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Abstract

Background: More than 650 000 Syrian refugees are hosted in Jordan. Refugees are at high risk of mental health problems.

Aims: To explore the perspectives of Syrian refugees and their host communities and community leaders in Jordan on barriers and facilitators to the use of mental health services by Syrian refugees.

Methods: A qualitative descriptive design was used to collect data through individual, semistructured interviews conducted between May and December 2019 in Jordan. A purposive sample was recruited from different sites.

Results: Twenty-four individual interviews were conducted: 16 for the clients and 8 for the community leaders. Three themes emerged as barriers to accessing mental health services: (1) lack of awareness of mental illness and available services; (2) availability, accessibility and affordability of mental health services; and (3) stigma and social discrimination. Findings show that respondents had low mental health literacy levels.

Conclusion: Policy-makers, care providers and decision-makers should take the findings of this

study into consideration by facilitating the use of mental health services through awareness-raising about mental illness and the provision of services at primary health care centres. Making the service available near to the people who require it and incorporating mental health services into a broad-based community environment such as schools, primary health centres, or case management system are recommended as a common strategy that could help address refugee needs.

Keywords: Syrian refugees; mental health, Jordan, barriers, Arab culture

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Introduction

More than 5.6 million Syrians have been displaced to Turkey, Lebanon, Jordan, Iraq and Egypt since the onset of the Syrian conflict. More than 650 000 Syrian refugees are hosted in Jordan and registered with the United Nations High Commissioner for Refugees (1). Many Syrians have witnessed or experienced the death of loved ones, physical harm, and a violent and terrifying situation before fleeing the Syrian Arab Republic, and during their journey to Jordan. The Syrian crisis has affected Jordan's resources and healthcare system and thus Jordanians' health. Due to their experience of trauma, forced migration, and stressors associated with migration, refugees are classified as a high risk for mental health problems. However, the utilization of mental health services has remained low after settlement (2–6). According to a national Australian study, only 13% of young men aged 16–24 years who had clinically significant symptoms sought professional help compared with one third of young women (7). Help-seeking behaviour has been investigated extensively and research has highlighted its complexity and various factors and barriers may affect it (4,5,8). However, qualitative methodology has not been used to study help-seeking behaviour for mental health services among Syrian refugees in

Jordan.

In Jordan, only physicians are allowed to prescribe psychotropic medications. Public sector primary healthcare physicians are allowed to prescribe psychotropic medications but under certain conditions; they may prescribe follow-up treatment, for example, but cannot initiate treatment. The number of psychiatrists in Jordan does not exceed 2 per 100 000 residents and the number of nurses is 0.04 per 100 000 (9).

It is important to look systematically at barriers and facilitators to accessing and providing mental health services to Syrian refugees in Jordan. Barriers to seeking services and factors influencing the effectiveness of services are not well understood. In the absence of such studies, policy-makers, programme managers and mental health professionals may lack the ability to improve access and utilization rate for mental health services to refugees.

The purpose of this study was to explore the perspectives of Syrian refugees and their host communities and community leaders in Jordan on barriers and facilitators to the use of mental health services by Syrian refugees.

Methods

Study design

A qualitative descriptive design was used to collect data through individual, semistructured interviews conducted between May and December 2019. A purposive sample was recruited from different sites in 6 main cities from different parts of Jordan. Twenty-four individual interviews were conducted among Syrian refugees. Sixteen individual interviews were conducted in clinics. The clinics provide psychosocial and mental health services and are run by international nongovernmental organizations. Eight interviews were conducted at the workplaces of the community leaders. Community leaders with knowledge of Mental Health and Psychosocial Support (MHPSS) services were identified by the heads of the clinics. Individuals who were considered knowledgeable of MHPSS service delivery, utilization and barriers to access were included in the interviews. Key informants were purposively selected because of their perceived levels of expertise and efforts were made to sample key informants across the geographic locations of interest; however, the level of expertise was prioritized. Two experts in qualitative research conducted the interviews.

Participants were asked to provide anonymous case descriptions for discussion based on their experience. Interviews were semistructured and a mixture of questioning strategies was used

around 2 main issues. Providers were asked to express their views and experiences related to barriers and facilitators for the refugees to access mental health services. Questions included: What is your experience with psychological disorders? What are the positive and negative aspects of your visit to the psychologist? What are the possible reasons for patients not asking for help? The interview lasted 15–60 minutes and data collection continued until saturation was achieved.

Interviews were recorded and transcribed. The field notes taken during the discussion were used for data analysis. Field notes were reviewed before the next interviews to allow exploration of emerging concepts. Qualitative data analysis was completed through data coding, identifying categories, clustering and extracting the themes by the first author, and then reviewed for validity by an independent rater.

Ethical considerations

The study was approved initially by the Institutional Review Board at Jordan University of Science and Technology. The study participants were assured of anonymity and confidentiality. The name of the participants and the health centre were not mentioned. All participants verbally consented to participate and were sent a summary of conclusions, which they approved before analysis began. No previous or existing relationships between participants and researchers were found.

Results

Twenty-four individual interviews were conducted. Sixteen (10 men and 6 women) were conducted with clients and 8 (5 men and 3 women) with community leaders. The participants were aged 18–65 years. Five of the community leaders were Jordanians. Three themes evolved in relation to barriers and facilitators of accessing mental health services: (1) lack of awareness of mental illness and available services; (2) availability, accessibility and affordability of mental health services; and (3) stigma and social discrimination.

Lack of awareness of mental illness and available services

Most participants did not understand or accept that they had a treatable health condition. The patients and their family members often dismissed their depression as “feeling down and lazy” and anxiety as simply “being over-worried”.

I did not think I had a psychological problem ... I did not eat or sleep, I stayed in the room all the time, I did not accept to go out or sit with my family or people in general. I was very tired and if

anyone spoke to me, I started crying ... ... My brothers were saying to me that you are young and at the beginning of your life you need to go outside and see people, I felt that their words were meaningless ... but neither I nor they knew that I had depression and my case required treatment. (male 21 years)

When we asked the participants how they dealt with psychosocial problems, most either did not believe that they had a problem requiring treatment; thought that they could handle the problem themselves; or thought that their problem would get better without any help.

I am not a sick person who is having a problem. My eldest daughter always creates problems at home. She does not accept sitting with her father and brothers and runs away from home at night… … I did not imagine that she was a psychotic patient. I said she is at the age of adolescence and I need to understand her, with time, she will calm down and come back to her senses prudently and diligently. (female, 33 years)

There is a lack of understanding of the symptoms of mental health conditions and the benefits that could be provided through treatment.

I am always thinking so much to the point that it is causing me migraine, and from the tension, I had stomach ache …. … I used to see doctors specialized in internal medicine and digestive diseases, and they were not aware of what I have … … one time I went to a general practitioner and he linked my pain to my psychological condition and advised me to see a psychiatrist. I was thinking these are symptoms of physical disease, even specialists did not know from the symptoms that it is a psychological problem. (male 45 years)

Limited knowledge about mental illness can prevent individuals from recognizing it and seeking treatment; poor understanding of mental illness also impairs families' abilities to provide adequate care for mentally ill relatives.

The last thing I expected was that my problem was psychological and that it needed treatment ... ... my family so far is not aware that I have a problem that affects my interaction with them, my level of activity, and my integration with the society … … my father always blames me for not achieving high marks in school like I did before. He thinks that if I take medicine, this would solve the problem, and then they have no responsibility towards me. (female 22 years)

Some participants with an untreated severe mental illness did not seek care because they believed they did not have a condition that required treatment. One team leader mentioned some clients who did not seek treatment because they wanted to solve the problem on their own and one of the clients confirmed: “I tried to solve my problem on my own, I was occupying myself with house chores.” (female 39 years)

Another participant said:

I was expressing what I felt to my family, and felt relieved after talking to them … … they advised me to pray more and read the Quran; I felt better than before but still had suicidal feelings ... I could not go beyond my problem and stayed a long time believing that I could solve my problem and this made my life worse. (male 55 years)

These findings suggest that lack of awareness about the nature of psychological disorders and not realizing the need for consistent treatment are significant barriers to care. There is a need to increase awareness about mental health issues with a goal of reducing stigmatization and encouraging those in need of help to access available services. Continued lack of awareness is a barrier to service utilization. “I know several people are in need of this service but they are afraid of what the community will say about them.” (female, community leader, 33 years)

Availability, accessibility and affordability of mental health services

Some of the participants said they would like to go to a health centre specializing in mental health, but complained that services were available on 1 or 2 days a week and most of the time the doctors were not available. One mother of a patient said:

I took my son and they said they aren’t treating children in this health centre; I have to take him to Irbid city … …. If they treated children in this centre it would be easier for us. I stopped my son’s treatment because there were no services for children in the city where we live and the journey was far away. (female 33 years)

Distance hindered access to mental health services, as stated by the participants: “The centre is far away from us, today we boarded 3 buses until we arrived. Sometimes transportation is

available to us and sometimes not, today we suffered a lot until we arrived." (male 18 years).

Other barriers related to mental health service affordability included transportation, as stated by 1 participant: "Difficulty of transportation, last time it was rainy and I did not have money for transportation so I did not come, today the weather is good and I walked." (female 22 years).

In terms of cost as a barrier, 1 participant stated: "My problem is with car rental, the transport cost is 2 dinars (3 US dollars) and this amount of money is not available to me." (male 19 years)

There is a need to increase access to services and embark on outreach activities. The top 3 barriers to seeking support for mental health problems were transportation, costs and lack of awareness. Additionally, there may be a lack of financial resources, even to cover indirect costs of services. One client suggested that they be provided with transportation or the cost of transportation. "I don't have money to come here every month that is why sometimes I miss my appointment, why don't they try to bring us here in their cars." (male 18 years). Another client suggested mobile clinics: "I am staying far from the health centre, why did they not come to our village to treat us there. They can come once a month, but instead, we come here and pay a lot for transportation." (female 33 years)

Stigma and social discrimination

Mental illnesses affect people of all ages, cultures and socioeconomic status. Participants stated that mental health is stigmatized in a way that physical health is not. People suffering from mental illnesses are often seen as unpredictable, different, weak, "crazy", or even dangerous. This negative stereotype has persisted through time and prevents many people with a mental health condition from seeking the treatment they need.

It is possible that they feel ashamed to say that they are consulting a psychiatrist; because of that they haven't come for treatment. (female, community leader, 22 years)

The community is looking at you as if you are crazy or something is wrong with you – a complex person, and people distance themselves from you. So, to avoid this, you do not go to the psychiatrist. I (male, community leader 32 years)

My husband does not know that I am seeing a psychiatrist and this is an important point because, if he knew, he would disapprove and he would not allow me to come again to be treated. The surroundings, the community, and the attitude of neighbours towards me would change. I always come here secretly. (female 33 years)

Women were found to be less likely to seek help due to concerns over privacy and stigma. “If my husband knows I have been visiting the mental health clinic he will divorce me.” (female 22 years) Participants recommended that to address such stigma, MHPSS services should increase engagement with families and communities.

Discussion

This qualitative study was conducted to explore the perspectives of Syrian refugees and their host communities and community leaders in Jordan on barriers and facilitators to the use of mental health services by Syrian refugees. Three themes were identified after analysing interviews. The first theme, lack of awareness of mental illness and available services, focused on the inability of refugees to recognize that the signs and symptoms they were experiencing were related to mental illness and may require treatment. This could be explained by the low mental health literacy levels of participants regarding this issue. Previous studies have highlighted the importance of mental health literacy in improving help-seeking behaviour (2,7,8,10). Individuals who have higher levels of mental health literacy may recognize their mental illness quickly and seek help during the earlier stages, and thus, they are more likely to recover and be cured of their illness (2,7,10–13). Also, individuals who have higher levels of mental health literacy may have more positive attitudes towards mental health services and treatment, and ultimately, they are more likely to have high levels of treatment adherence (2,7,8,10,14,15).

The second theme was availability, accessibility and affordability of mental health services, which described the barriers to access to mental health services. These barriers included the long distance to mental health services, the use of public transportation because of financial inability to own a car, and scarcity of

psychiatrists, psychologists and specialized mental

health centers in refugee camps or neighbouring cities. These barriers may decrease the rate of mental health service utilization even if individuals have high mental health literacy levels (14,16,17). Previous studies have found that low income, long distances to mental health services, and inability to own a car or free transportation, and scarcity of mental health

professionals are considered significant factors in decreasing the rate of mental health services utilization (18–21). Refugees and their families may have the desire to seek help but they lose this desire and do not attend or drop out of treatment when they encounter the barriers mentioned above (17,22). Consequently, patients with mental illness may relapse or their case may exacerbate rapidly leading to life-threatening complications such as suicide attempts, violence directed toward others, homicide, and substance abuse (23). Participants suggested the provision of free transportation to mental health service centres or reimbursement of the cost of transportation. Other suggestions to overcome the issue of transportation were: to build mental health services close to refugees' residence; hire and help mental health professionals to reach out to refugees who require this type of treatment; and training lay providers/peers to reach out to refugees, engage them in care, and in some cases, provide care. Previous studies have found that these suggestions were effective in improving utilization of mental health services (3,5,14,24).

The third theme was stigma and social discrimination, which is considered one of the most common barriers to mental health treatment. There are several types or aspects of stigma, and most of them were apparent during the interviews. For example, some refugees may have self-stigma toward mental illness, while others highlighted the issue of community stigma. Also, some people have stigma toward mental illness, while others have stigma toward mental health treatment, or both. There are several reasons for stigma among Syrian refugees. First, they are part of the Arabic collectivist culture that shows high levels of stigma toward mental illness and treatment (2,7,10,12,13). Second, low mental health literacy levels can affect attitudes toward illness and treatment negatively, and thus, may increase levels of stigma toward mental illness and treatment (11,13,17,19,23,25–27). Third, the high social pressure and disapproval that patients perceive from their families and significant others increase the likelihood of developing self-stigma toward mental illness and treatment (2,7,10,12,18,19,23). Previous studies have found that high levels of stigma may affect mental health help-seeking behaviour negatively (2,7,10,12). Consequently, the low utilization rate of mental health services caused by stigma may increase the risk of exacerbation and relapse among patients. Also, there is a strong positive relationship between high stigma levels and under-reported cases of mental illness, which make it difficult for healthcare professionals to reach those cases during the early stages of the illness (10,12,18,23). The participants in the present study suggested conducting campaigns to improve the awareness of refugees about mental illness and treatment approaches available. Previous awareness campaigns and mental health educational programmes have been effective in improving mental health literacy levels and access and utilization of mental health services (18,28–30).

This study had some limitations. Its external validity is challenged by the small size of the sample. The Syrian refugees and community leaders answered the questions based on their personal experiences; therefore, generalization of the findings to the wider population should be limited. Also, the recruitment method may have created a sampling bias as the participants were recruited from clinics managed by international organizations, which prevented the researchers

from gaining the perspective of the entire Syrian refugee population. Furthermore, since the interviewers stimulated the participants to mention additional barriers by asking them open questions regarding any other barriers, it is possible that the interviewees were encouraged to think and report about barriers that are not critical to the target population. Further research is needed to collect more data and generate more evidence by including a larger number of participants from different sites. Quantitative studies are needed to help data collection from a larger group.

Conclusion

Refugees are at high risk for mental health problems. Many Syrians have witnessed or experienced the death of loved ones, physical harm, and violent and terrifying situations before fleeing Syria, and during their journey to Jordan. This study presents the views of refugees and Jordanians from the host community and community leaders about barriers to seeking help for mental health problems. Three themes emerged from this study regarding barriers to utilization of mental health services: (1) lack of awareness of mental illness and available services; (2) availability, accessibility and affordability of mental health services and (3) stigma and social discrimination. Policy-makers, care providers and decision-makers should take the findings of this study into consideration by facilitating the use of mental health services through awareness-raising about mental illness and the provision of services at primary health care centres. Incorporation of mental health services into a broad-based community environment such as schools, primary intervention, or case management system is recommended as a common strategy that could help address the the needs of refugees.

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Competing interests: None declared.

Obstacles au recours des réfugiés syriens aux services de santé mentale en Jordanie : étude qualitative

Résumé

Contexte : Plus de 650 000 réfugiés syriens sont accueillis en Jordanie. Les réfugiés présentent un risque élevé de problèmes de santé mentale.

Objectifs : Examiner les points de vue des réfugiés syriens, de leurs communautés d'accueil et des dirigeants communautaires en Jordanie sur les obstacles et les facteurs facilitant le recours

de ces réfugiés aux services de santé mentale.

Méthodes : Un modèle qualitatif descriptif a été utilisé pour collecter les données par le biais d'entretiens individuels semi-structurés, menés entre mai et décembre 2019 en Jordanie. Un échantillon raisonné a été recruté dans différents sites.

Résultats : Vingt-quatre entretiens individuels ont été réalisés : 16 pour les clients de ces services et huit pour les dirigeants communautaires. Trois thèmes sont apparus comme étant des obstacles à l'accès aux services de santé

mentale : 1) le manque de sensibilisation à la maladie mentale et aux services disponibles ; 2) la disponibilité, l'accessibilité et le caractère abordable des services de santé mentale ; et 3) la stigmatisation et la discrimination sociale. Les résultats montrent que les participants avaient de faibles niveaux de littératie en santé mentale.

Conclusion : Les responsables de l'élaboration des politiques, les prestataires de soins et les décideurs devraient tenir compte des résultats de la présente étude en facilitant le recours aux services de santé mentale, grâce à une sensibilisation accrue aux maladies mentales et la prestation de service dans les centres de soins de santé primaires. Il est également recommandé de rendre le service disponible à proximité des personnes qui en ont besoin. Il est nécessaire d'intégrer les services de santé mentale dans un environnement communautaire élargi tel que les écoles, ainsi que dans les centres de soins de santé primaires ou le système de prise en charge des cas, en tant que stratégie commune susceptible de répondre aux besoins des réfugiés.

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[illegible] 2019 [illegible]

[illegible] 16 [illegible] 8 [illegible]

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