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## The provision of mental health services to immigrants and refugees in Italy: the barriers and facilitating factors experienced by mental health workers

### Summary

#### Objective

To explore the barriers and facilitating factors to the provision of mental health services to immigrants and refugees by exploring the experiences of mental health workers (MHWs.)

#### Method

A qualitative study was performed in May 2013 in a city in the Emilia Romagna region. Participants were recruited using purposive sampling and 14 semi-structured interviews were performed with MHWs. Framework Analysis was used to interpret the data.

#### Results

Five facilitating factors were identified: language skill of patients, involvement of patients' family, specialist cultural psychiatric services, voluntary services and organisation of the mental health system.

Five barriers were identified: patients' perceptions, lack of family support, cultural knowledge of MHWs, language skill of MHWs and funding of the mental health system.

#### Conclusions

The barriers and facilitating factors identified reflect findings from research in both European and non-European countries. Nevertheless, the results of this study highlight the fact that a national mental health policy for immigrants and refugees needs to be implemented alongside cultural competence training programmes and specialist cultural psychiatric services.

#### Key words

Italy • Immigrants • Refugees • Mental health workers

#### Key concepts

For the purpose of this study, immigrants were defined as people who:

- originate from a country outside the European Union (EU);
- (EU as of 2013);
- Have acquired citizenship in Italy;
- Have chosen freely to emigrate out of his/her country of origin.

(Appendix 1 shows the countries that are members of the 2013 EU)

For the purpose of this study, refugees were defined as people who:

- originate from any country in the world;
- have acquired refugee status in Italy;
- have been forced to flee out of his/her country of origin.

This study did not include immigrants without citizenship as they have different entitlements to the Italian National Health Service (INHS) in comparison to immigrants with citizenship and refugees<sup>1,2</sup>. EU immigrants and asylum seekers were not included, as it was deemed that the scope of this study would then be too wide.

## Introduction

### Migration and mental health

Immigrants and refugees have an increased risk of suffering from mental health disorders due to the challenging experiences that they encounter during the migration process, see Table 1<sup>3-6</sup>.

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## Migration in Italy

During the last three decades, Italy has become a popular destination for non-EU immigrants and refugees due to the collapse of the Soviet Union and political unrest in Northern Africa<sup>7</sup>.

The majority of non-EU immigrants and refugees settle in Central and Northern Italy<sup>8</sup>. In 2012 there were 3,637,724 non-EU immigrants holding residence permits and 58,060 refugees<sup>9,10</sup>.

The Italian government is yet to implement a programme that collects data about the health of migrants<sup>7</sup>.

## Mental health disorders of migrants

Migrant groups are all at increased risk of developing mental health conditions, however the rates of mental health conditions are often twice as high in refugee populations in comparison with economic migrants<sup>4</sup>. Several studies have shown that immigrants and refugees suffer from somatization disorder, post-traumatic stress disorder, psychotic disorder, anxiety disorder, and depression<sup>11–17</sup>.

## Immigrants and refugees experiences of mental health services

In Italy, immigrants and refugees are entitled to access mental health services<sup>1,2,18</sup>. Research has shown that they encounter barriers when accessing services, for example: individual health beliefs and discrimination from health workers<sup>1,7,19–27</sup>. Furthermore, mental health funding that specifically addresses immigrants' and refugees' mental health needs has not been implemented<sup>24</sup>.

## Mental health workers experiences of providing care to immigrants and refugees

In Italy, there is limited research about the experiences of mental health workers (MHWs) in the provision of care to immigrants and refugees<sup>25</sup>. Studies in Europe,

however, show that MHWs face barriers when providing care<sup>28,29</sup>. For example a United Kingdom (UK) study reports that MHWs face funding issues and receive insufficient cultural training<sup>29</sup>. Evidently, more research is needed regarding the experiences of MHWs in the provision of care to immigrants and refugees in Italy.

## Method

### Study site

The study was conducted in the city of Bologna (located in the Emilia Romagna region in Northern Italy).

In Bologna there are two specialist cultural psychiatric services: the Bologna Transcultural Psychosomatic Team (BoTPT) and a Cultural Consultation Centre (CCC)<sup>18,30</sup>.

The BoTPT is a multidisciplinary study and research Centre of the Department of Medical and Surgical Sciences- Bologna University. The team provides consultations in partnership with the Department of Mental Health of Bologna designed to identify the mental and psychosocial needs of migrants and to direct them to appropriate services. The consultation includes psychiatrist researchers, psychologists, medical doctors, students, psychiatry registrars and medical anthropologists, and if needed, a cultural mediator joins the team<sup>18</sup>. In addition, the BoTPT delivers training and support activities to informal carers, general practitioners, psychiatrists and mental health operators social workers, medical students and psychiatric trainees. Training is specially directed to social and voluntary workers working with asylum seekers and traumatized immigrants<sup>31,32</sup>.

The Cultural Consultation Centre (CCC) started in 2010 as an experimental project in partnership with the Department of Mental Health of Bologna, the Centre for International Health, the Department of Social Anthropology of Medical Knowledge of Bologna University and professionals in the field of ethnopsychiatry and social care<sup>33</sup>.

The CCC is based on a multidisciplinary approach to the psycho-social distress that immigrants, refugees and members of ethno-cultural communities experience. The CCC acts as a consultation liaison service with the aim of transferring knowledge and supporting health and social workers in the evaluation and assistance of migrants.

### Sampling

Expert sampling was used to recruit participants and elicit the views of those with specific experiences or expertise in providing care to immigrants and refugees. This was achieved by targeting MHWs in both Community Mental Health Centres (CMHCs) and mental health hospitals who had extensive experience of working with immigrants and refugees or who worked for the CCC or BoTPT.

**TABLE I.** Stages of migration and related mental health risk factors (da Carta, et al., 2005, Lindert et al., 2008, Bhugra et al., 2011, mod.)<sup>3,4,6</sup>.

Migratory stage	Risk factors
Pre-migration	Persecution in country of origin Experiences of violence or war
Migration	Extensive application process to obtain citizenship or refugee status Poor travelling conditions
Post-migration	Cultural bereavement Loss of status or family contact Poor or lack of employment Acceptance by new nation

## Participants

Overall thirteen consultant psychiatrists and one psychiatry registrar were recruited from seven facilities: five CMHCs and two inpatient hospitals. Five of the fourteen participants worked in either the BoTPT or the CCC. The mean age of participants was 46.4 years and the mean time participants had worked in Bologna was 11.3 years. Due to the selection criterion the majority of participants were recruited from CMHCs, as MHWs at CMHCs are responsible for coordinating treatment programmes for patients; therefore have regular patient contact<sup>19,34</sup>.

## Data collection

The study was conducted in May 2013 and semi-structured interviews were used to collect data. Interviews were held at CMHCs and the psychiatry institute. The main researcher who conducted all of the interviews only spoke English; four interviews were conducted in English and ten interviews required an interpreter. In total three interpreters were used, all of which had no conflicts of interest. All participants were provided with an information sheet and an explanation of the key concepts of the study. Only one question guide was used and leading questions were not included. All interviews were audio recorded and field notes were documented.

## Data analysis

Interviews were transcribed and six interviews (two per interpreter) were back-translated by an independent interpreter. No discrepancies were reported. Data was analysed using Framework Analysis<sup>35,36</sup>. Firstly data familiarisation was performed and then a coding framework was developed, which included a-priori themes from the question guide and themes that emerged from the data<sup>35,36</sup>. The data was then indexed, and each time the coding framework was modified all of the transcripts that had been indexed were re-analysed<sup>35,36</sup>. Charting was then performed, which involved data being summarised under relevant<sup>36</sup>. Finally, the data was organised into charts and interpreted. All data was independently analysed by the lead researcher.

## Ethical considerations

Ethical approval was obtained from Leeds University (UK) and the lead consultant psychiatrist. Consent forms were translated into Italian and back-translated to ensure consistency. Written consent was obtained from all participants.

## Results

### Facilitating factors

#### Patient level

### Language

Ten participants stated that if the patient was able to speak Italian then this was a facilitating factor as translators were then not required for appointments and to build a relationship.

“... they often learn Italian quickly, and then it is not necessary to involve the translator in the relationship, and this is good ...” (Interviewee 14- BoTPT worker)

### Family support

Four participants stated that family support was a facilitating factor and that good relationships had been established with family members.

“I have good relationships with families, they are often very helpful...” (Interviewee 13- BoTPT worker)

### Provider level

#### Specialist cultural psychiatric services

Eight participants; five of which worked at either the BoTPT or the CCC, stated that the specialist cultural psychiatric services were a facilitating factor. All of the psychiatrists working within the BoTPT or the CCC, explained how the teams provided them with support to deliver appropriate care.

“... The BoTPT is very helpful; if you have a problem with an immigrant patient; you can ask the team to help you with the problem” (Interviewee 11- BoTPT and CCC worker)

“If I have difficulties I can request a consultation with the CCC ... and I can discuss the case with the Experts” (Interviewee 7)

#### Voluntary services

Eight participants said that the voluntary services, such as ethnic community support groups, helped to facilitate care provision. Participants explained how the services provided them with an opportunity to learn valuable information and support when discharging immigrant patients.

“From 2007 we have meetings every month with workers from volunteer services ... they give us information so we can learn how to better care for immigrants” (Interviewee 9- BoTPT worker)

“When the patient was discharged from hospital we contacted a community group to help him ... it would have been difficult without them” (Interviewee 14- BoTPT worker)

Five participants, however, said that they had not worked with any of the voluntary services, and one participant was unaware of any voluntary services existing.

“I don’t know if voluntary services exist, do they exist?” (Interviewee 3)

The six participants that did not describe voluntary services as a facilitating factor did not have contact with either the BoTPT or CCC. This indicates that there are different knowledge levels among the participants about voluntary services.

### System level

#### *Organisation of the mental health system*

All fourteen participants referred to the organisation of the mental health system when discussing facilitating factors. Participants said that the registration and appointment systems were well-coordinated.

“Registration services are good, it works very well ... I can easily organise appointments with immigrant patients” (Interviewee 12)

“The appointment system is good ... consultations can easily be arranged with refugee patients” (Interviewee 6)

In addition, ten participants said that the mental health service had established a good working relationship with the local health authority (LHA).

“There is good communication with us and the LHA... if medical fees are a problem we can talk to them and organise for immigrants to be excused...” (Interviewee 5)

See Table II for a summary of the facilitating factors found.

### Barriers

#### Patient level

##### *Patients’ perceptions*

All fourteen participants stated that immigrant and refugee patients’ perceptions of mental health and MHWs caused difficulties when providing care. In addition, all fourteen participants stated that it was difficult to establish doctor-patient relationships with immigrants or refugees because of their misconceptions of MHWs.

“The development of the doctor-patient relationship is more difficult and a problem ... immigrants have different expectations and ideas of psychiatrists” (Interviewee 12)

In addition, all of the participants explained how immigrants’ and refugees’ perceptions of mental health caused difficulties when discussing symptoms.

“Immigrants don’t understand mental health ...” (Interviewee 8)

“... Some immigrants consider depression as a punishment of gods. It is very difficult to talk with immigrants about this issue” (Interviewee 7)

##### *Family involvement*

Ten participants explained that it was difficult to provide care to immigrant and refugee patients, because they did not receive the necessary family support. Eight participants stated that it was difficult to involve families because they did not live in Italy.

“... There are immigrant patients that are alone, they don’t have family in Italy, which then makes it difficult for me of course, because they don’t have support” (Interviewee 6)

**TABLE II.** Summary table: *Facilitating factors.*

Health system level	Facilitating factor	Number of participants who mentioned factor
Patient	Language	10
	Family support	4
Provider	Specialist cultural psychiatric services: Specialist services provide support to deliver appropriate care	8
	Voluntary services: Provide support and information	8
System	Organisation of mental health system	14
	Registration and appointment systems	
	Good working relationship with local health authority	10

One participant mentioned that lack of family involvement had caused difficulties when checking immigrant patients were adhering to their medication programmes.

“... Because I can't speak with immigrants' families I cannot make sure that medications are taken correctly, this is an issue ...” (Interviewee 4)

### *Provider level*

#### *Language skills of mental health workers*

All fourteen participants expressed that they faced language barriers during consultations with immigrants and refugees. The majority of participants explained how language barriers caused issues when attempting to determine an accurate diagnosis.

“Often immigrants and refugees do not speak Italian... so I have problems; sometimes you think you see major symptoms, but actually they are not ...” (Interviewee 10- CCC worker)

One participant even said that they could not provide psychotherapy due to language issues.

“Because of language difficulties immigrants do not receive psychotherapy” (Interviewee 3)

Thirteen participants mentioned that they used interpreting services to help them overcome language barriers. When participants were questioned about their experiences eight participants said that they had encountered issues. The most common issue, expressed by six participants was that interpreters did not always accurately interpret patients' responses.

“Psychiatry is made of words... and I find that interpreters can sometimes miss important aspects” (Interviewee 2)

“... The main problem is language, even if there is an interpreter, they miss something sometimes” (Interviewee 1)

Seven out of the eight participants who expressed that they had issues when using the interpreting services did not work at either the BoTPT or the CCC; indicating that participants who work at the BoTPT or the CCC may have better working relationships with interpreters.

#### *Cultural knowledge of mental health workers*

Nine participants said that their personal lack of cultural knowledge made it difficult to provide care to immigrants and refugees.

“I don't have any special cultural knowledge, and this is a problem... I treat immigrants the same way as I treat Italian people” (Interviewee 4)

All fourteen participants stated that they had not received any cultural training during their undergraduate medical education, as it was not recognised as an essential part of their education.

“I received no cultural training at University... back then it was not important...” (Interviewee 5)

Ten participants mentioned that the LHA did provide four annual lectures about health related issues, which sometimes included topics about immigrants' mental health. Nevertheless, the majority of participants suggested that more training was needed.

“...There are conferences provided by the LHA about ethnopsychiatry...” (Interviewee 13- BoTPT worker)

“Training is very important... an organised training programme is needed here...” (Interviewee 1)

Participants who worked at either the BoTPT or the CCC did not mention personal cultural knowledge as a barrier; indicating that they may be more confident in their abilities to provide care to immigrants and refugees.

### *System level*

#### *Mental health funding*

Twelve participants stated that the absence of mental health funding specifically for immigrants and refugees was an issue. Most participants explained that the main drawback was that there were no funding specifically for the provision of mental health care.

“The problem is that there is no specific funding strategies for immigrants...so there are no funding plans for them...” (Interviewee 11- BoTPT and CCC worker)

“... There are no funding strategies for the care of immigrant patients... which is why the health service does not fund the BoTPT...” (Interviewee 9- BoTPT worker)

See Table III for a summary of the barriers found.

## **Discussion**

### *Facilitating factors*

Over half of the participants explained how the BoTPT and CCC provided them with the support needed to deliver care for immigrants and refugees. Other studies have shown similar findings; such as a study in Cana-

TABLE III. Summary table: barriers.

Health system level	Barrier	Number of participants who mentioned factor
Patient	Patients' perceptions:	
	Patients' perceptions of mental health and mental health workers	14
	Difficult to establish doctor-patient relationship with immigrants and refugees	14
	Lack of support from patient families	10
Provider	Language:	
	Language barriers during consultations	14
	Issues with interpreters	8
	Mental health workers' cultural knowledge:	
	Lack of cultural knowledge	9
	Lack of cultural education during undergraduate medical education	14
System	No specific mental health funding for immigrants and refugees	12

da which shows that MHWs and General Practitioners, found a CCC helpful when treating immigrants<sup>37</sup>.

Six participants, however, did not mention specialist cultural psychiatric services as a facilitating factor. This could be because these participants may have not frequently come into contact with the BoTPT. In addition, these participants may have been unaware of the CCC, as it was only recently established in 2010.

Consequently, some immigrants and refugees may be receiving inadequate care. Clearly, more specialist cultural psychiatric teams are needed in Bologna and so it is recommended that a transcultural team and CCC are established in all CMHCs and inpatient hospitals. Funding should be obtained from the LHA and a monitoring system should be implemented to evaluate the performance of each BoTPT and CCC. This recommendation should be feasible if funding is secured as both services are already established. The main task required would be to recruit professionals to deliver the new services.

All the participants stated that the organisation of the mental health system was a facilitating factor. It is important to consider that participants may have stated that the organisation of the mental health system was a facilitating factor because they wanted to portray the system as a well-managed organisation rather than the reality of daily practice. In addition, patient level facilitating factors may have not been mentioned because participants wanted to project a positive image of the mental health system; therefore participants may have only chosen to vocalise facilitating factors at provider and system levels. Information about service delivery and immigrant and refugee patients' experiences is required to corroborate these findings.

### Barriers

All participants expressed that immigrants' and refugees' perceptions of mental health and MHWs caused

difficulties when providing care; for example when developing the doctor-patient relationship. Thus this barrier could potentially affect the quality of treatment provided. In addition, a UK study reports that providers were less likely to identify Punjabi patients with depressive symptoms because of the way Punjabi patients' express their symptoms<sup>38</sup>. Clearly, it would be valuable to perform a qualitative study to find out about immigrants' and refugees' knowledge, attitudes, and experiences of mental health and mental health services in Italy. The data from this study could be used to develop culturally relevant training programmes for MHWs. The majority of participants also identified family involvement as a barrier; which may affect success rates of treatment and rates of recovery. There is limited evidence however to support this finding; further research about family members' experiences and involvement with mental health services is needed to validate this finding.

MHWS' language skills and lack of cultural knowledge were also identified as barriers to providing care, and literature across Europe highlights this issue<sup>23 25 39</sup>. Both of these barriers could result in immigrants and refugees receiving inaccurate diagnoses. More research is indicated regarding MHW's experiences and immigrants' and refugees' knowledge, attitudes, and experiences of mental health care.

Cultural training was not provided to any participants during their undergraduate education. Although, this can be explained by the fact that the majority of participants attended university between the 1970s and 1990s; during this period of time immigration to Italy was only just beginning<sup>7</sup>. Cultural training, therefore, would not have been perceived as an essential aspect of medical education.

Optional courses about immigrants' and refugees' mental health are now provided by the BoTPT to un-

dergraduate and postgraduate students; nevertheless, it is vital to establish an annual cultural competence training programme for all MHWs who have contact with immigrants and refugees. The programme could be delivered by the BoTPT and CCC. Cultural competence training has been successful in Australia and Canada; reports show that MHWs are more responsive to immigrants' and refugees' needs after receiving training<sup>37,40</sup>. All participants stated that the absence of a mental health funding specifically for immigrants and refugees was a barrier; the main drawback identified was the absence of funding guidelines. Similarly, a Canadian study reports that MHWs face difficulties providing care to immigrants and refugees due to limited mental health policies<sup>41</sup>. It is vital therefore that the Italian government implements national mental health funding specifically for immigrants and refugees. The implementation of funding would allow resources to be allocated to the mental health sector to meet the needs of immigrants and refugees; allowing further research and cultural competence training programmes to commence. The INHS is regionally and locally managed, therefore, implementing a national funding strategy will be challenging<sup>1</sup>. Nevertheless, evidence from Spain and the UK shows that it is possible to establish national mental health policies and funding strategies for immigrants and refugees<sup>24</sup>.

### Limitations

A major limitation was that an interpreter was required, which may have caused relevant data to be lost, as it can be difficult for an interpreter to constantly translate everything a respondent says. To minimise the effect of this limitation, an independent interpreter back-translated six interviews. No discrepancies were reported. Time restriction was another major limitation as it prevented data saturation and respondent validation being achieved; ideally, it would have been preferable to interview a range of MHWs<sup>42,43</sup>. In addition, investigator triangulation was not achieved due to time constraints and consequently the coding framework used to perform the analysis could not be verified; in an attempt to compensate the lead researcher strived to perform a thorough analysis<sup>42,43</sup>.

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In addition, participants may have given responses that they thought would be viewed favourably by the lead researcher, a phenomenon known as social desirability<sup>44,45</sup>. To avoid social desirability bias occurring participants were encouraged to respond freely.

### Conclusions

The results of this study provide a foundation for further investigations regarding the experiences of MHWs in the provision of care to immigrants and refugees in Italy. Nevertheless, it cannot be ignored that the findings of this study have highlighted that a national mental health funding strategy specifically for immigrants and refugees needs to be implemented in Italy. Furthermore, cultural competence training programmes, Transcultural Psychiatric Teams and Cultural Consultation Centres need to be established across mental health facilities, and more research needs to be performed.

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### Contributors

Georgina Griffiths: Performed all 14 interviews, analysed data, and composed manuscript.  
Ilaria Tarricone: oversaw research study and provided guidance, also helped to compose the manuscript.

### Conflict of interest

None to declare.

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