Barriers to Accessing Mental Health Services Among Syrian Refugees in Ankara

Cengiz Kilic (cengizk@hacettepe.edu.tr)
Hacettepe University: Hacettepe Universitesi https://orcid.org/0000-0002-9270-8625
Edip Kaya
Ağrı İbrahim Çeçen Üniversitesi: Agri Ibrahim Cecen Universitesi
Ozge Karadag
Earth Institute at Columbia University
Sarp Uner
Lokman Hekim University: Lokman Hekim Universitesi

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Abstract

Background: Syrian refugees are seriously traumatized by the conflict in their country. Consequently, mental health problems, particularly depression and PTSD, are prevalent among refugees. Despite this fact, they make little use of mental health services. Using a population sample of Syrian refugees living in Ankara, we assessed the perceived need for and contact with mental health services, as well as the barriers to access these services.

Methods: This was a cross-sectional study of 420 Syrian refugees living in Ankara city center, using face to face interviews administered at the respondents' home by trained, Arabic-speaking interviewers. The data were collected in October–November 2016 in two neighborhoods of Ankara, where most of Syrian refugees were concentrated. PTSD and depression were assessed using Harvard Trauma Questionnaire and Beck Depression Inventory, respectively. Both measures have been validated in Arabic.

Results: Of all the refugees in our sample, 14.8% (N=62) stated that they felt the need for mental healthcare since arriving in Turkey. The actual number contacting any mental health service, however, was very low (N=6). Multivariate analyses revealed that traumatic stress scores predicted the perceived need for contacting services. Though women reported much higher need for contact with mental health services than men, there was no gender effect on actual contact. Speaking Turkish seemed to increase contact with services, which is in line with language being listed as the most important barrier to accessing care.

Conclusions: Our results show that, although refugees with mental health problems are more likely to contact services than others, most of those who need mental health care go untreated, and there is a significant gender inequity in this regard. To address this treatment gap, and to provide adequate care for refugees with mental health problems, common barriers (language, stigma, and awareness) should be identified and dealt with.

Background

Syrian refugees have been seriously traumatized by the conflict in their country. Consequently, mental health problems, particularly depression and PTSD, are prevalent among them [1]. Even though mental health problems are common among refugees, they are also known to make little use of mental health services [2-6]. Mental health research on Syrian refugees has focused mainly on the rates of mental disorders; the barriers to utilizing mental health services are less commonly studied [5,7,8]. Common barriers to seeking care reported by previous studies were: not speaking the language of the host country, lack of knowledge on available mental health services, inability to recognize mental health problems and their severity, fear of stigmatization, trust-related issues, transportation problems, financial difficulties and cultural factors [7, 9-11]. Problems related to service provision, such as difficulties in accessing mental health services, the high cost of services, long waiting times, stigmatizing and discriminating attitudes in the host country, and hardline policies and practices related to refugees also have significant and

negative effects on refugees' access to mental health services [12-15]. Consequently, studies conducted in host countries show that up to 80–90 percent of refugees with Post-Traumatic Stress Disorder (PTSD) or other mental disorders do not utilize mental health services at all. For example, in Germany, only around 5% of refugees in need of mental health services, are able to receive them [5]. In a study conducted with Iraqi asylum seekers in the Netherlands, only 8.8% of those with a mental disorder were found to utilize mental health services [16]. In a study conducted in Lebanon, only 1% of Syrian refugees were found to have access to mental health services [8].

Today, Syria is the origin country of the largest number of refugees in the world. According to the United Nations High Commissioner for Refugees (UNHCR) data (March 2021), 5.6 million refugees have taken refuge in other countries as a result of the war in Syria. Hosting more than 3.6 million Syrian refugees, Turkey is the country with the largest number of refugees in the world [17]. There are not many studies on the rate of mental health services use for refugees in Turkey. In a recent study on a large sample of refugees in Istanbul, Fuhr et al. have shown that only 9% of those in need of mental health care actually sought help, which is in line with other studies showing low rates of contact [18].

Using a population sample of Syrian refugees living in Ankara, we aimed to assess the perceived need for mental health services and the barriers to access these services. The results on the rates and predictors of mental health status of the refugees, as well as a more detailed description of the methods can be found in Kaya et al 2019 [1].

Methods

Sample: This was a cross-sectional study of 420 Syrian refugees living in Ankara, using face to face interviews administered at the respondents' home by trained, Arabic-speaking interviewers. The interviews were conducted in October–November 2016 in two neighborhoods of Ankara, populated mostly by Syrian refugees.

Measures:

Although our measures were developed to be filled-in by the respondent (i.e. self-report), the interviewers were instructed to read out the items and record the responses. This was necessary, since a large majority of the respondents had either no formal education or minimal (i.e. primary school) education.

Demographics: This section was developed by the researchers for the purposes of the current study. It included items assessing sociodemographic characteristics of the participants, their perceived physical and mental health status, utilization of and access to general and mental health services, and factors preventing access to those services. Social network variables such as having Turkish friends and speaking the language (i.e., Turkish). The services use section was quite detailed and inquired about the presence of physical or mental conditions diagnosed by a doctor, subjective assessment of physical and mental status by the respondent, alcohol/drug use history, current psychotropic use, contact with health

and mental health services in the past year, the subjective need to contact mental health services, and finally reasons for non-contact, if the respondent reported need for contact and did not contact.

Harvard Trauma Questionnaire (HTQ): The HTQ is a widely-used self-report measure of traumatic stress [19]. We used the Arabic version that assesses DSM-IV PTSD symptoms [20]. The participant is asked to rate each item on a four-point Likert scale (1=not at all, 2=a little, 3=quite a bit, and 4=extremely). The first 16 items such as “recurrent thoughts or memories of the most hurtful or terrifying events” or “feeling as though the event is happening again” assesses the presence of probable PTSD. The validation study of the original version was conducted with 91 patients originally from Cambodia, Laos, and Vietnam, using a semi-structured interview. Probable PTSD is computed following the algorithm suggested by the authors, since there is no established cutoff for the Arabic version. Cronbach’s alpha for the 16 PTSD symptoms in the current study was 0.82.

Beck Depression Inventory (BDI): This widely used, 21-item, self-report questionnaire measures depressive symptomatology for the last week [21]. All items are coded between 0 and 3; higher scores suggest more severe depression. Validity and reliability in Arabic were established by West [22] and Abdel-Khalek [23]. In the present study, both the BDI total score (range: 0-63), and the probable depression score (using a cutoff of 19) were used in analyses. Cronbach’s alpha for the current sample was 0.85.

Variable selection and transformations:

We used both categorical and continuous variables in reporting our results. We recoded some variables before analyses. For example, marital status (married, single, divorced) was recoded as married/not married. Command of Turkish language, which was coded on a 5-point scale (0=none, to 4 =very good), was recoded as 0=no, 1=yes, where yes=good, very good. Education (0=no education, 4=university graduate) and effect of symptoms on social functioning (1=none, 4=very much) were used as continuous variables. Since BDI and HTQ scores were highly correlated, we decided to include HTQ only as a measure of current psychopathology in our predictor analyses.

Procedure: Convenience sampling method was used to recruit participants into the study. The houses in the two neighborhoods, populated mostly by Syrian refugees, were visited by our six interviewers who were fluent in Turkish and Arabic. Each household was visited by at least two interviewers. Of the households visited, 15 declined to participate and so were not included in the study. Figure 1 shows the recruitment of participants to the study. SPSS 23.0 statistical software package was used for data analysis.

Results

General description of the sample:

The participants had a mean age of 35.4 years (Range: 18-80, SD:13.0); 56.4% were female and 84.7% were married. A large majority of the participants (70.1%) had an elementary school education or less;

2.9% reported having a diagnosed mental disorder in the past, and 2.1% reported currently being on medication for their mental disorder. The refugees were found to be highly traumatized; 88.8% reported having witnessed war or armed conflict, 44.0% reported having lost a family member; and 31.1% reported having witnessed a killing. The prevalence of probable PTSD and depression as measured by HTQ and BDI were 36.5% (N=152) and 47.7% (N=198), respectively. 238 people (%56.7) had either probable PTSD or depression.

Need for and contact with services:

Despite the high rate of traumatization and consequent mental disorders, only 14.8% of the refugees reported they felt the need for help for their mental health problems; and an even smaller minority actually sought help (6 out of 62; 9.7% of those who felt they needed help; 1.4% of the total sample). Although most of those with probable PTSD or depression did not report a need for help, five out of the 6 people who actually made a contact had probable PTSD and/or depression (Table 1). The rate of contact with mental health services among those with probable PTSD/depression (5 out of 238) was therefore much lower (2.1%).

Correlates of perceived need for mental health services:

The bivariate analyses showed that refugee women, refugees with a doctor-diagnosed physical or mental disorder, refugees who had contacted general health services in the last year, who are currently on psychotropics, and finally, refugees with high depression or PTSD scores were in significantly greater need for mental healthcare (Table 2). The most common barriers cited by those who felt they needed mental healthcare, but did not contact any services, were language problems/lack of translators and lack of information on available mental health services (Figure 2).

Correlates of contact with mental health services:

Although the actual number contacting services was very low, we nevertheless conducted bivariate analyses to examine the correlates of contact with mental health services. The six refugees who actually contacted services were more likely to have a past psychiatric diagnosis (4 out of 6, p=.001) and to be currently on psychotropics (p=.001). All six of them said they felt they needed contact with services for their problems (p=.001). The six participants who contacted mental health services had significantly higher scores of PTSD (p=.001) and depression (p=.04) than others (Table 3).

Regression analyses:

We employed binary logistic regression analyses in order to determine the independent predictors of subjective need for mental health services, as well as for actual contact. We entered the variables in two steps, entering the demographic variables in the first step and the clinical variables in the second. Table 4 shows that the subjective need for contact with services was related to female gender. The prediction by gender disappeared, however, after we added the clinical variables to the model at the second step. The HTQ score (severity of traumatic stress) was the sole predictor in the final model.

The regression analyses run to determine the predictors of actual contact revealed that those with good command of Turkish were significantly more likely to have contacted services. Although this prediction lost its significance after clinical variables were added, there still was a trend. Traumatic stress score as measured by the HTQ predicted contact in the final model (Table 5).

Discussion

This study has shown that contact with mental health services was very low among Syrian refugees in Turkey despite the high prevalences of reported traumatization and mental disorder. The findings of the present study are consistent with those of previous studies with Syrian refugees and other refugee groups, indicating that many refugees are in need of mental health support, and that very few of them make use of these services [18, 24-26]. Although the study designs were different, our results on the rates of contact were strikingly similar to those reported by Fuhr et al for Syrian refugees in Istanbul [18]. The contact rates reported in these two studies are much lower compared to studies done in the general population of Turkey [27]. Refugees with mental health problems were more likely to contact services. This is not comforting, however, since nine out of ten refugees do not look out for help, even though they acknowledge a need for help.

The main barriers to access mental health care reported in the refugee literature are language problems [3, 5, 28, 29] and lack of knowledge about where and how to get access to mental health services [24, 25, 30], which were our main findings as well. The language barrier was especially important: many refugees said they would go to the hospital if they knew there was a translator or an Arabic-speaking doctor/psychologist at the premises. Most said they were not able to read signs on the buses or buildings, showing that the problem is two-fold: a bus-sign in an unknown language as well as in an unknown alphabet. With the exception of the study by Fuhr et al [18], all studies on the mental health services use of Syrian refugees showed that the refugees regarded language as the major barrier to care [7, 11, 31]. Our study we believe is unique, in that we managed to show, through predictor analyses, that a good command of the (Turkish) language independently predicts services use.

Although the subjective reported need for services was three times higher among women than men, and women reported a higher interference of mental health symptoms with social functioning, there was no gender difference among those who contacted mental health services. This finding is alarming and shows that the mental health treatment gap is much wider for refugee women than men. We did not assess the possible reasons for this gender disparity, but it definitely deserves a closer look. Future research should examine the reasons why refugee women, who report they need psychological help, do not prefer to seek help: are they forced to stay behind by their spouses; are they discouraged because of language problems (those who can speak Turkish are much lower among female refugees); or are they too busy tending household duties?

Finally, as would be expected, a large majority of refugees are under serious financial hardship, and find it difficult to meet even their most basic needs [26]. Financial problems and transportation problems were

among the main reasons for non-contact. It is therefore possible that mental health provision is not high on their agenda.

Many efforts have been made in Turkey to remove the language barrier and increase refugees' access to healthcare services. With the support of an EU-funded health project titled "Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities" (SIHHAT Project), The Ministry of Health has established Migrant Health Centers (MHCs) and Strengthened MHCs to provide primary and secondary healthcare services to refugees [32]. Syrian health care workers and bilingual (Arabic-Turkish) patient guidance staff have been employed in these centers to overcome the language barrier [33]. In addition, translators have been employed in the secondary and tertiary public hospitals most frequently visited by refugees; signs in Arabic have been posted and informational leaflets have been distributed in those hospitals. Still, observations in the field suggest that we have a long way to go to eliminate the language barrier.

Despite its strengths, this study also has some limitations. Most importantly, the study sample was not representative of refugees in Ankara, let alone all refugees in Turkey. The second limitation relates to the multivariate analyses we conducted to identify predictors of contact with mental health services: there were only six people who made use of those services, which limited more in-depth analyses. Finally, although we used clinically valid instruments in face-to-face interviews, we did not employ clinical interviews that would allow us make clinical diagnoses.

Conclusions

This study confirmed the findings of previous studies showing that Syrian refugees rarely contacted mental health services, despite having experienced high rates of war traumas and current mental problems. The most important barrier to accessing mental health services was reported to be language problems. Lack of information on available mental health services was the second most commonly reported barrier. It is obvious that the second reported barrier is highly dependent on the first one; i.e language. The inequality favoring men over women in terms of contact was apparent, as well as the advantage of speaking the language in accessing care. The findings indicate that there is a need to strengthen mental health policies and services for refugees, as well as to increase their access to services. The struggle against barriers to mental health care should always be coupled with a fight against gender inequality.

List Of Abbreviations

PTSD: Post-Traumatic Stress Disorder; UNHCR: United Nations High Commissioner for Refugees; HTQ: Harvard Trauma Questionnaire; DSM: Diagnostic and Statistical Manual of Mental Disorders; BDI: Beck Depression Inventory; MHCs: Migrant Health Centers.

Declarations

Ethics approval and consent to participate

Ethical approval for the study was obtained from Hacettepe University Ethics Board, and institutional permissions were obtained from the Ministry of Interior's General Directorate of Migration Management, and the Ministry of Health's General Directorate of Public Health. All participants provided informed consent to participate in the study.

Consent for publication

Not applicable.

Availability of data and materials

The data that support the findings of this study are available on reasonable request from the corresponding author, [CK], with the permission of Hacettepe University.

Competing interests

The authors declare that they have no competing interests.

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Author contributions:

CK, EK, OK, and SU contributed to the design of the study. CK and EK analyzed the data. CK, EK and OK interpreted the data and wrote the first draft of the manuscript. CK wrote the revised final draft. CK and EK conducted interviewer training, implementation and supervision of the field work. All authors read and approved the final manuscript.

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Tables

Table 1 Sociodemographic characteristics of participants (n=420)

Sociodemographic variables	Female n (%)	Male n (%)	Total n (%)	p value*
Good command of Turkish (0=no, 1=yes)	10 (4.2)	39 (21.3)	49 (11.7)	<0.001
Has Turkish friend (0=no, 1=yes)	38 (16.0)	63 (34.6)	101 (24.1)	<0.001
Has income-returning job (0=no, 1=yes)	9 (3.8)	109 (59.9)	118 (28.2)	<0.001
Presence of any physical illness (0=no, 1=yes)	95 (40.1)	89 (48.9)	184 (43.9)	0.071
Contact with general health services in the last year (0=no, 1=yes)	124 (52.3)	70 (38.5)	194 (46.3)	0.005
Presence of past psychiatric illness (0=no, 1=yes)	10 (4.2)	2 (1.1)	12 (2.9)	0.058
Currently on psychiatric medications (0=no, 1=yes)	5 (2.1)	4 (2.2)	9 (2.1)	1.000
Presence of psychiatric disorder in the family (0=no, 1=yes)	13 (5.5)	14 (7.7)	27 (6.4)	0.362
Need for receiving mental health care (0=no, 1=yes)	45 (19.0)	17 (9.3)	62 (14.8)	0.006
Contact with mental health services (0=no, 1=yes)	2 (1.1)	4 (1.7)	6 (1.4)	0.701
	Mean (SD)	Mean (SD)	Mean (SD)	p value**
Age	34.3 (12.6)	36.9 (13.5)	35.4 (13.0)	0.040
Duration of asylum in Turkey (years)	2.1 (1.3)	2.3 (1.1)	2.2 (1.1)	0.164
Education level (0=none, 4=university)	2.9 (1.3)	3.1 (1.4)	3.0 (1.3)	0.083
Monthly family income (USD)	272.7 (153.7)	285.1 (145.5)	278.1 (150.1)	0.401
HTQ-16 (16-64)	36.7 (8.9)	32.6 (8.1)	34.9 (8.8)	<0.001
BDI (0-63)	22.0 (11.1)	18.5 (9.4)	20.5 (10.6)	0.001
Self-reported mental health (1-4)	1.8 (0.7)	1.8 (0.8)	1.8 (0.8)	0.627
Effect of mental problems on social functioning (1=none, 4=very much)	1.8 (1.1)	1.6 (1.0)	1.7 (1.1)	0.039

*:Chi Square test; **: t test; SD: Standard Deviation, USD: United States Dollars, n: Frequencies, HTQ: Harvard Trauma Questionnaire, BDI: Beck Depression Inventory

Table 2 Univariate analysis of factors associated with refugees' perceived need for mental health care (n=420)

		Need for receiving mental health care			
Sociodemographic variables		**Yes** **n (%)**	**No** **n (%)**	**Total** **n (%)**	**p value***
Gender	Male Female	17 (9.3) 45 (19.0)	165 (90.7) 192 (81.0)	182 237	0.006
Marital status	Married Not married	50 (14.1) 12 (18.8)	305 (85.9) 52 (81.3)	355 64	0.333
Good command of Turkish	Yes No	8 (16.3) 54 (14.6)	41 (83.7) 316 (85.4)	49	0.748
Has Turkish friend	Yes No	15 (14.9) 47 (14.8)	86 (85.1) 271 (85.2)	101	0.986
Income-returning job	Yes No	12 (10.2) 50 (16.6)	106 (89.8) 251 (83.4)	118	0.095
Contact with general health services in the last year	Yes No	37 (19.1) 25 (11.1)	157 (80.9) 200 (88.9)	194	0.022
		Mean (SD)	**Mean (SD)**	**Mean (SD)**	**p value****
Age	(years)	34.8 (11.2)	35.5 (13.4)	35.4 (13.0)	0.693
Duration of asylum in Turkey	(years)	2.4 (1.1)	2.2 (1.1)	2.2 (1.1)	0.319
Education level	(0=none, 4=university)	2.9 (1.3)	3.0 (1.3)	3.0 (1.3)	0.579
Monthly family income	(USD)	276.7 (119.6)	278.4 (155.1)	278.1 (150.1)	0.935
HTQ-16 (16-64)		40.8 (8.9)	33.9 (8.4)	34.9 (8.8)	0.001

BDI (0-63)	25.0 (10.5)	19.7 (10.4)	20.5 (10.6)	0.001

*:Chi Square test; **: t test; SD: Standard Deviation, USD: United States Dollars, n: Frequencies, HTQ: Harvard Trauma Questionnaire, BDI: Beck Depression Inventory

Table 3 Univariate analysis of factors associated with contact with mental health services (n=420)

		Contact with mental health services			
Sociodemographic variables		**Yes** **n (%)**	**No** **n (%)**	**Total** **n (%)**	**p value***
Gender	Male	2 (1.1)	180 (98.9)	182	0.701
	Female	4 (1.7)	233 (98.3)	237	
Marital status	Married	4 (1.1)	351 (98.9)	355	0.229
	Not married	2 (3.1)	62 (96.9)	64	
Good command of Turkish	Yes	2 (4.1)	47 (95.9)	49	0.148
	No	4 (1.1)	366 (98.9)	370	
Has Turkish friend	Yes	2 (2.0)	99 (98.0)	101	0.634
	No	4 (1.3)	314 (98.7)	318	
Income-returning job	Yes	0 (0.0)	118 (100.0)	118	0.191
	No	6 (2.0)	295 (98.0)		
Contact with general health services in the last year	Yes	5 (2.6)	189 (97.4)	194	0.100
	No	1 (0.4)	224 (99.6)		
Need for receiving mental health care	Yes	6 (9.7)	56 (90.3)	62	0.001
	No	0 (0.0)	357 (100.0)	357	
		Mean (SD)	**Mean (SD)**	**Mean (SD)**	**p value****
Age	(years)	31.8 (9.2)	35.5 (13.1)	35.4 (13.0)	0.495
Duration of asylum in Turkey	(years)	2.1 (1.1)	2.2 (1.1)	2.2 (1.1)	0.607

Education level	(0=no education, 4=university graduate)	3.3 (1.4)	3.0 (1.3)	3.0 (1.3)	0.485
Monthly family income	(USD)	194.5 (164.1)	279.3 (150.0)	278.1 (150.1)	0.170
HTQ-16 (16-64)		44.7 (7.7)	34.8 (8.7)	34.9 (8.8)	0.006
BDI (0-63)		29.0 (8.5)	20.4 (10.6)	20.5 (10.6)	0.048

*:Chi Square test; **: t test; SD: Standard Deviation, USD: United States Dollars, n: Frequencies, HTQ: Harvard Trauma Questionnaire, BDI: Beck Depression Inventory

Table 4 Predictors of refugees' perceived need for receiving mental health care (Logistic regression)

Sociodemographic variables	Perceived need for mental health care			
	Step I		Step II	
	OR (95 % CI)	p value	OR (95 % CI)	p value
Age	0.999 (0.977-1.022)	0,963	0.995 (0.972-1.020)	0.712
Gender (0=male, 1=female)	2.559 (1.117-5.859)	0.026	1.628 (0.690-3.845)	0.266
Education level (0=no education, 4=university graduate)	0.969 (0.775-1.213)	0.786	0.994 (0.792-1.248)	0.962
Marital status (0=not married, 1=married)	1.553 (0.755-3.194)	0.232	1.551 (0.715-3.364)	0.267
Income-returning job (0=no, 1=yes)	0.958 (0.373-2.465)	0.929	1.019 (0.388-2.675)	0.970
Duration of asylum in Turkey (years)	1.214 (0.939-1.569)	0.140	1.230 (0.937-1.614)	0.136
Good command of Turkish (0=no, 1=yes)	1.456 (0.582-3.643)	0.423	1.213 (0.464-3.175)	0.694
Has Turkish friend (0=no, 1=yes)	1.165 (0.579-2.344)	0.669	0.978 (0.470-2.038)	0.953
HTQ (16-64)	-	-	1.088 (1.050-1.126)	<0.001
Contact with general health services in the last year (0=no, 1=yes)	-	-	1.757 (0.959-3.220)	0.068
Constant	0.059	0.001	0.003	<0.001

OR: Odds Ratio, CI: Confidence interval, HTQ: Harvard Trauma Questionnaire

Table 5 Predictors of contact with mental health services (Logistic regression)

Sociodemographic variables	Contact with mental health services			
	Step I		Step II	
	OR (95 % CI)	p value	OR (95 % CI)	p value
Age	0.972 (0.903-1.047)	0,459	0.933 (0.845-1.030)	0.172
Gender (0=male, 1=female)	0.630 (0.097-4.065)	0.627	0.136 (0.011-1.692)	0.121
Education (0=no education, 4=university graduate)	1.072 (0.535-2.148)	0.844	1.257 (0.557-2.834)	0.581
Marital status (0=not married, 1=married)	2.360 (0.347-16.044)	0.380	2.800 (0.329-23.810)	0.346
Income-returning job (0=no, 1=yes)	0.000 (0.000–)	0.996	0.000 (0.000–)	0.995
Duration of asylum in Turkey (years)	0.694 (0.306-1.573)	0.381	0.573 (0.213-1.543)	0.270
Good command of Turkish (0=no, 1=yes)	8.316 (1.153-59.975)	0.036	7.623 (0.761-76.411)	0.084
Has Turkish friend (0=no, 1=yes)	3.198 (0.452-22.652)	0.244	2.464 (0.261-23.257)	0.431
HTQ (16-64)	-	-	1.137 (1.016-1.273)	0.025
Contact with general health services in the last year (0=no, 1=yes)	-	-	18.193 (0.682-485.089)	0.083
Constant	0.057	0.199	0.000	0.017

OR: Odds Ratio, CI: Confidence interval, HTQ: Harvard Trauma Questionnaire

Figures

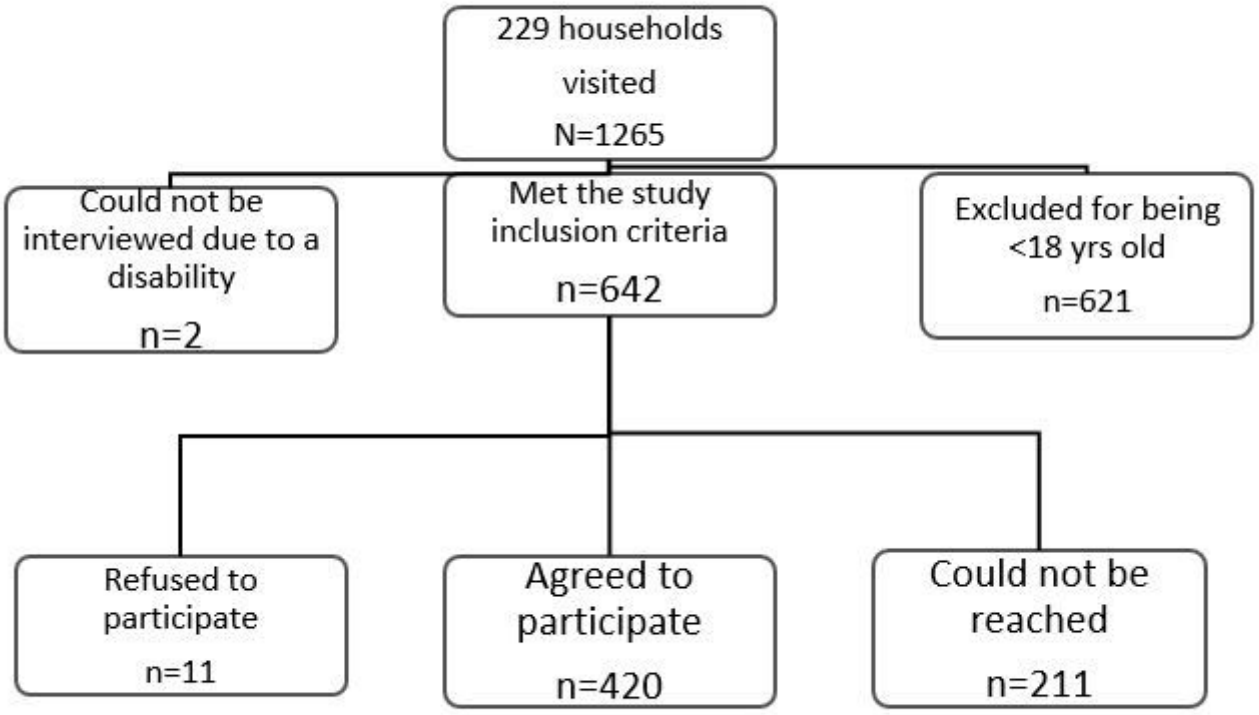

Figure 1

The recruitment of participants

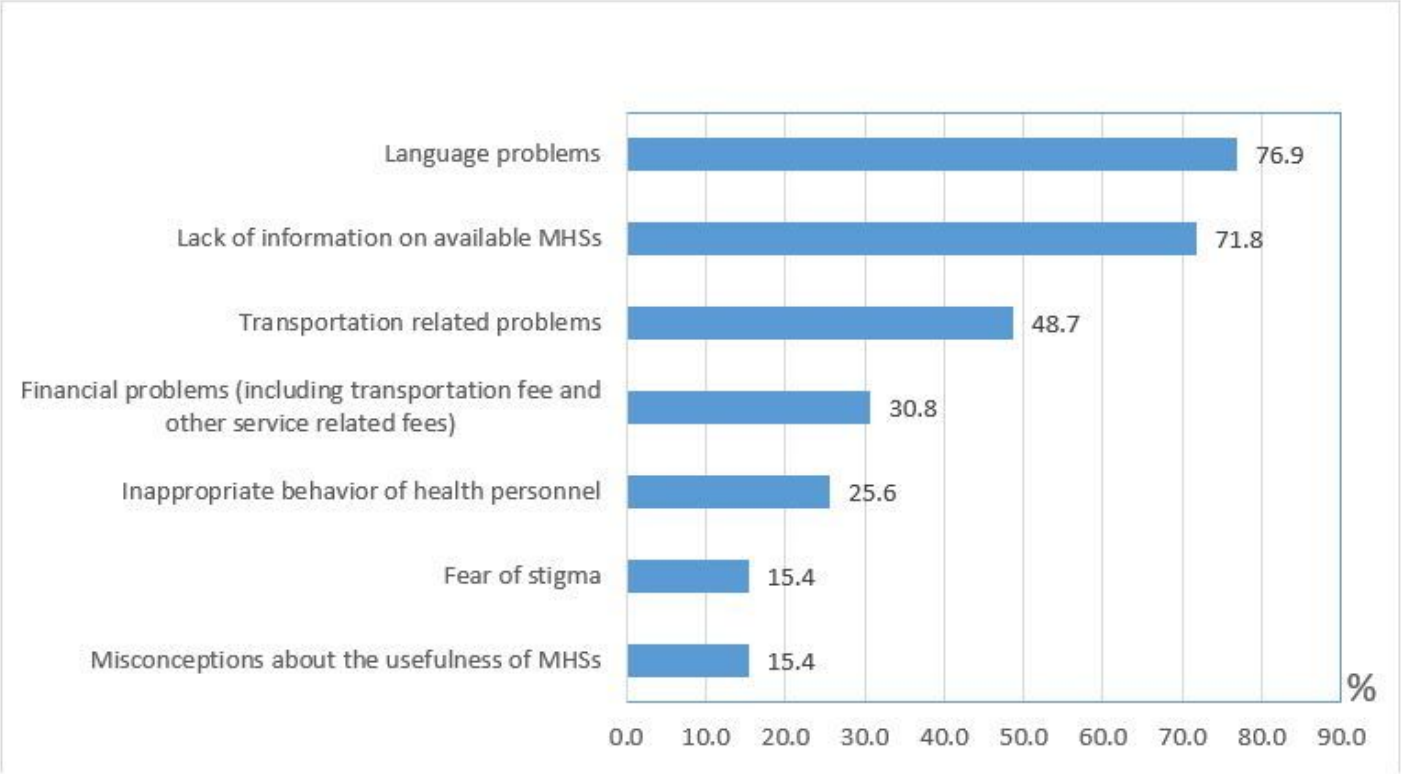

Figure 2

Barriers reported by refugees with perceived need for mental health services