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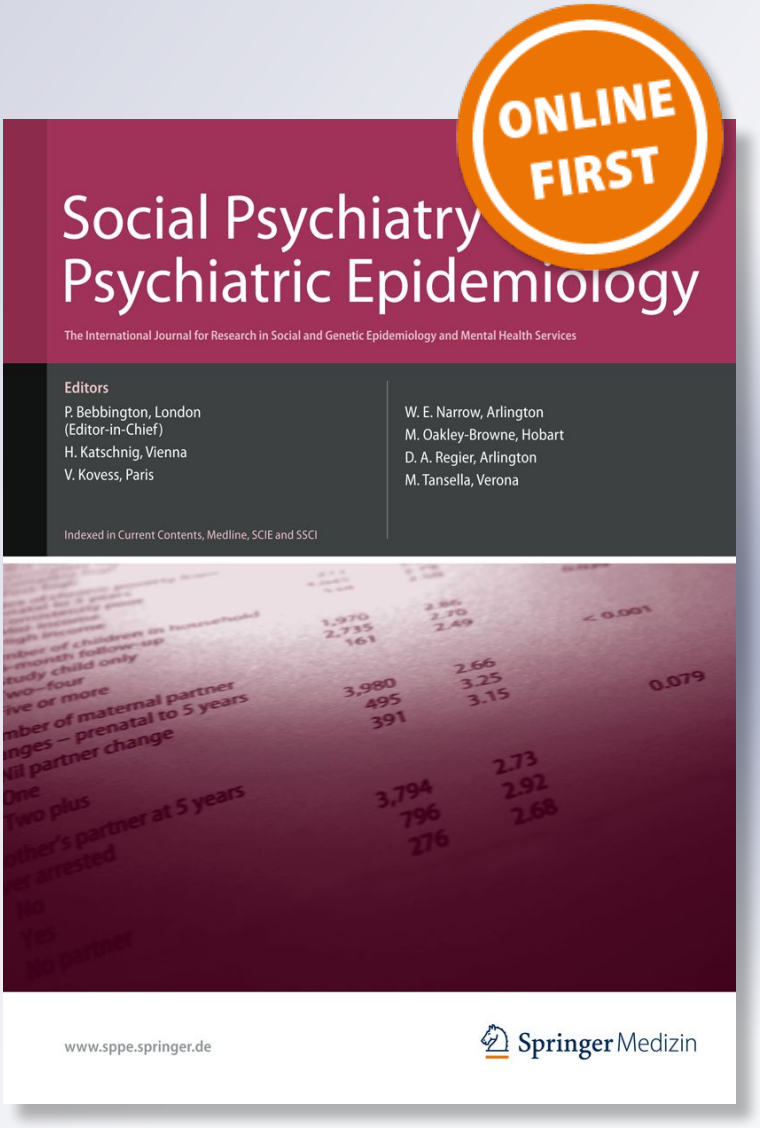

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ORIGINAL PAPER

Experiences with treating immigrants: a qualitative study in mental health services across 16 European countries

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Abstract
Purpose While there has been systematic research on the experiences of immigrant patients in mental health services within certain European countries, little research has explored the experiences of mental health professionals in the delivery of services to immigrants across Europe. This study sought to explore professionals' experiences of delivering care to immigrants in districts densely populated with immigrants across Europe.
Methods Forty-eight semi-structured interviews were conducted with mental health care professionals working in 16 European countries. Professionals in each country were recruited from three areas with the highest proportion of immigrants. For the purpose of this study, immigrants were defined as first-generation immigrants born outside the country of current residence, including regular immigrants, irregular immigrants, asylum seekers, refugees and victims of human trafficking. Interviews were transcribed and analysed using thematic analysis.
Results The interviews highlighted specific challenges to treating immigrants in mental health services across all 16 countries including complications with diagnosis, difficulty in developing trust and increased risk of marginalisation.

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Conclusions Although mental health service delivery varies between and within European countries, consistent challenges exist in the experiences of mental health professionals delivering services in communities with high proportions of immigrants. Improvements to practice should include training in reaching appropriate diagnoses, a focus on building trusting relationships and measures to counter marginalisation.

Keywords Migrants · Mental health services · Europe · Qualitative

Introduction

The experience of migration is heterogeneous in nature, making comparisons between migration processes and immigrant groups difficult [1]. Mental health care accessibility for immigrants can also differ between migrant groups, with health care service access and use being influenced by legal frameworks and different help-seeking patterns [2, 3]. Legal provision for health care varies depending on an immigrant's legal status. In a policy review of 16 European countries, policies and legislation stipulating rights to health care services for regular immigrants and refugees were usually similar to those for nationals, in both insurance-based and National Health Service systems [4]. Access to health care for irregular immigrants has been more divergent, ranging from full legal access to health care services with rights equivalent to that of nationals in France, Netherlands, Portugal and Spain, to no access other than emergency care in countries such as Austria, Denmark, Hungary and Poland [5].

Some common factors have also been indicated in the research on mental health in immigrant populations, such as a tendency towards a higher prevalence of certain mental health disorders amongst immigrant populations [6–8]. These high rates amongst immigrant populations may result from several factors [1], including pre-migration, migration and post-migration stressors [9, 10]. The process of migration itself and subsequent cultural and social adjustments have been suggested as key to the mental health of individual immigrants [6, 11].

As migration to Europe has increased and seems set to continue [12], mental health services have also experienced a rise in the number of immigrant patients. Countries such as the UK, France and Germany have a long history of immigration from culturally diverse backgrounds [13] and thus have experience in delivering mental health care to immigrant patients. However, other nations such as Lithuania [14], Hungary and Finland [15] have more recent histories of migration from non-neighbouring countries. Quantities of immigrants and country of origin also varied across the European Union (EU). Germany, Spain the UK, France and Italy reported the highest quantity of persons immigrating in 2008, whereas Lithuania received amongst the least. Moroccan and Turkish immigrants were the largest non EU-27 Member State populations acquiring citizenship to EU Member States. As a proportion of foreign populations: Iraqi, Afghan and Somali immigrants were amongst the highest proportions acquiring citizenship in Europe mainly in Scandinavian countries, Germany and the UK through flows of refugees and asylum seekers [16].

Generally the data on immigrant mental health in Europe are scarce, with mental health services in immigrant-dense areas holding the most knowledgeable accounts of the needs of immigrants and services available in Europe [7]. While there has been systematic research on the experiences of immigrant patients in mental health services within certain European countries [8, 17–25], little research has explored the experiences of mental health professionals in the delivery of services to immigrants across Europe. This study sought to explore professionals' experiences of delivering care to immigrants in districts with relatively high densities of immigrants across Europe and to ascertain whether mental health services felt equipped to face the challenges and demand on services and whether the challenges faced were consistent across European countries. The purpose of this study was to explore the experiences of those who have encountered immigrant patients in their services on a daily basis and to reflect on areas where difficulties may arise and how these are managed in mental health services.

Methods

As a part of the European Best Practices in Access, Quality and Appropriateness of Health Services for Immigrants in

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Europe project (EUGATE), semi-structured interviews were conducted with health care professionals from primary care, mental health care and emergency services across 16 European countries. These interviews aimed to identify the experiences of health care professionals on delivering care to immigrants within the participating countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Hungary, Lithuania, Netherlands, Poland, Portugal, Spain, Sweden and the UK.

The general aims and findings from the EUGATE interviews, across the three types of services investigated, have been published elsewhere [26, 27]. The analysis and findings outlined in this paper relate specifically to mental health services.

Recruitment and sampling

In each of the 16 participating countries, the research centre for that country identified three areas with relatively high proportions of immigrants. These areas were usually in the capital of each country or another urban context that had the highest proportion of immigrants. These areas were selected to ensure the participants had sufficient experience of providing mental health care to immigrants. The selected areas and mental health services in each of the 16 countries are listed in Table 1.

A refined definition of immigrants was used to aid classification of areas high in immigrant populations. Immigrants were defined as persons born outside the country of current residence (first generation) and aged between 18 and 65 years. In addition to this, regular immigrants (e.g. labour immigrants), refugees, asylum seekers, victims of human trafficking and irregular immigrants (e.g. undocumented immigrants) were all encapsulated in this definition.

A mental health service providing care to patients with severe mental illness was then identified in each of the three areas for each of the 16 countries ($n = 48$). The mental health service selected was usually the largest provider of mental health care in the area. Services were approached and asked to give details of the proportion of immigrant patients they have in their service. In most cases this was an estimate as most services did not routinely collect data on immigrant numbers entering services. No specific proportion was specified, but the number of immigrants entering services and receiving treatment had to reflect the proportion in the community, which was checked by the research centre collecting the data in that country. This recruitment requirement was set to ensure that the selected mental health services had sufficient experience of providing care to immigrant populations.

Once a mental health service was identified and confirmed for treating immigrants, the service was approached and asked for an interview with a practitioner, preferably with the most extensive experience of providing mental health care to immigrants in the service. The decision as to who was to be interviewed was made by the service in consultation with the research centre for that country to ensure they had sufficient experience.

Table 1 Sampled countries, selected cities and corresponding mental health service areas

Country	Selected cities	Selected mental health care areas
Austria	Vienna	Rudolsheim-Fünfhaus, Ottakring, and Brigittenau
Belgium	Brussels	Saint Josse, Schaerbeek, and Molenbeek
Denmark	Copenhagen	Areas within Bispebjerg Hospital, Hvidovre Hospital, and Glostrup Hospital
Finland	Vaasa, Pietarsaari, Oravais, Malax	Vaasa, Pietarsaari, and Malax
France	Paris	18th and 19th Arrondissements of Paris and Aubervilliers of Seine-St-Denis Department
Germany	Berlin	Tiergarten, Wedding, and Kreuzberg
Greece	Athens	Central Athens
Hungary	Budapest	Erzsébetváros, Kőbánya, Pesterzsébet
Italy	Rome	Districts I, VIII, and XX
Lithuania	Kaunas	Aleksotas and Zaliakalnis
The Netherlands	Amsterdam, Utrecht, Rotterdam, Hague	Amsterdam, Utrecht, and Rotterdam
Poland	Warsaw	Mokotow, Praga Poludnie, and Srodmiescie
Portugal	Lisbon	Amadora, Loures, and Lisboa
Spain	Barcelona	Cuitat Vella, Eixample, and Nou Barris
Sweden	Stockholm	Central, South East, and South West
UK	London	Hackney, Tower Hamlets, and Newham

The interviews

The interviews were semi-structured and conducted face-to-face between 2008 and 2010. Interviews were conducted in the language of the participating country and were presented in two parts: open questions regarding general experiences to gather a sense of issues encountered and areas of strength when delivering mental health services to immigrants, while the second part consisted of questions related to three case vignettes to address similarities and

Table 2 Structured interview questions for general experiences and case vignettes

Interview section	Questions
General experiences	From your perspective, what are the specific problems for you in the care of immigrant patient in your service that you would not have in the care of a patient with a similar condition from the indigenous population?
	From the perspective of a patient, what do you think are the specific problems faced by an immigrant patient coming into your service that are different from those faced by a patient with a similar condition coming from the indigenous population?
	In your experience, what are the strengths of your service in the care of immigrants?
	What would improve the care for immigrants in your service?
All case vignettes	From your perspective, what are the differences, if any, in the treatment for this patient compared with a patient with a similar condition from the indigenous population?
	From the perspective of a patient, what do you think are the specific problems this patient would encounter that are different from those of a patient with a similar condition from the indigenous population, and how would they be overcome?
	What are the specific further pathways and treatment options, if any, for this patient that are different from those of a patient with a similar condition from the indigenous population?
Illegal immigrant case vignette	Is this scenario at all possible, or are there barriers preventing illegal immigrants from using your service?
Refugee case vignette	Would you encourage the patient to join an organisation for refugees from the same country?
Labour immigrant case vignette	Would you arrange for a staff member from the same cultural background to care for her if possible?

differences in treatment based on immigrant status for (1) irregular immigrants, (2) refugees/asylum seekers and (3) labour immigrants. A complete list of the general experience questions and the specific case vignette questions can found in Table 2. The case vignettes were the same in each country, but varied only in terms of the immigrant's country of origin to represent a realistic country-specific scenario to the interviewees. Details of the care vignettes are as follows:

Illegal immigrant The patient arrived in the host country as an illegal immigrant about a year back. She is 25 years of age and of Sudanese origin. She does not speak the language of the host country, has no social contacts and appears severely depressed.

Refugee The male patient is 22 years of age, came to the host country from Iraq a year ago and has refugee status. He speaks a few words of the language of the host country. He appears to have persistent auditory hallucinations and feels persecuted.

Labour immigrant The female patient is 45 years of age and arrived from Pakistan 2 years ago. She has a regular residence permit, speaks the language of the host country well and suffers from a bipolar disorder with frequent and prolonged manic episodes.

Responses to the general questions and specific questions regarding similarities and differences in treatment based on the case vignettes were audio-taped in the majority of cases, but where this was not possible, responses were documented in writing. Ethical approval was obtained in Portugal, through the University Hospital S. João. In all other countries, ethical review was not required as no patient data were recorded.

Data analysis

The 48 interviews, including responses to the case vignettes, were transcribed verbatim by the research centres in the 16 participating countries, ensuring the removal of any identifying information to maintain anonymity. The prepared transcripts were analysed using thematic analysis [28]. This was a two-stage process, which involved line-by-line coding of data from the initial six interview transcripts, to the development of codes, which were used to code, categorise and group the data into overarching themes.

The first stage was to code the data from the initial interview transcripts line-by-line. This was conducted in each of the participating research centre with the first interview transcripts. Codes and their accompanying textual extracts were then used to develop a codebook. The codebook was then translated into English, reviewed and finalised amongst the researchers in all participating countries at a project meeting. Codes were accompanied by a definition and illustrated with examples. The codebook was then used to code the entire data corpus, with checks made after coding of the first interview transcript in each country in collaboration with the coordinating research centre. The validity of the codes was checked against data extracts to ascertain grounding in the data. Discrepancies in coding across centres were picked up early in the analysis and verified with the codebook.

The second stage of the analysis was the clustering of codes into emergent categories, which were then structured and grouped to form overarching themes [29, 30]. To ensure the themes and categories consistently represented the entire data corpus, final validation of codes against data extracts was undertaken between each participating research centre and the coordinating research centre.

The thematic analysis reported here focuses on the predominant themes noted in all 16 countries concerning the experiences of delivering care to immigrants in mental health services.

Results

Participants

Interviewees were recruited from various mental health services including psychiatric hospitals, acute and long-term psychiatric units, community mental health services and inpatient mental health services. The majority of the interviews were conducted with professionals currently working in the direct delivery of mental health care ($n = 34$), which included psychiatrists (17), mental health nurses (9), psychologists (5), therapists (1) and social workers (2). The remaining participants ($n = 14$) were primarily managers in mental health services with extensive previous and recent experience working as mental health practitioners in the selected service.

Challenges experienced

Three main themes describe professionals' experiences of challenges in the delivery of mental health care to immigrants: complications with diagnosis, difficulty in developing trust and increased risk of marginalisation. These were frequently mentioned in all 16 participating countries.

Complications with diagnosis

Common in the experiences of those interviewed were challenges arising when ascertaining a diagnosis, which manifested in four ways as characterised by the sub-themes of difficulties associated with language barriers, different belief systems, cultural expectations and previous traumatic experiences.

Language barriers

Disparities between the language capabilities of the practitioner and patient were commonly reported as a limiting factor when determining diagnosis. Clear and coherent communication was considered essential in the absence of viable alternatives to assess patients' symptoms and experiences. Effective communication was considered central to diagnosis and adequate treatment in any clinical context, but especially for those working in mental health services.

> First of all, language barrier. The possibility of communication and language is very important for the doctor-patient relationship. In psychiatry it is of key importance. (Poland, 231)

Immigrants entering mental health services with a poor command of the national language would often need an interpreter to translate during consultations. Indirect communication is often unavoidable in such cases, making symptom severity difficult to judge. Interviewees noted that observational methods of diagnosis were also complicated by an inability to directly communicate with patients.

Belief systems

Divergent belief systems may serve as explanatory models for immigrant patients' experiences of mental illness. According to the interviewees, these may hinder diagnosis and conflict with the practitioners' understandings, leading to difficulties in differentiating between certain beliefs and symptoms.

> One must clarify what the individual's ethnic and cultural background means for the symptoms he/she is presenting. Is he talking about spirits? Given the cultural and ethnic background, how much are you used to considering supernatural and non-physical phenomenon as something you actually relate to. (Denmark, ID 43)

The tendency to seek physiological explanations for psychological problems was reported as more common amongst immigrant patients than amongst nationals. Patients' inclination to deny mental illnesses or attribute the symptoms to a physiological aetiology was considered as the result of lack of knowledge about mental health, or from culturally-specific beliefs about mental health.

> Sometimes they have difficulties to understand that the somatic symptoms are a result of the mental problems. (Finland, ID 60)

> … [Immigrant] families frequently deny psychological problems, which strikes us in the family work again and again. This leads to problems on a daily basis. (Germany, ID 102)

Cultural expectations

Divergent belief systems between immigrant patients and practitioners had the potential to influence not only interpretation of symptoms, but also the expectations of treatment, further complicating diagnosis as a consequence. On occasion, lack of knowledge of a patient's cultural background would lead to misunderstandings of what was

considered as socially acceptable and typical behaviour. Expectations from one cultural background applied to another cultural context presented problems during the diagnostic process. Often, the challenge for practitioners was separating what was a culturally normal response from what was an indication of pathology.

> …difficulty in disentangling culturally acceptable behaviour and pathology: the first problem is understanding culture. Just this morning I was talking with colleagues about a Ukrainian 17 years old whose father had died. He didn't cry. For us it is a sign of pathology, a guy in the same situation in our culture cries. The difficulty is to distinguish what is normal and what is pathological in a specific culture. (Italy, ID 165)

> There is the risk of interpreting a certain behaviour or attitude or discourse in an individual from a different culture as something mystical, but for them it is part of their culture. (Portugal, ID 248)

Disparate cultural expectations extended beyond the practitioner and patient relationship, to interactions with the patient's family members. There was a general view that families should be engaged to understand the cultural characteristics behind the patient's behaviours and experiences, particularly in cases where there was a language barrier or a cultural expectation to keep mental health concerns within the family.

> I think we should get better at involving their relatives. […] they hold important information that we need, to be able to do things well enough. Therefore, we need to get hold of them and invite them in. It is not that they are not involved; they just mainly address their relatives and not the staff. They are more closed and private, but there is often a language barrier as well. (Denmark, ID 44)

Some interviewees discussed cultural differences in the knowledge and education immigrants' families have in understanding mental illness, in comparison with families of national patients in the host country. This had potential implications for a patient's willingness to accept a diagnosis.

> …to come back to the cultural issues, they may not be prepared to recognise their mental health problems, their families may not be educated about what it is to have a mental illness. (UK, ID 301)

> Taking cultural influences into account… does the family understand what's going on with the client or do they see it as something supernatural? (Netherlands, ID 209)

Professionals discussed the need for increased knowledge and awareness of cultural differences amongst practitioners, and the influence these differences potentially have for mental health services, both in terms of diagnosis and treatment.

> There is hardly any attention paid to multiculturalism during the providing of education at the university or elsewhere. (Netherlands, ID 202)

Preference was made for more provider level interventions such as the teaching of "*ethno-psychiatry*" (Lithuania, ID 191) in the education of mental health professionals to prepare them with "*more knowledge about the cultural aspects in mental disease*" (Sweden, ID 291).

Traumatic experiences

A further complication specific to reaching an appropriate diagnosis in psychiatry was the difficulty in differentiating between symptoms of psychotic disorders and reactions to prior traumatic experiences. Several interviewees mentioned the increased likelihood of encountering post-traumatic stress disorder (PTSD) amongst immigrant patients and the impact this has for establishing a diagnosis.

> Establishing a diagnosis is a problem in treatment. Re-experiences in the framework of post-traumatic stress disorder may be confused with psychotic symptoms or a normal reaction to an abnormal circumstance. (Netherlands, ID 207)

Distinguishing symptoms from normal responses to extraordinary situations added complexity in discerning a clear diagnosis. Patients would report thoughts and feelings, which would ordinarily be categorised as symptoms of a disorder if previous traumatic events and exceptional experiences were not taken into account.

> I had such a patient, who spoke in an interview about the fact that there was a period in his life when he was being followed. But this was the case in reality. For such patients, it is sometimes difficult—delusions may not be much different from reality. It is difficult to draw the line. (Poland, ID 226)

The context of meeting the immigrant as a patient in a mental health service would lead practitioners to seek symptoms and behavioural clusters.

> …he would be met with that, it would be interpreted as psychotic if he expresses that he is being persecuted. How to phrase it, something that may be a natural reaction to what he has experienced, can be interpreted in a pathological context, if we are not careful, and he does not need that. (Denmark, ID 45)

Complications with diagnosis required provider, organisation and system level responses to overcome these

particular challenges. Difficulties associated with language barriers required the organisational provision of professional and well-trained interpreters. Cultural expectations, different belief systems and previous traumatic experiences required provider level training in cultural awareness, as well as system level changes with regards to educating families and communities about mental illness and the methods by which mental health care are provided.

Difficulty in developing trust

Interviewees noted a general concern with the development of trust and the particular need to establish it with immigrant patients who might be distrustful of authorities, or were unfamiliar with the health care system as a whole or, more specifically with the way mental health services function.

> … Find themselves in a situation, another country with a different culture, a lack of perspective, a sense of alienation, lack of confidence in foreign doctors… afraid to speak about their symptoms. Says he feels good [because he] does not understand the situation and is afraid that he might be sent back. (Poland, ID 231)

> … and he does not know if he can trust us, which is a matter of time…by trying to make continuous appointments and to let him slowly grow. (Austria, ID 8)

Particular cues had certain negative associations for some immigrant patients, which required additional attention to ensure a safe and trusting environment in care. Patients' negative experiences might stem from previous experiences of torture, oppression and ethnic conflict, which may induce negative responses to the way that care is delivered in the host country.

> The patient cannot form a trust relationship with the doctor that is necessary in these cases (Greece, ID 122).

According to those interviewed, the development of a trusting relationship was required to attenuate the influence of these experiences on patient engagement with the service.

> It has to do with making it clear to the person that you do not wish to harm him… A person from a different background can hold a completely different picture of what the treatment entails—what an intervention entails. And also the consequences of not cooperating. (Denmark, ID 43)

Development of a trusting relationship with immigrant patients extended beyond the practitioner and patient relationship, to the interpreter and patient relationship in certain cases. Interviewees suggested numerous reasons why immigrants might distrust interpreters, especially if they come from the same community.

> And also in some cases the interpreter comes from their own social group, and they don't want that… If it's political sometimes they don't want that, or if they do have family and friends in the local community then they might not want someone from that community to be involved in interpreting. That's often a problem that I've come across. (UK, ID 301)

Trust needed to develop at the provider level. Responses given for overcoming the challenges in developing trust were related to provider level changes, such as allowing more time for the a trusting relationship to develop by allocating longer appointments to those with trust issues or by increasing the frequency of visits to allow for familiarity and trust to develop over time.

Increased risk of marginalisation

A particular concern amongst those interviewed was the increased risk that immigrant patients were more prone to becoming marginalised than local-national patients with similar conditions. The combination of living with mental health disorders and adjusting to a new unfamiliar environment with few supportive social contacts, and limited economic resources, could potentially hinder progress and engagement with services.

> … believing that others are persecuting him may make him very isolated; family and his community may not understand his illness and turn away from him; lack of language and his illness may prevent him from contacting the local community (UK, ID 300)

> The problem is one of social exclusion. The problem for people from Northern and Sub-Saharan Africa is poverty. A social problem. (France, ID 802)

A related, yet less commonly reported concern in interviews was the increased risk of immigrants being discriminated against based on their immigrant status. The perception of immigrants as something different raised concerns for discriminatory practices and the resulting potential to marginalise immigrants from services.

> It is something I find very worrying, it is the question of racism. Because it is true that, if that exists, I remember of a psychiatrist one day in a hospital who rings: Yes, but I, I do veterinary medicine with these people (Belgium, ID 22)

In relation to reducing the risk of marginalisation, interviewees discussed the requirement for practitioners to

work with social services and other community groups where possible to increase social integration.

> The practitioner should collaborate with social services in order to link the patient to a social network. (Spain, ID 266)

> If this person came to the country without her family, lack of social support would be a serious problem. We should try to provide a substitute for such support—encouraging involvement of social services or people from her neighbourhood or community, e.g. neighbours, friends. (Poland, ID 231)

Such system level responses were proposed for overcoming marginalisation by working with local communities to increase integration. However, organisational level responses were also required to reduce the risk of exclusion from services based on discriminatory attitudes towards immigrants experienced from within services.

Discussion

Main findings

Interviews with health care professionals, in various mental health service settings across Europe, identified three challenges faced by those involved in the delivery of mental health care to immigrants in areas with dense immigrant populations. This is the first time consistent challenges in the delivery of mental health care for immigrants have been identified across such a wide range of European countries. These issues were comprehensive and covered responses made in all 16 countries. The challenges raised gave insight into the experience of delivering mental health services to immigrant patients from different backgrounds and different national contexts. Although professionals were directly asked about methods employed to counter the challenges they experienced, these were given to a lesser extent. Respondents were more disposed to identify the challenges, than suggest appropriate solutions that they considered were both practical and achievable within the service. The lack of responses given suggests that the application of simple solutions at the service provider level alone might not be enough to tackle these challenges.

Interviewees were more forthcoming and consistent in their emphasis on difficulties arising at the point of first contact with immigrant patients. Complications with making a formal diagnosis shaped experiences and created difficulties in providing appropriate mental health to immigrant patients. Initial encounters with immigrant patients to ascertain a diagnosis appeared the most problematic for navigating language barriers, belief systems, cultural expectations and previous traumatic experiences. These had consequences throughout treatment, but were most prevalent at diagnosis. Issues regarding the development of trust were specific to immigrant patients with distrust for authorities and/or unfamiliarity with how services operated in the host country. Similarly, concerns for immigrant patients becoming marginalised were also made specific to those unfamiliar with the host country, particularly those with few supportive social contacts.

Findings such as the reported building of trust with patients, the reduction of marginalisation and understanding different cultural expectations and belief systems, are all inclusive principles which extend beyond the care of immigrant patients to general principles of care for all mental health patients. The development of trust was seen as integral to open and honest communication in any therapeutic relationship, as were wider social networks and supportive contacts to the prognosis of individuals prone to social marginalisation. Patients presenting with language barriers, differing cultural expectations and differing belief systems may have been reported as more prevalent in interactions with immigrant patients, but the underlying principle of providing a mental health service that is centred on patient requirements was common in the experience of those interviewed in this study.

Strengths and limitations

The main strength of this study was the scope, with the inclusion of experiences from 16 European countries, including countries from different parts of the EU covering more than 85 % of the EU population. The wide scope of this study enabled the participation of countries with diverse immigration histories, policies, funding arrangements and experiences. Consistent findings were noted for both those with recent histories of immigration and those with more substantial experience over time. However, it is important to be aware of the political and regulatory framework within each country to fully understand the extent of the reported similarities in experience. Dependent on a country's policies and legislation, irregular immigrants without coverage and therefore without access to services may only seek treatment when symptoms are severe, compared with national populations. Practitioners interviewed may have only encountered those with high symptom severity, a potential limitation of this research, as this may have biased the sample of irregular immigrants encountered. Although, it is important to factor in the political context behind the practical experiences in services, which may have impacted on who was seen by services and who was not. This was not the aim of this study, which focused on commonalities in experiences as

opposed to differences based on context. The relationship between regulatory frameworks and practice is not always clear cut. Recent research has indicated that countries with no access and partial access to health care for undocumented immigrants still provide treatment services based on principles of human rights and the professional ethics of individual practitioners [5]. This reflects the position that no coverage does not necessarily equate to no or limited access to services in practice [26].

The selection criteria and the same interview schedule (apart from the origin of immigrants in the case vignettes) were maintained for all countries. Meticulous rigour was also applied to the qualitative data analysis, which was collected in multiple centres, in multiple languages and in various mental health care settings. The process of local and central analysis assured quality, as well as consistency, in the development of codes, categories and themes that were relevant to data from all participating countries. Interviews were specific to mental health service delivery as experienced by those delivering care in areas with high immigrant populations. Obtaining the experiences of those most experienced at providing mental health care to immigrant patients made data saturation possible with 48 interviews.

This study is not without methodological limitations. Although the selection and identification of areas and mental health services for recruitment represented well services where immigrant patients would receive treatment, convenience sampling was used to select professionals to participate in the study. This potentially introduced bias with the self-selection of mental health professionals with strong and polarised views on the delivery of mainstream mental health services to immigrants. Interviewees may have had personal or political agendas regarding how services should be delivered to immigrants, although the consensus noted in the findings from this sample would suggest otherwise. Additionally, statements about the delivery of care to immigrants may reflect socially desirable responses rather than the reality of daily practice. No information was collected on measures of actual service delivery, organisational arrangements and immigrant experiences to substantiate the experiences of the mental health care professionals interviewed in these interviews. Individual researcher bias in interpretation of the findings was limited in this study due to the accordance reached in the analysis across multiple researchers with multiple perspectives. However, translations into English were required for the final analysis, which can potentially lead to certain information being lost in translation as a consequence.

Comparisons with the literature

The issues raised in the provision of mental health services to immigrants, by mental health care professionals, mirrored those identified in previous research. Although not addressed explicitly in relation to complicating diagnosis in mental health research, language barrier was an obvious and common thread hindering both access and treatment for immigrants requiring mental health services. Often referred to more generally in the literature as communication difficulties [31], this extended beyond language barriers to both social and cultural references, resulting in low mental health service usage, fewer follow-ups, poorer understanding in consultations and poorer satisfaction ratings among immigrant patients compared with national averages in certain European countries [2].

Linked to language issues was the influence of cultural expectations. Lack of knowledge of services, how they operate and what involvement family and the wider community have in services have been associated with cultural expectations in this study. This level of awareness has also been reflected in a Canadian study [32], where suggestions to obtain better access for immigrant patients and their families included the capability to address cultural differences in understandings of mental health, to recognise the plasticity of culture, as well as establishing good collaborative links. Similar emphasis has also been placed on the importance of cultural factors, over language and general health, in the low utilisation of mental health services by Chinese immigrants in Canada [33].

Addressing the challenges of differences in language, cultural expectations, differing belief systems and past experiences noted in this study led some to suggest changes at the provider level to increase training and awareness of different cultures and belief systems. However, organisational level approaches were also required to tackle the availability of suitably trained interpreters in this study, and system level approaches were also required to educate communities about mental health and to reduce the risk of marginalisation. The findings from this study suggested interventions at all three levels to target these challenges in providing mental health care to immigrant patients.

A similar approach has been suggested in the literature as the interculturalisation of mental health services, which entails a method for adapting services to patients from various cultural contexts [6, 34]. Central to interculturalisation is the relationship between health care professionals and immigrant patients, adapting treatment at an organisational level, forming relationships with communities and informing the perceptions of mental health in the wider social context. In keeping with the findings from this study, the onus has been placed on services to improve relations with local immigrant populations in the literature [32]. A more effective approach would see a shift from mainly provider level approaches, to organisational level and system level approaches as well, to reduce the challenges faced by immigrants at all three levels. However,

commentators have noted that organisational level changes to improve cultural competence can be complicated to implement in multicultural societies, when cultural competence needs to be multidimensional in education, training and practice [35].

Divergent belief systems influenced the explanatory models some immigrant patients used to understand psychiatric symptoms and disorders. Such beliefs may guide cultural differences in the expression of the illness, but more notable amongst the practitioners interviewed in this study was the concern for the implications divergent belief systems had on influencing diagnosis and treatment expectations.

In the literature, belief systems held by patients have been associated with cultural expressions of illness and how services are assessed and approached by immigrants. In a survey of Punjabi and English patients in the UK, practitioners assessed Punjabi patients with common mental health disorders as being more likely to have physical and somatic symptoms or sub-clinical disorders. Punjabi patients with depressive thoughts were less likely to be identified, compared with English patients [18]. Interviews with Somali refugees in the UK [36] and Turkish and Moroccan labour immigrants in the Netherlands [19] detected distinctly different cultural beliefs on mental health and service use from western perspectives. In literature outside of Europe, Ethiopian immigrants and refugees in Canada were more likely to consult traditional healers than health care professionals. Increased incidence of somatic symptoms in this population placed greater use on health services as a consequence [37]. These studies suggest a link between how cultural beliefs and corresponding cultural expectations shape service access and user preferences. The practitioners interviewed in this study, in contrast, linked beliefs and corresponding cultural expectations specifically to a willingness to accept diagnosis, and provided suitable treatment that addresses the barrier between patients' and practitioners' cultural beliefs and expectations.

Time spent in a country, to some degree, minimised the impact of divergent belief systems. Knipscheer and Kleber [20] reported that length of residence in a country was an important predictor of behaviours and attitudes, which may account for variation, as well as originating culture, in belief systems and understanding of mental health services in Europe. Such findings support the need for provider level and organisation level approaches to improve access to mental health care for immigrants and to train practitioners to identify psychological symptoms that may otherwise be difficult to detect due to cultural expression, differing belief systems and corresponding cultural expectations.

Difficulty in differentiating between symptoms of psychotic disorders and a response to prior traumatic experiences has also been noted elsewhere as complicating diagnosis and interventions [1, 25, 36]. In a review of the risk factors and mental health needs of recent immigrant and refugee populations in the United States, pre-migration and migration stressors such as war, torture, terrorism, natural disasters, famine, loss of extended kin and social networks compounded mental health issues [38]. Eisenbruch [9] noted that refugees may have mixed responses to their experience of exile. Inability to freely return and feelings of nostalgia will be described alongside feelings of mass social loss and grief. Transition will bring anxieties of change, where withdrawal behaviour and cultural bereavement can be confused with other psychiatric conditions [1, 9].

Negative experiences stemming from torture, oppression and ethnic conflict often created a lack of trust among immigrants to any form of authority or public service, according to those interviewed in this study. Issues in developing trust extended beyond the practitioner–patient relationship to interpreters. Interviews in Sweden with war-wounded Kurdish refugees noted that differences in cultural background, fear, suspicion and lack of confidence in interpreters all contributed to lack of patient confidence in the service [39]. In the Netherlands, ethnic similarity between therapist and patient was noted as a strong predictor for satisfaction with the relationship among Surinamese immigrants. The authors noted that empathy, expertise and sharing world views were considered important to the therapeutic relationship, which accounted for the reporting of greater patient satisfaction [40]. Our finding on the development of trust as important to the practitioner–patient relationship supports the view that the quality of the relationship is more important than shared ethnicity, with time devoted at the provider level for the development of trust.

Concern amongst those interviewed for immigrant patients being prone to greater social marginalisation supports previous findings [1]. Post-migration stressors including low levels of education and skills, living in overcrowded inner cities, living in areas high in crime, the cycle of poverty, discrimination, prejudice, acculturation stress and cultural bereavement were all discussed as marginalising immigrants from services and society as whole [38]. In New Zealand, circumstances surrounding the reasons for migrating moderated rates of mental health disorders for Chinese migrants [41]. In Sweden, mental illness was associated with poor social networks, economic insecurity and low levels of socio-cultural adaptation in immigrants [25]. Similarly in Norway [8, 42] and Denmark [24] immigrant groups had less social support, less education, lower employment and higher psychological distress. Ethnic discrimination and psychological distress worsened with a lack of economic support in Spanish immigrants [22]. These issues cannot be tackled entirely at

the provider level or at the organisational level. To reduce the impact of marginalisation, the findings of this study support wider social and system level responses and changes to overcome the challenges marginalisation brings for immigrants' mental health.

Implications for improving practice

In order to manage the most common challenges reported in this study, changes at the provider level to daily practice and building professional collaborative relations with immigrant communities may reduce some of the impact of these factors on service delivery. Training that considers communication barriers, cultural expectations and previous traumatic experiences may guide greater clarity in diagnosis. Others have championed models of intercultural surveillance as part of mainstream mental health in multicultural societies [34], to reduce the influence of these barriers in communication and understanding.

Development of trust and reduction of marginalisation could be improved by building trusting relations at the provider level and system level changes for greater inclusion. Working with local immigrant communities and other organisations to engage and develop trusting relationships between mental health services and immigrant populations may potentially aid these processes. Training and on-going supervision for professionals may be useful in the development of appropriate strategies to engage with immigrant patients and build their confidence in services. Collaborating with social services and families, where appropriate, may reduce the risk of marginalisation for certain individuals, although wider social and economic factors may limit what can be achieved at the provider level.

Although differences in service delivery may vary between and within European countries, consistent challenges exist in the experiences of mental health care professionals delivering services in communities with high proportions of immigrants. The consistency in these findings across Europe implies the suitability of best practice models at a European level, with similar challenges being met across Europe; recommendations for best practice may also be appropriate at a European level. Indeed, recent research has similarly noted consensus among experts across Europe on the major principles of good practice that need to be implemented in health care to immigrants [43]. This evidence of consistent findings across Europe calls for more research utilising the strengths and positive experiences that have been made in different European countries, assessing the feasibility of sharing and implementing best practice examples for immigrant mental health care across European countries.

Considerations for practical reform should take into account research on the experience and views of those delivering mental health services. The implications of the findings in this study were specific to immigrants in mental health services. However, the underlying principles of improving access, adapting diagnostic procedures to meet individual patient needs, building trust and reducing marginalisation were elements central to good practice in multiple care settings across Europe [26, 27, 43, 44].

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