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"My life feels insecure": barriers to mental health and healthcare help-seeking, access and utilization among women with lived experience of forced migration

Abstract

Background: Research on forced migration and its impact on the health/mental health of migrant groups is scarce and data is often absent or inconsistent. Research that centers the voices of women with lived experience of forced migration is almost completely absent, and thus rarely used to inform policies at a global, national and local level. We aim to address these gaps and report findings from a qualitative, participatory research study aimed at identifying the key factors serving as barriers to mental health/healthcare as identified by women with lived experience of forced migration.

Methods: This qualitative study employed theme-based content analysis of data gleaned from in-depth focus groups with women with lived experience of forced migration using an inductive approach. Four 1.5hr focus groups were held over a period of 2 months.

Results: Five major categories emerged as key barriers to utilizing mental healthcare: (1) Fear and Distrust; (2) Discrimination; (3) Unique Experiences of Women; (4) Affordability and Appropriateness of Services; and, (5) Lack of Culturally-Responsive Services.

Conclusion: This is the first study to examine mental health distress and barriers to help-seeking and accessing mental health/healthcare from the perspective of women with lived experience of forced migration in New York City. By learning directly from the population, we aim to address the gaps in existing care; inform the development of appropriate, effective, culturally-responsive services; and, promote awareness of and advocacy to stimulate policy changes responsive to the needs of this ever-increasing and marginalized group.

Keywords: forced migration, help-seeking, barriers, mental health, healthcare, women

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Introduction

Forced migration remains a core issue in 2023, with the number of forcibly displaced people expected to increase to 117 million by the end of 2023.[1] Globally, approximately 1 out of 88 individuals have been forced to flee their homes. It is currently estimated that 108.4 million individuals worldwide have been forcibly displaced including, 35.3 million refugees, 62.5 million internally displaced people, and 5.4 million asylum seekers.[2] By the end of 2022, 43.3 million of all forced migrants (40%) were children and approximately 50% are women and girls[3] escaping violence, persecution, hunger, and natural disasters.

In the United States, as of August 2023, there were 983,094 asylum cases pending.[4] As of December 2022, nearly 800,000 cases were defensive asylum cases[i] awaiting adjudication from an Immigration Judge (IJ), and 842,000[1] were affirmative asylum cases,[ii] awaiting decisions by asylum officers.[52]

A significant increase in cases has been seen over the last year due to the war in Ukraine, leading to a number of added provisions regulating the entry and residence in the US for Ukrainian people[6] and resulting from the humanitarian evacuations from Afghanistan. These two major conflicts have shed light once again on the feminization of forced migration, with more women than men engaging in perilous journeys to find safety, often trapped within national borders or in neighboring countries. The racialization of forced migration is also manifest in the ways in which refugee management systems operate, the disparate treatment of Ukrainian refugees as compared with Afghan refugees or the tens of thousands of asylum seekers from Central and South America being blatant examples[7,8] BIPOC/racialized and indigenous women are often barred from routes of evacuation, sexually exploited during the entire migration journey, and receive dehumanizing treatment at the border.[9]

People with personal histories of forced migration experience trauma before, during, and after their migration journey.[10] In addition to living through the complex, dangerous and painful situations in their countries of origin, they may also face violence, abuse, or torture along their journey to safety. Once in their host country, a new set of stressors contributes to the maintenance, increase and/or onset of emotional and psychological distress experienced by many asylum seekers including poverty, unemployment and underemployment, lack of stable or adequate shelter, isolation, hopelessness, fear of deportation, unpredictable legal situations, lack of self-efficacy, and a general sense of being out of control.

[i]Defensive asylum cases represent asylum cases in the immigration courts, for people that overstayed their legal status, or entered the United States without documents and were apprehended by CBP officers.
[ii] Affirmative asylum cases represent asylum application by people legally in the United States (that came here under a different visa, and applied for asylum while still legally on US territory), or people that were never apprehended by border authorities when entering the country.

Women asylum seekers encounter additional challenges stemming from their main roles as caregivers to multiple members in their families and their heightened responsibility for the wellbeing of their children, (especially single mothers), women experience higher levels of depression, anxiety, PTSD, suicidal ideation, untreated chronic illnesses, and reproductive health challenges.[10]

The unprecedented number of forced migrants globally is challenging the world order and locally is changing communities, posing new challenges on local governments and service providers. Over 150,000 individuals seeking asylum arrived in New York City since Spring 2022, with more than half still being in the city's care.[11] In this context, access to accurate and timely information, basic services, and trauma-informed care providers is essential in protecting migrants' rights, and reclaiming our shared humanity in the process.

At a time when women are most vulnerable, access to health mental healthcare services that could provide needed medical and psychosocial treatment and concrete supports is limited at best and more often unavailable. While the city has opened 188 housing facilities, including 18 humanitarian centers to respond to the needs of asylum seekers coming to NYC, the information is still scarce and fragmented, and the mental health care needs of this population are far from being at the center of program and policy development. Even when they exist, they are often unknown and/or under-utilized. Access to basic health and mental healthcare services for asylum seekers is a triple challenge: Availability of services is low, access is limited and restrictive, and utilization of existing services is bounded by fear and distrust. Some services are non-existent (i.e. transportation services for women suffering of PTSD that cannot use public transportation), others extremely limited (i.e., services in indigenous languages), while still others are cost-prohibitive. Limited information reaches this vulnerable and marginalized population, while a lack of cultural awareness and understanding of the overall context of forced migration, stigma, and fear prevent women from seeking health and mental healthcare.

Further, families with children, and mothers especially, are facing compounded complex challenges as they try to navigate the city, locate resources, follow the required steps to apply for asylum, secure and maintain employment, enroll children in schools, and make sure they are getting the mental health support needed for themselves and their children to establish a productive and happy life in NYC. Service providers are struggling to expand services in the context of already limited resources, with little (if any) additional training to make sense of the complexities of forced migration and the importance of trauma-informed care in meeting the needs of this population.

These challenges are only exacerbated by the more restrictive immigration provisions and policies introduced within the last 5 years, particularly at the start of the pandemic,[iii] pushing asylum seekers to the background out of fear and lack of awareness of rights.[12] This only serves to further prevent them from seeking just due services (such as the use of Medicaid and the last resort of the emergency room), even when desperately needed to address their pressing health, emotional and psychological concerns.

The voices of migrants are crucial in providing effective guidance on these matters, and informing policy changes and adequate mental health pr^{3}ogram development. To address these concerns, we established Her Migrant Hub (HMH), a community-driven program aimed at increasing access to and improving quality of health and mental healthcare among women asylum seekers.

Research on migration challenges in general, forced migration and its impact on the health and mental health of different population groups in particular, is scarce and data is often absent or inconsistent. While large international organizations worked with universities and independent scholars around the world to improve migration data (see UNHCR data sets, and the Global Migration Portal of the IOM), migrant-driven research is almost completely absent, and rarely used to inform policies at a global, national and local level. This paper will report findings from a qualitative, participatory research study aimed at addressing this major gap and focused identifying the key factors contributing to mental health challenges and barriers to accessing psychosocial and medical care as identified by the core group of HMH Activists (women with lived experience of forced migration), gleaned through a series of focus groups. By learning directly from the population, we aim to address the gaps in existing services; inform the development of appropriate, effective, culturally-responsive services to build a culture of safety; and, promote awareness of and advocacy to stimulate policy changes responsive to the needs of this ever-increasing and marginalized group.

Materials and methods

Sample

With approval from the appropriate Institutional Review Board, twelve women asylum seekers living in New York City receiving services from HMH partner organizations (community-based organizations providing services to the NYC migrant population) served as the sample for this study. Purposive sampling was used. Inclusion criteria included: Women; having lived experience of forced migration; living in New York City; English or Spanish speaking; authorized for temporary stay in the US (with asylum cases pending or under temporary protection status); over age 18.

Focus group procedures

We used focus groups as a data collection method as they provide an effective means for capturing sensitive, experiential information elicited through the context of group dialogue/interaction. Four 1.5hr focus groups were held over a period of 2 months. Rather than assuming to know what topics would be meaningful and important to explore with the participants, the first focus group was initiated with two key open-ended questions of, "What are some issues related to health care affecting your communities? What are some challenges you have heard of/experienced/would want to share?". Based on the literature focused on mental health and forced migration and previous practice experience with the population, open-ended discussion guides were prepared by HMH Co-Directors for the focus group facilitators to use to stimulate further dialogue, modified according to participant responses to the opening questions.

Due to the pandemic, focus groups were held over zoom and led by the co-authors, PhD level social work professors with research and clinical experience with this population and with basic to advanced Spanish fluency. To assure anonymity, verbal consent was obtained using a protocol summary consent. At the beginning of each focus group, the moderators described the purpose of the group and overall project. The opening questions and follow-up discussion guide were then used to generate dialogue about the following topics: challenges faced as a female asylum seeker in New York City; mental health functioning; barriers to obtaining health and mental healthcare.

[iii]The infamous Title 42 provision, although ultimately terminated as of May 2023, led to the deportation of more 2.8 million people, and informed more restrictive immigration policies following its demise.

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Data analysis

The primary approach to analysis employed for this study was theme-based content analysis of the qualitative data using an inductive approach. Participant responses were reviewed by the study PIs and the group of HMH women activists to identify recurring themes. These units were then collapsed to create a set of preliminary categories. The categories were then clustered, and themes were identified. Following this, all coders then compared and discussed their results and consensus was reached on the final set of themes. Initial coding was conducted independently and followed by team meetings during which the full team reviewed the categories and idiosyncratic and/or redundant responses were removed. In the case of discrepancies, definitions of the categories were clarified, and coding was reviewed until inter-rater consistency of at least 80% for all items was reached, per standards in the literature.[13] Quotations representing the major themes identified are reported in the results section along with a summary, description, and interpretation of the themes.

Results

Characteristics of the focus group participants

The focus groups included 12 female asylum seekers, over the age of 25. Fifty percent (50%) of participants were married and 40% had at least one child. The majority of participants were Hispanic/Latina (60%). Other represented national origins included Russia (1), Bukina Faso (1), Ivory Coast (1), Ethiopia (1), and Nigeria (1). On average, participants reported 3 years of US residency. All applicants were asylum seekers at the time of this study.

Mental healthcare

HMH Activists unanimously agreed that mental healthcare should be considered a priority among women asylum seekers. In particular, they reported common experiences shared among women in their communities of depression, often with thoughts of suicide; PTSD; and, anxiety.

It is often suggested that this population does not seek help because of stigma, lack of understanding if mental illness or cultural norms that limit help-seeking outside of family.[14,15] However, HMH Activists explained this was not the case for their communities. They were well aware of their mental health challenges and wanted to receive help for it. It is the barriers they encounter when they actually seek help that are preventing them from accessing the help they need. The HMH Activists clearly identified the issues they were facing:

"My main health problem has been my mental health. Months after arriving in the United States I started with strange symptoms in my body and in my way of facing difficulties. I felt a tachycardia that started suddenly, agitation, dizziness, shortness of breath. I thought I was dying and several times and I had to call 911. I went to the emergency room very frequently but they always said that it was okay for me to go home and if I feel bad again to return to the emergency room. It was always with the same response from the medical staff. Conversing with an emotional support group for immigrants, a volunteer psychologist identified my problem in a free consultation that she offered me in her office. She gave me the diagnosis of post-traumatic disorder and panic attacks."

"I had a lot of mental health problems. I just got out of postpartum depression and currently see a therapist…but I almost took my life away."

"I was trying to figure out why I was always sad. I thought maybe death was the solution….I was not okay. I was going through depression."

"When women have a problem like depression, the first person to talk to is an adult, like a husband, mom, or sister, but some people don't wanna talk about depression. In my case I talked about it to my husband and he said why I felt depressed? I didn't want to talk about it at first. He said I should talk to my doctor. I went to an OBGYN 1 or 2 weeks after birth, at this appointment I started crying and began to explain my depression, and that I feel like killing myself since the day I gave birth. The doctor told her me I had postpartum depression, and they are gonna do something about it right now. I started crying and said, "I am an immigrant." The doctor responded that it didn't have anything to do with it. Then, I was able to get a therapy appointment on the same day. Now I feel comfortable talking about this."

"I was able to name each mental symptom I experienced: excessive paranoia, worry, anxiety, long-lasting sadness, and irritability. But I'm glad I'm using the past tense as today my life is much better and I'm emotionally stable even though I will never forget."

Yet, even with this recognition, they reported several barriers to receiving adequate health and mental health support. Five major categories emerged from the inductive thematic analysis: (1) Fear and Distrust; (2) Discrimination; (3) Unique Experiences of Women; (4) Affordability and Appropriateness of Services; and, (5) Lack of Culturally-Responsive Services. Some of the overall categories were comprised of several subthemes that are described below.

Fear and distrust

Fear of public charge: Participants expressed an inability to ask for local mental health and health treatment mainly due to fear related to being deemed a public charge[16] (reflecting a pervasive yet albeit inaccurately understood policy that dictates that an immigrant who is deemed likely to become primarily dependent on the government support for meeting their basic needs (a 'public charge'), can be denied admission to or lawful permanent residence in the United States that in fact does not relate to use of healthcare services. The policy was never intended for asylum seekers.[16] The fears generated by the misunderstanding of this policy and overall minimal access to accurate information left many women asylum seekers with very few options for accessing healthcare and mental health care. The only options they would consider included the emergency room, as well as low- to no- cost clinics where many providers do not understand the experiences related to forced migration, are not trained in trauma informed care, and/or have little understanding of the unique concerns of women forced migrants.

As expressed by one HMH Activist:

"I was so concerned about public charge…You are afraid of so many things. You don't want to go against the law"

"My friend has been in the U.S. for 30 years without papers. She does not want to go outside & does not want to go to the hospital because she is afraid of deportation. What she has right now is more than depression. She is killing herself slowly, slowly, slowly."

Distrust of US doctors and medical system: HMH Activists highlighted a significant distrust in American doctors and the medical system, in general. Some participants reported distrust stemming from a lack of familiarity and/or comfort with the style of healthcare in the United States. As explained by the HMH Activists:

"People would rather avoid going to medical doctors because they don't have the same connection to doctors from their home country. Many don't feel connected to the doctors here (language, culture) so many people wait to the last moment to go to the doctor, or only go if they need to get medication.

"...Women ask why they have to get a certain gynecological test each year in Venezuela, but not here. The people have tradition and here are changing for another system. Many times I say this is the only option that you have."

"Doctors here don't always do what we expect them to do, it is done differently in my country."

"I, and many others, don't trust doctors here and miss my doctors in Venezuela. I would rather call people from my country to get information on my symptoms. It's a matter of trust."

"They give you medication for depression, but they don't know why! They never ask me, 'Why you have depression?'"

"There are doctors who are not concerned that the patient has understood the reason for their diagnosis. Most of the people I see on a daily basis express that they prefer a Venezuelan doctor via telephone than going to the doctor here."

However, more concerning are experiences grounded in a persistent fear of being taken advantage of, intentionally mistreated, and even harmed by doctors. HMH Activists reported:

"One day when I was pregnant, I couldn't hear the baby's heartbeat. I was advised to go to the hospital. They asked me too many questions, I was scared and didn't know what to say, I didn't know what would implicate me as undocumented. This was my first baby. When I was being checked they were touching me with so many machines and they weren't getting it right and didn't know if what they were using was safe for the baby. The doctor got angry and I felt I couldn't say anything because I was afraid. I went home and cried. I had to do a series of shots so the baby could be very strong and I was afraid. I called someone to ask if this was okay, they also told me that sometimes the doctors here give unnecessary treatments so they can charge the government."

"There are rumors that immigrants are being killed in hospital. Therefore, some prefer to go to certain pharmacies where they can have equivalents of drugs that they already know from their country."

"Most immigrants are afraid of getting sick here because they know they won't get good care from past experiences"

Stigma and discrimination

HMH Activists identified stigma and discrimination against immigrants as key barriers to accessing care.

Recalling such experiences, HMH activists shared:

"One of the things we must fight for is to improve the treatment of the pharmacy staff at each hospital. The treatment that I have experienced and other people in my presence is not very good, nothing less than contempt."

"How can we respond to bad treatment?" - Once I was skipped and someone else took my spot because they heard my accent and didn't give me priority. I went home crying."

"You can always improve your language but not your accent… accent discrimination is real though… and it is very frustrating…I think the accent defines you as an immigrant"

"At my job they would talk about immigration. I would make a case for all immigrants (to be welcome in the US) and they would say things like, 'We want immigrants like you. We don't want those other immigrants" But I identify as those 'other immigrants'. The people they were shunning were actually me!"

"I had a bad experience in vehicles and motors when I was in the process of obtaining my driver's license. The agent who was receiving my documents began to make fun of one of the requirements (birth certificate) because it was a copy of the manual registration book from my country and no matter how much I explained and showed other documentation, she did not accept the documents and I was denied (my license). She humiliated me and left me talking to myself. it was very unpleasant and unpleasant of her."

"One day I went to take the bus and was talking in my language on the phone and a white man told me, "if you're not quiet, I am going to shoot you right now."

"There`s a small revenge when you`re in the place inside the diaspora neighborhood and everybody speaks your language and then a stranger walks in. However, I know that a lot of Americans complain if you speak your language near them. They are like - you cannot speak your language when you're at work. They think you`re plotting against them."

Unique experiences of women

HMH Activists commented strongly on the lack of recognition of the unique needs of women asylum seekers, particularly mothers and married women. Most concerning was the sense of vulnerability and risk of abuse and violence that characterized the experiences shared by several participants. To illustrate, HMH Activists commented:

"I think that women should be educated about they are equally valued as men and that being a wife and mother is not the only way to be realized for a woman. Very often women are forced into early marriage and then they are not free for the whole life."

"One time she called the police, and when the police went to her house, the woman told the police that everything was fine. If she reported him, her family back home would tell her she is "bad," that this man brought her to this country and she is ungrateful."

"Sometimes she's hungry. I tell her your son was born here, just go to apply for food stamps." She tells the husband that she has food stamps and he takes the money. Her life is not secure because that man can go crazy one day and do something"

"One time, my boss (at the restaurant I worked) asked if I would have a drink with him after work. After I refused, he would tell me that I can't eat in the restaurant and he started to take me off the schedule. I thought, 'this is really uncomfortable'. So, I had to quit this job. Also, he was insulting me like 'you are illegal". These circumstances put women immigrants at risk for sexual harassment or discrimination. I wanted to put in a complaint, but felt unsafe doing so because I might get into trouble. This is really unfair. How do you deal with your real experiences and try to protect yourself in your asylum seeking process?"

"My first home was at a homeless shelter….one woman there got hurt…she was so vulnerable. I think she was actually sexually assaulted. She told me this in private but I instinctively knew not to talk"

"I think next week we can talk about babies and mothers. Women give birth and then they don't want to accept the baby due to the depression that they have. It's not their fault they have something.

They went through a lot, it's not their fault." She said the worst thing is "when you have a depression and you keep it inside."

Affordability and appropriateness of services

HMH Activists shared several concerns regarding the nature of mental health treatment that serve as key barriers to help-seeking and treatment utilization. Perceptions regarding affordability, efficacy, and appropriateness of treatment serve to detract forced migrants from seeking health and mental healthcare. In their own words, these are some of the main concerns affecting their help-seeking and their overall health and mental health:

"As usual, the basic insurance covers only medical help like psychiatry - doesn`t cover sessions with a therapist. There are support groups but they are IN ENGLISH and also there are groups - and what we need is in person service, not medication but talk."

"What I see around is that people are treated with medications that are not always good for them but rarely do they have access to the therapy."

"What I've noticed by my personal experience and experiences of my few friends who are also female immigrants. For example, when we just immigrated to the U.S.," they could not get a job and so were only eligible for Emergency Medicaid. Since then, they found better jobs and "the question of medical insurance arises and our reaction was, we are relatively healthy people and we don't go to physicians for regular checkups. However, the next insurance after Medicaid will cost per month I think 500/600 dollars." This is pricey given that they don't use medical services that often. "That's sort of a tricky question we always discuss: What to do? For example some people decide not to get insurance at all, which is risky. Some of them decided, in the case of health treatments, that they will go back to their home country, which I also do not think is the best solution"

"When I got here, at the very beginning in 2016, I went to the hospital and my insurance did not come and it was slow and the hospital started calling me to tell me that I owed them a lot of money and therefore that I should pay them myself as soon as possible. I explained to them that I was not working yet and that I did not have money to pay them myself. But they didn't stop calling me to claim their money so I got scared and so, I didn't go there anymore when I felt sick."

"But recently, I had like pimples appearing on my eyes. Worried I went to my primary doctor who made me an appointment with an ophthalmologist. After the first consultation with the ophthalmologist, it was decided a surgery to make these buttons disappear. But the day i went there for my surgery the ophthalmologist refused to do my surgery on the pretext that he was not sure that my insurance covers this kind of surgery. So it's all disappointed that I came home and I still have these pimples on my eyes and that continues to grow. I try as I me to make it disappear myself but it turns out to be impossible for the moment."

Culturally-responsive care

Participants highlighted the importance of cultural responsiveness in healthcare services, from being able to access interpretation services and seeing providers that speak their native language to working with providers trained in trauma informed care.

Lack of culturally & linguistically competent professionals: The ability to express oneself in one's native tongue is critical to receive mental health support as the burden to explain one's experience accurately in a second language is often cumbersome enough to dissuade from seeking care. Concerns ranged from ensuring that medical personal are able to understand what they intend to communicate regarding their symptoms and experiences to their own correct understanding what diagnoses/recommendations/instructions the doctors have for them. Several HMH Activists remarked:

"It`s crucial that in the moment of uncertainty you have a medical help on your language. Some things just are very hard for translation. Also, English speaking therapists rarely understand immigration issues. They have to be educated."

"It's a different process when you need to say that in other second language."

"The translator had trouble understanding me. I realized that he did not speak French very well, the language I spoke, and it was serious for me because I had gastric ulcers problems and so every time I go to the hospital I report this because there are drugs that I cannot take. I reported this as usual and unfortunately this translator did not report this to the doctor. Luckily, when I got home I used a translator on google to try to read the notices (on the medication I was prescribed) and I found it was well noted that people with gastric ulcer should not take this medication. I then called the doctor to change this medicine for me. She told me that the translator never told her that I said I had a gastric ulcer problem. It would have been more serious for me if I had not had the presence of mind to try to translate the notices myself to understand."

"Also I should say that it`s also uncomfortable even to schedule the appointment as even if you know English - doesn't matter, they can speak very fast, they can have some local accents (we are taught the classic English mostly, and in my country we are taught the British English, not American!)."

Lack of understanding of the forced migration context: However, according to the HMH Activists, misunderstanding is not simply driven by language. Lack of understanding of the forced migration context drives miscommunication, as well. In particular, the HMH Activists reported feeling as though their experience of forced migration is commonly ignored or misunderstood as 'migration by choice', dismissing their traumatic migration experiences and minimizing their degree of loss and psychosocial distress. As they explained:

"They treat you like you are any immigrant coming to this country to pursue the "American Dream" by choice....they don't think of people who are forced to migrate and are feeling another thing"

"Being a forced migrant is not the same as leaving your country because you want to"

"Leaving your country behind is like "losing your identity"

Lack of community-specific services (i.e., Russian LBGT community, indigenous groups, etc.): *"Russian speaking LGBT asylum seekers, especially women, suffer from different mental problems….It would be great to have Russian speaking therapists for such cases. And they should be LGBT friendly. Most of Russian speaking doctors are not…"*

"When we come to the US - we are undocumented for a long period of time! And this makes access to medical help very hard. Certainly you can pay but it`s really expensive here. Also, I can see that help in the low cost clinics is not always good. And also, though we have a basic right to have a help in our language, in fact we rarely have such possibility"

Lack of knowledge regarding rights and resources

"You have no information, nobody tells you anything…You don't know who to talk to. Information is key."

"The other problem is that we don't understand how the system classifies things. Many people don't want to go to the ER where it takes more than 6 hours to wait to get attention. Sitting in ER for a long time is difficult. Here the system has other options when it's not a real emergency, but we don't know all the systems. She eventually learned that over time you can go to urgent care rather than the hospital. People need to have access to this information."

"I can't even express how essential access to information is. I'd been in the U.S. 6 years prior. It's just a whole different world here. You are almost immediately disempowered."

"This country has these rights and it is difficult to work without papers now you must wait almost year before you can get for first interview. Things are getting more complicated for immigrants."

Discussion

This is the first study to examine mental health distress and barriers to help-seeking and accessing medical and psychological support from the perspective of women with lived experience of forced migration in New York City.

Preliminary data from the HMH project shows that once in New York, forced migrant populations face multiple barriers that prevent them from receiving the health and mental healthcare and services they need to even begin to re-establish their identities and develop a new sense of home in their host city. Existing services are often largely cost-prohibitive and lack cultural and linguistic relevance, at best and, at worst, are entirely unknown to the population that needs them most. Unfortunately, even more problematic is the basic lack of providers prepared to effectively engage with and provide care to this population in a trauma-informed manner that acknowledges the distressing experiences related to pre-migration, migration and resettlement journeys.

It is important to note that the views and concerns expressed by the HMH Activists are not far-fetched, or misguided perceptions but rather reflect the true experiences of this community. Indeed, it is widely recognized that immigrant New Yorkers have poorer health and less access to healthcare than their US-born counterparts.[17] This cannot be attributed to a lack of resources but to a lack of strategies responsive to current contexts. NYC has an extensive network of health and mental healthcare providers and has allocated billions of dollars towards training, workforce development, and improving the integration of mental and physical health services. Nevertheless, there remains a critical shortage of mental health care professionals and the full range of health and mental healthcare services available in NYC remains severely constrained for those who rely on public insurance, and even more so those who are uninsured.[18,19] For this group, wait time for an appointment with a psychiatrist or mental health specialist often is several months and primary care providers themselves report limited ability to make referrals for specialty mental healthcare for this population. The need for services in languages other English further limits access and even when such services are available and affordable, forced migrants may believe that they do not exist, are not unavailable to them, or that accessing them will call the attention of immigration enforcement-related organizations. Overall, forced migrants tend to have a limited understanding of their right to health, and particularly mental healthcare, and struggle with racism and discrimination, the stigma of being undocumented and uninsured, and the lack of culturally responsive services.[20–22] As reported by Pavilon & Virgin[19] approximately 40% of immigrants in NYC reported needing access to healthcare in the last 12 months but not receiving it.[23]

As clearly identified by the participants in this study, access to affordable, adequate, culturally competent, and trauma-informed health and mental healthcare is critical to ensure mental health distress does not exacerbate and the forced migrant population in NYC and beyond is able to reach its potential. Research strongly indicates that in the absence of such care, risk of life is at stake. Indeed, Proctor et al. coined the term 'lethal hopelessness' to describe the increased suicide risk in asylum seekers due to the combination of limited access to mainstream services, financial support, culturally safe health care, and employment rights.[24] The complex interplay of political, social and economic forces, combined with cultural factors and individual biological and physiological make-up interact to generate increased rate of psychological distress and suicide among forced migrants.

Further, employing a social determinants of health and mental health lens,[25,26] it is essential to understand that upon arrival in a different country, forced migrants often find themselves living at the lowest end of the social gradient, placing them at increased risk for exposure to poor social conditions, such as over-crowded, unsafe living housing situations, pollution, crime, and poor nutrition. Consequently, this poor socioeconomic status, has been shown to be associated with higher levels of depression and anxiety, making access to mental healthcare even more essential.

Prior research from other countries exploring the views and perspectives of asylum seekers related to health and mental healthcare also confirms the views shared by HMH Activists. For example, several studies in Europe demonstrated a negative effect of language limitations between physician and asylum-seeker patients as a significant barrier to care.[27–30] Other studies have identified gatekeeper-associated problems, lack of resources, lack of awareness of symptoms and availability of treatments/services, fear of stigma, and a discord between local healthcare systems and the perceived needs asylum seekers as key barriers to accessing and utilizing services. Additionally, in 2016, the World Health Organization (WHO) examined 69 studies conducted in Europe examining asylum seekers and healthcare utilization and concluded several key barriers based on the systematic review the literature that directly align with our findings including: insufficient language skills of providers; lack of trust in services and authorities; insufficient knowledge regarding the host country's healthcare system; and, expectations for treatment that do not align with the healthcare system of the host country (traditional healing versus psychopharmacological treatment).[31] More recent research in Europe further demonstrates consistent findings in these areas.[32] Ultimately, this research highlights another major problem related to the health and mental healthcare of this population- that these issues have been recognized for decades but due to structural and systemic discrimination, little has been done to address these barriers.

Implications for practice, policy and advocacy

In conclusion, what needs to be done to finally begin to address these barriers and ensure the fundamental right to mental health and healthcare of asylum seekers is met?

Several recommendations derive from our participatory analysis of these findings:

1. Shifting from crisis intervention to early intervention and prevention measures: Existing research[33–35] has demonstrated

that mental health distress among forced migrants, including risk of suicide, may be curbed through early intervention, namely early identification of signs and symptoms of mental illness and expressions of suicide ideation. However, for early intervention to be effective, providers need to be equipped with appropriate and sufficient knowledge and skills.

2. Promoting trauma-informed services at all levels: Training on trauma-informed interventions and service provision needs to be made available to medical and mental health providers and allied professionals serving the forced migrant population. Particular attention should be given to addressing previous trauma in the pre-migration period and during one's migration journey, while also providing needed psychosocial support to facilitate access to care and increase migrants' wellbeing and their capacity to integrate fully in their host communities.

3. Establishing a dialogue between people with lived experiences of forced migration and mental health care service providers, to share and compare perceived challenges to help-seeking and accessing treatment; and develop models of care that center the voices of the people directly affected.

4. Engage in advocacy efforts at an organizational, and local governance level to address the systemic access barriers (improve training on forced migration for service providers; allocate resources for trauma-informed training; increase access to bilingual mental health care providers; and develop a first line of community health care workers recruiting from the migrant population to raise awareness on mental health issues, traumatic and post-traumatic stress, and existing and appropriate services and interventions; provide timely information on the rights of this population, and the various ways in which they can access care; etc.)

5. Employ migrants' narratives to affect wider policy changes.

Limitations

This study has a number of clear limitations. First, based on the small number of participants, findings may not be generalizable to the larger population of asylum seekers. However, given the limited knowledge to date from the voices of people with lived experiences of forced migration, this study offers a crucial insight into the lived experiences of forced migration and the ways in which women forced migrants are perceiving the challenge and barriers they face in accessing care. Second, it could be possible that social developments and policy changes influenced our results; as more restrictive policies and new policies to address the recent influx of new arrivals to NYC, resettlement conditions and related mental health outcomes may be impacted. And third, this study reflects the views and experiences of women asylum seekers in NYC, prior to the most recent migration wave. Therefore, we do not assume their experiences reflect fully the experiences of the new arrivals in NYC in the context of aggravating factors and the crisis responses that followed. We did not explore long-term mental health conditions or outcomes of service utilization. To fully determine the effects of the barriers identified on long-term treatment decisions and mental health outcomes, longer-term and prospective studies should be conducted.

Conclusion

Our findings highlight the need for significant improvement in access to mental health and mental healthcare services. In the words of the forced migrants themselves, "Most immigrants are afraid of getting sick here because they know they won't get good care. And, it maybe not a medical problem but social (or mental). Even if you have insurance, there are some unexpected costs and the system is so complicated. So most people stay home." Indeed, as another participant answered when asked what she does when she feels sick or overwhelmed, she said: "I drink some tea, and keep going. I cannot afford to think about how I feel".

To prevent further escalation of what is shaping into a mental health crisis among migrant populations, the key barriers that need to be addressed and removed include, fear and distrust of the medical system and related personnel; addressing experiences of discrimination; active consideration the unique experiences of women asylum seekers; increasing the affordability and providing psych education on the appropriateness of treatments/interventions; and, developing culturally/linguistically-responsive health and mental health services. Training on trauma-informed care for providers serving this community is essential. Centering women migrants' voices needs to be manifest in intentional and active working with women asylum seekers to develop innovative training materials, and engage in advocacy, reclaiming access to health and mental health care as a right, not limited by the legal status and not linked to citizenship. A right that defines our shared humanity.

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Conflicts of interest

The Authors declares that there are no conflicts of interest.

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