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Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland

Nikolai Kiselev [a], Monique Pfaltz[a,b], Florence Haas[a], Matthis Schick [a], Marie Kappen[a], Marit Sijbrandij [c], Anne M. De Graaff [c], Martha Bird[d], Pernille Hansen[d], Peter Ventevogel [e], Daniela C Fuhr [f], Ulrich Schnyder[b] and Naser Morina [a]

aDepartment of Consultation-Liaison Psychiatry and Psychosomatic Medicine, University Hospital Zurich, Zurich, Switzerland; bUniversity of Zurich, Zurich, Switzerland; cDepartment of Clinical, Neuro- and Developmental Psychology, Vrije Universiteit Amsterdam and Amsterdam Public Health Institute, Amsterdam, The Netherlands; dReference Centre for Psychosocial Support, International Federation of Red Cross and Red Crescent Societies, Copenhagen, Denmark; ePublic Health Section, United Nations High Commissioner for Refugees, Geneva, Switzerland; fFaculty of Public Health and Policy, Department of Health Services Research and Policy, London School of Hygiene & Tropical Medicine, London, UK

ABSTRACT
Background: Due to their experiences of major stressful life events, including post-displacement stressors, refugees and asylum seekers are vulnerable to developing mental health problems. Yet, despite the availability of specialized mental health services in Western European host countries, refugees and asylum seekers display low mental health-care utilization.
Objective: The aim of this study was to explore structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland.
Method: In this qualitative study, key-informant (KI) interviews with Syrian refugees and asylum seekers, Swiss healthcare providers and other stakeholders (e.g. refugee coordinators or leaders) were conducted in the German-speaking part of Switzerland. Participants were recruited using snowball sampling. Interviews were audiotaped and transcribed, and then analysed using thematic analysis, combining deductive and inductive coding.
Results: Findings show that Syrian refugees and asylum seekers face multiple structural and socio-cultural barriers, with socio-cultural barriers being perceived as more pronounced. Syrian key informants, healthcare providers, and other stakeholders identified language, gatekeeper-associated problems, lack of resources, lack of awareness, fear of stigma and a mismatch between the local health system and perceived needs of Syrian refugees and asylum seekers as key barriers to accessing care.
Conclusions: The results show that for Syrian refugees and asylum seekers in Switzerland several barriers exist. This is in line with previous findings. A possible solution for the current situation might be to increase the agility of the service system in general and to improve the willingness to embrace innovative paths, rather than adapting mental healthcare services regarding single barriers and needs of a new target population.

Barreras estructurales y socioculturales para acceder a cuidados de salud mental para refugiados y solicitantes de asilo sirios en Suiza

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Antecedentes: Debido a sus experiencias de eventos vitales estresantes mayores, incluidos los estresores posteriores al desplazamiento, los refugiados y solicitantes de asilo son vulnerables a desarrollar problemas de salud mental. Sin embargo, a pesar de la disponibilidad de servicios especializados de salud mental en los países hospedadores de Europa occidental, los refugiados y los solicitantes de asilo muestran una baja utilización de cuidados salud mental.
Objetivo: El objetivo de este estudio fue explorar las barreras estructurales y socioculturales para acceder a cuidados de salud mental para refugiados y solicitantes de asilo sirios, en Suiza.
Método: En este estudio cualitativo, se realizaron entrevistas informante-clave (IC) con refugiados y solicitantes de asilo sirios, proveedores de cuidados de salud suizos y otros grupos de interes (por ejemplo, coordinadores o líderes de refugiados) en la parte de habla alemana de Suiza. Los participantes fueron reclutados mediante muestreo de bola de nieve. Las entrevistas fueron grabadas en audio y transcritas, y luego analizadas mediante análisis temático, combinando codificación deductiva e inductiva.
Resultados: Los resultados muestran que los refugiados y solicitantes de asilo sirios, enfrentan múltiples barreras estructurales y socioculturales, siendo las socio-culturales percibidas como más pronunciadas. Los informantes-clave sirios, los proveedores de cuidados de salud y otras grupos de interes, identificaron el idioma, problemas asociados con la

HIGHLIGHTS
• Barriers to mental health care specific for Syrian refugees and asylum seekers in Switzerland were explored in a qualitative study.
• Findings show that Syrian refugees and asylum seekers face multiple barriers such as language, gatekeeper associated problems, lack of resources, lack of awareness, fear of stigma and a mismatch between the local health system and perceived needs of Syrian refugees and asylum seekers.
• The results of the study confirm previous research findings and show that the barriers to accessing mental healthcare for refugees and asylum seekers in Switzerland still exist and have not improved over years and decades.

CONTACT Naser Morina ✉ naser.morina@usz.ch ✐ Department of Consultation-Liaison Psychiatry and Psychosomatic Medicine, University Hospital Zurich, Culmannstrasse 8, Zürich CH-8006, Switzerland

puerta de entrada a las instituciones, falta de recursos, falta de conciencia, miedo al estigma y discordancia entre el sistema de salud local y las necesidades percibidas de los sirios refugiados y solicitantes de asilo como barreras clave para acceder a la atención.

Conclusiones: Los resultados muestran que para los refugiados y solicitantes de asilo sirios en Suiza existen varias barreras. Esto está en línea con hallazgos previos. Una posible solución para la situación actual podría ser aumentar la agilidad del sistema de servicios en general y mejorar la disposición a adoptar caminos innovadores, en lugar de adaptar los servicios de salud mental con respecto a las barreras y necesidades individuales de una nueva población objetivo.

瑞士的叙利亚难民和寻求庇护者获取精神保健的结构性和社会文化障碍

背景: 由于经历过重大应激生活事件, 包括流离失所的应激源, 难民和寻求庇护者很容易出现心理健康问题。然而, 尽管西欧东道国提供了专门的精神保健服务, 但难民和寻求庇护者的精神保健利用率较低。

目标: 本研究旨在探究瑞士的叙利亚难民和寻求庇护者获得精神保健的结构性和社会文化障碍。

方法: 在这项定性研究中, 在瑞士德语区对叙利亚难民和寻求庇护者, 瑞士医疗保健提供者以及其他利益相关者 (例如, 难民协调员或领导者) 进行了关键信息 (KI) 访谈。使用滚雪球采样招募参与者。对访谈进行录音和转录, 然后使用主题分析, 结合演绎和归纳编码进行分析。

结果: 结果发现, 叙利亚难民和寻求庇护者面临多重结构性和社会文化障碍, 人们认为社会文化障碍更为明显。叙利亚主要信息提供者, 医疗保健提供者和其他利益相关者认为, 语言, 与门卫相关的问题, 资源不足, 认识不足, 对污名的恐惧以及当地卫生系统与叙利亚难民和寻求庇护者感知需求之间的不匹配, 是获取护理的主要障碍。

结论: 结果表明, 对于瑞士的叙利亚难民和寻求庇护者, 存在一些障碍。这符合以前的发现。当前情况的一个可能解决方案可能是提高服务系统的整体灵活性, 并提高采用创新途径的意愿, 而不是针对单个障碍和新目标人群的需求调整精神保健服务。

Abbreviations: AMHRG: Applied Mental Health Research Group; BASEC: Business Administration System for Ethics Committees; DIME: Design, Implementation, Monitoring, and Evaluation; HCP: Healthcare Provider; KI: Key-Informant; PM+: Problem Management Plus; PTSD: Posttraumatic Stress Disorder; SEM: State Secretariat for Migration; SH: Stakeholder; SKI: Syrian Key-Informant; STRENGTHS: Syrian REfuGees mental healTHcare Systems; UNHCR: United Nations High Commissioner for Refugees; WHO: World Health Organization

1. Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), there were over 70.8 million forcibly displaced people worldwide by the end of 2018 (UNHCR, 2019). This population has been continuously increasing over the past 20 years and is currently at a record high (UNHCR, 2019). In 2018 alone, the number increased by around 2.3 million (UNHCR, 2018, 2019). The increase in the past years is particularly driven by the armed conflict in Syria, due to which around six million people left the country and another six million were internally displaced (UNHCR, 2018). In Switzerland, there are currently more than 120′000 refugees and asylum seekers.[1] Almost 20′000 of them are Syrians (State Secretariat for Migration SEM, 2019). After Eritreans, Syrians represent the second largest population applying for asylum in Switzerland (SEM, 2019).

Forcibly displaced populations typically report exposure to a high number of potentially traumatic events in their country of origin and during displacement (Ben Farhat et al., 2018; Ibrahim & Hassan, 2017; Morina, Schnyder, Klaghofer, Muller, & Martin-Soelch, 2018; Steel et al., 2009). After arrival in safe host countries, refugees and asylum seekers often face numerous stressors and challenges related to their post-displacement environment, such as insecurity about their legal status, discrimination, worry about friends and relatives who stayed behind, struggles to find livelihoods and education opportunities (Li, Liddell, & Nickerson, 2016; Schick et al., 2016). Estimating prevalence data for mental health conditions among refugees and asylum seekers is methodologically challenging but in general, significantly increased prevalence rates of mental disorders and psychosomatic complaints have repeatedly been observed in such populations (Charlson et al., 2019; Morina et al., 2017; Silove, Ventevogel, & Rees, 2017). In a systematic review by Steel et al. (2009), based on the analysis of 161 articles reporting results of 181 surveys comprising 81,866 refugees and other conflict-affected persons from 40 countries, weighted prevalence rates in refugee and asylum seeker populations are estimated at 30.8% for depression and 30.6% for Posttraumatic Stress Disorder (PTSD), respectively. A recent systematic review conducted by the WHO, including 129 studies estimated the prevalence of mental disorders (depression, anxiety, post-traumatic stress disorder, bipolar disorder, and

schizophrenia) in conflict-affected populations from different countries at 22.1% (Charlson et al., 2019). Studies on mental health of Syrian refugees and asylum seekers suggest high prevalence estimates for depression between 27.4% and 70.5% (Acarturk et al., 2018; Euteneuer & Schäfer, 2018; Fuhr et al., 2019; Ibrahim & Hassan, 2017; Javanbakht et al., 2018; Marwa, 2016; Naja, Aoun, El Khoury, Abdallah, & Haddad, 2016; Poole, Hedt-Gauthier, Liao, Raymond, & Barnighausen, 2018; Tekeli-Yesil et al., 2018; Tinghog et al., 2017), and for PTSD between 19.6% and 83.4% (Acarturk et al., 2018; Al Ibraheem, Kira, Aljakoub, & Al Ibraheem, 2017; Alpak et al., 2015; Cheung Chung et al., 2018; Chung et al., 2018; Fuhr et al., 2019; Javanbakht et al., 2018; Kazour et al., 2017; Marwa, 2016; Tekeli-Yesil et al., 2018; Tinghog et al., 2017). Moreover, untreated mental health disorders in refugees and asylum seekers might be highly persistent or even worsen over time (Hémono et al., 2018; Kaltenbach, Schauer, Hermenau, Elbert, & Schalinski, 2018; Priebe et al., 2009). In contrast, the estimated prevalence of common mental disorders in the general population in Western Europe varies between 4.6% and 7.4% for depression (Perrez & Baumann, 2005) and 1.5% for PTSD (Maercker, Hecker, Augsburger, & Kliem, 2018). Moreover, functional impairment related to mental health problems has been shown to negatively impact social and occupational integration of refugees and asylum seekers in host societies (Li et al., 2016; Schick et al., 2016).

Despite high prevalence rates of mental health problems, refugees and asylum seekers underutilize mental health services due to various barriers (Bartolomei et al., 2016; Brendler-Lindqvist, Norredam, & Hjern, 2014; Kantor, Knefel, & Lueger-Schuster, 2017; Laban, Gernaat, Komproe, & De Jong, 2007; Lamkaddem et al., 2014; McColl & Johnson, 2006; Satinsky, Fuhr, Woodward, Sondorp, & Roberts, 2019; Slewa-Younan et al., 2017; Wong et al., 2006). Barriers to accessing healthcare can be classified as either structural or socio-cultural (Ayers et al., 2018; Leong & Lau, 2001). Structural barriers relate to socioeconomic status and institutional conditions, such as language problems, financial difficulties, logistical issues, lack of knowledge on how the local health system works, issues associated with general practitioners and long waiting lists in specialized treatment units (Griffiths et al., 2017; Jensen, Norredam, Priebe, & Krasnik, 2013; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Oetterli, Niederhauser, & Pluess, 2013; Valibhoy, Szwarc, & Kaplan, 2017; Wohler & Dantas, 2017). Socio-cultural barriers comprise a dissonance between cultural systems of the country of origin versus the host country, such as stigma, a lack of mental health awareness and cultural mismatch between refugees' and asylum

seekers' problems and needs and the health system in the host country (Bartolomei et al., 2016; Jensen, Johansen, Kastrup, Krasnik, & Norredam, 2014; Jensen et al., 2013; Kantor et al., 2017; Leong & Lau, 2001; Omar, Kuay, & Tuncer, 2017; Shannon, Vinson, Cook, & Lennon, 2015; Valibhoy et al., 2017).

In order to tailor healthcare to the needs of refugees and asylum seekers, policymakers need to better understand the barriers to access and the reasons behind low utilization of available mental health services in this group. So far, studies in Switzerland focused on perspective of specialized professionals and (mental) healthcare providers working in the refugees and asylum sector without specific attention for the perspectives of refugees and asylum seekers (Bartolomei et al., 2016; Bischoff et al., 2003; Müller, Roose, Landis, & Gianola, 2018; Oetterli et al., 2013). Yet, understanding refugees' and asylum seekers' viewpoints, in combination with those of healthcare professionals and other stakeholders working with refugee and asylum seeker populations is essential to increase the flexibility of the mental healthcare system in Switzerland. This is especially important because there is a lack of specialized treatment services for refugees and asylum seekers, mainly due to the limited number of specialized professionals working with this target population for refugees and asylum seekers (Oetterli et al., 2013). Furthermore, mental health problems among refugees and asylum seekers are often mis- or underdiagnosed, and this results in low treatment coverage which may lead to negative long-term treatment outcomes and ultimately higher healthcare costs (Maier, Schmidt, & Mueller, 2010).

In sum, Syrian refugees and asylum seekers are a new and rapidly growing population in Switzerland. Previous research provides profound evidence for the increased risks of this population to develop mental health disorders, highlighting that this population needs access to the local mental healthcare system. However, refugees and asylum seekers face several barriers to accessing mental health services. Yet, the number of studies from Switzerland is limited. Specifically, Syrian refugees and asylum seekers in Switzerland have not yet been assessed. Moreover, studies that identify barriers to accessing mental healthcare for refugees and asylum seekers in Switzerland, which include the perspective of the affected population, are lacking.

The purpose of the current study was to describe the structural and socio-cultural barriers to mental healthcare in Syrian refugees and asylum seekers in Switzerland by exploring perspectives of three different groups of informants: (a) Syrian key informants (KI) (living in Switzerland), (b) Swiss

healthcare providers, and (c) other stakeholders, i.e. other professionals working with refugees and asylum seekers.

2. Methods

A cross-sectional, qualitative design was applied using in-depth interviews, conducted from June to August 2017 in the German-speaking part of Switzerland. Ethical approval for the study was issued by the Ethics Committee of the Canton of Zurich (BASEC-Nr. 2017–00404).

This study was part of the STRENGTHS project, a multi-centre study evaluating the adaptation, implementation and scaling up of Problem Management Plus (PM+), a psychological intervention developed by the World Health Organization (WHO), among Syrian refugees and asylum seekers (Dawson et al., 2015; Sijbrandij et al., 2017). This study was the second step (of three) within a formative phase to adapt PM+ for use with Syrian refugees and asylum seekers in Switzerland. The first step was a qualitative study among 30 Syrian refugees and asylum seekers about problems of the target population in Switzerland (Kiselev et al., submitted). The last step was two focus group discussions on the results of the first two studies.

To assess barriers to accessing mental healthcare, semi-structured KI interviews were conducted following the DIME methodology (Design, Implementation, Monitoring and Evaluation) with people who were knowledgeable about either the Syrian community in Switzerland or the Swiss healthcare system and policy (Applied Mental Health Research Group AMHRG, 2013).

2.1. Participants

We aimed to interview five Syrian KIs (SKI), five Swiss healthcare providers (HCP) and five stakeholders (SH). Following previous research in the field (Episkopou et al., 2019; Griffiths et al., 2017; Jensen et al., 2013; McKell, Hankir, Abu-Zayed, Al-Issa, & Awad, 2017; Melamed, Chernet, Labhardt, Probst-Hensch, & Pfeiffer, 2018; Murray et al., 2012) and in accordance with the DIME manual (AMHRG, 2013) as well as Lincoln and Guba (1985), we aimed to interview 15 persons. Interview questions were constructed by authors of this paper (DCF, MB, PH).

Participants for the KI interviews were recruited with snowball sampling (AMHRG, 2013). This sampling method does not primarily aim at the representativeness of participants, but instead at their knowledge regarding the topic in question.

2.1.1. Syrian KIs

Syrian KIs included Syrian refugees and asylum seekers of 18 years and above and who had arrived in Switzerland after the outbreak of the Syrian civil war in 2011. Syrian mental healthcare professionals were excluded, as the purpose was to explore general perceptions by lay people from Syria, rather than perceptions influenced by professional training. People with (a history of) mental health disorders were excluded as well. The KIs were selected based on answers from an earlier qualitative study among 30 Syrian refugees and asylum seekers in Switzerland, in which interviewees were asked to list persons whom they deemed knowledgeable about the problems of Syrian refugees and asylum seekers in Switzerland (i.e. integration into Swiss society, language problems, social issues at home, medical and psychological issues, etc.) (Kiselev et al., submitted).

2.1.2. Healthcare providers

Healthcare providers were invited from the professional network of the Centre for Victims of Torture and War in Zurich. These KIs were selected based on their experience in working with Syrian refugees and asylum seekers in Switzerland.

2.1.3. Other stakeholders

Non-Syrian professional stakeholders, such as representatives of Swiss authorities or (non-Syrian) religious leaders, were invited to participate in the stakeholder interview. They were either mentioned by the participants of the previous study or were identified from the professional network of the Centre for Victims of Torture and War in Zurich.

2.2. Interviewers

Arabic language interviews were conducted by Syrian research assistants – one male and one female. Other interviews were conducted in German by two female master students in clinical psychology (MK & FH). All interviewers had prior interviewing experience and were trained (by NM & NK) in practising open-ended interviewing.

2.3. Procedure

Interviews were conducted in Arabic or (Swiss-) German depending on the participant's mother tongue. All interviews were audiotaped, transcribed verbatim and Arabic transcripts were translated into English by professional interpreters. However, the translation was made as close as possible to the original source.

Informed consent was obtained orally (since we did not ask about any personal or health-related questions there was no necessity for written informed consent). There were no monetary or other incentives for participation.

2.4. Analysis

Qualitative data analysis was completed using thematic analysis with a combination of deductive and inductive approaches (Joffe, 2012). NK and MB initially examined the dataset to create a coding framework. Two independent coders (FH & MK) employed the existing coding framework on roughly 20% of the full dataset. The interrater reliability was k = .91. This allowed a split of the original data such that FH and MK coded an equal number of interviews. Subsequently, the coded dataset was analysed by deducing the prevalence of themes and examining the relationship between codes regarding the mutual occurrence or group differences. Analysis was performed using NVivo 11 software (International, 2015).

3. Results

To support a general overview of all barriers, the summarized results for barriers (section 3.2, 3.3, and 3.4) are presented first and the explanation of each barrier can be found in the subsections (3.3.x and 3.4.x).

3.1. Demographics

Interviews (N = 14) with Syrian KIs (n = 5), healthcare care providers (n = 5) and other stakeholders (n = 4) lasted between 45 and 90 min. Five stakeholder interviews were planned for this subgroup as well. One stakeholder could not be interviewed due to illness. The professional background of the KIs is presented in Table 1. All KIs were older than 18 years, and nine out of 14 KIs were female. Thirteen KIs had a university degree and one had graduated from high school.

3.2. Overall overview on reported barriers to access

The most prevalent barrier to use mental healthcare services mentioned across all KI groups (93%) was a mismatch between the Western system of diagnosis and treatment and problems and needs perceived by Syrians. Twelve (86%) KIs mentioned a lack of awareness followed by 11 (79%) reporting fear of stigma and a lack of resources. Detailed results are presented in Table 2. The single barriers and explanations are presented below (subsections 3.3.x and 3.4.x).

3.3. Structural treatment barriers

Five structural barriers were mentioned (Table 3): (a) a lack of resources, (b) language, (c) gatekeeper-related problems, (d) not understanding how the health system works, and (e) bureaucracy and complex procedures. These and their subcategories are explained subsequently. Subcategories mentioned only once (i.e. lack of childcare opportunity and transport costs) are not included in the table. Lack of doctors is used for lack of both psychological (psycho-)therapists and medical (psycho-)therapists.

3.3.1. Lack of resources

Along with general statements concerning resources, a lack of resources was specified as facing long waiting lists, and a lack of doctors, financial means, translators, childcare opportunity and transport costs. KI criticized that there are not enough resources available to screen refugees and asylum seekers for mental disorders, nor to refer them to counselling services or to communicate with or treat them adequately. This is also reflected by the lack of specialized treatment programmes for traumatized refugees and asylum seekers, apparent from this asylum coordinator's comment:

Table 1. Professional background of the participants in KI interviews.

Nr.	Syrian key informants (SKI)	Healthcare providers (HCP)	Stakeholders (SH)
1	Administrator of refugee shelter [f]	General practitioner (GP) [f]	Priest of a refugee church [m]
2	Legal consultant at asylum centre [f]	Psychotherapist [f]	Politician [f]
3	Dentist [m]	Gynaecologist & Family doctor (GP) [f]	Municipal refugee coordinator [f]
4	Actress [f]	Head of the psychiatric outpatient clinic [m]	Integration mediator [f]
5	Head of an association of Syrians in Switzerland [m]	Medical director of psychiatric hospital [m]	

Full sample N= 14; [] is referred to the gender of the participant (f – female, m – male).

Table 2. Percentages of treatment barriers.

Treatment barrier			
Structural barriers	Frequency	Socio-cultural barriers	Frequency
Lack of resources	11 (79%)	Mismatch between Western system and Syrian problems and needs	13 (93%)
Language	10 (71%)	Lack of awareness	12 (86%)
Gatekeeper	10 (71%)	Fear of stigma	11 (79%)
Not understanding the system	5 (36%)	Gender aspects	5 (36%)
Bureaucracy and complex procedures	4 (29%)	Basic needs are prioritized	4 (29%)

Full sample N = 14; Barriers or sub-barriers mentioned only once are not included.

Table 3. Percentages of structural treatment barriers.

Structural barriers		Subcategory	
Name	Frequency	Name	Frequency
Lack of resources	11 (79%)		
		Long waiting lists	9 (64%)
		Lack of doctors	8 (57%)
		Lack of financial means	6 (43%)
		Lack of interpreters	5 (36%)
Language	10 (71%)		
Gatekeeper	10 (71%)		
		Lack of knowledge	5 (36%)
		Restrictive doctor	2 (14%)
		Restrictive social worker	2 (14%)
Not understanding the system	5 (36%)		
Bureaucracy and complex procedures	4 (29%)		

Full sample N= 14; Barriers or sub-barriers mentioned only once are not included.

These services need to be extended. […] We have war refugees, that is, specific cases of women torture [gender based violence], female circumcision, rape, which, I believe, need to be treated by specialized institutions offering intercultural expertise. (SH 3)

A psychotherapist and medical director of a psychiatric hospital (HCP 5) also confirmed the need for more specialized mental healthcare services for refugees and asylum seekers.

Other major barriers were long waiting lists and a lack of doctors offering mental health treatment to refugees and asylum seekers:

There are too few treatment units such as the trauma center at […] it takes up to three years until someone gets a place for treatment. (SH 2)

The long waiting period could also lead to some sort of resignation, as a general practitioner reported: '*you register [refer] them and then it takes ages*' (HCP 1). The State Council (SH 2) indicated '*that's why I think my people [e.g. refugees coordinators, social workers] most often already resigned and don't even register people anymore*'. The medical director of a psychiatric hospital added that '*we don't have the capacity to have enough well-trained therapists for patients that are traumatized in a specific way*' (HCP 5).

Another frequently mentioned barrier is the lack of interpreters. All but one of the healthcare providers mentioned the absence of qualified interpreters helping to translate during the therapy session. While HCPs and SHs reported a lack of funding for interpreter costs, Syrian KIs reported the inability to pay for the treatment itself. Yet, the mandatory basic health insurance in Switzerland should cover healthcare costs, as this asylum coordinator explained:

So that they can find psychologists and psychiatrists? Yes, that is possible. Each person has basic insurance and as soon as there is a referral, theoretically, it would be [possible], as long as the health insurance covers the costs [of the interpreter or of the treatment], for us then it's possible. (SH 3)

However, according to the medical director of a psychiatric hospital (HCP 5), funding of interpreters seems to depend on the Canton, while the other one (HCP2) complained about interpreter's costs not being covered. Other barriers such as lack of childcare opportunity for women and transport costs were mentioned once each.

In sum, Syrian refugees and asylum seekers, healthcare care providers and stakeholders suggest more resources are needed to provide adequate mental healthcare. Especially, a lack of specialized treatment units leads to long waiting lists for treatment and a lack of interpreters plus their unregulated cost bearing further complicates the provision of care.

3.3.2. Language

KIs stated that there is a general communication problem due to language barriers. The medical director of a psychiatric hospital (HCP 5) elaborated on the consequences of language barriers:

We, as an institution, grant access to treatment to any patient regardless of ethnicity, religion, gender or age, that is in theory, that's how it should work, but in reality, and I see that a lot, that patients who don't know English or French, but as an example just a little bit of German and Arabic, then it's often said that treatment isn't possible. We see cases where we know that treatment would be necessary, but it isn't possible [because of the language barrier], so we have to terminate the treatment. (HCP 5)

That a treatment is not conducted due to language problems is related to the view of one provider who said that '*it is not enough if they speak a bit of English or French, they have to express themselves in their [own] language*' (HCP 2). Not being able to communicate properly can result in undetected and undiagnosed mental health problems, because '*refugees can't make themselves clear, […], simply due to the linguistic barrier*' (SH 4). This points out the great importance of well-trained interpreters. The interpreter-related problems were further underlined by the example of the

general practitioner (HCP 1) that has a dilemma when parents bring children as their interpreters:

> I can't interpret with a 12-year old child [who translates for their parent] that's already difficult regarding a somatic suffering […] because I don't know if he [the child] translates […] properly. Because a child doesn't know what it's all about. And when it even gets more complicated [during the course of the therapy], it will definitely not work. But sometimes, they [the patients] do that, just a 12-year old child, that translates stuff, because obviously, he [the child] can do it better, knows the language better [than the parent]. That's a gap filler solution, because probably it's a little bit too hard to get somebody [translating]. (HCP 1)

Another issue related to communication problems raised concerns the engagement in therapy: '[health] professionals, they then certainly can't explain [to the patients] why this therapy would be necessary or how this therapy works' (SH 2). Finally, a Syrian KI (SKI 2) explained that many Syrians are not familiar with the Latin alphabet and therefore face difficulties in finding the appointment with their health professional services (e.g. reading of bus timetables, reading of written invitation to the appointment, etc.).

3.3.3. Gatekeepers

There are two types of gatekeepers working with refugees and asylum seekers: medical gatekeepers and authorities. Medical gatekeepers are family doctors or local internists that are responsible for the referral of the patient to the specialized healthcare. Authority gatekeepers are social workers and related persons like refugee and asylum seekers coordinators who decide whether a person may visit a doctor or not.

Most KIs pointed out that mental health problems are under- or misdiagnosed by general practitioners and remained veiled from social workers. This could possibly be due to a lack of resources, as stated by a psychotherapist:

> My opinion is that the social workers have too few resources and do not have the possibility to get to know the clients they are responsible for and to understand better what kind of situation they are in. (HCP 2)

More specifically, a medical director of psychiatric hospital (HCP 5) pointed out that a lack of trained staff involved in the referral to mental healthcare services could also be a reason for not identifying symptoms of distress. Second, the general practitioner (HCP 3) and the state council (SH2) questioned whether the initial detection of possible patients in the group of refugees and asylum seekers is sufficient:

> I'm there when they're already coming, I'm not recruiting them. […] who goes into the accommodations and looks there. But it is probably also difficult to pick out the people. (HCP 3)

> … care givers [refugee coordinators or staff working with refugees] […] should notice when [a refugee] should be referred to a [mental health] professional. (SH 2)

Both general practitioners (HCP 1 and 3) expressed the need for more information on where to refer distressed refugees:

> There are no clear guidelines how to proceed. Everybody just does what he thinks is right. That's missing […]. It's just a chaos. (HCP 1)

A recurrent barrier concerned 'restrictive doctor/ social worker' because the referral to mental healthcare services is dependent on the evaluation of one person, either the general practitioner or the social worker. In Switzerland, an asylum seeker or refugee usually needs the approval of a social worker or asylum doctor before being allowed to visit a specialist. One KI expressed concerns about the equality of access to treatment:

> But if the doctor, for example, is suspicious and thinks, all the asylum seekers are taking advantage

Table 4. Percentages of socio-cultural barriers.

Socio-cultural barriers		Subcategory	
Name	Frequency	Name	Frequency
Mismatch between Western system and Syrian problems and needs	13 (93%)		
		Lack of trust in system	3 (21%)
		Fear of mistreatment	3 (21%)
		Distrust of doctors	2 (14%)
		Culturally based explanations of mental illness	1 (7%)
Lack of awareness	12 (86%)		
		Lack of mental health awareness	10 (71%)
		Lack of awareness of rights or opportunities	4 (29%)
Fear of stigma	11 (79%)		
		Hard to ask for help	7 (50%)
		Need to maintain privacy	3 (21%)
		Psychological problems are taboo	3 (21%)
Gender aspects	5 (36%)		
Basic needs are prioritized	4 (29%)		

Full sample N= 14; Barriers or sub-barriers mentioned only once are not included.

of Switzerland and on top of that they fake being psychologically distressed, […] then it can be really bad. Then it can get horrible for some people who really are suffering. (SH 1)

In summary, social workers and general practitioners act as gatekeepers when it comes to the initial detection of psychological symptoms. As this results in one single person deciding whether or not the refugee and asylum seekers are referred to mental health services, a bottleneck may be a probable outcome.

3.3.4. Other structural barriers

The two less often discussed structural barriers: bureaucracy and complex procedures, and 'not understanding the system', relate to a fairly complex health system, which appears to be difficult to understand (e.g. referral pathways, health cost coverage) especially for persons coming from abroad. In particular, lack of transparency about where to go and what to do in case of medical or psychological problems seems to be a big difficulty for the target population.

3.4. Socio-cultural barriers

Five socio-cultural barriers emerged from the KI interviews: a mismatch between the Western system of diagnosis and treatment and the problems and needs experienced by Syrian refugees and asylum seekers, fear of stigma, lack of awareness, gender aspects and that basic needs are prioritized. Detailed results are presented in Table 4.

3.4.1. Mismatch between western system and Syrian problems and needs

Besides general statements regarding a potential mismatch between the Western system of diagnosis and treatment on the one hand, and the problems and needs experienced by Syrian refugees and asylum seekers on the other hand, there was the possibility to specify the code into culturally based explanations, fear of mistreatment, distrust of doctors and lack of trust in systems (Table 4). Most comments referred to a general mismatch between the Swiss system of treatment and diagnosis and the needs of Syrian refugees and asylum seekers [In fact, the term 'mismatch between Western system (of diagnosis and treatment), and Syrian problems and needs were never directly mentioned by participants. The term was applied to summarize reported statements accumulatively]. This is reflected in the experience of the professional that treatments need to be culturally adapted to be effective. Specifically, KIs mentioned that in the Syrian culture for the majority of people, a different concept of mental health service use exists. KIs mentioned that it is not common to see a professional for mood-related problems:

> But it's really unconventional that somebody would say, I see a psychiatrist because I have difficulties with my life or depression. One always says you can talk to your mother and with your friends. This is the way it is in Syria. (SKI 1)

Furthermore, a woman working at social services (SH 4) stated that in the Arab culture it is easy to talk about being mentally distressed, but at the same time, it is very uncommon to seek professional help for such a problem. A priest of a church for refugees and asylum seekers, working as intercultural consultant, confirmed this as well by saying:

> In their culture, you don't see a psychiatrist or someone like that, that's a huge exception, I would say. They sort out problems in their families, in this family, there they live and fight and argue, and that's some sort of therapy as well. That's not like here [Switzerland] where somebody maybe lives alone and then, at one point, it's just normal that he'll see a psychiatrist. (SH 1)

In addition to this different concept of mental health, there is also a lack of trust in the local health system, partly reflected in a distrust of doctors and fear of mistreatment. For example, a Syrian KI said that Syrians are *'not trusting the doctor and assuming that he doesn't believe their complaints'* (SKI 3). Furthermore, he explained that Syrians are also afraid of not receiving proper care, and are hesitant to take medications:

> Aspirin and painkillers are ok, but as soon as it gets more complicated or if you say something to sleep better, it doesn't work at all. Up to now I've never achieved this [giving medication for psychological problems] not even in the smallest dose […]. They somehow always think that it will change them. […]. He [a refugee] will throw it in the trash right away. (HCP 1)

As for culturally based explanations of mental illness, it was mentioned once by a Syrian KI that religious beliefs play a role in their perception of the reasons for their suffering.

3.4.2. Fear of stigma

Syrian KIs and Swiss KIs explained it could be shameful for Syrians if someone else knew they are seeking psychological help. A Syrian KI pointed out that this is mostly due to prejudices against mental illness:

> They still think everybody who has a psychological problem is crazy. Or that they can't live a normal life. (SKI 1)

These prejudices may influence others, because *'their negative views may affect the surroundings, that*

visiting the doctor is useless' (SKI 3). According to the Syrian KIs, when someone decides to seek professional help, there is a need to maintain privacy, as mental health problems are usually kept inside the family and *'it is uncommon to talk about psychological problems in Arab countries'.* (SKI 2)

Together with not talking about issues related to mental health, it also seems to be difficult to ask for help:

> Asking for help is admitting that there is a problem. There are people who do not like to admit that they have problems and they always want to be in complete charge of their lives. (SKI 3)

Altogether, the difficulty of asking for help might pose a barrier to accessing mental healthcare, such as starting psychological treatment or searching for psychological help anonymously.

3.4.3. Lack of awareness

General statements referred to a lack of awareness about all aspects of health (health illiteracy), such as not knowing about possible positive consequences of prevention and therefore resulting in a general bad health. A general practitioner stated *'they're not even aware that they are traumatized'* (HCP 3). This may be reflected in help-seeking behaviour, which was stated as mostly for physical complaints:

> For example, a headache can be psychological, and the doctor can't do anything and yes, they say then, the physicians don't get me. They can't help me. They prescribe Paracetamol, but this doesn't help. Not like the doctors in Syria, they were different. You often hear this. They [refugees] are convinced that they have actual physical problems. (SKI 1)

A general practitioner (HCP 1) and the medical director of psychiatric hospital (HCP 5) confirmed this pattern and another Syrian KI explained, *'they don't accept [when a doctor makes a] link between skin problems and their psychological problems'* (SKI 2). However, the medical director of a psychiatric hospital (HCP 5), the general practitioner (HCP1) and two Syrian KIs suggested that Syrians with higher education and those who have been here for longer show more mental health awareness.

Furthermore, many KIs mentioned a low level of attention being paid to mental health not only by Syrians, but also on a national level by Swiss politicians. This could be related to the subcategory 'lack of awareness about rights and opportunities', as all statements regarding this topic referred to Syrian refugees and asylum seekers not knowing which point of contact they should go to when they feel distressed or whether they have a right to see a therapist. One Syrian KI explained: *'if someone would show them that they need help and how they could get this help, they would do it'.* (SKI 1)

All in all, not being aware of one's own mental health, the pathways to get proper help and its effectiveness seem to present significant barriers to accessing mental healthcare services.

3.4.4. Other socio-cultural barriers

Other socio-cultural barriers included gender aspects in healthcare-seeking behaviour and the prioritization of basic needs over mental health problems. KIs mentioned that seeking psychological care is especially difficult for Arab men, as psychological support is perceived as a threat to their concept of masculinity. KIs furthermore mentioned that mental health is not the focal point of attention of refugees and asylum seekers, as there are other issues perceived as more urgent, such as finding a job or housing problems.

4. Discussion

Despite high levels of mental healthcare needs, refugees and asylum seekers still show low mental healthcare utilization (Lay, Lauber, Nordt, & Rössler, 2006; Maier et al., 2010; Satinsky et al., 2019). Yet, despite the low utilization, Switzerland's mental healthcare system is already overloaded with the number of refugees and asylum seekers and recognizes the need for new approaches to face this issue (Müller et al., 2018; Oetterli et al., 2013; Spycher, 2016). This study aimed to identify possible barriers to accessing mental health services among Syrian refugees and asylum seekers in Switzerland. Five main structural and socio-cultural barriers emerged. Healthcare providers, stakeholders and Syrian KIs identified a mismatch between the Western system of treatment and diagnosis and problems and needs perceived by Syrians, followed by a lack of awareness, fear of stigma, lack of resources, language and gatekeeper-associated problems. These barriers were mentioned by almost 75% of the respondents.

In a study examining characteristics of mental health referrals, language barriers including interpreter-related issues were to some extent responsible for unsuccessful referrals (Shannon et al., 2015). A recent report for the Swiss Federal Office for Public Health strongly supports these findings (Müller et al., 2018). The authors stated that providing care for refugees and asylum seekers is challenged by communication problems, largely due to a lack of covered interpreter services (Müller et al., 2018; Oetterli et al., 2013). Additionally, the survey under Swiss outpatient mental health professionals identified lack of funding for interpreters as the second frequently mentioned barrier that prevents professionals from treating more refugees and asylum seekers (Kiselev et al., under review). This is closely related to a lack of financial means. Two KIs reported high costs for psychological treatment as barrier to

accessing mental healthcare. However, all healthcare costs are covered by the basic health insurance indicating a lack of knowledge on healthcare coverage and mental healthcare in general. It also reveals a lack of knowledge about the cost coverage of interpreter services among healthcare providers. Finally, there is a lack of official guidelines as it seems that both professionals and patients do not know how to deal with situations where trained interpreters are needed.

Long waiting lists due to the lack of resources for specialized treatment were a frequently mentioned barrier. This was already reported in a former report to the State Secretariat of Migration. However, only about a third of interviewed refugee and asylum seekers coordinators reported this as a barrier at that time (Oetterli et al., 2013). In the present study, eight out of nine Swiss KIs endorsed that long waiting lists were a problem in accessing mental healthcare. Oetterli et al. (2013) conducted their study before the start of the European refugee crisis in 2015, and since then, the pressure on the healthcare system may have increased, due to the high influx of (Syrian) refugees and asylum seekers in Switzerland. Over the last years, the waiting period for specialized treatment for refugees and asylum seekers in Zurich varied several times in the range of six to 18 months (Schick & Schnyder, 2017).

The third key barrier found in this study refers to gatekeeper-associated problems. This was also found in a study about mental healthcare referrals, where providers fail to make proper referrals (Shannon et al., 2015). Maier et al. (2010) found that doctors rarely refer refugees and asylum seekers to mental health services, even though there are no legal or financial restrictions regarding any kind of psychiatric treatment for asylum seekers in the Swiss healthcare systems. Another study reported that refugee or asylum status may influence the treatment decision of health professionals in a negative manner (Drewniak, Krones, Sauer, & Wild, 2016). This study showed a significantly lower willingness of general practitioners to treat a person with refugee or asylum status in comparison to the regular citizens or labour immigrants.

Furthermore, this study indicates a lack of medical professionals who are specialized in working with refugees and asylum seekers. This is a common structural barrier, not specifically mentioned in earlier studies but included in the report to the State Secretariat of Migration, resulting in long waiting lists for refugee and asylum seeker patients (Oetterli et al., 2013).

In contrast to recent studies (Bartolomei et al., 2016; Kayrouz et al., 2015; Oetterli et al., 2013), refugees' and asylum seekers' lack of understanding of how the local health system works was only mentioned in about a third of interviews and clearly was a less apparent barrier in our study. Also, we neither found logistical issues nor transitory asylum seeker status as prevalent barriers. Only two respondents mentioned problems associated with refugees' and/ or asylum seekers' transitory status, saying that the N status (i.e. temporary residence permit during asylum procedure) implies an insecure length of stay and therefore treatments might not be provided.

Regarding socio-cultural barriers, preceding studies consistently found stigma, a lack of mental health awareness and mismatch between the Western system of diagnosis and treatment on the one hand and the problems and needs experienced by refugees and asylum seekers on the other hand as key barriers (Shannon et al., 2015; Wohler & Dantas, 2017).

A study in Switzerland among caregivers showed that asylum seekers' negative opinion of psychiatry and fear of being stigmatized were the two major reasons for not seeking care (Bartolomei et al., 2016). Yet, another study conducted in Switzerland among traumatized migrants found that despite little mental health knowledge, prejudices and fear of stigma, participants still attended psychotherapy (Maier & Straub, 2011). This finding may be explained by statements in our study that suggest the duration of stay in Switzerland has a positive influence on the rate of help-seeking. Maier and Straub (2011) finding may therefore partly be explained by the refugees' and asylum seekers' time spent in Switzerland.

Regarding mental health awareness, Hassan et al. (2015) explained that Syrians often express mental problems in the form of physical symptoms. This supports our finding that Syrians tend to talk about their physical pain rather than their psychological distress. Al-Krenawi (2005) points out that people of the Arab culture show a different help-seeking behaviour as their first support system in times of psychological problems is their own family, followed by the family practitioner. Furthermore, Hassan et al. (2015) point out that suffering is seen as a normal part of life, not necessarily requiring an intervention. This is in accordance with our finding that among the Syrian population a different concept of mental health service use exists. This is an important finding in relation to research showing that culturally non-responsive and non-adapted treatments are the main reason for mental healthcare referrals not being successful among refugee and asylum seeker populations (Shannon et al., 2015).

Slightly contradictory to previous studies (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015; Morris et al., 2009) only few interviewees in the present study reported on gender matching being important in

healthcare delivery. Further, in our sample, neither family issues nor religion or religious beliefs seem to play a major role in mental healthcare access. Religious beliefs and their role in the perception of the reasons for the suffering were mentioned only once. Family issues were mentioned twice. The result regarding religious beliefs was unexpected since usually religious beliefs play an important role in Middle Eastern populations, especially among Muslims (Ahmed & Amer, 2013), and the opinion of the religious leader can influence a person regarding the utilization of professional mental healthcare (Pluess, Moghames, Chehade, McEwen, & Pluess, 2019). The fact that the transport costs were mentioned only once is not surprising given that, in Switzerland, refugees and asylum seekers are strongly dependent on social or refugee welfare during the first years of their stay in Switzerland. In case of travel to the indicated healthcare services, transport costs are covered by the local authorities. Lack of childcare opportunities for women was also mentioned only once. This low number was expected in the context of Switzerland as a highly developed welfare state, as there are several possible solutions for childcare, in cases of medical needs.

4.1. Limitations

This study has a number of limitations. It is a study that reflects the perspective of a small number of selected key informants, comprising Syrian refugees and asylum seekers, health professionals and other professional stakeholders. The selection method may have created a sampling bias as healthcare providers were selected depending on their expertise and the researchers' professional network. Furthermore, the inclusion criteria for Syrian KIs (i.e. no history of mental health problems, participants from the German-speaking part of Switzerland) further limits the perspectives on barriers to healthcare access.

An additional limitation might be the strong focus on barriers on the side of Syrian refugees and asylum seekers rather than on possible barriers on the side of mental healthcare providers or supervisors of refugees and asylum seekers. It needs to be mentioned that it is unknown whether mental health professionals in Switzerland are properly prepared to treat refugees and asylum seekers. For example, professionals may present with stigma concerning refugees and asylum seekers, which might contribute to mistrust among their (potential) patients. Furthermore, Western assessment tools may be inadequate for diagnosis and treatment of Middle Eastern populations (e.g. somatization of psychological problems) (Hassan et al., 2015; Rohlof, Knipscheer, & Kleber, 2014). Also, a bridging process between the professional assessment of the problem and the treatment

needed and the patient's concepts on being medicated, which should take place before offering medication, may be lacking. Finally, interviews only assessed perceived barriers and there was no question on actual help-seeking behaviour. Furthermore, we did not look at data on service utilization among refugees and asylum seekers. In addition, it has been shown that not every perceived barrier has an effect at a behavioural level (Maier et al., 2010), so it remains unclear which specific barrier should be removed to actually increase mental health service utilization. Further research should examine individual barriers, their possible interdependence, and influence on the access to mental healthcare services in greater depth. This should be kept in mind as our study was exploratory in nature and thus aimed at collecting all possible perceived barriers from the perspective of professionals and stakeholders working with Syrian refugees and asylum seekers and of Syrian refugees and asylum seekers themselves.

4.2. Practical implications and conclusion

In summary, Syrian refugees and asylum seekers in Switzerland face multiple structural and socio-cultural barriers to accessing mental healthcare with socio-cultural barriers being more prominent. Based on these findings, there are several implications for the Swiss health system, which are presented in the following section accompanied by our suggestions:

Social workers, refugee and asylum seekers coordinators and general practitioners, as the main gatekeepers in referring refugees and asylum seekers to mental healthcare in Switzerland, should receive information on the cultural expression of distress and training in diagnosing refugee and asylum seeker patients as proposed by Maier et al. (2010). Concerning the problem of initially reaching refugees and asylum seekers, who might be in need of mental healthcare, a short systematic screening conducted by trained staff working in the asylum centres could help identifying these persons. Additionally, clear guidelines for general practitioners on how to proceed when a refugee and asylum seeker show signs of psychological distress could be beneficial (including creating and updating of a list with all contact points/services available). This guideline should also entail information on the funding of treatment and interpreters, as this seems not to be transparent for a large part of the healthcare professionals and gatekeepers.

Finally, due to the fact that further refugee and asylum seeker influx like the significant refugee and asylum seeker influx in 2015 can emerge at every moment of time, we suggest a holistic approach to tackle the current situation successfully. In addition to increasing flexibility and adapting mental healthcare services regarding single, identified barriers and needs

of a new target population, we suggest to focus on increasing the agility of the entire service system to allow more innovative paths to continuously meet the emerging needs of (emerging) target populations. Agility is understood as the capability to pro-actively adapt to unexpected changes and provide customer-centric services through the integration and configuration of different resources as well as best practices in a knowledge-driven context in a fast-changing market environment (Goldman, Nagel, & Preiss, 1995; Tolf, Nystrom, Tishelman, Brommels, & Hansson, 2015; Yusuf, Sarhadi, & Gunasekaran, 1999).

Tackling the problem of lack of resources currently, counselling programs such as Problem Management Plus (PM+) could be one possible solution (Dawson et al., 2015). This is a scalable psychological intervention that can be conducted by non-professional, such as refugees and asylum seekers themselves, under the supervision of mental health professionals (Sijbrandij et al., 2017). This programme is expected to be more cost-efficient compared to standard professional treatment. Furthermore, using Syrian non-professionals can help to overcome the treatment gap for Syrian refugees and asylum seekers with mental disorders and thus might reduce waiting lists for treatment. It will also bypass the lack of trained interpreters as providers of PM+ do not only speak the same language as the recipient, but also know the cultural expressions and idioms of distress. This is in line with the results of the situational analysis on treating migrant patients, where it was concluded that the provision of services could be enhanced by low-intensity psychological treatments and making better use of employees from the same cultural background (Oetterli, Laubereau, Krongrava, Essig, & Studer, 2017). Interventions conducted by lay therapists seem to be effective as a recent meta-analysis showed (Singla et al., 2017), which compared studies in which non-specialist provided interventions in low- and middle-income countries. The results show medium to strong effects for symptom reduction among people with common mental health disorders who were treated by lay therapists.

To take on the most common socio-cultural barrier, a mismatch between the local health system and problems and needs as perceived by Syrians, idioms of distress and cultural illness models need to be considered. This would allow better communication, as interventions can be explained better (Hassan et al., 2015). In PM+, this may be done by employing peer-refugee acting as non-professional 'therapists' from the same cultural background and by culturally adapting the PM+ program (or any other evidence-based program) to the assessed Syrian needs and problems. With this, the implementation of the PM + program complies with the proposal of Kaczorowski et al. (2011) recommending that an intervention should be established within the community to respond better to a potential distrust in mental health professionals.

Next to PM+, other interventions, e.g. telepsychiatric interventions, could be considered (Jefee-Bahloul, Moustafa, Shebl, & Barkil-Oteo, 2014). However, given that Switzerland is one of the countries with the highest density of mental healthcare professionals in Europe, face-to-face interventions may be feasible in the Swiss context. Nevertheless, telepsychiatric interventions might be an alternative to conventional approaches by minimizing stigma-related barriers.

Closely related to this, ensuring confidentiality and building trust is of great significance to address the fear of stigmatization. Referrals were more often successful when providers established trust before referring their refugee and asylum seeker patients to mental health professionals (Shannon et al., 2015). To address lack of awareness, psychoeducation, especially a biopsychosocial view on health, could be provided. It has been shown that this results in more successful referrals to mental healthcare (Shannon et al., 2015). Yet, when addressing 'mental health illiteracy', dictating Western models of mental health should be avoided (Colucci et al., 2015).

In conclusion, the review of the results of our study regarding the barriers to accessing mental healthcare for refugees and asylum seekers in Switzerland shows that barriers still exist and do not seem to have improved over recent years. The results of the present study are in line with previous findings. We suggest that a possible solution for the current situation is to, in addition to addressing single barriers and needs of new target populations accessing the existing healthcare services, to increase the agility of the service system as a whole, and to explore innovative delivery methods for mental healthcare, such as involving Syrian refugee themselves as providers of low-intensity lay-counselling interventions.

Note

1. In Switzerland, an asylum seeker is a person who has already applied for asylum in Switzerland but is not yet recognized as refugee. In the present study, we assessed both asylum seekers and refugees. We, therefore, refer to 'refugees and asylum seekers' throughout the manuscript.

Availability of data and material

The datasets are available upon reasonable request from the corresponding author.

Disclosure statement

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ORCID

Nikolai Kiselev http://orcid.org/0000-0003-0617-0353
Matthis Schick http://orcid.org/0000-0002-8212-6277
Marit Sijbrandij http://orcid.org/0000-0001-5430-9810
Anne M. De Graaff http://orcid.org/0000-0001-6686-4432
Peter Ventevogel http://orcid.org/0000-0002-3567-8861
Daniela C Fuhr http://orcid.org/0000-0001-9020-4629
Naser Morina http://orcid.org/0000-0002-6470-4408

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