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Health and Mental Health

Topic of the Month Europe Must Act 2024

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An Introduction to Health and People on the Move

The events of the last few years have meant that health and the threat to health have often been in the spotlight. On an individual level, the Covid-19 pandemic and the ensuing lockdowns heightened our awareness of our fragility. While, on a more collective level, ageing populations across Europe also stand as a beacon of how far health and medical practices have advanced, with the average life expectancy in the EU standing at 81 years in 2023.



Image sourced from Europe Must Act

Health is a fundamental human right, yet people on the move often face significant barriers when it comes to accessing healthcare.

On top of this, although generally people on the move are likely to be healthy, they can often **become at risk of ill physical or mental health while migrating or upon arrival in Europe**.

Why?

The WHO provides us with an initial answer:

> Migration functions as a social determinant of health. The health status of refugees and migrants is shaped by their surrounding conditions in their place of origin, during transit and in host communities. The particular conditions refugees and migrants often experience, such as restrictive migration policies, issues related to legal status, economic hardship and antimigrant sentiments, increase health inequities for them.

What's clear is that a person's migration status doesn't intrinsically impact their health. Nonetheless, the experiences of refugees and asylum seekers and the structural inequalities in Europe do mean that many who come under the banner of 'on the move' face health consequences.

Throughout this report, we aim to combine policy, reports and academic research to provide a comprehensive yet digestible examination of health and migration. When it comes to the end of the report, we have decided to focus on some of the positive and innovative approaches to health and mental health that we have found. Therefore demonstrating that, while health inequalities exist, we can do better.

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Defining the Right to Health

States are bound by international law to uphold, respect and fulfil the right to health, which the World Health Organisation (WHO) constitution defines as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

This right is also enshrined in a number of international and regional human rights instruments including the Universal Declaration of Human Rights (UDHR)[1].

In line with these legislations, and the 1951 Refugee Convention, the European Commission states that 'The European Union is an area of protection for people fleeing persecution or serious harm in their country of origin.' As such, for those coming to EU member states to seek safety, the Common European Asylum System (CEAS) aims to ensure that people seeking asylum are treated fairly, in a dignified manner and to uniform standards across all member states.

These standards laid out by the CEAS in the Reception Conditions Directive also state that people seeking asylum are entitled to necessary health care, including mental health care.

Now, with the adoption of the new EU Pact on Migration and Asylum, the policies on the provision of health care and mental health care for people seeking asylum have been updated and must officially come into effect in all EU member states by June 2026.

What are the current requirements?

Reception Conditions Directive 2013/33 (26 June 2013)

This directive requires member states to provide applicants with necessary healthcare, such as emergency care and essential treatment of illnesses and mental disorders. It also acknowledges those with special reception needs, who will be provided with 'appropriate mental health care where needed'. But what does this look like in reality?

Long waiting lists and a lack of culturally appropriate support or interpretation services mean that those in need of mental health care often slip through the cracks. With member state governments currently facing no serious repercussions for failing to meet the standards laid out in the directive, governments are getting away with providing inadequate mental health support for displaced communities in Europe.

For example, a recent German study surveyed over 700 people (who had either asylum seeker or refugee status) regarding their access to and utilisation of mental health services. They found that:

"Of those [in need of professional mental health treatment], less than half had contact to any service provider, with only 1 in 14 receiving minimally adequate psychotherapy. Overall, no more than one in seven of refugees in need received minimally adequate treatment. Despite a comprehensive mental healthcare system, refugees' access to mental health care and the treatment provided are inadequate. Health policies are urgently needed to provide equitable mental health care for all."[2]

[1] Universal Declaration of Human Rights (UDHR), 1948, Article 25
[2] Christian Lorenzo-Blanco, Nuria del Río, and Rosa Esteban-Izquierdo, "Mental Health of Asylum Seekers and Refugees in the European Union: A Comprehensive Review," Applied Psychology: Health and Well-Being, accessed September 29, 2024, https://iaap-journals.onlinelibrary.wiley.com/doi/full/10.1111/aphw.12523.

Furthermore, Human Rights Watch pointed to double standards when it comes to accessing mental health care. They highlight that Ukrainian refugees, receiving temporary protection, gain access to funding under the EU4Health programme, which includes mental health support. Crucially, they argued that this should be seen as a path forward for all those seeking protection, rather than a special programme for some.

While Sustainable Development Goal 3.8 aims to achieve universal health coverage (including access to quality essential health-care services by 2030) currently we are a long way off from reaching this target. However, these aims serve as a useful tool for measuring the progress of the latest Reception Conditions Directive and the challenges they should seek to reform.

So, let's take a look...

Reception Conditions Directive 2024/1346 (14 May 2024)

The above-updated directive expands on the 2013 standards for healthcare. Some difficulties remain[3]. Throughout the new 2024 Directive the concept of "vulnerable persons" has been replaced with that of "applicants with special reception needs"[4].

ECRE notes that while two new groups are listed in the latter - LGBTI+ applicants and persons with mental disorders including post-traumatic stress disorder - the list remains non-exhaustive. Furthermore, the implications of this change in the directive are unclear. As the European Council on Refugees and Exiles (ECRE) points out, it would seem...

"unlikely that applicants can be considered vulnerable without being classified as needing special reception conditions and therefore benefiting from the protections provided. Nonetheless, Recital 47 talks about having due regard to the "inherent vulnerabilities" of the person as applicant for international protection and the Explanatory Memorandum for the proposal clarifies that "persons with special reception needs are persons who are in need of special guarantees in order to benefit from the rights and comply with the obligations provided for in the Reception Conditions Directive, regardless of whether these persons are considered vulnerable". It therefore appears that these concepts are not equivalent."p 25-26

This lack of clarity creates further barriers for people seeking asylum to access their entitlements when it comes to mental health services and ties into more general debates around the question of intrinsic vulnerability.

The concept of vulnerability creates additional difficulties as, by defining asylum seekers as vulnerable, it feeds into the stereotypical notion that those fleeing lack agency and are completely dependent on the state[5]. On top of this, the concept of vulnerability has also been linked to ideas of hierarchies of vulnerability, where those who are seen as "less vulnerable" are also deemed to be undeserving of protection[6]. Ultimately, it illustrates how these ambiguous policies, and the failure to define special reception needs or vulnerability, exacerbates challenges to accessing services.

[3] Read about the changes here: European Council on Refugees and Exiles (ECRE), "Comments on the Recast of the Regulation on Reception of Applicants for International Protection," September 2024, 17,
[4] See European Union, "CHAPTER IV: Provisions for Applicants with Special Reception Needs, Article 24 Applicants with Special Reception Needs,"
[5] "Strasbourg case-law has triggered debates on the actual meaning and implications of the Court's acknowledgement of asylum seekers' intrinsic vulnerability, as well as concerns relating to the inherent risk of the vulnerability concept fuelling stereotypical notions of asylum seekers as individuals lacking agency and being completely dependent on the welfare state" in Asylum Information Database (AIDA), "The Concept of Vulnerability in European Asylum Procedures," November 2020, 9,
[6] Kate Smith & Louise Waite (2019) New and enduring narratives of vulnerability: rethinking stories about the figure of the refugee, Journal of Ethnic and Migration Studies, 45:13, 2289-2307, DOI: 10.1080/1369183X.2018.1496816

For example:

In Ireland, the inconsistent application of vulnerability assessments has meant that many people who are entitled by law to special reception needs are not given access to their entitlements.

In March 2024 the Irish government announced that the vulnerability assessment, introduced in 2021, would be suspended "due to the increased numbers of arrivals of protection applicants in the State as well as constraints on available accommodation across the IPAS portfolio" [7] and no date has been given for when it would be reinstated. The result of these inconsistent and ill-functioning assessment processes has meant that many people who are entitled by law to special reception needs are not given access to their entitlements.



Image sourced from Pexels

The failure to meet reception standards and its effect on health

A final important question when it comes to health and asylum seekers, is whether the newly revised reception condition standards laid out in the 2024 Directive will be implemented.

ECRE has published its comments and recommendations for the new directive. In particular, they highlight that when discussing the context of mental health, a major issue to be taken into consideration is the negative effect reception conditions in the EU have on people's mental health and well-being when they get to Europe[8].

In their analysis of Article 20: Arrangements for material reception conditions, ECRE has identified that, while these arrangements were by and large taken into consideration in the 2013 directive, these requirements, such as access to basic utilities, sanitation and sleeping quarters[9], have failed to be met in many instances in reception centres in member states.

As living in such conditions plays a massive role in negatively affecting people's mental health and well-being, the question also remains as to whether these requirements laid out in the 2024 Directive will be enforced.

At the end of this two-year transition period, will governments face repercussions for failure to implement adequate, equal living conditions and provide equal access to mental health care? Currently, it's a game of wait and see, as the European Commissioner for Home Affairs Ylva Johansson has said that EU countries failing to implement the New Pact on Migration and Asylum could face legal action and governments are expected to introduce their national implementation plan by December 2024.

[7] Oireachtas, "Debates: Asylum Seekers and Vulnerable Groups," May 2, 2024
[8] Ibid, ECRE, 2024
[9] Ibid., ECRE p18.

Conflict, Health and the Decision to Leave

People can be forced to flee their own country and seek safety in another, for a huge variety of reasons[10]. However, forced migration is often attributed to a well-founded fear of persecution as a result of who they are, what they believe in, or because of armed conflict, war or humanitarian or environmental disaster.

When looking at conflict-exposed populations, the health impacts in such contexts are extensive and often overlooked. Although it is not easy to collect data on the topic due to disruptions in local health systems[11], multiple studies have demonstrated how conflict situations and emergencies cause more mortality and disability than any major disease[12].



Image sourced from Unsplash

Moreover, conflict also creates major disruptions to healthcare systems, as infrastructure breaks down, health workers flee and there are medication/medical supply shortages[13]. This has both long-term and short-term impacts, particularly as health conditions develop into long-term physical and mental health disorders.

Thus, it is widely accepted that war, violence and armed conflicts bring a series of lasting debilitating consequences, which negatively impact the lives and the health of conflict-affected populations even after the conflict has ended and people have fled.

The mental health impact of conflict

As a direct result of exposure to war and armed conflict, people are more likely to suffer from an array of mental health problems; some will develop new and debilitating mental disorders, others will experience psychological distress, and those living with pre-existing mental disorders will often need more help than before. This affects entire populations, but women are often more affected than men[14] and other vulnerable groups include children, the elderly and the disabled.

The WHO documents how traumatic events and loss caused by armed conflict and other emergencies result in the proportion of the affected population already suffering from moderate mental disorders to rise from approximately 10% to 15-20%. The most common conditions are depression, anxiety and psychosomatic problems such as insomnia, stomach issues or high blood pressure[15].

[10] For more information on the complex reasons that people flee, read our previous report here.
[11] Abudayya, Abdallah, Fugleberg Bruaset, Geir Tarje,Nyhus, Hedda Bøe, Aburukba,Radwan, & Tofthagen Randi (2023). Consequences of war-related traumatic stress among Palestinian young people in the Gaza Strip: A scoping review, Mental Health & Prevention, Volume 32
[12] J.J. Lopez-Ibor, G. Christodoulou, M. Maj, N. Sartorius, A. Okasha, Disasters and mental health, Wiley Online Library (2005).
[13] Arage MW, Kumsa H, Asfaw MS, Kassaw AT, Dagnew EM, Tunta A, Kassahun W, Addisu A, Yigzaw M, Hailu T, Tenaw LA. Exploring the health consequences of armed conflict: the perspective of Northeast Ethiopia, 2022: a qualitative study. BMC Public Health. 2023 Oct 24;23(1):2078. doi: 10.1186/s12889-023-16983-z.
[14] R. Srinivasa Murthy and Rashmi Lakshminarayana (2006), Mental health consequences of war: a brief review of research findings, World Psychiatry
[15] World Health Organization. World health report 2001 - Mental health: new understanding, new hope. Geneva: Switzerland; 2001, p. 43,

Going beyond physical violence

So far, we have examined the way in which conflict and violence impact the health and mental health of people on the move. However, it's important to also consider the experience of violence outside of direct conflict as this also has a significant impact on health.

Structural violence can be a significant factor in shaping the experiences of people on the move, both in their home country and when they arrive in Europe. Here we've highlighted two examples to demonstrate how structural violence impacts people's ability to access their right to health.



Image sourced from Pexels

Structural violence limiting access to health services

A number of studies suggest it is often the poorest and most disenfranchised communities that suffer most in conflict, as they commonly face the most oppression[16]. For example, a report from Amnesty International found that South Sudan's civil conflict was definitively worsened by the intentional destruction of much of the population's source of livelihood and the unlawful obstruction of humanitarian aid by warring factions.

Moreover, while health services in the country were already severely limited and of poor quality, civil war further devastated a collapsing health system. Lack of resources, poor infrastructure, and sociocultural and financial barriers all contributed to hindering citizens' right of access to healthcare services. Amnesty's report concluded that the government of South Sudan violated a number of obligations under international law to uphold and respect the right to health of its citizens.

Structural violence creates a threat to the health of people on the move

There is a continuum between direct and structural violence. The physical violence that migrants suffer operates within the brutal conditions they are exposed to.

Davies, Isakjee and Desi illustrated the operation of structural violence through a detailed analysis of the conditions of the Calais jungle[17]. Displaced people in Calais literally embodied the destitution of the camp, with many suffering hunger, injury, infestation and infection. The limited provision of one meal a day was distributed via a third-sector organisation and was deliberately insufficient, as a strategy to keep refugees without any reliable source of food.

In July 2015, when this research took place, it was estimated that these meals would only be provided for 1500 people out of the 3000 in the camp. Meal boxes were often being stored unsafely by refugees so that the meagre ration could be stretched out over several days.

[16] Sousa Cindy, A. Political violence, collective functioning and health: a review of the literature. Med Confl Surviv. 2013 Jul-Sep;29(3):169-97.
[17] Davies, Thonm, Isakjee, Arshad, and Dhesi, Surindar. (2017). Violent Inaction: The Necropolitical Experience of Refugees in Europe. Antipode.



Image sourced from Unsplash

The structural conditions observed by Davies and others in Calais represent a strategy of deterrence, through which European state authorities aim at making the life of persons on the move unsustainable and tortuous, attacking their mental and physical health.

This serves as a form of exemplary punishment for others who might attempt to come to Europe while producing a de-facto reality where asylum and refuge become absurd enterprises. European policies conceal brutality "behind a veil of inaction" through which basic means of life are withheld.

The Effect of Detention on Migrants' Mental Health

Migrant detention centres have a profound effect on the mental health of those unlucky enough to be placed in them, with several studies consistently reporting high rates of psychological distress.

Research highlights that detainees experience significantly higher rates of anxiety, depression, and post-traumatic stress disorder (PTSD) compared to both the general population and other vulnerable groups like prisoners. For instance, a systematic review revealed that 64.7% of migrants in detention experience anxiety, 73.5% depression, and 46.4% PTSD[18]. These statistics underline the severe emotional and psychological toll detention exerts on migrants.

In addition to these psychological disorders, detained migrants frequently report feelings of helplessness, hopelessness, and fear, exacerbated by prolonged uncertainty about their legal status. One study stressed that many detainees suffer from cumulative psychological distress due to both pre-migration trauma and the stresses of detention itself[19]. These include experiences of war, violence, and displacement in their home countries, which are then aggravated by the restrictive and often dehumanising conditions in detention.

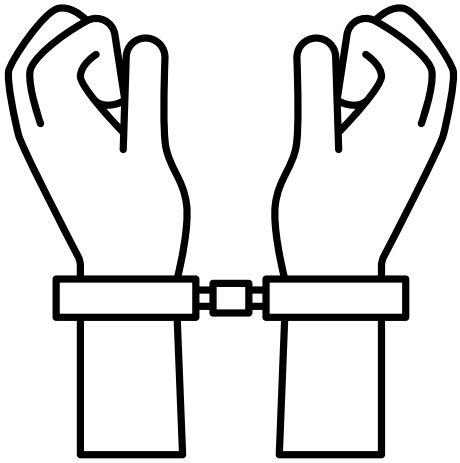
[18] The Mental Health Burden of Immigration Detention: An Up- dated Systematic Review and Meta-Analysis, Stéphanie Baggio, Leonel Gonçalves, Alexandre Heeren, Patrick Heller, Laurent Gétaz, Marc Graf, Astrid Rossegger, Jerome Endrass & Hans Wolff (2020)
[19]Refugee mental health and the role of place in the Global North countries: A scoping review,Guntars Ermansons, Hanna Kienzler, Zara Asif, Peter Schofield (2023)

The specific conditions within detention facilities—such as overcrowding, isolation, lack of access to mental health services, and limited legal recourse—significantly amplify the psychological suffering of detainees. Research shows that such environments intensify feelings of despair and emotional breakdown, further straining detainees' mental health[20]. A study examining the conditions of detention highlighted that the deprivation of autonomy and the exposure to constant surveillance leave detainees feeling trapped, leading to higher levels of stress and anxiety[21].

On top of this, many detention centres also suffer from inadequate medical and psychological care. Detainees often lack access to sufficient psychiatric care or counselling services, which prevents them from receiving appropriate treatment. For instance, in some European facilities, insufficient access to psychiatric services has been documented, with reports noting that detainees' mental health symptoms frequently go untreated[22]. This lack of care exacerbates the detainees' psychological conditions, making recovery difficult, if not impossible, within the detention setting.

Long-term psychological consequences of detention

Detainees who remain confined for extended periods often experience a progressive decline in their mental health, including worsening symptoms of depression, anxiety, and PTSD. One study found that individuals held in detention for over six months exhibited more severe psychiatric symptoms than those detained for shorter periods, indicating the negative impact of long-term confinement on psychological well-being [23].



For many people trapped in migrant detention, the psychological damage does not end with release from detention. Research reveals that many former detainees continue to struggle with anxiety, depression, and PTSD long after their release[24], demonstrating that the mental health consequences of detention are both immediate and enduring.

Detention Conditions in Europe

In Europe, immigration detention practices vary significantly, but the mental health consequences for detainees are universally severe.



In the UK: Concerns have been raised about the long periods of detention and the poor living conditions in facilities such as the notorious Yarl's Wood Detention Centre. Reports from detainees describe feelings of fear, powerlessness, and despair, exacerbated by inadequate access to mental health services[25].

In Switzerland: Detainees face harsh conditions, including isolation and lack of access to proper psychiatric care, further contributing to the deterioration of mental health[26].

[20] The impact of immigration detention on mental health: A systematic review, Martha von Werthern, Katy Robjant, (2018)
[21] Subjectivity and identity in detention: Punishment and society in a global age, Mary Bosworth (2012)
[22] Ibid, Stéphanie Baggio et al. (2020)
[23] Ibid, ,Guntars Ermansons et al. (2023)
[24] Ibid, Martha von Werthern, Katy Robjant, (2018)
[25] Ibid, Stéphanie Baggio et al. (2020)
[26] Ibid, Martha von Werthern, Katy Robjant, (2018)

The variability in detention conditions across European countries creates inconsistencies in the mental health outcomes of detainees. While some countries have made progress in improving the living conditions within detention centres, others continue to operate facilities that are overcrowded, unsanitary, and lacking in adequate psychological support[27]. This uneven approach to detention and mental health care has significant implications for the well-being of detainees across the region.

Specific concerns and inconsistent approaches

Vulnerable Populations	Minors
The detention of vulnerable populations—particularly children, the elderly, and individuals with pre-existing health conditions—remains a (rightly) contentious issue in Europe.	The situation for minors in European detention centres is particularly concerning. Research suggests that detained minors are especially vulnerable to psychological distress, with studies indicating that between 50% and 100% of detained children show signs of anxiety, depression, or PTSD[29].
Some countries, such as Germany and the Netherlands, have implemented more humane policies aimed at reducing the detention of vulnerable groups, others continue to detain vulnerable populations in harsh conditions[28]. These conditions often lack appropriate support structures for individuals with complex psychological needs, leading to further deterioration in mental health.	This high prevalence of mental health disorders among detained minors reflects the harmful impact of detention on young people. Detention facilities in Europe, particularly in countries like Greece and Italy, have been criticised for their treatment of minors, with reports highlighting the overcrowded and unsafe conditions many detained children endure[30].

Implications for Policy and Practice

The high prevalence of mental health disorders among detainees in European countries underscores the urgent need for policy reform. The variability in detention conditions and access to mental health care across Europe suggests that a more standardised approach to managing detention facilities is necessary.

Overwhelmingly, we need to ensure the following essential steps in order to address the mental health crisis caused and exacerbated by detaining people on the move:

- Consistent access to mental health services,
- Improving living conditions within detention centres,
- Exploring alternatives to detention, particularly for vulnerable populations like minors.

[27] Ibid, Mary Bosworth, (2012)
[28] Mental health consequences of long-term stays in refugee camps: preliminary evidence from Moria, Willemine van de Wiel, Carla Castillo-Laborde, I. Francisco Urzúa, Michelle Fish & Willem F. Scholt (2021)
[29] Ibid, Stéphanie Baggio et al. (2020)
[30] Ibid, Martha von Werthern, Katy Robjant, (2018)

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Psychosocial Intervention and Resources for Refugee Support in Mental Health

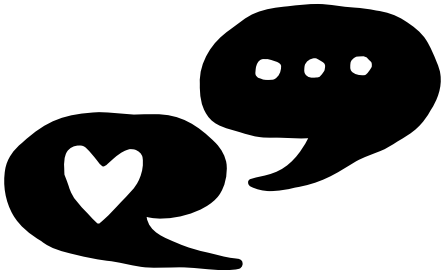
In this section, we review different means of psychiatric, psychological and psychosocial intervention with refugees. They represent the general state of the art in Europe at large, but there are a number of strategies which have been more common in the work addressed specifically to refugees, guided mostly by a focus on trauma. Most typical interventions in mental health consist of:

Medication



Medication with drugs, especially in domains governed by the medical profession (Psychiatry). Public healthcare across Europe often induces drug treatment for persons in distress. Yet, the British National Institute for Health and Care Excellence (NICE), in its guidelines for adults suffering from Post-Traumatic Stress Disorders (PTSD), recommends against the use of pharmacology as a first-line treatment.

These guidelines also recommend against pharmacotherapy in children as a first-line approach, as it is not supported by evidence.



Psychotherapy

Individual psychotherapy (based on one-on-one verbal interaction between clinician and patient over a timely process) provides a more structured intervention approach. Access to psychotherapy by refugees depends on its availability from NGOs or, more infrequently, from public services.

he two most successful psychotherapeutic approaches today are cognitive behaviour therapy (CBT) and narrative exposure therapy (NET). CBT works on the ways in which a person thinks about their daily problems and circumstances, and monitors them by inviting the person to perform certain tasks and activities. NET is particularly designed for PTSD, as it focuses on specific past traumatic events experienced by the person, inviting them to remember them and elaborate on these memories under the guidance of the clinician.

NET and Narrative Therapy (aimed at elaborating and re-shaping the autobiographic memories of the patient) have the added personal value of rebuilding the person's personal identity and dignity to carry on with their life after trauma. While trauma-focused therapies show promise, they are not widely available. Nonetheless, committed clinicians and community workers can provide a therapeutic environment and instrumental support to refugee patients.

Both CBT and NET have been found successful in reducing symptoms, particularly for Post-Traumatic Stress Disorders[31]. However, there is limited evidence of their effectiveness for anxiety and depression, particularly, as the dominant focus on PTSD overlooks other aspects of refugees' mental health and well-being, such as current family relationships, integration problems or their sense of meaning. A broader look at users' lives while addressing post-traumatic symptoms may support refugees to face other sources of stress in their lives[32].

[31] Slobodin, O., & de Jong, J.T.V.M. (2015). Mental health interventions for traumatized asylum seekers and refugees: what do we know about their efficacy? Int J Soc Psychiatry, 61(1): 17–26.
Patel, N., Kellezi, B., Williams, A.C. de (2014). Psychological, social and welfare interventions for psychological health and wellbeing of torture survivors. Cochrane Database Syst Rev. 11.
[32] Nickerson, A., Bryant, R.A., Silove, D., Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. Clin Psychol Rev, 31:399–417.

The role of NGOs and community projects

Some refugee patients may resist structured therapies when they feel unready to re-engage with traumatic memories. Some research suggests that only a minority of refugee patients can tolerate direct exposure techniques and that cognitive restructuring may also be deemed inappropriate by patients[33]. Therefore, the development of community projects to elaborate on past experiences, or networks that will allow for sharing those experiences informally, can also help for narrative elaboration in more informal ways.

A good deal of this informal work is done by NGOs working side by side with people on the move in European camps and cities through group and mutual support. Often, these interventions are aimed at building and strengthening collective identity and supporting networks. This has the added benefit of using group-based interventions to address social isolation and advocate for the rights and material needs of refugees, building connections between host and guest communities.

As such, many activities organised for refugees (e.g. art, sports, hiking) support mental health as much as they enhance quality of life and social integration.

Adaptations of services and interventions can be basic, e.g., by way of translating materials into minority languages, raising awareness of racism and cultural dilemmas, or making refugees and migrants more visible in mainstream society. There are also deeper adaptation strategies that aim to co-adapt services in partnership with members of stakeholder communities and introduce cultural aspects of care[34]. These interventions at the group and community level mesh together with protection and prevention strategies to create a holistic approach to mental health.





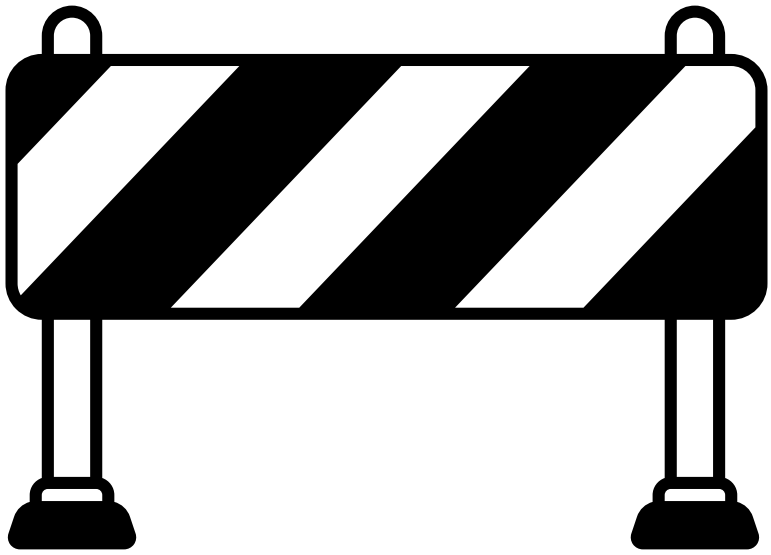
Images sourced from Europe Must Act

[33] Cleveland, J., Rousseau, C., & Guzder, J. (2014). Cultural Consultation for Refugees. In: Kirmayer, L., Guzder, J., & Rousseau, C. (eds.) Cultural Consultation, Springer, pp. 245-268.
[34] Jarvis, G. Eric, and Kirmayer, Laurence J. (2023). Global migration: Moral, political and mental health challenges. Transcultural Psychiatry, Vol. 60(1) 5-12.

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Barriers to Accessing Healthcare - A Lack of Cultural Sensitivity and People-Centred Health Systems

So far, we've touched upon some of the reasons why people who have fled to Europe may not receive the health and care they are entitled to. Now, we're going to see that, even when services are available, language and cultural barriers can be particularly significant obstacles to equitable healthcare access and how a lack of cultural competence among healthcare providers can contribute to discouraging migrants from seeking help.



Language barriers often lead to misunderstandings or miscommunication with healthcare providers, making it difficult for those who recently arrived to express their symptoms or understand medical advice [35]. Migrants frequently report that language isolation leaves them feeling disempowered and that they feel dismissed or not taken seriously, particularly when physicians do not prescribe adequate pain relief or seem inattentive to their medical histories.

These misunderstandings can result from conscious or unconscious discrimination and racism within the healthcare system[36]. There is also scope for misinterpretation, especially when language barriers prevent effective communication. This creates difficulty, as these feelings of being overlooked or receiving a lower quality of care can undermine trust and exacerbate patients' reluctance to engage with the healthcare system[37].

Furthermore, patients often have to rely on non-professional interpreters or acquaintances, which compromises the quality of care they receive, but studies have shown that critical cultural meanings can be lost even when interpreters are present, leading to misunderstandings that neither patients nor physicians are fully aware of and resulting in dissatisfaction among both parties[38][39].

Ethnographic Study in Switzerland

An ethnographic study[40] gives insight into complexities beyond the mere language barrier, describing the interactions between patients of Albanian and Turkish origins and their physicians in Switzerland and reporting from both points of view. Clinicians reported difficulties in communicating essential medical advice. Patients may not adhere to prescribed therapies or monitor their blood glucose or blood pressure regularly, behaviours that physicians sometimes attribute to a lack of basic medical knowledge. However, when asking the patients, these behaviours are often influenced by more complex factors, like difficulty adhering to medical advice due to stressors like demanding work schedules or financial instability, usually making prioritising health appointments and treatment plans impossible.

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[35] Ansar, Anas & Johansson, Frida & Vásquez, Laura & Schulze, Mario & Vaughn, Taylor. (2017). Challenges in access to health care among involuntary migrants in Germany. A case study of migrants' experiences in Oldenburg, Lower Saxony. International Migration.
[36] Pattillo, M., Stieglitz, S., Angoumis, K. et al. Racism against racialized migrants in healthcare in Europe: a scoping review. Int J Equity Health 22, 201 (2023). https://doi.org/10.1186/s12939-023-02014-1
[37]Paternotte E, van Dulmen S, Bank L, Seeleman C, Scherpbier A, Scheele F. Intercultural communication through the eyes of patients: experiences and preferences. Int J Med Educ. 2017 May 16;8:170-175. doi: 10.5116/ijme.591b.19f9. PMID: 28535143; PMCID: PMC5457791.
[38] Piacentini, T., O'Donnell, C., Phipps, A., Jackson, I., & Stack, N. (2018). Moving beyond the 'language problem': developing an understanding of the intersections of health, language and immigration status in interpreter-mediated health encounters. Language and Intercultural Communication.
[39] Degrie, L., Gastmans, C., Mahieu, L. et al. How do ethnic minority patients experience the intercultural care encounter in hospitals? A systematic review of qualitative research. BMC Med Ethics, (2017).
[40] Würth, K., Langewitz, W., Reiter-Theil, S. et al. Their view: difficulties and challenges of patients and physicians in cross-cultural encounters and a medical ethics perspective. BMC Med Ethics (2018)

A more nuanced view of these cross-cultural interactions shows that both patients and practitioners are navigating difficult terrain. Patients often operate within constrained socio-economic conditions that directly impact their health behaviours, while healthcare providers work within a system that may not fully equip them to handle the diverse needs of a migrant population. Practitioners, for example, face systemic issues such as time limitations and resource shortages that make it challenging for them to address the cultural and social needs of migrant patients. Legal frameworks that restrict access to healthcare for specific migrant groups, particularly undocumented individuals, further complicate this dynamic[41].

Case study: The Impact of the Covid-19 Pandemic on Refugees and Asylum Seekers

Nearly 5 years after the initial outbreak, many studies and reports are showing that the Covid-19 pandemic adversely affected asylum seeker and refugee populations as well as worsening pre-existing healthcare challenges and hardships.

Many of the factors we have already mentioned (such as overcrowding, inadequate sanitation, poor hygiene, malnutrition, and limited access to healthcare and public services) not only increased the risk of virus transmission but also contributed to the rise of psychiatric illnesses.

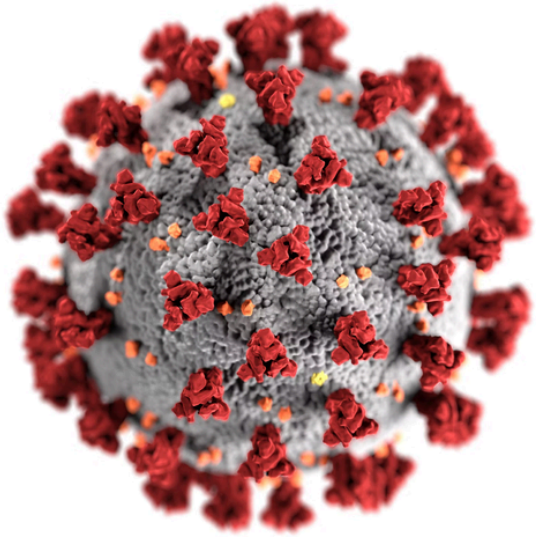


Image sourced from Unsplash

This situation disproportionately affected migrants and those in poor socio-economic conditions, leading to heightened anxiety and mental health deterioration.

A Greek study indicated that psychiatric diagnoses among refugees were nearly four times higher than those in the native population. On top of this, studies conducted in Paris and Turkey revealed a significant increase in depression among refugees during lockdowns. In Paris, 72% of refugees, primarily from Sub-Saharan Africa, experienced depression—over three times higher than the native French population, which had a 20.4% depression rate. Severe depression among refugees nearly doubled from 9% to 17%.

These findings collectively highlight the pandemic's detrimental impact on refugees' mental health, underscoring the way in which the impact of the pandemic was not felt equally and the continued need for support and resources for these communities.

However, while the statistics above are illuminating, they primarily highlight that refugees and asylum seekers were more likely than the native population to experience a decline in their mental health due to the pandemic, without exploring the specific factors that contributed to this disparity.

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*[41] Suphanchaimat, R., Kantamaturapoj, K., Putthasri, W. et al. Challenges in the provision of healthcare services for migrants: a systematic review through providers' lens. BMC Health Serv Res **15**, 390 (2015).*

Key indicators influencing the increase in mental health issues among migrants and refugees during Covid-19

Impact of Financial Insecurity: The pandemic's impact on economic stability played a significant role in worsening mental health among refugees and migrants. Those who faced greater challenges in securing basic needs such as housing, employment, food, and clothing reported higher levels of anxiety, depression, and hyperarousal. Financial instability often forced refugees into overcrowded or unsafe living conditions, further increasing stress and mental health deterioration.

Lack of Healthcare Access and Treatment Compliance: Barriers to Medical Support emerged as a critical factor influencing mental health outcomes among migrants. Data from the NRC and UNHCR indicated that over 100 countries had local Covid-19 transmission as of March 2020, including 34 countries with refugee populations exceeding 20,000.

In these settings, refugees often resided in overcrowded areas with strained or insufficient public health services, making it difficult to prevent and manage the virus effectively. According to a 2020 Statista study, approximately 42% of undocumented individuals reported a decline in access to medical care due to the Covid-19 pandemic.

Stigmatisation and Discrimination: Social exclusion was found to be a strong indicator of poor mental health among refugees during the pandemic. According to a recent study, certain subgroups of refugees—such as those with insecure housing or residence status, older individuals, and women—reported experiencing higher levels of discrimination and daily stressors, leading to increased anxiety and mental health issues.

Social Support and Community Connections: Social support was identified as a double-edged sword in mental health management among refugees. While social networks are typically crucial for coping with mental health distress, many migrants face barriers to accessing formal support services, often relying on informal networks. However, discussing trauma and distress with others in similar situations sometimes exacerbated psychological distress, indicating that the quality of social support plays a critical role in mental health outcomes.

When combined, the ways that Covid-19 was felt and experienced by refugees and asylum seekers demonstrate a palpable impact of the barriers to health. More broadly, they also highlight the inequalities that exist within healthcare systems and the detrimental effects of these barriers.



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Positive Approaches and Initiatives to Healthcare

Finally, we look to the ways that we can begin to overcome these barriers and inequalities when it comes to healthcare for people on the move.

Although there are numerous ways to approach healthcare for refugees and asylum seekers, depending on a person's individual needs, here we've compiled a few interesting approaches we discovered in our research that we want to highlight.

Cultural Competence and Humility in Cross-Cultural Healthcare

Cultural competence and cultural humility have emerged as key approaches to addressing the challenges in cross-cultural healthcare encounters.

Cultural competence refers to the ability of healthcare professionals to understand and effectively interact with patients from different cultural backgrounds. Training in this area typically focuses on learning about various cultural groups' health beliefs and practices.

However, while helpful, this approach can lead to oversimplification, as it risks stereotyping patients based on group attributes rather than addressing their unique circumstances, as both migrant and local populations are highly diverse, making it difficult to generalise behaviours across groups[42].

Therefore, cultural humility, as proposed by Tervalon and Murray-García, is a more dynamic alternative to cultural competence. It emphasises lifelong learning and self-reflection, and importantly, it encourages healthcare providers to recognise and address power imbalances in healthcare relationships. By viewing patients as equal partners, practitioners can foster more collaborative and respectful interactions, ensuring the patient's perspective is fully considered[43].

Implementing Solutions: Examples of approaches to health and mental healthcare

Intercultural communication training: The Rotterdam Trial

To address the communication barriers faced by culturally and linguistically diverse patients, healthcare providers must develop strong intercultural communication skills[44]. One effective approach is seen in a randomised controlled trial conducted with general practitioners (GPs) and patients in Rotterdam.

In this study, GPs received intercultural communication training, and patients were provided with instructional videos on improving communication with their GPs. The results showed that after six months, mutual understanding between GPs and patients improved significantly, highlighting the importance of continuous and targeted communication training[45].

[42] Würth, K., Langewitz, W., Reiter-Theil, S. et al. Their view: difficulties and challenges of patients and physicians in cross-cultural encounters and a medical ethics perspective. BMC Med Ethics (2018)
[43] Tervalon, Melanie and Jann Murray-García (1998) Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. Journal of Health Care for the Poor and Underserved
[44]Barbara C. Schouten, Linn Manthey, Claudio Scarvaglieri (2023). Teaching intercultural communication skills in healthcare to improve care for culturally and linguistically diverse patients, Patient Education and Counseling
[45] Harmsen, H., Bernsen, R., Meeuwesen, L., Thomas, S., Dorrenboom, G., Pinto, D., & Bruijnzeels, M. (2005). The effect of educational intervention on intercultural communication: Results of a randomized controlled trial. British Journal of General Practice

Community Involvement in Intervention Design: The Amsterdam STI/HIV Programme

In addition to educating healthcare professionals and involving individuals from diverse backgrounds as caregivers, engaging communities directly in the design of health interventions can be an effective strategy. The Amsterdam STI/HIV program illustrates this well by actively including community-based organisations (CBOs) in the development of interventions aimed at improving sexual health. The program primarily targeted residents of African, Antillean, Aruban, and Surinamese descent, ensuring that their specific cultural and social contexts were considered in the interventions.

CBOs, many of which were led by individuals from these communities, were invited to propose and implement projects tailored to their cultural needs. These projects included innovative strategies such as educational theatre performances and radio programs, which were more effective at engaging their respective communities than traditional health campaigns. With ongoing support and training from the Public Health Service (PHS), CBOs were empowered to design relevant interventions, ultimately improving community engagement and enhancing the overall effectiveness of the program[46].



Empowering Communities through Participatory Health Promotion: The C4H Project

The Communication for Health (C4H) project in the UK is an example of how active community involvement can lead to more effective and culturally appropriate health interventions. The project worked with women from Bangladeshi (Bengali/Sylheti), Chinese (Cantonese/Mandarin), and Pakistani (Urdu/Mirpuri/Punjabi) communities to co-create a breast cancer screening video. Using a participatory approach, participants were involved in writing the script, directing scenes, and acting, ensuring that the health messages were delivered in their native languages and aligned with their cultural contexts.

This method helped dispel common misconceptions about breast cancer and screening, allowing the women involved to communicate these messages more effectively within their own communities. Participants were able to address myths and barriers that are often misunderstood in traditional health promotion approaches. Beyond the immediate impact, the project also helped to build skills in areas like video production and communication, fostering a sense of ownership over the health messages being shared.

The C4H project illustrates how involving communities directly in the design and delivery of health interventions can create more tailored solutions to overcome cultural barriers. This participatory model provides an alternative to top-down approaches, allowing those most affected to take an active role in shaping the healthcare messages that address their needs[47].

[46] STI/HIV prevention programme in Amsterdam : Wagemakers, Annemarie & Husen, Gwen & Barrett, Jennifer & Koelen, Maria. (2014). Amsterdam's STI/HIV programme: An innovative strategy to achieve and enhance the participation of migrant community-based organisations. Health Education Journal
[47] C4H Communication for health Video-Project for breast cancer screening in NHS (Chiu, Lai Fong. (2009). Culturally Competent Health Promotion: The Potential of Participatory Video for Empowering Migrant and Minority Ethnic Communities. International Journal of Migration, Health and Social Care

Kulturdoula in Sweden

A practical approach used in Sweden is the integration of cultural doulas - women from migrant backgrounds who assist women during pregnancy and childbirth by providing emotional support, language assistance, and practical guidance[48]. These doulas function as cultural mediators, helping patients navigate unfamiliar healthcare systems and ensuring that healthcare providers are better equipped to meet patients' specific cultural needs.

This model has shown positive outcomes in improving communication and trust between migrant women and healthcare providers. Studies have indicated that women supported by cultural doulas report a better understanding of medical information, feel more comfortable asking questions, and are generally more satisfied with their overall care.

While the model has its complexities, including concerns around the scope of doulas and the reinforcement of gendered labour patterns, it is clear that it is one among many innovative ideas[49].

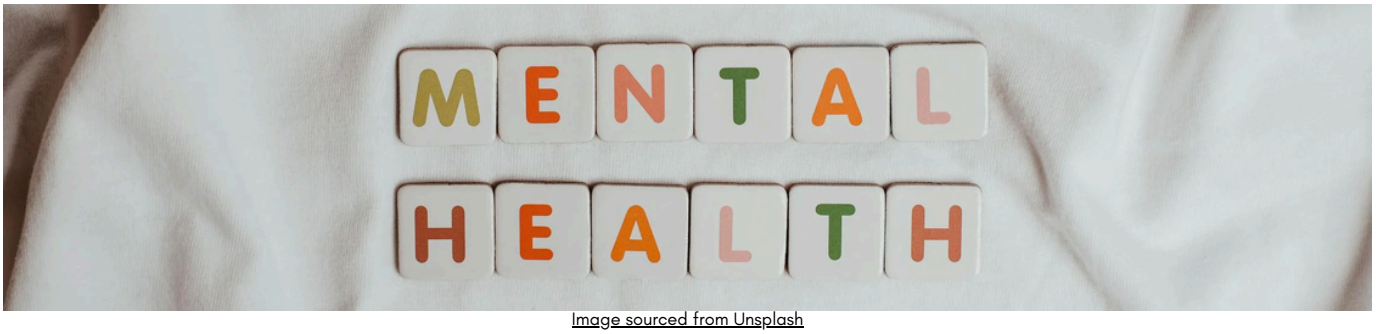


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An approach to refugee mental health care

When it comes to mental health, we've chosen to highlight Kronick's [50] targets for quality care:

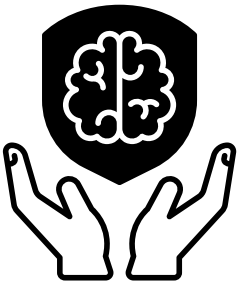
Dealing with trauma	Vicarious trauma
Whereas refugees typically experience high rates of trauma before, during and after their journey, mental health professionals should avoid urging the disclosure of trauma, especially in first encounters, because of the risk of inducing trauma and stigma, and because of the potential impact of such disclosure on families and communities. If and when trauma is disclosed, practitioners should take an empathic and supportive stance, especially given that refugees may face incredulity in other contexts, such as at refugee hearings.	Vicarious traumatization refers to the risk that therapists may become traumatised themselves through exposure to trauma narratives. Researchers have acknowledged that the transmission of trauma also affords the possibility of post-traumatic growth and resilience in the clinician.

[49] Essén B, Eriksson L. Paradoxes in the cultural doula concept for migrant women: Implications for gender-inclusive care versus migrant-friendly maternity care. Midwifery. 2023 Nov;126:103805. doi: 10.1016/j.midw.2023.103805. Epub 2023 Sep 2. PMID: 37714043.
[50] Kronick, Rachel (2018). Mental Health of Refugees and Asylum Seekers: Assessment and Intervention. The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie Vol. 63(5), 290-296.

Integration	Children
Specialised mental health treatment includes advocacy in collaboration with lawyers and non-governmental organisations. Interventions that support asylum seekers obtaining secure immigration status, adequate housing, employment, and family reunification are fundamental to patient recovery and the re-establishment of meaningful roles in the host country. On top of this, connecting refugees with their cultural or religious communities can help protect them from isolation and discrimination. However, it is important to understand the person's specific identity and affiliation, as not everybody will feel connected or will want to connect with their background communities.	When undertaking supportive or structured therapies with children, consideration should be given to the protective value of avoiding traumatic material, in the context of the child's cultural background and developmental stage. Children can benefit from adapted, non-verbal approaches to therapy, which do not take trauma as a focus but 'workaround' traumatic topics (e.g., drawing, play).

This is in no way an exhaustive list of the approaches to physical and mental healthcare for refugees and asylum seekers. However, it serves as a basis for considering new possibilities for health and mental health care.

Ultimately, helping us imagine a new reality where migration no longer functions as such as such a powerful social determinant of health.



A Final Thought...

Throughout this report, we've explored many facets and experiences of health, mental health and healthcare for people on the move. With health inequalities being felt across multiple groups of people across society it's important to continue to work for better healthcare for all, regardless of their migration status or any other social determinant.

As we mentioned at the start of this report, health is a fundamental human right. But, ensuring that right requires continuous work and pressure to protect all who are vulnerable.

So, what can we do?

- Continue to educate ourselves,
- Put pressure on politicians to prioritise healthcare services that are accessible to all,
- And, continue to fight for an end to measures, such as detention centres, unfit refugee accommodation and restrictive migration policies, that are impacting people's health and exacerbating these health inequalities.

We can do better.

EUROPE MUST ACT.

*We're volunteers and asylum and migration is a complex topic. This means we try to include a variety of opinions and approaches to a topic. We do our best to research and use our expertise accurately however, we also believe it's vital to encourage healthy discussion and stop misinformation. Therefore we encourage any feedback or constructive criticism of our work.

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Europe Must Act (EMA) is a growing grassroots movement, bringing together volunteers and NGOs to campaign for the humane and dignified reception of refugees in Europe.

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2024