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Perceived barriers to access mental health services for refugees and asylum seekers: a systematic review of qualitative studies

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Abstract

Background Previous experience of violence and other traumata as well as post-migration stressors affect the mental health of refugees and asylum seekers. There is a fundamental gap between mental health needs and care utilization. To address this gap, it is important to understand the perceived access barriers to mental health care among refugees and asylum seekers. This review analyzed the barriers using Penchansky and Thomas' (1981) concept of access.

Methods A systematic review of qualitative studies was conducted in April 2024 by two independent reviewers. The search included three databases: PubMed, Web of Science and PsycINFO. Studies published since 2013, with self-reported barriers or hurdles to access mental health services by legal adult refugees or asylum seekers were included. Information about the study design and setting, participant characteristics, and reported barriers to mental health care utilization were extracted. Risk of bias was assessed by the Mixed Methods Appraisal Tool. Due to the high heterogeneity, a narrative analysis was chosen.

Results 25 studies were identified. Barriers were social and cultural factors as well as a lack of awareness. Here, most prominent was the negative stigmatization of mental health and misinformation about mental health services. Furthermore, language barriers hinder refugees and asylum seekers to seek help. Accommodation was a rarely mentioned barrier.

Discussion The reported access barriers occurred in a specific combination of country of origin and destinations. In contrast to previous studies, we identified the refugees' and asylum seekers' fear of experiencing discrimination and the perceived lack of benefits of therapy as barriers. Refugees and asylum seekers had a preference to solve mental health problems by getting support in their social environment. Epistemic injustice and the relationship between different barriers highlight the complexity of access barriers. The generalizability might be limited.

Conclusion Self-reported access barriers among refugees and asylum seekers are multidimensional. Access barriers occur within the health care system as well as within the refugees' and asylum seekers' community. A rise in awareness, acceptability, and availability of mental health services is needed to ensure adequate care. Furthermore, cultural and religious differences between the providers and the refugees and asylum seekers should be considered.

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Keywords Refugee, Mental health, Barriers, Treatment

Background

The number of refugees and asylum seekers worldwide has tripled in the last 10 years from 12.9 million in 2013 to 36.6 million in 2023 [1]. According to the *1951 Convention and Protocol Relating to the Status of Refugees* a refugee is characterized as a person who has a well-founded fear of persecution or human rights violations and is therefore in a country of which he or she is not a citizen [2]. Refugee status is formally recognized by the host country [3]. In addition, an asylum seeker is someone who has left his or her country due to the same reasons as a refugee and has claimed asylum but has not yet been legally recognized as a refugee [4, 5].

Refugees and asylum seekers frequently experience a disproportionately high burden of mental health conditions, including a high prevalence of disorders such as depression and posttraumatic stress disorder (PTSD) [5–11]. This can be attributed to their extensive exposure to risk factors, including traumatic events and violence, both before (pre-migration stressors such as violence in their country of origin or inadequate mental health services), during (peri-migration stressors such as challenges with transportation and hygiene during forced migration) and after their flight (post-migration stressors affecting somatic and mental health upon arrival in the host country) [12]. This increased vulnerability leads to a significant and often unmet need for mental health care [10]. Furthermore, specific groups, such as refugees with particularly stressful experiences [12] and asylum-seeking women [6, 13, 14] show an even higher prevalence of depression, anxiety, and PTSD than other migrant groups or the host population. Their mental health is also negatively associated with various post-migration factors and social determinants, including the duration of displacement [5, 9, 15], the length of stay in temporary accommodations such as asylum centers [8, 11] and their economic situation, including work permits and income [5, 8, 9, 11, 16, 17]. Given this profound need and the complex interplay of these factors, it is reasonable to hypothesize that refugees and asylum seekers encounter additional, specific barriers when accessing mental health services, which are attributable to structural and cultural differences in healthcare provision in the host country.

Despite this apparent need and the hypothesized barriers, empirical data reveal low utilization rates of mental health services by refugees and asylum seekers. Doocy, Lyles [15] analyzed the patterns of health service utilization by Syrian refugees in Jordan and found that mental health services accounted for 1.4% of service utilization. The minority of immigrants, including refugees, in Canada who acknowledge their own emotional problems got help by a professional. The same study identified severe emotional problems and perceived stress as access barriers to health care services [16]. Furthermore, McCrone, Bhui [18] reported high unmet needs among Somali refugees in the UK due to low utilization of mental health services and high mental health needs. A cross-sectional survey documented treatment gaps of 88–90% for PTSD, anxiety and depression among Syrian refugees in Turkey [19].

To address these treatment gaps, it is important to understand the access barriers perceived by refugees and asylum seekers. Penchansky and Thomas [20] introduced access as a concept, that describes the match between patients and the health care system, where multidimensional barriers lead to underutilization of needed services and unsatisfied patients. A perceived lack of outpatient services, due to access barriers, can lead to higher utilization of hospital care, when perceived as substitute by the patient [20]. Studies in the refugee and asylum seeker population indicated that mental disorder is strongly stigmatized, which may leads to social exclusion if the illness is known in the community [19, 21–23]. Nevertheless, refugees tend to seek help from others than mental health professionals [16]. Lack of information about services and language barriers [19, 21, 22], as well as costs of treatment [19] were identified as problems in seeking professional help.

Existing reviews on mental health care access barriers for refugees often focus on specific regions or populations, or do not differentiate between refugee and other migrant groups, or between patient and professional perspectives [4, 22, 24–27]. Some also cover general healthcare rather than exclusively mental health [28, 29]. These reviews highlight differences in the health care utilization between refugee and non-refugee migrants. Immigrants, including refugees perceived barriers to access health care in Europe, including financial barriers, unfamiliarity with the host country's language, misunderstanding of the system, and discrimination. Refugees and undocumented migrations faced additional legal barriers [28]. In addition, Szajna and Ward [29] found discrepancies in the perceived access barriers to health care. Refugees reported a fear of discrimination from the provider, other refugees, or the host government, while providers did not perceive this barrier.

To our knowledge, no previous review has comprehensively focused on mental health access barriers that were perceived by adult refugees and asylum seekers in a worldwide setting, nor has distinguished between quantitative and qualitative findings. Quantitative studies aim to test given hypotheses and usually report mean values of larger populations that are evaluated by standardized questionnaires. This means, they usually anticipate answers or

more specific they ask for predefined barriers [30]. Qualitative studies provide more insights into social, emotional, and personal aspects by giving the participants the opportunity to use their own words and addressing their unique perspectives [30]. Qualitative methods include interviews, either individual or in focus group, which allow for more in-depth responses to questions and the development of a conversation on the topic in question [30, 31]. In order to increase service utilization and improve mental health outcomes, there is an urgent need to obtain a thorough understanding of access barriers described by the affected population. It is the objective of this review to gather and present information from this unique perspective.

Focusing on the adults and qualitative research allows to qualify the problem of access barriers by obtaining first-hand experience and in-depth information. These findings enable the development of appropriate, effective and target interventions within the health care system and communities. Children and adolescents are not taken into account, as their frequent role as unaccompanied minors makes them a vulnerable group whose needs deserve special attention and should be dealt with in a specific review.

Methods

This systematic review follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [32]. The objectives, methods and data analysis were specified in a registered protocol (CRD42024498821) at PROSPERO (International Prospective Register of Systematic Reviews).

Search strategy

The search was conducted in April 2024 within three databases: PubMed, Web of Science and PsycINFO. Additionally, article references were searched for relevant publications. The predefined search strategy based on synonyms of the terms [1] access, barrier or utilization [2], mental health service or help-seeking, and [3] refugee or asylum seeker. The full search strategy is provided in Appendix 1. The time period selected for the search was 1 January 2013 to 16. April 2024. This time frame was chosen to ensure relevance to contemporary access issues, aligning with the recent global increase in refugee and asylum seeker populations and major crises [33, 34].

Eligibility criteria

Qualitative studies were included in the review if they met the following criteria [1]: published between 2013 and the final search (16. April 2024) [2], included the population of adult refugees or adult asylum seekers, and [3] examined the perceived barriers to access mental health services by refugees or asylum seekers. To ensure accuracy in data extraction and assessment only studies published in languages spoken fluently by the authors were included (English and German). Studies that were excluded from the review [1]: had a non-qualitative design [2], included non-adults [3], considered illegal, undocumented or internal refugees or asylum seekers [4], documented barriers that were reported only by others than refugees or asylum seekers e.g. health care providers or social workers [5], examined perceived barriers to access that were not explicitly reported in a mental health service context, or [6] documented intervention-specific barriers or barriers that were the result of policy intervention.

Study selection

After the database search, duplicates were removed. The screening process for relevant articles was conducted in three steps: title, abstract, and full text screening. The first and second author (RT and LK) independently completed each screening step. Disagreements between the individual judgments were resolved by discussion. If a disagreement could not be solved, a third reviewer (CB) was consulted. Furthermore, article references were checked for additional relevant studies. The software system Endnote 21 was used to support study selection.

Data extraction and thematic analyses

The extracted data included the authors and year of publication, information about the study design, method and setting, participant characteristics, and all reported barriers to mental health care utilization. Barriers were only extracted when reported by refugees or asylum seekers and categorized according to the theoretical framework. If needed, the authors of the included studies were contacted. RT conducted the data extraction in excel spreadsheets. LK reviewed the datasheet for accuracy.

A potential risk of bias was considered by using the qualitative category of the Mixed Methods Appraisal Tool (MMAT) [35]. RT and LK appraised the quality of the included studies independently and discussed any disagreements. If a disagreement could not be solved, CB was consulted.

Due to the heterogeneity of the included studies, the results were analyzed using a narrative method. Perceived barriers were counted in frequency and grouped into key themes according to the concept of access by Penchansky and Thomas [20].

Theoretical framework

Penchansky and Thomas' [20] concept of access is used in this systematic review to categorize and discuss the findings. It was developed to ease the understanding of the relationship between patients and the health care system and considered five dimensions of access: affordability, availability, accessibility, accommodation and acceptability. The concept has been applied several times, including in mental health care studies [25, 36, 37]. Various studies added

further dimensions of access, such as awareness by Russell, Humphreys [38], Saurman, Kirby [39], and Saurman [40], as well as stigma and help seeking by Satinsky, Fuhr [25]. In addition to Penchansky and Thomas's five dimensions [20], we included awareness, language barrier, social and cultural barriers (including stigma), and other barriers, as these often represent personal access dimensions specific to refugees and asylum seekers. All categorized barriers are presented in Table 3. The dimensions are defined as:

- Affordability focuses on the price of the service, the patient's ability to pay for the service and patient's perception of the service as worth the money [20].
- Availability describes the match between existing services and the actual need for services [20], which can include personnel resources e.g. quantity of service and waiting time as well as the referral system.
- Accessibility considers the location of services and the location of patients, including the necessary resources to arrive at the service point [20], including the distance to services and transportation opportunities.
- Accommodation describes the organization of services and the ability of patients to use them, e.g. service hours and appointment system [20].
- Acceptability describes patients´ attitude towards acceptable providers and the actual characteristics and vice versa, this can include gender, ethnicity, social class and type of coverage [20, 25]. Access barriers related to the patient-provider relationship.
- Awareness describes patient's knowledge about their health needs and about existing services to meet these needs, patients understanding who services are for, what they do, when, where and how to access and use them, as well as maintaining of that knowledge. Furthermore, information about services need to be appropriate and aware of the local context and population needs [40].
- Language barrier occurs when the patient and the provider do not share a common language [41]. Communication is fundamental to accessing the health care system, includes the learning about services and health [42], and allows the health care providers to understand the patients´ beliefs about health and illness and interpret complaints [41, 43].
- Social and cultural barrier includes stigma and prejudices toward mental health and mental health services. These can result in shame, status loss, and discrimination [25]. Furthermore, the understanding of psychopathology differs between culture as well as the acceptance of mental health care [44].
- Other barriers includes barriers, which do not fit clearly in another dimension.

Nevertheless the dimensions of access are not completely separated, they affect each other [20] and are influenced by the context [39]. For instance, it is conceivable that a lack of language knowledge could affect the availability of service due to the need for an interpreter. There may also be barriers in respect to the accessibility of services caused by potential problems with using public transport, or the inability to make an appointment by themselves (accommodation). Insufficient language proficiency can lead to a lack of awareness of mental health services due to missing comprehensible information. The dimension help seeking, as implemented in the concept of access by Satinsky, Fuhr [25], was not included in the main analysis, but will be discussed. Help seeking refers to a person's preference of an adaptive coping process and the attempts to seek help by others than professionals [25]. While 'help seeking' may influence service utilization, we do not categorize it as an access barrier, as it represents a personal choice. Classifying it as such would imply that professional help is the sole 'correct' approach, potentially leading to epistemic injustice (cf. [45]).

Results

Study selection

The screening process is illustrated in the flowchart in Fig. 1. The database search resulted in 7060 articles from which 2094 duplicates were removed. After the title and abstract screening, 59 potentially relevant studies were identified for the full text screening. 35 studies were excluded, see Fig. 1 for the reasons of exclusion. One additional study was identified through article references. This resulted in $n = 25$ eligible studies for inclusion in this review.

Quality assessment

To appraise the quality of the included studies the quality assessment tool MMAT was used [35]. For each study, all questions were answered with "Yes". Therefore, the studies demonstrated no methodological quality concerns.

Study and participant characteristics

The systematic review includes 25 studies [46–70]. Twelve studies used focus group discussions [46, 50, 52, 55, 59, 61–66, 70], eleven studies semi-structured interviews [47–49, 51, 54, 56, 58, 60, 68–70], and three studies in-depth interviews [53, 57, 67]. The sample size ranged from 5 to 310 participants [50, 54, 57], with a mean number of 41 participants. Four studies focused on barriers perceived by female participants [46, 49, 54, 70] and one study interviewed only Muslim men [61]. Some studies focused on specific mental disorders or previous traumatic events [46, 50, 52, 58, 62, 70]. As asylum seekers are people who have applied for asylum but have not yet been recognized as refugees, they are sometimes

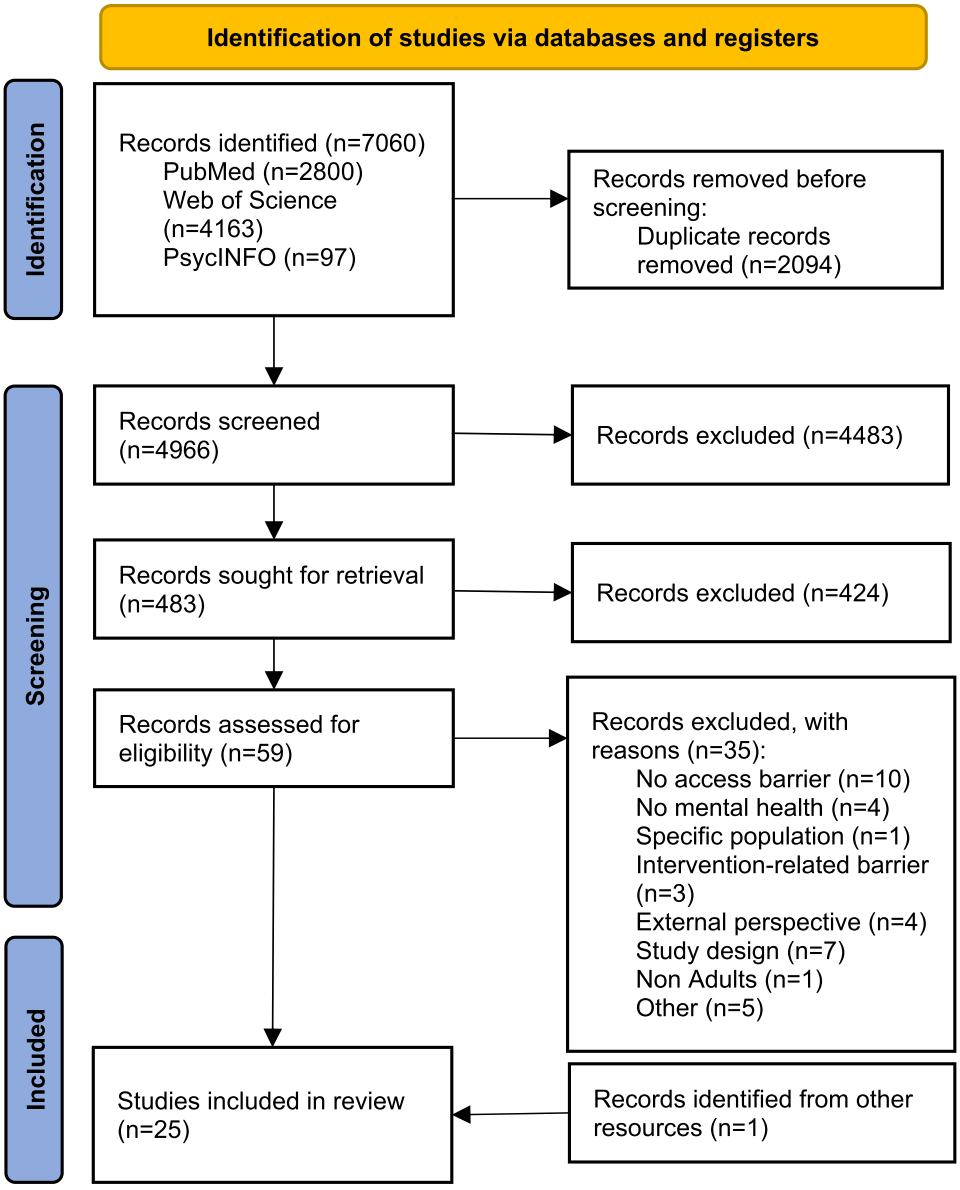

Fig. 1 Flow diagram

generally referred to as refugees [46, 49, 57, 68]. Most of the included studies did not specify whether asylum seekers were included or excluded in the term *refugees*. Their inclusion was explicitly mentioned in five studies [49, 55, 57, 64, 68], while Valibhoy, Szwarc [69] excluded asylum seekers. The remaining studies presented in Table 1 did not specify the status of the participants. In eleven studies, refugees and asylum seekers arrived in the destination country less than 10 years ago [46, 48, 51, 55, 58, 62, 65, 66, 68–70]. Other studies had a longer timeframe of arrival, while six studies did not report the time of arrival [47, 50, 52, 59, 60, 64]. See Table 1 for more details.

Most studies were conducted in Australia [49, 51, 53, 54, 58, 61, 64, 69, 70] and the United States of America [48, 56, 63, 65–67]. The most frequent regions of origin were Syria [46, 47, 52, 57, 60, 62, 68], Afghanistan [49, 51, 64, 68, 70] and Myanmar [50, 56, 65, 70]. Table 2 shows the origin of the participants and where they have fled to. Most studies reported a flight of greater distance (80%) while a short distance e.g. to neighbor countries were reported by 24%.

Reasons for migration were not explicitly reported, except for two studies, which focused on the migration due to war in Syria and Bosnia [52, 54]. An exodus or a forced migration can be based on an interaction between different factors in the country of origin. These factors can manifest as conflict, insecurity, war, violation of human rights, genocide, torture, persecution due to their sexual orientation, political-oppositional stance or religion, famine, political instability [72]. These factors may also apply to

Table 1 Study and participant characteristics

No.	Author (Year)	Context (country)	Time period	Sampling method	Interview type and time	Design of thematical analysis **	Participants	Sample size (% female)	Age (range/mean)	Time since arrival (% of sample)	Specific disorder
[46]	Ahmed et al. (2017)	Canada	N/A	Purposive sampling	1 focus group discussion 90 minutes	Emergence and inductive approach (Strauss & Corbin 2008)	Syrian refugee women, who were pregnant or less than one year postpartum	n = 12 (100%)	20–37 years	Less than 9 months (92%)	58% possible depression 50% possible anxiety
[47]	Bawadi et al. (2022)	Jordan	May - December 2019	Purposive sampling	16* semi-structured individual interviews 15–60 minutes	Inductive approach	Syrian refugees	n = 16* (37.5%)	18–65 years	N/A	None
[48]	Branam et al. (2023)	USA	April - June 2020	Convenience sampling	10 in-depth semi-structured individual interviews 30–60 minutes	Inductive, iterative approach using flexible coding (Deterding & Waters 2021)	Kurdish refugees from the Iraq	n = 10 (50%)	23–58 years	Less than 5 years	None
[49]	Burford-Rice et al. (2022)	Australia	October 2016 - May 2017	Convenience and snowball sampling	11 semi-structured individual interviews Average 60 minutes	Inductive approach (Braun & Clarke 2013) Deductively analysis using Andersen's model of determinants of health care utilization (Andersen & Newman 1973)	Afghan Hazara women refugee and asylum seeker	n = 11 (100%)	18–60 years Mean: 30 years	5 month – 16 years Mean: 6.8 years	None
[50]	Chynoweth et al. (2020)	Bangladesh Italy Kenya	July 2018 - May 2019	Local and international humanitarian agencies engaged community mobilizers to recruit refugees.	55* semi-structured focus group discussions	Thematic analysis with initial coding Codes were analyzed using a social ecological framework	Rohingya refugees in Bangladesh Refugees, who traveled the central Mediterranean migration route in Italy Eastern Democratic Republic of the Congo, Somalia and South Sudan refugees in Kenya	n = 310* (N/A)	15–65 years	N/A	Most have second- and third-hand accounts of sexual violence Some disclosed their own victimization
[51]	Copolov & Knowles (2023)	Australia	December 2015 - January 2016	Convenience and snowball sampling	18 semi-structured individual interviews 60–90 minutes	Deductive thematic analysis with modified interview schedule (Tempany 2008) and inductive components (Braun & Clarke 2006, 2013)	Afghan and Pakistani Hazara refugees, who are Shi'a Muslims	n = 18 (50%)	18–30 years	1 - 16 years Average: 7.17 years	None

Table 1 (continued)

No.	Author (Year)	Context (country)	Time period	Sampling method	Interview type and time	Design of thematical analysis **	Participants	Sample size (% female)	Age (range/mean)	Time since arrival (% of sample)	Specific disorder
[52]	Doğan et al. (2019)	Turkey	June - August 2018	Purposive sampling	4 focus group interviews 60 minutes	Phenomenological interpretation method Colaizzi (1978)	Syrian, who were monitored in a specialized refugee mental health polyclinic	n = 24 (58.3%)	18–63 years	N/A	Diagnosed with mental disorders, 75% did not know their diagnosis
[53]	Fauk et al. (2021)	Australia	N/A	Snowball sampling	20* in-depth individual interviews	Framework approach (Ritchie and Spencer 1994) Framework was developed deductively and inductively	Refugees from eight different African countries	n = 20* (50%)	18–60 years	1 - 20 years	None
[54]	Karakas & du Plooy (2024)	Australia	August 2019	Purposive sampling	5 in-depth semi-structured individual interviews 45–70 minutes Average 55 minutes	Inductive approach (Braun and Clarke 2006)	Bosnian refugee women, who previously accessed mental health services	n = 5 (100%)	50–69 years	18 - 26 years	None
[55]	Khanom et al. (2021)	Wales	N/A	Convenience sampling	8* semi-structured focus groups interviews 45–80 minutes	Framework analysis (Levesque et al. 2013)	Refugees and asylum seekers and from 13 different countries	*N* = 50* (48%) n = 26 refugees n = 24 asylum seekers	21–68 years	3 days – 6 years	None
[56]	Kim et al. (2021)	USA	N/A	Convenience sampling	11 semi-structured individual interviews 35–120 minutes Average 80 minutes	Inductive approach (Braun and Clarke 2006)	Burmese refugees, various ethnic community leaders (Karen, Burman, other)	n = 11 (45%)	20–73 years Mean: 41 years	1.5 - 20 years Mean: 9.6 years	None
[57]	Kiselev et al. (2020)	Switzerland	June - August 2017	Snowball sampling	5 in-depth individual interviews 45–90 minutes	Deductive and inductive approaches (Joffe, 2012)	Syrian refugees and asylum seekers	n = 5* (60%)	> 18 years	Arrived after 2011	None
[58]	McCann et al. (2016)	Australia	N/A	Purposive sampling	28 in-depth semi-structured individual interviews with young refugees 4 focus group discussions with adults 20–90 minutes	Inductive approach (Braun and Clarke 2006)	Sub-Saharan refugees, young or adults (parents or community leader)	*N* = 69 (39.1%) n = 28 young refugees (35.7%) n = 41 adults (41.5%)	Young refugees: > 16 years Mean: 20 (SD: 3.7)	Young refugees: less than 6 years (89%) Parent and community leader: 6–10 years (78%)	Young refugees had experience with mental health or substance use problems

Table 1 (continued)

No.	Author (Year)	Context (country)	Time period	Sampling method	Interview type and time	Design of thematical analysis **	Participants	Sample size (% female)	Age (range/mean)	Time since arrival (% of sample)	Specific disorder
[59]	Mutiso et al. (2019)	Kenya	N/A	Purposive and saturation sampling	4* focus group discussions	Content analysis (Wynaden et al., 2005).	Somali refugees	n = 60* (50%)	Adults and adolescents	N/A	None
[60]	Noubani et al. (2020)	Lebanon	N/A	Convenience, snowball and purposively sampling	18 semi-structured individual interviews Average 15 minutes 2 group model building workshops	Thematic analysis including open coding, themes and subthemes	Syrian refugees	*N* = 43* (51%) n = 18 interviews n = 25 workshops	> 18 years	N/A	None
[61]	Omar et al. (2017)	Australia	October 2013 - March 2014	Through primary researcher's African networks	5 semi-structured focus group interviews 90–120 minutes	Inductive approach (Thomas, 2006).	Horn of Africa Muslim men refugees	n = 36 (0%)	18–29 years 40–60 years	7 months – 25 years	None
[62]	Öztürk et al. (2024)	Turkey	November - December 2021	Purposive sampling	3 semi-structured focus group interviews Average 60 minutes	Phenomenological interpretation method Colaizzi (1978)	Syrian refugees	n = 19 (63.2%)	Mean: 36 years	Mean 8.52 years	High share of mental disorders, One third had attempted suicide.
[63]	Poudel-Tandukar et al. (2019)	USA	August - December 2016	Convenience snowball sampling	8 focus group discussions Approximately 60 minutes	Two-step interpretative analysis. Barriers were sorting into three primary domains of the PEN-3 cultural model (Airhihenbuwa et al. 2014)	Bhutanese refugees	n = 67 (49.3%)	18–65 years Mean: 38 (SD: 15.9)	5 years or more (56.7%)	None
[64]	Saberi et al. (2021)	Australia	2014	Snowball sampling	2 semi-structured focus group interviews 2 semi-structured individual interviews Average 75 minutes (female) and 115 minutes (male)	Inductive approach with line by line coding (Braun and Clarke 2012)	Hazara refugee women and asylum seeker men	n = 15 (46.7%)	18–29 years	N/A	None
[65]	Shannon et al. (2015)	USA	2009 – 2011	N/A	13 semi-structured focus group interviews 90–120 minutes	Thematic categorization into domains, categories, themes, and subthemes (Spradley 1979)	Bhutanese, Karen, Oromo and Somali refugees	n = 111 (43%)	18–78 years	Mean 1 - 5 years	None
[66]	Soukenik et al. (2022)	USA	February - April 2020	Convenience and parallel sampling	1 focus group discussion 90 minutes	Thematic analysis using open, axial and selective coding (Saldaña, 2016).	Bhutanese and Nepalese refugees	n = 6 (50%)	20–50 years Mean: 31.75 (SD: 12.5)	Mean 10 years (SD: 0.816)	None

Table 1 (continued)

No.	Author (Year)	Context (country)	Time period	Sampling method	Interview type and time	Design of thematical analysis **	Participants	Sample size (% female)	Age (range/mean)	Time since arrival (% of sample)	Specific disorder
[67]	Tonui (2022)	USA	N/A	Snowball and purposive sampling	13 in-depth individual interviews 40–90 minutes	Phenomenological interpretation method (Colaizzi 1978)	Rwandan refugees	n = 13 (23%)	> 18 years	1.5 - 21 years	None
[68]	Trueba et al. (2023)	UK	June - July 2018	Purposive and snowball sampling	9 semi-structured individual interviews	Thematic analysis by categorizing barriers (Saldaña 2016)	Afghan, Sudanese, Syrian refugees Afghan asylum seekers	*N* = 9* (33.3%) n = 7 refugees (43%) n = 2 asylum seekers (0%)	17–30 years	Less than 5 years	None
[69]	Valibhoy et al. (2017)	Australia	N/A	Purposive sampling	16 semi-structured individual interviews 60–120 minutes	Inductive approach analysis (Braun and Clarke 2006)	Refugees, who had attended mental health services from 9 different countries	n = 16 (56.3%)	18–25 years	Less than 6 years (56.3%)	None
[70]	Willey et al. (2020)	Australia	April - July 2018	N/A	1 focus group interview 17 semi-structured individual interviews	Inductive approach (Braun and Clarke 2006) and deductive approach	Refugee women, including asylum seekers (Burmese or Dari speaking Afghan) Migrant women	*N* = 22 (100%) n = 17 refugee women n = 5 migrant women	N/A	Less than 6 years (68.2%)	High risk of anxiety symptoms (50%) Risk of major depression (31.8%)

* The study considered a sample with refugees, asylum seekers, and others (provider, community leader, social worker, stakeholder etc.). Only participants with refugee or asylum seeking background and without a medical background were considered in this review

** Detailed information of the references can be found in Appendix 2

Table 2 Path of migration

Country of origin (ethnical community)	Country of destination	Mentioned in
Afghanistan (including Hazara)	UK	[68]
	Australia	[49, 51, 64, 70]
Bhutan	USA	[63, 65, 66]
Bosnia	Australia	[54]
Democratic Republic of the Congo	Kenya	[50]
Ethiopia (Oromo)	USA	[65]
Iraq (Kurdish)	USA	[48]
Kenya (Oromo)	USA	[65]
Myanmar (Burmese, Karen, Rohingya)	Bangladesh	[50]
	Australia	[70]
	USA	[56, 65]
Nepal	USA	[66]
Rwanda	USA	[67]
Somalia	Kenya	[50, 59]
	USA	[65]
South Sudan	Kenya	[50]
Sudan	UK	[68]
Syria	Lebanon	[60]
	Jordan	[47]
	Switzerland	[57]
	UK	[68]
	Canada	[46]
	Turkey	[52, 62]
Region of Origin		
Horn of Africa	Australia	[61]
Sub-Sahara	Australia	[58]
8 African countries[1]	Australia	[53]
Refugees, who traveled the central Mediterranean migration route[2]	Italy	[50]
9 countries[3]	Australia	[69]
13 countries[4]	Wales	[55]

[1]: includes the Democratic Republic of Congo, South Sudan, Liberia, Sierra Leone, Burundi, Ethiopia, Kenya, and Somalia

[2]: including most commonly Egypt, Tunisia, Bangladesh, Syria, Cote d'Ivoire, Guinea, Pakistan, Eritrea, Cameroon, Algeria, other [71]

[3]: includes Iraq, Afghanistan, Iran, Sudan, Pakistan, Tanzania, Ethiopia, Côte d'Ivoire, and Democratic Republic of the Congo as Country of birth

[4]: includes Albania, Afghanistan, Angola, Bangladesh, Ethiopia, Iran, Iraq, Libya, Malaysia, Pakistan, Syria, Vietnam, Zimbabwe

the participants in the included studies, either in combination or individually. For example, there are war, violence or conflicts in Afghanistan, Syria, South Sudan [72], Congo, Ethiopia, Myanmar [33], Rwanda [34]. Civil conflicts and war were migration drivers for many African refugees [53, 73]. Ethnic groups often experience traumatic events [48], such as Afghan Hazara women that have suffered human rights violations under the Taliban regime [49].

Access barriers

Table 3 and Appendix 3 provide an overview of perceived access barriers. While frequency of reporting is noted, it does not necessarily reflect a barrier's importance, as data collection often involved semi-structured interviews allowing for free participant reporting rather than structured assessment of predefined barriers.

Affordability

Financial issues constituted a significant barrier [47, 50–53, 57–60, 62, 66, 68, 69], encompassing direct service and medication costs [47, 51–53, 58–60] and medication [51, 52], as well as general financial constraints [50, 57, 62, 66, 68, 69]. For instance, African refugees in Australia prioritized essential needs like school uniforms or electricity bills over additional mental health services not covered by insurance [53].

Availability

Fourteen studies highlighted a mismatch between available and needed mental health services [47, 50–57, 60, 62, 65, 66, 68], with seven specifically noting limited service quantity [47, 50, 51, 56, 57, 60, 66]. This included a lack of culturally responsive services in the USA [56, 66], absence of local services in Jordan and the UK [47, 68], and no interpreter-based services in Wales [55]. Specialized services for specific groups, like male survivors of sexual violence, were also lacking, alongside poor referral systems [50]. Misdiagnosis by general practitioners [53, 57] and excessively long waiting times [52–56, 62] further hindered access Furthermore, fear of legal repercussions, such as deportation or negative impacts on visa status, deterred refugees from seeking care [51, 65]. Male survivors of sexual violence in Bangladesh and Kenya faced legal charges for exposing their sexual orientation as a result of the criminalization of same-sex sexual relations and the LGBTQ±community [50].

Accessibility

Available mental health services need to be at the right place. The placement of the service was perceived in half of the included studies as a barrier [47, 50–53, 55, 57, 59, 60, 62, 66, 68, 69]. A great distance, the necessity to travel to services or inadequate services nearby were mentioned in seven studies [47, 51, 53, 59, 60, 68, 69]. A lack of transportation options was named in Jordan and the USA [47, 66] as well as high costs according to get to the service e.g. public transportation [47, 50, 52, 53, 55, 57, 62, 68].

Accommodation

Service organization, particularly appointment systems, was a reported barrier in five studies [52, 55, 57, 62, 64]. Refugees often struggled with booking appointments due to language barriers [52, 55, 62, 64] including difficulties with online systems [62] and reading the Latin alphabet [57].

Acceptability

60% of the included studies documented barriers related to acceptability of services and of providers [47, 50, 51,

Table 3 Key barriers

Dimension	Key barrier	N	Mentioned in
Affordability	Service	7	[47, 51–53, 58–60]
	Financial constraints	6	[50, 57, 62, 66, 68, 69]
Availability	Quantity of service	7	[47, 50, 56, 57, 60, 62, 66]
	No service	4	[47, 50, 55, 68]
	Entry points and referral system	3	[50, 53, 57]
	Waiting time	3	[53, 55, 56]
	Trustful services without fearing legal consequences	3	[50, 51, 65]
Accessibility	Cost of transportation	8	[47, 50, 52, 53, 55, 57, 62, 68]
	Distance to services	7	[47, 51, 53, 59, 60, 68, 69]
	Transportation to service	2	[47, 66]
Accommodation	Appointment system	5	[52, 55, 57, 62, 64]
Acceptability	Mistrust the doctor	7	[51, 54, 57, 59, 60, 66, 69]
	Provider were different in culture and religion	6	[56, 58, 61, 64, 66, 69]
	Privacy concern against the service providers	5	[47, 50, 55, 61, 62]
	Untrained providers	3	[50, 59, 64]
Awareness	Unaware about mental health services	13	[50, 51, 53–58, 63, 65–67, 69]
	Unaware about mental health (understanding and unrecognized needs)	10	[49, 50, 53, 55–58, 65, 67, 70]
	Believed mental health is not a problem or not treatable	5	[47, 56, 59, 64, 69]
	Linked mental disorders with physical conditions (misconception)	4	[47, 49, 51, 57]
	Believed in service threshold	2	[58, 69]
	Believed problems get better without help or over time	2	[47, 59]
Language barrier	Lack of language skill	7	[49, 51, 56, 57, 59, 66, 68]
	Language barrier (no further explained)	6	[52, 56, 62, 63, 67, 70]
	Lack of interpreter	6	[50–52, 55, 59, 62]
	Bad quality of interpreter (professional or family member)	3	[55, 59, 62]
	Privacy concerns regarding the interpreter	3	[46, 52, 63]
Social and cultural barrier	Stigma	15	[46–48, 51, 53, 56–60, 62, 64, 65, 69, 70]
	Cultural conception of mental health and service utilization	11	[47, 49–51, 53, 56, 58, 60, 61, 67, 69]
	Distrust/dislike the kind of therapy	10	[48, 51, 54, 57, 60–63, 65, 69]
	Lack of perceived benefits	9	[47, 48, 50, 53, 61, 63, 65, 69, 70]
	Shame	7	[50, 53, 56, 57, 65, 69, 70]
	Fear of discrimination and racism	7	[49, 50, 52, 53, 59, 62, 69]
	Fear of social isolation	6	[49, 50, 53, 56, 64, 65]
	Cultural norm	6	[48, 53, 63–65, 69]
	Fear, that someone in the community will know	5	[46–48, 50, 63]
	Fear of family reputation and security	5	[49–51, 58, 65]
	Mistrust or fear of medications	4	[54, 55, 60, 61]
	Mismatch between Western system of diagnosis and perceived needs or culture	4	[51, 57, 66, 69]
	Husband as a gatekeeper	4	[46, 47, 49, 53]
	Seen as god punishment, bad karma or possession by evil spirit	4	[53, 56, 57, 60]
	Fear of gossip	2	[48, 69]

N: Number of studies reporting key barrier

54–62, 64, 66, 69, 70]. Refugees distrusted the doctor's ability to treat their condition properly [51, 69]. Syrian refugees and asylum seekers in Switzerland, Somali refugees in Kenya, Syrian refugees in Lebanon, and Bhutanese and Nepalese refugees in the USA distrust the physician without further explanation [54, 57, 59, 60, 66]. A particular concern was the confidentiality of the service providers [47, 50, 55, 61, 62]. Syrian refugees reported, that one Arabic-speaking physician handled all Syrians, and when the hospital was crowded treated patients simultaneously [62]. Providers were also perceived as untrained for their situation and limited in cultural competence [50, 59, 64]. The ability of the providers to appropriate treat and prescribe their condition was

questioned by Syrian refugees in Lebanon [60]. Refugees and asylum seekers from various countries of origin, who had migrated to the USA or Australia, named the difference in culture or religion between the provider and themselves as a barrier to seek professional help [56, 58, 61, 64, 66, 69].

Awareness

Limited knowledge about mental health services and disorders, leading to unawareness and unrecognized needs, was reported in 76% of studies [47, 49–51, 53–59, 61, 63–67, 69, 70]. This included insufficient awareness of available services and the healthcare system [50, 51, 53–58, 63, 65–67, 69], with Bhutanese refugees noting a lack of culturally appropriate information [63]. Perceived service thresholds, where treatment was only for severe disorders, also acted as a barrier [58, 69].

Low mental health literacy manifested as misunderstanding disorders and failing to recognize symptoms [49, 50, 53, 55–58, 65, 67, 70]. Refugees had insufficient information about mental health [50, 57, 65, 67], such as men who did not recognize that sexual victimization can be associated with mental health issues [50] and women in Australia who were reluctant to accept depression diagnoses [70]. Some refugees stated that mental health problems are not treatable [47, 59, 64, 69] or a non-permanent problem, which will get better over time and without help [47, 59]. Mental health problems were also linked to physical conditions such as migraines or stomach aches [47, 49, 51, 57].

Language barriers

Language barriers were documented in 60% of the studies [46, 49–52, 55–57, 59, 62, 63, 66–68, 70], which led to challenges to express the mental health problems to the providers. While some mentioned their own lack of language skills and inability to talk to health professionals [49, 51, 56, 57, 59, 66, 68], a lack of interpreters [50–52, 55, 59, 62] or their poor quality [55, 59, 62] was also mentioned. Poor quality was caused by different dialects and incorrect or incomplete knowledge of medical terms by professional interpreters [55]. Somali refugees in Kenya described the usage of family members with higher language skills as informal interpreters but also mentioned concerns about misinterpretation of symptoms and incorrect translations [59]. Fear of disclosure if an interpreter was involved, especially if the interpreter belonged to the same community, was mentioned by Syrian refugee women in Canada and Turkey and Bhutanese refugees in USA [46, 52, 63]. Refugees in Italy [50] discussed the lack of cultural mediators and interpreters as a potential communication barrier to seek help. Relatedly, Soukenik, Haran [66] reported a lack of providers who spoke the same language as the refugees and a lack of linguistically appropriate services for Bhutanese and Nepali refugees in the USA. Burmese and Karen refugees explained a linguistic challenge based on the fact, that there is no equivalent word for mental health in their language or it equals craziness, which makes it difficult to understand the correct meaning and the translation even through an interpreter [56].

Social and cultural barriers

Social and cultural barriers, reported in 84% of studies showed little regional variation. Prominent among these was the negative stigma of mental disorders, often perceived as 'craziness' or dangerous [46–48, 51, 53, 56–60, 62, 64, 65, 69, 70]. alongside feelings of shame and embarrassment [50, 53, 56, 57, 65, 69, 70]. Cultural conceptions frequently equated mental illness with 'madness' [49, 56, 69], public exposure [53, 61, 67], or a sign of weakness [58]. Some believed mental disorders were divine punishment or caused by evil spirits [53, 56, 57, 60]. Cultural norms frequently hindered help-seeking [48, 53, 58, 63–65, 69]. Many refugee groups, including Kurdish, Hazara, and Bhutanese, reported a norm against discussing problems, especially mental disorders, driven by concerns about social perception and stigma [48, 63–65]. Beliefs that mental health issues weaken men were also noted [53, 61], as were general norms discouraging direct problem articulation and specific cultural expectations for women not to discuss problematic issues [65]. Additionally, husbands sometimes acted as gatekeepers to mental health services for married refugee women [46, 47, 49, 53].

Social barriers included a pervasive fear of social avoidance and isolation from family or community [49, 50, 53, 56, 64, 65], as seeking mental health care could jeopardize one's social standing Kim, Yalim [56]. Refugees also avoided services due to fear of discrimination or racism from their own community, health professionals, or the host country [49, 50, 52, 53, 59, 62, 69]. Privacy concerns, driven by the strong stigma, led to fears of disclosure within their social circle [46–48, 50, 63], including gossip [48, 69] and negative impacts on family reputation [49–51, 58, 65]. For male survivors of sexual violence, fears of exposure regarding their victimization or sexual orientation further endangered family safety [43].

Barriers related to the nature of mental health services included a lack of perceived benefits [47, 48, 50, 53, 61, 63, 65, 69, 70] and a general distrust or dislike of therapy, particularly psychotherapy [48, 51, 54, 57, 60–63, 65, 69]. Many refugees found talking about trauma counterproductive, preferring to avoid painful memories [51, 54, 61, 63, 65, 69], and some cultural norms discouraged direct eye contact during expression [69]. Fear of medication was also common [54, 55, 60, 61], with concerns about worsening health [55] or routine injections [61]. Furthermore,

a perceived mismatch between Western diagnostic and treatment systems and individual cultural needs often complicated finding suitable services [51, 57, 66, 69].

Barriers only mentioned in one included study

Table 4 presents additional context-specific barriers mentioned in only one study. These included practical issues like missing childcare [57] and bureaucratic hurdles [62], fears of retaliation by abusers [50] or hospitalization [65], and systemic gaps like a lack of trained community representatives [61] or uncertain, temporary support services [68]. Mobility restrictions due to disabilities [50] and intergenerational mental health illiteracy [64] were also reported.

Discussion

This systematic review revealed multidimensional access barriers to mental health services for refugees and asylum seekers, predominantly related to affordability, availability, accessibility, provider concerns, socio-cultural beliefs, and lack of awareness. It is crucial to recognize that many of the barriers apply to other potentially disadvantages populations as well [74, 75], and particularly for those with intersectional vulnerability, such as refugees identifying with the LGBTIQ+ community [76] or survivors of sexual violence [50]. Finally, while we will hereafter focus primarily on frequently reported barriers, we do not wish to dismiss the barriers mentioned once as insignificant. These less frequently reported barriers should inform future research. This is particularly true for barriers that did not fit into a specific dimension and might otherwise be overlooked.

Relationship between different barriers

Affordability barriers often coincided with accessibility barriers. Financial barriers to accessing services were associated with barriers such as great distance to services or a lack of transportation opportunities [47, 50, 53, 57, 59, 60, 62, 66, 69]. Sub-Saharan refugees resettled in Australia had issues with the affordability of services, without the financial situation affecting the accessibility of the services [58].

Four out of seven studies that reported mistrust in health care professionals also reported a lack of language skills [51, 57, 59, 66]. Previous studies linked effective communication and a trusting relationship between providers and patients to adequate health service delivery [77]. Somali refugees in Kenya had privacy concerns and feared misinterpretation if using a family member as interpreter [59]. Communication via interpreters or family members was viewed with suspicion due to potential inaccuracies [59] and was not conducive to a trusting provider-patient relationship [77]. Conversely, the consistent use of interpreters can help build trust and reduce privacy concerns, even if the provider and patient are different in culture or nationality [78].

In addition, the lack of perceived benefits of mental health services was often reported together with a high stigma of mental disorder [47, 48, 53, 64, 69, 70] and shame [50, 53, 65, 69, 70]. Privacy concerns were simultaneously reported with negative social and cultural attitudes towards mental health. Privacy concerns regarding providers or interpreters, alongside fears of community disclosure about mental health service use, were consistently linked to negative stigma, cultural norms, and/or fear of social consequences [46–48, 50, 52, 58, 62, 63, 66, 69]. Negative perceptions of mental disorder have contributed to a lack of access to services, as well as a barrier to information seeking [46].

Table 4 Additional barriers

Dimension	Key barrier	N	Mentioned in
Availability	Support uncertainty	1	[68]
	Postpone appointments	1	[52]
Accessibility	Childcare	1	[57]
	Mobility	1	[50]
Awareness	Lack of trained community representatives	1	[61]
	Parents poor mental health literacy and inability to teach them	1	[64]
Other	Infiltration by spies	1	[65]
	Fear of being hospitalized	1	[65]
	Fear of losing job or house	1	[65]
	Fear of retaliation	1	[50]
	Bureaucracy	1	[57]
	Official regulations	1	[62]

N: Number of studies reporting barrier

Other offers preferred

Refugees' preference for alternative offers may reduce access to mental health services. Syrian refugees in Jordan and Lebanon reported the preference to handle mental health problems by themselves because they do not want to burden others [47, 60], while Bhutanese, Karen, Oromo and Somali refugees in USA feared social isolation [65]. Afghan and Pakistani Hazara refugees in Australia preferred self-help strategies and sports activities [51]. Furthermore, religious practices, such as praying or reading the Quran [49, 55, 56, 61, 64] or talking to religious leaders [53], traditional healers [63] or non-professionals [69] were mentioned to solve mental health problems. Refugees from the Horn of Africa preferred to go to their region of origin for a cultural rehabilitation to solve mental problems. This encompassed practices like marriage, cultural and religious learning, and being with relatives [61]. Other refugees preferred social support from their surroundings. They were more likely to talk to family members [49, 51, 56, 60, 61, 63, 69, 70], and friends [49, 51, 56, 60, 61, 69]

than to a health care professional. Instead of visiting professionals, diverse coping mechanisms were used by Syrian refugees in Lebanon [60]. A larger social network or a high level of social emotional support reduced the odds of common mental disorders, such as depression or anxiety [79] and reduce social isolation, thereby potentially reducing the perceived need for mental health services [26]. Simultaneously, stress caused by loneliness, isolation and low social support were more frequently reported by refugees who were in psychiatric-psychotherapeutic therapy, than by refugees who were not [80].

Differences between refugees and asylum seekers

Although six studies included asylum seekers [49, 55, 57, 64, 68, 70], no significant differences in perceived access barriers were found compared to refugees. While asylum seekers may exhibit a higher prevalence of mental disorders, their service utilization does not necessarily increase [81].

Asylum seekers identified additional barriers, that were related to the resettlement process, including prioritizing housing, employment and food security instead of health care [82]. Furthermore, the access to health services is legally restricted in several host countries for newly arrived refugees and asylum seekers, with most EU countries regulating based on the stage of the asylum claim [83, 84], thereby creating additional legal barriers. The uncertainty of the asylum claim, as a post migration stressor, was associated with anxiety, perceived discrimination and lower social status in the community [64]. We found a reduced frequency of resettlement barriers, legal barriers and the fear of deportation within our review. This may be because the majority of studies focused on refugees with legal residence status. This prohibits the host country from expelling or returning them to their country of origin (see Article 33 of the UN Convention and Protocol relating to the status of refugees) [2].

Contribution to the state of research and practical implications

The findings of this systematic review largely align with other reviews on asylum seekers and refugees, despite the limited number of studies in this area. Other reviews focus on high-income countries [22, 25] or expanded the sample by including providers [4, 24, 27, 29]. Previous systematic reviews documented social and cultural access barriers [22, 25, 26, 29] which led to mistrust against the services and the providers, a preference to seek mental health support from others rather than health care professionals [4, 24], and negative consequences in their own [22, 29] and family's [4, 24] daily life if seeking help. Furthermore, refugees and asylum seekers expressed language barriers [4, 24–26, 29], a dependence on interpreters, who are insufficient in number, and privacy concerns when using a family member as an interpreter [22], and concerns about being deported if they seek mental health care [4, 24].

The external perspective on refugees' and asylum seekers' access barriers, e.g. from service providers in other studies, could be inaccurate and differs from the internal perspective, e.g. refugees [23, 82]. Barriers reported by providers are based on conjecture and their own opinions rather than their own flight experiences [23, 85], which do not necessarily reflect the actual barriers [86, 87]. Therefore, it is important to distinguish between those perspectives [23], while considering both to develop interventions [82]. Providers often underestimated or failed to identify several barriers perceived by refugees, such as fear of discrimination, legal consequences, hospitalization, or mistrust in psychopharmaceuticals [4, 23, 29, 82]. Furthermore, provider-reported barriers often omitted mistrust in Western medicine and discrimination as overarching access barriers to healthcare. Instead, they sometimes attributed mistrust to specific providers, often due to language barriers [82]. Findings on the specific role of interpreters are also notably absent from provider-reported literature. Our review demonstrates that refugees and asylum seekers themselves perceived all of these factors as barriers. Those differences in perceived access barriers may be based on the perspective (internal or external).

The findings of this review emphasize the importance of talking to those affected in order to identify barriers and propose interventions to eliminate them. Qualitative research can address complex issues and report on diversity and context-specific individual perspectives in a way quantitative research cannot. Although qualitative research is scarce in the area of refugee mental health access barriers, it provides the most insights and contributes crucially to the evidence [31]. Although, the generalizability of single studies is constrained by various factors, including the characteristics of the participants, their place of origin and the host countries, each study provides context specific insights. Synthesizing these insights from multiple studies enables the transfer of information into less specific contexts.

The findings of this study indicate a necessity for the promotion of awareness among refugees, asylum seekers, mental health care providers and social workers. However, it is important to acknowledge the heterogeneity of refugee and asylum seekers communities as well as health care systems. Interventions must be unique, as there is no universal approach that can meet the diverse needs [56]. Most of the barriers can be eliminated through interventions within the communities and systems. Refugees and asylum seekers need to be aware of their mental health, including symptoms, causes and treatments [46]. There is a high need to address language differences in the provision of services, e.g. language schools, informational materials in different languages, qualified and accountable

interpreters. Furthermore, education-based programs can address health inequities [69]. Culturally sensitive training for providers, interpreters, and social workers can improve their understanding of refugees' and asylum seekers' mental health concepts and facilitate appropriate problem-solving, potentially reducing mistrust in services [46, 53, 61]. Community and resettlement agencies have the potential to assist refugees and asylum seekers in navigating the health care system [46, 51]. This can be achieved by encouraging members of the refugee community [58, 69] or by collaborating with religious organizations and leaders [67, 69], to ensure more accessible and appropriate care. The implementation of educational programs for refugees and asylum seekers improves their mental health literacy [61, 63] and knowledge about the mental health and health system in the host country [67]. Concurrently, these programs can also contribute to the destigmatization of mental health care utilization [53, 56]. Some barriers affect specific groups, e.g. missing childcare or transportation opportunities are more relevant for mothers and those in rural areas. Older and refugees with lower educational attainment [49], as well as unaccompanied minor refugees are more vulnerable to mental disorders [78] and perceive a mismatch with the Western medicine more often [51].

In addition, it is important that mental health providers understand the barriers to services for a population with refugee background and are aware of social determinants of the resettlement, e.g. social isolation or poverty, can also impact the access and the mental health [49, 51, 61]. Supportive programs in the host countries could improve to deal with resettlement stress and therefore improve newcomers mental health [26]. Kiselev, Pfaltz [57] and Tonui [67] discuss a beneficial effect of a systematic screening by trained staff in asylum centers and guidelines for general practitioners to proceed with refugees' signs of psychological to facilitate entry into mental health care [57].

Strengths and limitations

The strength of this analysis is the state-of-the-art approach. Two reviewers conducted the review in consensus procedure; a third reviewer was contacted to reach consensus, if necessary. All included studies were assessed using a validated quality tool (MMAT [35]). The review followed the PRISMA guidelines [32] and was registered on PROSPERO beforehand. Another strength is the focus on qualitative studies to observe the perceived barriers by refugees and asylum seekers. Qualitative data enables in-depth understanding of internal and population-relevant barriers. In addition, this systematic review included studies that were published within a timeframe ensuring results being up-to-date and relevant to the mist recent international crises. Although nearly 75% of the refugees live in low- and middle-income countries [88], most of the included studies were conducted in high-income countries, which increases their relevance for these countries. However, some high-income countries that offered protection to a large number of refugees, e.g. Germany with more than 3 million, were not considered in the study. Therefore, the transferability of findings to these settings might be complex [89].

This systematic review had several limitations. A limitation is the exclusion of studies not published in English or German, which may have led to neglecting perspectives of refugees in neighboring countries, where research might be published in local languages. In addition, the findings of qualitative studies are difficult to compare because they are specific to the context in which they were conducted. Generalization to other settings cannot be guaranteed. Perceived access barriers of refugees and asylum seekers must be considered in a specific combination of country of origin and destination. Nevertheless, the systematic collection of barriers in this review suggests that some access barriers are common across refugee and asylum seeker populations, irrespective of the specific context. In addition, informal and illegal refugees, child and adolescent refugees, and internally displaced persons were not included. New arrivals were underrepresented, with most refugees having immigrated several years prior. This limits the comprehensive reporting of barriers for newly arrived individuals, as studies suggest longer residency and better language skills correlate with increased health service access [90–92]. Another limitation is a possible publication bias and the fact that the authors of the included studies may have unintentionally failed to report all mentioned barriers. The interviews and focus group discussions were not anonymous, which may have led to reticence or unmentioned barriers, precisely because the topic was highly stigmatized. Finally, a limitation is the absence of benchmark groups in the included studies. Benchmarks would enable the identification of barriers specific to refugees and asylum seekers. Consequently, we cannot exclude the possibility that some reported barriers are general access barriers affecting all segments of the host country's population. For example, it is conceivable that some barriers, such as stigma and a lack of information about services also apply to at least parts of the population. However, a benchmark group is not typical in qualitative studies [31].

Conclusions

This systematic review offers unique insights into the multifaceted access barriers to mental health services as perceived by refugees and asylum seekers. These barriers are closely interconnected. The qualitative nature of the included studies allowed for a profound understanding of the internal perspectives.

Furthermore, the review clarifies that access barriers are not monolithic but are shaped by intersectional

factors: Legal status, cultural and social beliefs, language proficiency, and specific vulnerabilities (e.g., among LGBTIQ+ refugees or survivors of sexual violence) affect the nature and intensity of the perceived obstacles. This underscores the necessity to refrain from one-size-fits-all approaches.

From our findings, specific implications arise:

- Clinicians and Healthcare Professionals: It is crucial to implement culturally sensitive training, ensure qualified interpreter services, and develop a deep understanding of the social determinants of mental health in the context of resettlement. Systematic screenings can facilitate early access to care.
- Policymakers: The removal of legal access barriers in the early stages of the asylum process should be a priority. Policy frameworks should include the promotion of awareness campaigns for destigmatizing mental illness and the funding of needs-based, culturally sensitive care models.
- Service Planners: The development of community-based and participatory approaches, including collaboration with religious organizations and community leaders, is of great importance. Services should consider the preference for alternative coping strategies and social support.

In summary, effective mental health access for refugees and asylum seekers demands a shift from generic solutions to a profound, context-sensitive, and person-centered approach addressing their complex, interconnected barriers.

Appendix

Appendix A: Search strategy

Using:

(Barrier* OR Access* OR Hurdle* OR Obstacle* OR challenge* OR Use OR Usage OR Utilization OR Using*) AND (mental Health OR psychological distress OR mental health service* OR Mental health program OR Help-seeking OR Psychiatr* OR psychotherap* OR post-trauma* OR Therap* OR trauma*) AND (refuge* OR Asylum* OR displaced person* OR ((undocumented OR unauthorized OR illegal) AND immigrant*) OR ((undocumented OR unauthorized OR illegal) AND migrant*)) for title and abstract; year: since 2013.

Appendix B: References of the methodologies of the included studies

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Appendix C: Barriers by included study

No.	Author (Year)	N*	Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Language	Social and cultural barrier	Other
[46]	Ahmed et al. (2017)	4	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	– Fear of disclosure by the interpreter	– Stigma as crazy - Fear, that someone in the community will know – Husband as a gatekeeper	Not mentioned
[47]	Bawadi et al. (2022)	15	– Service costs	– Quantity of service – No service	– Distance to services – Transportation to service – Transportation costs	Not mentioned	– Privacy concern against the service providers	– Mental health is not a problem or treatable - Linked mental disorders with physical conditions (misconception) – Problems get better without help or over time	Not mentioned	- Stigma as crazy, dangerous, unpredictable – Lack of perceived benefits of mental health care services - Cultural conception: depression as feeling down, anxiety as being over worried - Fear, that someone in the community will know – Husband as a gatekeeper	Not mentioned
[48]	Branam et al. (2023)	6	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	– Stigma negatively – Lack of perceived benefits of mental health care services - Mistrust/dislike the kind of therapy - Cultural norm: "Do not talk about it", "It is important how other see you" - Fear, that someone in the community will know – Fear of gossip	Not mentioned
[49]	Burford-Rice et al. (2022)	9	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	– Misconception of mental health as contagious - Linked mental disorders problems with physical conditions (misconception)	– Lack of language skill	– Fear of social isolation – Cultural conception of mental health as mad or crazy – Fear of discrimination and racism – Husband as a gatekeeper – Fear of family reputation and security	Not mentioned

Appendix C (continued)

No.	Author (Year)	N*	Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Language	Social and cultural barrier	Other
[50]	Chynoweth et al. (2020)	17	– Financial constraints	– Quantity of service – No service for male survivors of sexual violence – Entry points and referral system - Trustful services without fearing legal consequences (criminalization of same-sex sexual relations)	– Mobility for refugees with disabilities – Transportation costs	Not mentioned	- Untrained providers, including lack of empathy, humiliating or homophobic comments – Mistrust the doctor	– Unaware of mental health services – Unaware about mental health issues that are linked to sexual victimization	– Lack of interpreter and cultural mediators	- Lack of perceived benefits of mental health care services - Cultural conception – Shame – Fear of social isolation – Fear of discrimination by the provider - Fear, that someone in the community will know – Fear of family reputation and security	– Fear of retaliation by abuser
[51]	Copolov & Knowles (2023)	15	– Service costs – Medication costs	- Trustful services without fearing legal consequences (risk to be deported and effects on the visa status)	– Distance to services as a lack of same language speaking health professionals nearby	Not mentioned	- Distrust health professionals (women who experienced domestic violence) - Concern, that health professionals are not listening and problems are not addressing properly	- Linked mental disorders problems with physical conditions (misconception) – Unaware of mental health services	– Lack of language skills – Lack of interpreter	– Stigma negatively – Western psychological therapies were not helpful or culturally relevant – Dislike therapy and perceived as retraumatisation – Cultural influence as barrier to access – Fear of own or families reputation if services were used	Not mentioned
[52]	Doğan et al. (2019)	8	– Medication costs	- Long waiting time, due to the need of Arabic-speaking psychiatrists – Postpone appointments	– Transportation costs	– Unable to get appointments on the phone due to the lack of an Arabic language option	Not mentioned	Not mentioned	- Lack of Arabic-speaking psychiatrists – Lack of interpreter – No effective communication with the present of an interpreter	- Discrimination by professionals and pharmacies, as shorter treatment time, longer waiting time patients without ID Card were not discharged, the prescriptions were only partially filled or request extra payment	Not mentioned

Appendix C (continued)

No.	Author (Year)	N*	Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Language	Social and cultural barrier	Other
[53]	Fauk et al. (2021)	16	– Service costs	– Entry points and referral system by general practitioner – Waiting time	– Distance to services – Transportation costs	Not mentioned	Not mentioned	– Unaware about mental health services - About mental health, led to unrecognized needs	Not mentioned	– Stigma as crazy and abnormal – Cultural conception of mental health as exhibionist exposure of the genitals in public - Lack of perceived benefits of mental health care services, especially talking in therapy – Shame – Fear of social isolation - Cultural norm: "Mental problems weaken a strong dominant men" – Fear of discrimination and racism – Husband as a gatekeeper – Seen as god's punishment, that don´t deserve help	Not mentioned
[54]	Karakas & du Plooy (2024)	5	Not mentioned	– Long waiting time	Not mentioned	Not mentioned	– Distrust governmental services due to negative experiences with authority before resettlement	– Unaware of available services	Not mentioned	– Overprescription of psychopharmaceuticals – Dislike therapy and perceived as retraumatisation	Not mentioned
[55]	Khanom et al. (2021)	10	Not mentioned	– No service offers through interpreter – Waiting time	– Service costs	– Appointment system by telephone	– Privacy concern against the service providers	– Lack of knowledge about mental health services system - About mental health, led to unrecognized needs	– Lack of interpreter - Bad quality of Interpreter through dialect, incorrect or incomplete medical terms	- Fear of medications, which worsen the long-term health	Not mentioned
[56]	Kim et al. (2021)	13	Not mentioned	– Quantity of service by a suitable provider – Waiting time	Not mentioned	Not mentioned	- Provider were different in culture and religion, therefore it is difficult to find a suitable provider	– Lack of knowledge about mental health services system - About mental health, led to unable to recognize signs of problems and how to solve problems – Misconception of mental health	– Lack of language skill - Language barrier, no equivalent word for mental health makes it hard to understand the meaning	– Stigma as crazy - Cultural conception of mental health, mental health as a new concept – Shame - Fear of social isolation, own mental health issues jeopardize the position in the community – Seen as punishment for bad karma or possession by evil spirit	Not mentioned

Appendix C (continued)

No.	Author (Year)	N*	Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Language	Social and cultural barrier	Other
[57]	Kiselev et al. (2020)	17	– Financial constraints	– Quantity of service – Referral system and misdiagnosed by general practitioner	– No childcare opportunity – Transportation costs	– Appointment system through unable to read the Latin alphabet	– Mistrust the doctor and the system – Mismatch between Western system of diagnosis and perceived needs by Syrian	– Unaware about mental health services – About mental health and how to solve problems - Linked mental disorders with physical conditions (misconception)	– Lack of language skill	- Stigma negatively, as crazy - Mistrust/dislike the kind of therapy – Shame – Seen god as a perception of the reason for suffer	– Bureaucracy and complex procedures ensures difficulties by understanding the system
[58]	McCann et al. (2016)	8	– Service costs	Not mentioned	Not mentioned	Not mentioned	- Provider were different in culture and religion, led to misunderstanding the cultural context of mental disorder	– Unaware about mental health services - Believed in service threshold, seeking help only if problems became serious – About mental health led to unrecognized needs	Not mentioned	– Stigma negatively – Cultural conception of help seeking as weakness and failure – Fear of family reputation	Not mentioned
[59]	Mutiso et al. (2019)	11	– Service costs	Not mentioned	– Distance to services	Not mentioned	– Mistrust the doctor – Untrained providers to providing integrated mental health services	– Mental health is not a permanent problem or treatable – Problems get better without help or over time	– Lack of language skill – Lack of interpreter - Bad quality of family interpreter, who may misinterpreted symptoms	– Stigma as crazy – Fear of discrimination makes it uncomfortable to be treated in the same facilities as the locals	Not mentioned
[60]	Noubani et al. (2020)	9	– Service costs	– Quantity of service	– Distance to services	Not mentioned	– Mistrust the doctor's ability to treat their conditionand to prescribethe appropriate medications	Not mentioned	Not mentioned	– Stigma – Mistrust the quality of service and mistrust therapy – Cultural conception – Seen as god testing their patience when passing through life struggles	

Appendix C (continued)

No.	Author (Year)	N*	Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Language	Social and cultural barrier	Other
[61]	Omar et al. (2017)	7	Not mentioned	Not mentioned	Not mentioned	Not mentioned	– Provider were different in culture and religion – Privacy concern against the service providers	– Lack of trained community representatives who understand the services and facilitate access to services	Not mentioned	– Lack of perceived benefits of talking therapy - Mistrust/dislike the kind of therapy – Fear of getting injected medications - Cultural conception, men denied to have mental disorders and as exhibionist exposure of the genitals in public	Not mentioned
[62]	Öztürk et al. (2024)	14	– Financial constraints	– Long waiting time – Number of health professionals are insufficient	– Transportation costs	– Unable to make appointments due to the phone – Booking appointment online took too long	- Privacy concerns, one physician handled all Syrians	Not mentioned	– Language differences – Lack of interpreter – Incorrect or incomplete translations	– Stigma as crazy - Dislike the kind of therapy "The psychiatrist does not act like a doctor here. He sits and does not speak." - Experienced discrimination by health professionals as less time was allocated to them because of their race, their waiting times were longer, meetings were kept short, citizens of the country were given priority	– Official regulations
[63]	Poudel-Tandukar et al. (2019)	7	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	– No culturally appropriate information	- Language barrier (no further explained) – Fear of disclosure by the interpreter	- Lack of perceived benefits of talking in therapy, it makes things worse - Dislike the kind of (western) therapy, especially older refugees - Cultural norm "Do not talk about mental health problems" - Fear, that someone in the community will know	Not mentioned
[64]	Saberi et al. (2021)	8	Not mentioned	Not mentioned	Not mentioned	– Appointment system	– Provider were different in culture and religion – Untrained providers and lack of cultural competency	– Mental health is not a problem or treatable	Not mentioned	– Stigma – Fear of social isolation - Cultural norm "Do not talk about problems"	– Poor parents mental health literacy led to own illiteracy

Appendix C (continued)

No.	Author (Year)	N*	Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Language	Social and cultural barrier	Other
[65]	Shannon et al. (2015)	13	Not mentioned	- Trustful services without fearing legal consequences (risk to be deported)	Not mentioned	Not mentioned	Not mentioned	– Lack of knowledge about mental health services – Knowledge about mental health	Not mentioned	– Stigma as crazy – Lack of perceived benefits of mental health care services - Dislike the kind of therapy because they do not want to talk about suffer and avoid painful memories, previous experiences (e.g. refugees had been tortured, arrested or raped for speak about political opinion) silenced their voice and make it difficult to speak about their suffering – Shame – Fear of social isolation - Cultural norm: "Women were not supposed to discuss issues" and cultural shyness – Fear of family reputation and security	– Infiltration by spies – Fear of being hospitalized – Fear of losing job or house
[66]	Soukenik et al. (2022)	8	– Service costs	– Quantity of culturally responsive services	– Transportation to service	Not mentioned	– Provider were different in culture – Mistrust the doctor – Mismatch between Western system of diagnosis and perceived needs or culture	– Knowledge about mental health services	– Lack of language skill	Not mentioned	Not mentioned
[67]	Tonui (2022)	4	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	– Lack of knowledge and unaware about mental health services – About mental health led to unrecognized signs and symptoms	- Language barrier (no further explained)	– Cultural conception of mental health as exhibionist exposure of the genitals in public	Not mentioned

Appendix C (continued)

No.	Author (Year)	N*	Affordability	Availability	Accessibility	Accommodation	Acceptability	Awareness	Language	Social and cultural barrier	Other
[68]	Trueba et al. (2023)	6	– Financial constraints	– No service within the city center – Support uncertainty through donation and volunteers based services	– Distance to services – Transportation costs	Not mentioned	Not mentioned	Not mentioned	– Lack of language skill	Not mentioned	Not mentioned
[69]	Valibhoy et al. (2017)	17	– Financial constraints	Not mentioned	– Distance to services	Not mentioned	– Provider were different in culture and religion and rarely refugees themselves – Mismatch between Western system of diagnosis and their culture – Negative expectations about providers	– Unaware about mental health services – Believed in service threshold for severe level of disorders – Misconception of mental health – Mental health is not a problem or treatable	Not mentioned	– Stigma negatively - Lack of perceived benefits of mental health care services, talking-based treatments are inappropriate and ineffective - Dislike the talking therapy, because it is painful and they do not feel safe – Cultural conception led to dehumanization users of mental health services - Shame, embarrassment guilt - Cultural norm of discourage directness, which is inconsistent with psychotherapy – Fear of discrimination and racism – Fear of gossip	– Need for autonomy
[70]	Willey et al. (2020)	5	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned	– About mental health and not accepting own issues	- Language barrier (no further explained)	– Stigma negatively – Lack of perceived benefits of mental health care services and would not follow up a referral – Shame to see a psychologist	Not mentioned

N = Number of perceived barriers

Abbreviations

CB	Christian Brettschneider
LK	Léon Kreis
MMAT	Mixed Methods Appraisal Tool
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTSD	Posttraumatic stress disorder
RT	Rebecca Thiel
UK	United Kingdom
USA	United States of America

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Authors' contributions
Contributor Roles Taxonomy (CRediT). Conceptualization, CB, HHK; Data curation, RT, LK; Formal analysis, RT, LK, CB; Funding acquisition, CB, HHK, SS; Investigation, RT, LK, CB; Methodology, RT, CB; Project administration, HHK, SS; Supervision, CB, HHK; Validation, SS; Writing - original draft, RT; Writing - review and editing, CB, LK, SS, HHK.

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Declarations

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Not applicable.

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Competing interests
The authors declare no competing interests.

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