support services play a pivotal role in access to care. The cost of interpreter services often presents a barrier to mental health care for refugees. Sweden has addressed this challenge by establishing a legal right to interpreter services and implementing a system that provides these services free of charge, thus removing financial barriers and enhancing access to essential care. Such policy frameworks are crucial in ensuring that language support is accessible and equitable for refugees in need of mental health services (25).

### *3.1.2.* Culture

As described in the introduction, the World Health Organization's Mental Health Action Plan 2013–2020, highlights the importance of delivering mental health services that are responsive to the unique needs of refugee populations (8). One critical strategy to achieve this is through the provision of culturally sensitive care. Cultural adaptation plays a central role in this approach and is defined by Bernal et al. as "the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (42).

In Germany, the Sonnenberger Guidelines, comprising twelve recommendations, were developed as part of a national effort aimed at enhancing psychiatric and psychotherapeutic care for migrants. These guidelines, created by healthcare professionals, proposed a series of quality benchmarks to improve service accessibility and cultural appropriateness. Key recommendations included ensuring culturally sensitive care through the employment of staff trained in cross-cultural competence, providing continuing education in transcultural psychotherapy for clinical staff, and promoting research on mental health within the context of migration (25).

#### *3.1.2.1.* Culture and illness and disease perceptions

Refugees often arrive with culturally shaped explanatory models that influence their understanding of health and illness. The perception, interpretation, and acceptance of mental health conditions are, among other factors, significantly shaped by cultural background and sociocultural context. Traditional beliefs may constitute an integral part of an individual's explanatory framework. Consequently, the incorporation of culturally relevant knowledge, values, and belief systems into clinical care may enhance mutual understanding and improve the therapeutic alliance between healthcare providers and patients. Cross-cultural training programs for healthcare providers can play a pivotal role in this context. These programs will be discussed in greater detail in subsequent sections.

Linney et al. conducted a community-based qualitative study exploring Somali perceptions of mental health and healthcare access in an established UK Somali community. The study highlights the profound stigma associated with mental illness within the Somali community, which is also noticed by Wood et al. Participants noted that individuals with mental health conditions are often labelled as "crazy," leading to social exclusion and reluctance to seek help. Educational initiatives can help reshape perceptions and encourage individuals to seek help without fear of being labelled as "crazy" (33, 40). Other authors also highlight the significant shame and stigma associated with labelling psychological distress as a psychiatric condition, particularly within Syrian culture (43). To address these barriers, it is essential to engage in proactive outreach efforts in collaboration with community agencies. Introducing mental health services in a non-pathologizing manner can facilitate acceptance and encourage individuals to seek support without fear of stigma or social exclusion. This approach fosters trust and increases accessibility to mental health care within refugee communities (36, 40).

When Somali refugees residing in Bristol were asked about treatment options for individuals experiencing mental health issues, participants suggested a combination of approaches. They emphasized the role of religious healing, particularly through recitation of the Qur'an, as a key

therapeutic practice (33). Many refugees may view mental health issues as taboo, with body and mind closely linked, often influenced by religion or spirituality. Refugees also often hold strong family-values. Therefore, the intervention should integrate these cultural perspectives while gently introducing Western practices and offer a balance between traditional beliefs and Western medical approaches. For example, emphasizing communal or family-based responsibilities, rather than focusing solely on individual well-being, would resonate better within their value systems. Educating refugees about Western concepts of mental health and treatment methods is crucial. It is important to provide clear explanations to help refugees understand and legitimize Western practices. Psychoeducational components would allow refugees to learn about mental health issues, which could help reduce stigma and increase their willingness to engage with treatment (37).

It is important to include clear information about confidentiality and data protection within the intervention. This will help refugees feel more comfortable with the process, particularly when dealing with sensitive topics, surrounded with a lot of stigma, like mental health (37, 40).

Since refugees come from diverse countries, cultures, and backgrounds, it is also essential to represent this diversity in the intervention. Using images of people from various nationalities, colours, and cultural dress would also help to make the intervention feel more inclusive and relatable (37).

#### *3.1.2.2.* Culturally sensitive care - training programs

Given the increasing cultural diversity among patient populations, the development of cross-cultural competence has become an essential component of professional practice for mental health and general healthcare providers (25). Several authors examined and suggested training programs for healthcare professionals to improve mental health care for refugees (25, 26, 31, 33, 34).

Bäärnhielm et al. described a mixed method study in which a training program on cross-cultural psychiatry was tested in Sweden. The training program was organised by the Transcultural centre in Stockholm for employees from the social services, employment agencies, primary care centres and psychiatric clinics. The aim of this training program was to improve knowledge about culture, mental health, migration and trauma. After the training program there was a significant increase in self-perceived knowledge about health problems and treatment for refugees. Several themes were discussed in focus groups before and after the training program. Following the training, participants reported challenges related to insufficient collaboration concerning newly-arrived refugees, as well as experiences with structural barriers. They highlighted the necessity for clear structures and local platforms to facilitate collaboration. Additionally, participants underscored the importance of understanding the operational approaches of other care providers and organizations, along with having knowledge of the framework of their respective assignments. Beside the importance of good collaboration another core area that was discussed before and after the courses were the relations with refugees. Before the training participants talked about communication problems including difficulties in understanding refugees cultural backgrounds, other languages and the use of interpreters. After the training on the other hand, the participants described that the training had contributed to an increased understanding of the refugees' situation and an increased emotional engagement. Participants, in particular, valued the segments of the course in which former patients shared their personal experiences with mental illness (25, 26).

In 2016, the Transcultural Centre organised another comprehensive Cross-Cultural Training Program specifically aimed at professionals within the field of psychiatry. This training program included interactive lectures, discussions, and case presentations addressing a variety of key topics, including: the regulations and authorities involved in refugee reception, rights and access to care for migrants with varying civic statuses (such as asylum seekers, undocumented individuals, and refugees with residence permits), the impact of migration and trauma on refugee health, culture and psychopathology, and strategies for working with interpreters, as well as effectively discussing trauma, torture, and migration with patients (34). The training participants primarily consisted of social workers, psychologists, and nurses. To assess the impact of the training, participants completed pre- and post-test questionnaires measuring perceived knowledge. The results demonstrated a significant improvement in participants' perceived knowledge regarding the effects of the migration process on adult mental health, Additionally, participants' perceived knowledge about interpreting symptoms of mental illness among asylum seekers and newly arrived refugees increased significantly. Furthermore, 77.6% (N = 160) of participants reported that they found the training to be useful or very useful following its completion (34).

The Transcultural centre also provides professionals in Stockholm consultative support in their clinical work, supporting them in addressing patient-related and clinical concerns. These services are accessible at no cost to practitioners from all professional disciplines within the region (25).

Jirovsky et al. developed, piloted, and evaluated an online capacity-building course composed of several modules (Acute health needs of refugees; Legal issues; Provider–patient communication; Mental health; Sexual and reproductive health; Child health; Chronic disease, health promotion, and prevention) designed to address key gaps in knowledge related to issues faced by primary care health workers when providing care to refugees and other migrants in destination countries. The average pre-test score for the mental health module was 66%, which increased by 17% in the post-test. However, this change was not statistically significant. Additionally, more than half of the participants expressed appreciation for the online course, which was the most highly evaluated model (31).

It is clear that mental health care professionals require enhanced training to develop awareness and knowledge of the diverse manifestations of mental illness and symptoms of distress across different cultural communities. In focus group discussions, participants provided a range of perceptions regarding the symptoms of mental illness. These perceptions included somatization, wherein individuals express psychological distress through physical symptoms, such as headaches. Additionally, participants reported behaviours ranging from social withdrawal to more overt displays of unusual behaviour. This spectrum of views underscores the necessity for culturally competent practices in mental health care to ensure appropriate recognition and treatment of mental health conditions (33).

#### *3.1.2.3.* Peer-to-peer interventions

Several authors highlight the potential benefits of incorporating individuals with refugee or migrant backgrounds into mental health service delivery. Their lived experience and cultural familiarity enable them to navigate the nuanced complexities associated with intercultural interactions more effectively (25, 27, 40, 41).

There are multiple ways brought up to apply this. Firstly wood et al. describe the use of interpreters as cultural consultants. They are mentioned to educate local clinicians and health professionals, they can support a health care worker with a case from behind the scenes or they can actually offer live assistance during a consultation (40). Bäärnhielm et al. note the utilization of interpreters with psychology training (25). As is further explained in *' 3.1.2.4. Psycho-education'* Wrede et al. positively evaluated a community health care program focussed on psychoeducation, where informative sessions were led by peers with a health care education who received additional training (41). Böge et al. proposed a similar intervention being used in Berlin, amongst other solutions. Their reports also include group sessions led by two peer trainers (27). Instead of a solely educational purpose as seen with Wrede et al., these sessions are meant to offer psychosocial support, focussing on a safe and accepted feeling, reinforcing of the participants resources, development of self-awareness of their needs and facilitating the development of effective coping strategies (27, 41). The paper states that by using peer trainers the 'hierarchical' teaching of professional therapists can be avoided and trainers can use their own experiences of being strange in a new country (27). Additionally, Böge et al. describe a complementary system implemented in Aachen, which includes peer-led sessions exclusively accessible for women. This way they strive to support vulnerable adult women while addressing their specific cultural needs by creating a safe environment (27).

#### *3.1.2.4.* Psycho-education

Wrede et al. report on the effectiveness of the 'Hälsostod' program, a Swedish community health program providing psycho-education to recently arrived refugees. In this program participants could follow five 2-3h sessions, led by community health workers with a migratory background, some form of health care education and an additional specific training. These sessions are organised to be highly accessible, since they are free of charge, held in the native language of the participant and take place in public venues (41). In each of these five sessions, a specific topic is covered: "introduction; possible health effects of migration; ways to identify and prevent stress and depression; the health effects of lifestyle factors; and the organization of the Swedish health care system." (41). During these sessions frame empowering discussions could be held around these topics, aiming to, as quoted in the programs manual: "strengthen a positive development of mental health through providing the individual with tools for coping with minor mental health issues". Wrede et al. observed a seven point decrease in the GHQ12 score of participants before and after the program. This suggests that the self-reported mental health of participants improved significantly and they had a lower need for further mental health investigation. Their results also state that they found no significant relationship between sociodemographic factors and changes in mental health. The researchers stated that further research is needed to explore the impact of such programs in different contexts, to further optimize the program and investigate the role of sociodemographic factors in shaping mental health outcomes (41).

Baarnhielm et al. reported on similar programs in Swedish counties, although it is unclear if they include the 'Hälsostod' program. They describe the use of health advisors and how they work with groups of refugees and immigrants using a dialogue-based approach conducted in their native languages to facilitate effective communication. These discussions encompass topics such as migration, acculturative stress, overall health, and health-promoting strategies, while also providing

essential information about the structure and function of the healthcare and mental health care systems. It is to be noted that this is very similar to the 'Hälsostod' program (25).

Finally Böge et al. present a fundamentally identical program observed in Munich, Germany. This program consists of culturally sensitive sessions for small groups to present participants with supplemental resources and knowledge to cope with depressive symptoms and psychological stressors, including various cognitive and behavioural techniques. The sessions are being led by psychologists and/or psychiatrists, supported by interpreters and split up by gender, which is also seen in the women's-only group in Aachen (as mentioned in *'3.1.2.3. Peer-to-peer interventions'*) (27).

The fact that there is much to be gained from psychoeducation is also demonstrated by Dekinger et al. They created a psychoeducational short film titled 'Coping with Flight and Trauma', to address the stigma surrounding mental health. Directly after watching the film, a significant reduction in self-stigma was noted. At the long-term follow-up (3.8 months after watching the film) the results were no longer significant but participants showed a statistically significant reduction in stigma and elevated receptiveness for mental health services, as well as having conversations about mental health. Furthermore the film was highly accepted by participants, since 90% would recommend watching the film to peers. Additionally participants reported to have learned new information about mental health and possible treatments, as well as recognising and understanding their own symptoms. Finally they describe different positive emotions like relief, understanding, reduction of shame and hope. Although a lot of positive change is noted with this short film, there is a risk to be considered. Twenty percent of participants experienced negative emotions like helplessness or fear being caused by the reminders of war and flight, with four individuals discontinuing the film viewing. Researchers note that it could be beneficial to implement the film into a broader-stepped care model (29).

The Sonnenberger Guidelines in Germany highlight the importance of effective information transmission as well. They recommend providing information in the migrant's native language to reduce access barriers and ensure accurate communication, minimizing the risk of misinterpretation (25).

In conclusion, these studies show, regardless of their different approach, the importance of psycho-education to improve mental health outcomes. Educating refugees helps to increase awareness and to lower the barrier to mental health care, by substantially lowering the stigma. This leads to better mental health and more people getting adequate mental health care (25, 27, 29, 41).

#### *3.1.2.5.* Therapy

Gruner et al. analysed several different individual psychotherapies: Narrative Exposure Therapy (NET), Common Elements Treatment Approach (CETA), Stress Management (SM), Cognitive Behavioural Therapy (CBT), and Interpersonal Therapy (IPT) (30).

In the next phase, they explored the theories that explain why these community-based mental health services for refugees work, as well as the theories of why these services do not work. Factors that contribute to the success of community-based psychotherapy for refugees include first of all migrant-sensitive healthcare settings. Addressing their mental health needs requires considering the

appropriate care setting, with studies showing interventions in various locations, from clinics in high-resource settings to homes and community spaces in low-resource settings. Specialized settings tailored to refugee or specific ethnic/cultural groups are important, as these often provide migrant-sensitive services like language interpretation and culturally relevant support, acknowledging the social determinants of health (30).

Next, the authors describe task-shifting in mental health care, which entails the shifting of tasks in primary mental health care from highly trained (e.g. psychiatrists, psychologists etc.) to less trained individuals, such as teachers, lay counsellors, social workers, and appropriately trained former refugees, to make efficient use of resources. Certain qualifications were expected from individuals applying. Gruner et al. enlist these as: “language fluency (English and mother tongue); educational attainment (attended primary school and/or secondary school); interest in mental health/counselling; and shared cultural, religious, and political experience.” (30). Unfortunately, the specific training required for these individuals is not discussed in further detail. While the included literature within this systematic review did not address the provision of psychotherapy or counselling by primary care physicians, the authors propose this as a potentially pertinent avenue, given these clinicians' existing knowledge base in the diagnosis and management of mental health disorders (30).

Third, cultural adaptations in mental healthcare interventions for refugee populations are critical due to the significant influence of culture on the development, experience, and treatment of psychopathology. These adaptations should also aim to make use of current strengths (e.g. community support as well as family support) and current coping mechanisms (e.g. meditation, social gatherings, singing). This concept is also elaborated upon by other authors, as detailed within section *'3.1.2.1.Culture and illness and disease perceptions'* (30, 33, 37).

Finally, psychotherapy intensity is a key factor. Each of the investigated individual psychotherapies has a treatment manual, explaining the protocol to follow. This includes a proposed intensity, divided in length of psychotherapy sessions and frequency of sessions. Studies where therapies are adhering to recommended treatment intensity, as per protocol, generally achieve better outcomes, while briefer interventions may show weaker symptom improvement, highlighting the need for adequate duration and frequency to address refugees' mental health (30).

#### *3.1.2.6.* Trauma informed-care

A specific approach to mental healthcare for refugees is trauma-informed care, as highlighted by Wood et al.. The authors are advocating for its integration into the design and delivery of services for this population. Trauma-informed care is defined by its core principles: “safety, trust, choice, collaboration, empowerment, and respect for diversity and inclusion”, all underpinned by an understanding of the profound impact of trauma. This approach acknowledges that presenting symptoms and behaviours are often adaptive responses to traumatic experiences (40).

Each of these principles plays a vital role. “Safety” involves establishing both physical and emotional safety for clients within the service environment. Practically, this means that programs should secure long-term housing and financial stability, as the insecurity around these issues can be a major source of distress. The authors also advise that services should be delivered in community-based

settings, for example with making home-visits, to enhance accessibility and reduce the potential stigma associated with seeking help (40).

"Trustworthiness" focusses on building trust which requires consistency, transparency, and reliability in all interactions. For refugees, who may have experienced betrayal or instability, clear and consistent communication from service providers is essential. Additionally, it is critical to provide sufficient assurances around confidentiality (40).

"Choice" entails that refugees should be offered choices in their care to the greatest extent possible. This begins with providing comprehensive information about available services to empower informed decision-making. Furthermore, continuous financial investment in mental healthcare, looking beyond rapid acute care, is recommended to provide flexible access to trauma-focused treatment when clients are mentally better prepared to engage in therapy (40).

"Collaboration" emphasizes a partnership between clients and providers, where both have a voice in the decision-making process, fosters a collaborative environment. This also means actively involving refugees in the planning and delivery of services, incorporating their feedback and preferences to ensure that interventions are relevant and appropriate (40).

"Empowerment" focuses on recognizing and building upon clients' strengths and resilience, supporting their efforts to regain a sense of agency and self-efficacy. For refugees, empowerment can involve facilitating access to resources that support integration, such as for example the learning of a language and employment programs (40).

Finally, "Respect for Inclusion and Diversity" is recognizing the diverse backgrounds and experiences of refugees, services must be culturally sensitive and adaptable to individual needs, integrating an understanding of how factors like culture, gender, and religion influence the experience of trauma and the recovery process (40).

By integrating these principles, service providers can create an environment that fosters healing and empowerment, which is particularly important for refugees who may have experienced violence, displacement, and a profound loss of control. The authors also stress the necessity of cultural competence and flexibility in mental health services to effectively engage with and meet the diverse needs of refugee communities (30, 40).

## *3.2. Organisation of mental healthcare for refugees*

### *3.2.1.* Stepped care models

A stepped care model represents a hierarchical protocol for the delivery of care, specifically in this context, mental healthcare. Within this framework, clients progress through a sequence of intervention levels, each constituting a specific intervention. The core principle of stepped care is to match the intensity of intervention to the individual's needs, starting with the least intrusive and resource-intensive treatments and progressing to more specialized care only if necessary. To illustrate, the initial step in such a model is typically designed for broad population reach, characterized by low cost and minimal resource utilization (27, 29, 36).

Böge et al. proposed a stepped care and collaborative model (SCCM) that directly exemplifies the principle of matching intervention intensity to individual client needs.

The first step in this model consists of peer-to-peer group interventions, which utilizes trained individuals from the refugee community to lead group sessions with the main aim of offering psychosocial support.

The second step involves the Smartphone application 'Balsam', a digital tool developed to help migrants and refugees understand their stress mechanisms and acquire adequate coping strategies.

The third step provides a gender-sensitive intervention, tailored to address the cultural needs of women, delivered in women-only groups to create a safe space for discussing their distress and focusing on psychoeducation and gender-specific topics.

The fourth step involves an empowerment group intervention, wherein psychologists or psychiatrists facilitate a group therapy designed to provide psychoeducation to clients. The objective of this intervention is to enhance clients' preparedness for managing stressors and experienced symptomatology.

The fifth and most intensive step involves a psychiatrist/psychotherapist, where individuals with the most severe symptoms receive direct treatment from expert clinicians, with interventions varying based on the clinician's expertise and the patient's needs (27).

The psychoeducational short film developed by Denkinger et al. was designed to fit within a stepped care model by serving as an accessible first step, potentially at Level 1 or 2, to raise awareness and encourage help-seeking behaviours (29). When culturally adapted, Spanhel et al. describe an Internet-based intervention to be strategically placed within a stepped care framework, possibly at Level 2, similar to the smartphone application used in Böge et al. 's SCCM (27, 37). Both the film and the internet intervention are elaborated upon in greater detail within the sections titled '3.1.2.4. Psychoeducation' and '3.2.1.2. Digital mental health', respectively (29, 37).

#### *3.2.1.1.* Screening questionnaires

There are some questionnaires to screen for mental health issues, such as the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25, although only one third of the existing screening tools are specifically designed for a refugee population. Furthermore Nagy et al. mention that most of these tools focus on one single mental illness, making them less useful for general screening, as is needed in primary health care. Finally psychosomatic symptoms are underrepresented, while at the same time they play a significant role in how mental health manifests in the refugee population. Therefore Nagy et al. concluded the need for a screening tool identifying mental health treatment needs in refugees (35).

They constructed and validated the RAST-MT-screener, a culturally sensitive screening tool for primary care assessing the need and urgency for mental health care, which is available in seven languages (English, French, German, Farsi, Arabic, Turkish, and Serbian). It was constructed by an expert focus group and was statistically evaluated with a sensitivity of 0.74 and a specificity of 0.66. This allows it to accurately classify 85.5% of cases in comparison to expert ratings. This approach

facilitates the efficient screening of a large population, ensuring that individuals with identified needs can access appropriate and timely care (35).

#### *3.2.1.2.* Digital mental health

Böge et al. describe the integration of a digital tool within their SCCM (27). Furthermore, other authors also note the potential for implementing their respective digital instruments within a stepped care framework (26, 37). Access to traditional mental health services is often hindered by factors like stigma, language barriers, and inadequate infrastructure. Digital mental health interventions, including telemedicine, mobile applications, and online platforms, offer scalable solutions that can overcome these barriers (32, 34, 37).

Internet-based interventions offer widely accessible and highly adaptable platforms for delivering essential mental health care. Digital solutions may be particularly advantageous for refugee populations residing in environments where physical infrastructure and resources for mental health services are insufficient or unavailable (32, 34). But even for refugees living in places where there are a lot of resources, digital mental health services could be very useful since it reduces the need to be seen in spaces that could be very stigmatizing for them within their communities (32).

Digital mental health interventions are also well-suited for implementation at the family level and may be particularly beneficial for multigenerational refugee families experiencing shared mental health stressors. These interventions offer logistical advantages, such as shared device access, collective or private engagement, and age-specific content (32, 34).

Despite their advantages, digital mental health interventions present several challenges and potential drawbacks. The hardest to reach refugees—such as those who are in transit, residing in remote rural areas, older individuals, or those with limited technological literacy—may face difficulties in accessing and utilizing digital platforms. This digital divide risks systematically excluding the most vulnerable individuals, who may have the greatest need for mental health support, thereby exacerbating disparities in mental health service utilization (32).

Additionally, privacy and security concerns pose a considerable risk, as breaches within digital interventions could compromise the confidentiality and safety of refugee populations, who are often in precarious situations. Ensuring robust data protection measures is therefore critical to maintaining trust and safeguarding users from potential harm (32).

It has unfortunately been shown that internet-based interventions are less effective in ethnic minorities. Cultural adaptation of internet-based interventions appears to enhance their effectiveness when applied to populations distinct from the original target group and is therefore crucial when delivering internet-based interventions to refugees (37).

Spanhel et al. culturally adapted an existing Internet-based intervention for sleeping problems, highlighting the importance of tailoring digital tools to this population's specific needs and preferences (37). This intervention could as well be strategically placed within a stepped care framework, possibly at Level 2, offering targeted support for a common mental health concern while minimizing the need for more intensive, resource-demanding treatments in the initial stages, similar to the smartphone application used in Böge et al.'s SCCM (27, 37).

### *3.2.2.* The role of NGOs

Straßmayr et al. conducted semi structured interviews with mental health experts and discussed the role of NGOs in primary health care for refugees (38).

NGOs often specifically target this population and consequently have an important role in the mental healthcare for refugees. As a result, they have developed more expertise, which makes them more adapted and able to offer specific services, for example interpreting services, cultural mediators, the provision of social work consultation, the delivery of targeted psychotherapies, proactive outreach strategies to enhance client engagement, the dissemination of psychoeducation, and the provision of legal support.. Thanks to the humanitarian character of NGOs, they are able to provide low threshold access. This also enhances credibility, as refugees perceive NGOs as reliable sources of support, even when other services are unavailable. Additionally, they are reported to be better trusted by refugees, due to established community recognition and positive prior experiences reported by community members (38).

Secondly there are NGOs reported to be helping without an official mandate. This means NGO's going outside of their fixed service profile with assigned funding, for example providing shelter for illegal immigrants, which could be illegal depending on the country's legislation (38).

Thirdly it is observed that referrals to the correct service can happen based on informal networks and personal contacts. Refugees have a tendency to turn to services they know and trust, such as NGOs. When the specific NGO is not equipped for a certain kind of care, an informal referral can provide a sense of trust and safety to the client, facilitating access to appropriate care (38).

Bäärnhielm et al. describe how in Germany mental health care for asylum seekers is restricted, with insurance only covering acute cases. NGO's are reported delivering basic medical care through a network of healthcare providers offering services on a voluntary basis. Additionally, NGOs try to fill the void of mental healthcare by providing specialized treatment for refugees, as is also described by Straßmayr et al. (25, 38).

# 4. Discussion

This systematic review tries to address the complex challenges in providing adequate mental health care to refugees, a unique yet diverse population. As outlined in the introduction, these challenges are multifaceted, encompassing social stigma associated with mental health conditions (9-14), a general mistrust and aversion towards authority figures , pre-existing perceptions regarding mental health (3, 9, 10, 12, 13), limited mental health literacy (3, 9, 10, 12-15), lack of awareness regarding available services (3, 9, 10, 12-15, 17), practical, structural and political barriers (9, 10), negative attitudes of healthcare professionals and their competence in addressing the unique needs of this group (9, 11, 13, 14, 16), and language barriers (3, 9, 11). This discussion reflects on potential solutions and strategies identified in the literature to mitigate these barriers and improve mental health care delivery for adult refugees within primary care settings in Europe.

The findings of this systematic review underscore the crucial role of professional interpreters in the provision of mental health care for refugees. Effective communication is fundamental to any therapeutic interaction, and the utilization of a trained interpreter can significantly enhance both access to and the quality of mental healthcare services (25, 28). The incorporation of individuals with refugee or migrant backgrounds into mental health service delivery, including their role as cultural consultants alongside interpreters, presents additional benefits.

While alternative communication strategies, such as digital technologies, were outside the scope of this review, they represent a potentially valuable adjunct to conventional interpreter services. Recent advances in digital tools, including real-time translation software and AI-assisted interpreting platforms, offer new avenues for addressing language barriers in healthcare. Although these technologies cannot currently replicate the cultural sensitivity, contextual understanding, or emotional atonement of trained human interpreters, they may serve as practical interim solutions, particularly in acute or resource-limited settings. Further empirical research is warranted to rigorously evaluate the effectiveness, accuracy, and ethical implications of artificial intelligence in clinical interpreting, especially within mental health care for linguistically diverse populations.

This systematic review highlights the critical importance of cultural sensitivity in the delivery of mental health care to refugee populations (8, 42). Across a range of interventions, including culturally adapted psychotherapies, psycho-educational initiatives, and peer-to-peer programs, a consistent finding emerged: culturally informed approaches are essential for improving mental health outcomes among refugees. Refugees' perspectives on health and illness are deeply influenced by their cultural and social backgrounds. These beliefs often form explanatory models that shape how they perceive, interpret, and respond to mental health issues. Traditional practices and values frequently inform these models, impacting both the recognition of symptoms and attitudes toward treatment (33, 36, 37, 40). The review identified several studies that described the significant stigma associated with mental illness among refugees, leading to social exclusion and reluctance to seek help (33, 36, 40). Integrating culturally relevant beliefs into healthcare delivery can strengthen the provider-patient relationship, fostering trust and improving outcomes. For instance, religious healing practices, such as recitation of the Qur'an, appear to play a significant role (33). Although no studies in this review explicitly examined the involvement of religious institutions in supporting refugee mental health within primary care settings, engaging faith-based organizations represents a

promising strategy. Given the influential role that faith communities often play within refugee populations, future research should explore how partnerships with religious leaders and organizations can be leveraged to enhance mental health literacy, reduce stigma, and facilitate access to care.

Cross-cultural training for healthcare professionals is crucial to equip them with the skills necessary to navigate diverse perspectives on mental health (34). Several studies demonstrated that targeted educational interventions can significantly enhance healthcare providers' self-perceived knowledge of migration-related health issues, cultural expressions of mental illness, and strategies for effective communication with refugee patients (25, 26, 31, 33, 34). Programs such as those organized by the Transcultural Centre in Stockholm and the online course piloted by Jirovsky et al. indicate the feasibility and general acceptance of both in-person and digital training formats among healthcare professionals (25, 31, 34). Nevertheless, the systematic integration of education and training on intercultural competence and diversity sensitivity into basic healthcare curricula is essential to ensure that all healthcare professionals consider these skills a fundamental aspect of their routine practice.

An important strategy to mitigate cultural disparities involves the recruitment of healthcare personnel from within the cultural groups being served, as exemplified by the peer-to-peer interventions and the use of peer-interpreters. This approach enables healthcare workers to leverage personal experiences and pre-existing knowledge of familiar cultures and practices (25, 27, 40, 41). Their contribution may even extend beyond real-time assistance to include indirect support, such as advising clinicians on culturally sensitive communication and treatment planning (25). Determining the optimal strategy, whether to train existing professionals in culturally sensitive care or to train culturally sensitive peers in healthcare provision, requires further consideration. An integrated approach likely represents the most efficacious solution. However, the practical implementation of this model faces challenges, including the limited availability of individuals with this dual expertise, the lack of standardized training pathways, and resource constraints within mental health systems. Consequently, this approach should be considered a long-term objective, necessitating targeted investment and structural support to ensure its viability as a component of routine care.

Stigma and divergent perspectives on mental health between refugees/asylum seekers and host countries constitute a significant barrier (9). Various authors propose different types of psychoeducation to address this barrier (25, 27, 29, 41). Given the evidence supporting the benefits of psychoeducation across different modalities, its broader implementation could be suggested. For instance, individuals seeking care could be encouraged to participate in standardized psychoeducational programs, or resources such as the aforementioned short film could be widely disseminated (25, 27, 29, 41). These represent preliminary ideas and their cost-effectiveness and other implementation factors warrant further investigation.

Many of the findings align with the core principles of trauma-informed care (30, 40). These six fundamental values provide a general framework for trauma intervention but can be extrapolated to the care of refugees and asylum seekers. Despite their apparent logical validity, these principles require greater awareness and more consistent implementation within existing service structures (40).

Refugees face numerous obstacles in accessing adequate mental health care, as highlighted in the introduction. These barriers can lead to delayed access to services and insufficient treatment (36). Stepped care models have emerged as a promising strategy to address these challenges by providing a framework for delivering efficient and accessible mental health interventions (27, 36). This approach is particularly relevant for refugees, as it offers a potential strategy for optimizing the allocation of financial resources for refugee mental health services (27, 29). By employing sequential intervention levels and conducting evaluations at each step to ascertain the necessity of progressing to a more intensive and resource-demanding stage, stepped care facilitates the provision of care to a broader population while maintaining individual needs as the central determinant of intervention intensity. Consequently, only those clients requiring more intensive and costly interventions receive them, thereby reducing overall expenditure and resource utilization. This allows for the efficient allocation of scarce resources while ensuring that individuals receive the appropriate level of care (27, 36). Furthermore, by offering low-threshold interventions such as psychoeducational resources or group-based support within primary care settings, access barriers can be reduced, and early intervention can be promoted (27, 29). Stepped care models can also be more readily adapted to incorporate culturally sensitive interventions. For example, these models can consider language, cultural background, and individual experiences to address the specific needs of refugee populations. This can improve engagement and outcomes among refugees (36, 37). Moreover, stepped care models can help to overcome the shortage of mental health specialists by enabling non-specialist providers, such as primary care clinicians or trained peers, to deliver initial interventions (27, 30, 36). For the efficient and sustainable implementation of a stepped care model, governmental integration within a broader systemic framework, potentially necessitating additional costs, seems to be required.

Culturally adapted screening questionnaires present a potentially valuable tool for primary healthcare professionals to efficiently assess large cohorts and expedite the identification of patients experiencing mental health difficulties (35). The RAST-MT screener exemplifies such a tool, designed to evaluate the need and urgency for mental healthcare intervention (35). This facilitates broad population screening, ensuring access to appropriate care for those identified as requiring it (35). Given these attributes and its potential for cost-effective implementation, such a screening questionnaire could function as an optimal initial phase within a stepped care model.

The findings of this review highlight digital mental health as a promising approach to address barriers to accessing mental healthcare, including stigma, language barriers, and inadequate infrastructure. Telemedicine, mobile applications, and online platforms are suggested as potential interventions (32, 34, 37). These interventions not only reduce the need for in-person consultations in potentially stigmatizing settings but also offer flexible access across various contexts, including refugee camps and under-resourced urban areas (32). Moreover, their adaptability to different languages further supports their scalability and cultural responsiveness. However, this approach is not without limitations. The digital divide remains a major barrier, particularly for older adults, refugees in transit, or individuals with limited digital literacy. Consequently, the use of digital interventions risks excluding the most vulnerable, potentially exacerbating health disparities rather than reducing them (32). Privacy and data protection represent another significant concern in the use of digital mental health interventions (32). A breach in digital confidentiality could have severe consequences, including re-traumatization and loss of trust in health systems. These concerns are also described in

the WHO's ethical guidance for digital health in low-resource settings, which emphasizes the need for data security, informed consent, and transparency in digital health applications, particularly among vulnerable populations (44). Lastly, cultural adaptation plays an important role in the effectiveness of digital mental health interventions (37). Engaging refugee communities in the cultural adaptation of digital mental health interventions can enhance cultural relevance, improve acceptability, and build mutual trust.

Given the inherent strengths of NGOs, enhanced utilization of NGOs by governmental bodies and primary healthcare providers could be proposed (38). Governmental support could be augmented through increased financial allocations or improved structural support. Primary care practitioners could foster closer collaborative relationships with NGOs, recognizing the potential for complementary and mutually reinforcing service delivery. Furthermore, it is crucial for primary healthcare professionals to maintain knowledge of available NGO services to facilitate appropriate referrals when encountering patients from refugee populations. Finally, enhanced inter-organizational linkages between NGOs should be considered. Analogous to the recommended collaborative approach with primary care, this bundling could foster complementary and mutually reinforcing dynamics, facilitating the exchange of specialized expertise and the expansion of service networks through reciprocal utilization. Conversely, while it would be beneficial to build on the already existing strengths of NGOs, it warrants consideration that their current operational context creates a diversion from their primary mandates to address gaps in governmental service provision. This may contribute to the establishment of less sustainable frameworks and a diminished level of integration within the overarching healthcare system. The optimal strategy regarding this matter warrants further debate.

The operational efficacy of NGOs is reportedly sometimes impeded by limitations in their mandates, occasionally resulting in actions that contravene legal statutes, such as the provision of shelter to undocumented immigrants. This issue presents a dichotomy. From one perspective, arguments can be made that housing, feeding, education, medical care, etc., are fundamental human rights, and organizations like NGOs should be permitted to ensure access to these rights (45). Conversely, it can be argued that NGOs are obligated to adhere to the legal frameworks of their operating countries, as exemption from these laws could undermine the judicial system. Furthermore, given that NGOs often receive government funding, it could be considered inappropriate for such organizations to utilize state resources to contravene the very laws enacted by that state.

The review employed several methodological strengths. Title, abstract, and full-text screenings were conducted independently and in duplicate by two reviewers, with discrepancies resolved through discussion, thereby minimizing the risk of selection bias and enhancing the reliability of study selection. The search strategy incorporated both controlled vocabulary (MeSH terms) and free-text keywords, allowing for a comprehensive retrieval of relevant literature. Furthermore, the use of two large multidisciplinary databases, PubMed and Web of Science, provided access to a broad range of peer-reviewed studies across medical and social science disciplines. Clear and predefined eligibility criteria were applied consistently throughout the screening process, promoting transparency and reproducibility. A standardized data extraction form was used to ensure systematic and consistent collection of key study characteristics. Moreover, the review process demonstrated transparency,

including the adaptation of the research scope following initial screening, thus maintaining methodological integrity despite necessary refinements.

Nevertheless, several limitations must be acknowledged. First, following the initial screening, the scope of the review was refined to focus solely on solution-oriented studies due to feasibility constraints associated with the volume of retrieved articles and the time limitations of a master's thesis project. Although this decision was made in consultation with the supervisory team, it represents a deviation from the original protocol and may have introduced selection bias. Second, the search was restricted to only two databases, potentially leading to the omission of relevant studies indexed in other repositories, such as PsycINFO or Embase. Third, only studies published in English were included, introducing a potential language bias and limiting the inclusivity of non-English literature, which may be particularly relevant in a cross-cultural research context. Fourth, no formal assessment of study quality or risk of bias was conducted. As a result, the robustness and methodological rigor of the included studies could not be systematically evaluated, which may affect the strength and reliability of the review's conclusions. Finally, few studies were identified that fully aligned with the specific focus of the research question. Many studies addressed broader migrant populations rather than refugees exclusively, which may limit the direct applicability of the findings to the refugee population of interest.

Future research should prioritize the rigorous evaluation of culturally adapted interventions within primary care settings to enhance mental health service delivery for adult refugees. Specifically, there is a need for longitudinal studies employing robust methodologies to assess the long-term effectiveness of stepped care models that integrate digital mental health tools, peer-to-peer support, and trauma-informed care principles (25, 27, 29, 32, 34, 36, 37, 40, 41). Further investigation is warranted to explore the optimal training strategies for primary care providers to enhance their cultural competence and confidence in addressing the complex mental health needs of this population (25, 26, 31, 33, 34). Additionally, research should focus on developing and validating culturally sensitive screening tools for early identification of mental health difficulties in refugee populations within primary care (35). Finally, qualitative and mixed-methods research designs are essential to gain a deeper understanding of the lived experiences of refugees accessing mental health care, to further identify persistent barriers, and to inform the development of more responsive and equitable services.

# 5. Conclusion

This systematic review underscores the complexity inherent in addressing the mental health needs of refugee populations within primary care settings. While the preceding literature demonstrates a substantial body of evidence regarding the epidemiology of mental disorders among refugees and a well-established understanding of the barriers to mental healthcare, comparatively less attention has been devoted to practical strategies for improving access to mental health services in primary care contexts.

Through a synthesis of the current evidence, this review highlights the unique and multifaceted barriers refugees face, including language difficulties, limited mental health literacy, cultural divergences, social stigma, systemic/structural barriers such as insufficient availability of mental health services and the absence of a cohesive organizational framework among mental healthcare providers and services, limited awareness of available services, challenges in navigating healthcare systems, and a shortage of culturally competent providers. The findings emphasize the necessity of multi-layered, tailored interventions to address these challenges effectively.

Key strategies identified include the deployment of qualified interpreters with specialized training in mental health care, the delivery of culturally adapted psychoeducation, the provision of cross-cultural competence training for healthcare providers, the integration of peer-to-peer support mechanisms, and the adoption of trauma-informed care principles. Furthermore, stepped care models and digital mental health interventions represent promising approaches to expanding service accessibility in a flexible and scalable manner. However, challenges such as the exclusion of highly vulnerable refugee populations—particularly those in transit or residing in remote rural areas—from digital interventions risk exacerbating existing disparities in mental health service utilization, and concerns regarding data security must be carefully addressed. Notably, this review found no specific solutions proposed for addressing broader structural barriers. Additionally, the prominent role of non-governmental organizations in bridging service gaps underscores the need for enhanced collaboration among governmental agencies, primary care systems, and community-based organizations.

Despite the methodological strengths of this review, limitations must be acknowledged, including redefining the scope of the review following the initial screening, the use of a language filter—potentially introducing language bias, which is particularly pertinent in cross-cultural research—the restriction to two databases, and the absence of a formal risk of bias assessment. These factors may limit the comprehensiveness and generalizability of the findings. Nevertheless, the evidence indicates that culturally sensitive, trauma-informed, and systemically integrated approaches are pivotal for the effective delivery of mental health care to refugee populations.

Future research should prioritize the rigorous evaluation of the long-term cost-effectiveness and scalability, as well as the concrete implementation of these interventions within primary care settings. There is also a critical need for the development and validation of culturally sensitive screening tools and the systematic integration of intercultural competence training within healthcare curricula. Ultimately, achieving equitable access to mental health care for refugee populations will require not only targeted clinical innovations but also broader structural reforms that foster inclusivity, trust, and resilience within healthcare systems.

## 6. References


1. Refugees UNHCf. Refugee Data Finder: UNHCR; 2024. Available from: https://www.unhcr.org/refugee-statistics.
2. Turrini G, Purgato M, Acarturk C, Anttila M, Au T, Ballette F, et al. Efficacy and acceptability of psychosocial interventions in asylum seekers and refugees: systematic review and meta-analysis. Epidemiol Psychiatr Sci. 2019;28(4):376-88.
3. Priebe S, Giacco D, El-Nagib R. WHO Health Evidence Network Synthesis Reports. Public Health Aspects of Mental Health Among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular Migrants in the WHO European Region. Copenhagen: WHO Regional Office for Europe

© World Health Organization 2016.; 2016.
4. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. Lancet (London, England). 2005;365(9467):1309-14.
5. Giacco D, Laxhman N, Priebe S. Prevalence of and risk factors for mental disorders in refugees. Semin Cell Dev Biol. 2018;77:144-52.
6. Organization WH. Mental health of refugees and migrants: risk and protective factors and access to care. Geneva, Switserland; 2023.
7. huisarts-migrant.nl. Psychose en schizofrenie bij migranten: huisarts-migrant.nl; 2023. Available from: https://www.huisarts-migrant.nl/psychose/.
8. WHO Team: Mental Health BHaSUM. Mental health action plan 2013 - 2020. WHO; 2013.
9. Dumke L, Wilker S, Hecker T, Neuner F. Barriers to accessing mental health care for refugees and asylum seekers in high-income countries: A scoping review of reviews mapping demand and supply-side factors onto a conceptual framework. Clin Psychol Rev. 2024;113:102491.
10. Byrow Y, Pajak R, Specker P, Nickerson A. Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. Clin Psychol Rev. 2020;75:101812.
11. DeSa S, Gebremeskel AT, Omonaiye O, Yaya S. Barriers and facilitators to access mental health services among refugee women in high-income countries: a systematic review. Syst Rev. 2022;11(1):62.
12. Firth A, Haith-Cooper M, Dickerson J, Hart A. Perinatal depression: Factors affecting help-seeking behaviours in asylum seeking and refugee women. A systematic review. J Migr Health. 2022;6:100128.
13. Salam Z, Odenigbo O, Newbold B, Wahoush O, Schwartz L. Systemic and Individual Factors That Shape Mental Health Service Usage Among Visible Minority Immigrants and Refugees in Canada: A Scoping Review. Adm Policy Ment Health. 2022;49(4):552-74.
14. van der Boor CF, White R. Barriers to Accessing and Negotiating Mental Health Services in Asylum Seeking and Refugee Populations: The Application of the Candidacy Framework. J Immigr Minor Health. 2020;22(1):156-74.
15. Satinsky E, Fuhr DC, Woodward A, Sondorp E, Roberts B. Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. Health policy (Amsterdam, Netherlands). 2019;123(9):851-63.

16. Peñuela-O'Brien E, Wan MW, Edge D, Berry K. Health professionals' experiences of and attitudes towards mental healthcare for migrants and refugees in Europe: A qualitative systematic review. Transcult Psychiatry. 2023;60(1):176-98.
17. Pollard T, Howard N. Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. Int J Ment Health Syst. 2021;15(1):60.
18. Refugees UNHCf. Who we protect: Refugees: UNHCR; 2024. Available from: https://www.unhcr.org/about-unhcr/who-we-protect/refugees.
19. Refugees UNHCf. Who we proctect: Asylum-seekers: UNHCR; 2024. Available from: https://www.unhcr.org/about-unhcr/who-we-protect/asylum-seekers.
20. Fund WHOUNCs. A vision for primary health care in the 21st century. 2018.
21. organisation WH. Mental disorders: WHO; 2022. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.
22. Brian Frederick Windley WHB. Europe: Britannica; 2025. Available from: https://www.britannica.com/place/Europe.
23. Refugees UNHCf. Syria Refugee Crisis Explained: UNHCR; 2025. Available from: https://www.unrefugees.org/news/syria-refugee-crisis-explained/#WhendidtheSyrianrefugeecrisisbegin.
24. Refugees UNHCf. Migrant definition: UNHCR. Available from: https://emergency.unhcr.org/protection/legal-framework/migrant-definition.
25. Bäärnhielm S, Jávo C, Mösko MO. Opening Up Mental Health Service Delivery to Cultural Diversity: Current Situation, Development and Examples from Three Northern European Countries. In: Alarcon RD, editor. Cultural Psychiatry. Advances in Psychosomatic Medicine. 332013. p. 40-55.
26. Bäärnhielm S, Edlund AS, Ioannou M, Dahlin M. Approaching the vulnerability of refugees: evaluation of cross-cultural psychiatric training of staff in mental health care and refugee reception in Sweden. BMC Med Educ. 2014;14.
27. Böge K, Karnouk C, Hahn E, Schneider F, Habel U, Banaschewski T, et al. Mental health in refugees and asylum seekers (MEHIRA): study design and methodology of a prospective multicentre randomized controlled trail investigating the effects of a stepped and collaborative care model. Eur Arch Psychiatry Clin Neurosci. 2020;270(1):95-106.
28. Chiarenza A, Dauvrin M, Chiesa V, Baatout S, Verrept H. Supporting access to healthcare for refugees and migrants in European countries under particular migratory pressure. BMC Health Serv Res. 2019;19.
29. Denkinger JK, Rometsch C, Murray K, Schneck U, Brisslinger LK, Azad ZR, et al. Addressing barriers to mental health services: evaluation of a psychoeducational short film for forcibly displaced people. Eur J Psychotraumatol. 2022;13(1).
30. Gruner D, Magwood O, Bair L, Duff L, Adel S, Pottie K. Understanding Supporting and Hindering Factors in Community-Based Psychotherapy for Refugees: A Realist-Informed Systematic Review. Int J Environ Res Public Health. 2020;17(13).
31. Jirovsky E, Hoffmann K, Mayrhuber EA, Mechili EA, Angelaki A, Sifaki-Pistolla D, et al. Development and evaluation of a web-based capacity building course in the EUR-HUMAN project to support primary health care professionals in the provision of high-quality care for refugees and migrants. Glob Health Action. 2018;11(1):1547080.

32. Larsen A, Guler J. Digital Mental Health Approaches to Improve Well-Being of Refugee Families. Psychiatric services (Washington, DC). 2024;75(2):198-201.
33. Linney C, Ye S, Redwood S, Mohamed A, Farah A, Biddle L, et al. "Crazy person is crazy person. It doesn't differentiate": an exploration into Somali views of mental health and access to healthcare in an established UK Somali community. Int J Equity Health. 2020;19(1):190.
34. McDonald JT, Dahlin M, Bäärnhielm S. Cross-cultural training program on mental health care for refugees - a mixed method evaluation. BMC Med Educ. 2021;21(1):533.
35. Nagy E, Herpertz SC, Schohl K, Zehetmair C, Gebhardt N, Friederich HC, et al. The refugee and asylum seeker mental health treatment screener (RAS-MT-screener): Feasibility and psychometric properties of a questionnaire detecting refugees' and asylum seekers' need and urgency for mental health treatment. Gen Hosp Psychiatry. 2023;83:43-50.
36. Orang TM, Missmahl I, Thoele AM, Valensise L, Brenner A, Gardisi M, et al. New directions in the mental health care of migrants, including refugees-A randomized controlled trial investigating the efficacy of value-based counselling. Clin Psychol Psychother. 2022;29(4):1433-46.
37. Spanhel K, Schweizer JS, Wirsching D, Lehr D, Baumeister H, Bengel J, et al. Cultural adaptation of internet interventions for refugees: Results from a user experience study in Germany. Internet Interv. 2019;18:100252.
38. Strassmayr C, Matanov A, Priebe S, Barros H, Canavan R, Díaz-Olalla JM, et al. Mental health care for irregular migrants in Europe: Barriers and how they are overcome. BMC Public Health. 2012;12.
39. Wenk-Ansohn M, Gurris N. Intercultural encounters in counselling and psychotherapy--communication with the help of interpreters. Torture. 2011;21(3):182-5.
40. Wood M, Gerskowitch C, Kayal H, Ehntholt K, Blumberg J. Trauma and resettlement: lessons learned from a mental health screening and treatment programme for Syrian refugees in the UK. Int Rev Psychiatry. 2022;34(6):588-95.
41. Wrede O, Löve J, Jonasson JM, Panneh M, Priebe G. Promoting mental health in migrants: a GHQ12-evaluation of a community health program in Sweden. BMC Public Health. 2021;21(1).
42. Bernal G, Jiménez-Chafey MI, Domenech Rodríguez MM. Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. Professional Psychology: Research and Practice. 2009;40(4):361-8.
43. Hassan G, Kirmayer, L. J., Mekki-Berrada, A., Quosh, C., el Chammay, R., Deville-Stoetzel, J. B., Youssef, A., Jefee-Bahloul, H., Barkeel-Oteo, A., Coutts, A., Song, S., & Ventevogel, P. Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians : A review for mental health and psychosocial support staff working with Syrians affected by armed conflict.; 2015.
44. Organisation WH. Global strategy on digital health 2020-2025. 2021.
45. international A. Mensenrechten, lijst van mensenrechten: Amnesty international. Available from: https://www.amnesty.nl/encyclopedie/mensenrechten-lijst-van-mensenrechten.

# Appendix A

| Research question (e.g. PICO format): Addressing Barriers to Mental Healthcare for Refugees in Primary Care: A Systematic Review of Proposed Solutions in Europe | | |
|---|---|---|
| Type of review (e.g. systematic review, scoping review, narrative review, etc.): Systematic review | | |
| NAME OF DATABASE (interface): PUBMED | | |
| Concept | Line number | Search strategy |
| Concept 1: Mental health | 1 | Mental health [MESH] OR Mental disorders [MESH] OR Psychiatry [MESH] OR “Mental illness"[tiab] OR “Mental health condition*"[tiab] OR “Mental health"[tiab] OR “global mental health"[tiab] OR “Mental disorder*”[tiab] OR “Psychiatry “[tiab] OR “Psychiatric illness*” [tiab] |
| Concept 2: Primary care | 2 | Primary health care [MESH] OR Community health workers [MESH] OR General practitioners [MESH] OR Social workers [MESH] OR Community health centers [MESH] OR OR "Family Practice"[Mesh] OR "Physicians, Family"[Mesh] OR "Nurse Practitioners”[Mesh] OR General Practice [MESH] OR Physicians, primary care [Mesh] OR psychological first aid [MESH] OR family practice*[tiab] OR general practice*[tiab] OR family practitioner*[tiab] OR family physician*[tiab] OR general practitioner*[tiab] OR nurse practitioner*[tiab] OR primary care*[tiab] OR community health*[tiab] OR community health worker*[tiab] OR social work*[tiab] OR “Primary healthcare"[tiab] OR “Primary health care"[tiab] |
| Concept 3: Refugees | 3 | Refugees[Mesh] OR Emigrants and Immigrants[Mesh] OR “displace*”[tiab] OR “undocumented”[tiab] OR “stateless”[tiab] OR “asylum*”[tiab] OR “immigra*”[tiab] OR “immigre*”[tiab] OR “emigra*”[tiab] OR “emigre*”[tiab] OR “migra*”[tiab] OR “refugee*”[tiab] OR “expatriat*”[tiab] OR “asylee*”[tiab] OR "displaced person*"[tiab] OR "displaced people"[tiab] OR “incomer*”[tiab] OR "new comer*"[tiab] OR “newcomer*”[tiab] OR “resettler*”[tiab] |
| Concept 4: Europe | 4 | (“africa”[MeSH Terms] OR “asia”[MeSH Terms] OR "australia"[MeSH Terms] OR "canada"[MeSH Terms] OR "central america"[MeSH Terms] OR "north america"[MeSH Terms] OR "united states"[MeSH Terms] OR "south america"[MeSH Terms]) NOT (“europe"[MeSH Terms] OR “Turkey" [MeSH Terms] ) |

| | | |
|---|---|---|
| Combination of concepts | 5 | #1 AND #2 AND #3 |
| Combination of concepts | 6 | #5 NOT #4 |

# Appendix B

| Research question (e.g. PICO format): Addressing Barriers to Mental Healthcare for Refugees in Primary Care: A Systematic Review of Proposed Solutions in Europe | | |
|---|---|---|
| Type of review (e.g. systematic review, scoping review, narrative review, etc.): Systematic review | | |
| NAME OF DATABASE (interface): Web of science | | |
| Concept | Line number | Search strategy |
| Concept 1: mental health | 1 | TS=(Mental illness OR Mental health condition* OR Mental health OR global mental health OR Mental disorder* OR Psychiatry OR Psychiatric illness*) |
| Concept 2: Primary care | 2 | TS=(primary health care OR family practice* OR general practi* OR family practitioner* OR family physician* OR nurse practitioner* OR primary care* OR community health* OR community health worker* OR social work* OR Primary healthcare OR Primary health care OR Psychological first aid) |
| Concept 3: Refugees | 3 | TS=(refugee* OR displace* OR undocumented OR stateless OR asylum* OR immigra* OR immigre* OR emigra* OR emigre* OR migra* OR expatriat* OR asylee* OR displaced person* OR displaced people OR incomer* OR new comer* OR newcomer* OR resettler*) |
| Combination of concepts | 4 | #1 AND #2 AND #3 |