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Psychotherapy use among migrants: a register-based longitudinal study

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ABSTRACT

Background Migrants use less mental health services compared with non-migrant populations, but there is very little information on the use of long-term psychotherapy among migrants. Finnish register data allow for studying the whole migrant population in Finland and collecting data on all publicly supported rehabilitative psychotherapy.

Methods This study is based on a sample of migrants (n=185 605) and Finnish-born controls (n=185 605). Participants who had received reimbursements for rehabilitative psychotherapy during 2007–2020 were identified from a register maintained by the Social Insurance Institution of Finland. Cox regression analysis was used to study the effect of migrant status on the time until the start of therapy. Multinomial logistic regression was used to study the association between migrant status and the number of psychotherapy sessions.

Results Finnish-born participants received psychotherapy more often (n=7258) than migrants (n=1516). The adjusted HR for initiating psychotherapy among migrants compared with Finnish-born individuals was 0.27 (95% CI 0.25 to 0.28). Migrants from sub-Saharan Africa and Asia and recently arrived migrants were least likely to receive psychotherapy. Migrants were more likely to receive short treatment periods than Finnish-born controls.

Conclusion Lower use of rehabilitative psychotherapy among migrant population in Finland is not likely to reflect lower need for treatment. More efforts are needed to promote equal access to psychotherapy.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ There are socioeconomic disparities in the use of psychotherapy.
⇒ Migrants use less mental health services than non-migrants.

WHAT THIS STUDY ADDS

⇒ Migrants are less likely to receive psychotherapy than Finnish-born participants.
⇒ Migrants also receive shorter periods of psychotherapy.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Barriers to psychotherapy should be addressed to promote equality in mental healthcare.

INTRODUCTION

Psychotherapy is an effective treatment for many common mental disorders,[1–3] but there are social disparities in its utilisation. Several studies have shown less use of psychotherapy among those with low educational level[4–7] or occupational position,[4 5] male gender[4 7] or older age.[4]

Migrant populations use less mental health services compared with the rest of the population in many countries,[8–11] but little is known about the use of psychotherapy,[12] which has been shown to be an effective treatment for depressive, anxiety and post-traumatic stress disorders (PTSD) both among refugees and other migrants.[13 14] A Swedish register-based study showed that migrants diagnosed with common mental disorders in primary care were less likely to receive psychological treatments when compared with Swedish-born patients.[15] A UK study linked survey data with register data and found that when adjusted for need, migrants were less likely to use psychological treatment.[16]

In Finland, migrants use less mental health services than non-migrants and they are more likely to receive low-intensity treatment.[17] They also discontinue psychotropic medication earlier than non-migrants.[18 19] Migrants of Russian, Kurdish and Somali origin use less rehabilitative services than Finnish-born population.[20] There is no information specifically about the use of psychotherapy. To ensure that psychotherapy is accessed equally by the migrant and non-migrant population, it is important to analyse current patterns in its use.

A very large proportion of psychotherapy provided in Finland is long-term psychotherapy called rehabilitative psychotherapy, which is partly funded by the social insurance system. The number of people receiving rehabilitative psychotherapy has rapidly increased and is currently the most common form of rehabilitation organised by Kela, the Social Insurance Institution of Finland.[21] The aim of this study is to examine whether migrants and Finnish-born controls are equally likely to receive rehabilitative psychotherapy and whether there are differences in the number of received psychotherapy sessions.

METHODS

This study uses a register-based sample of migrants and Finnish-born controls living in Finland. The data are maintained by the Finnish Institute for Health and Welfare (THL). All the data-keeping organisations have given their permission to use their confidential register data in this study.

Sample

The original sample included all migrants who were residents of Finland and over 15 years old on 31 December 2010 (n=185 605) and matched Finnish-born controls (n=185 605). Migrants were identified by the country of birth and mother tongue from the Central Population Register kept by the Digital and Population Data Services Agency (DVV). Asylum seekers or recent migrants could not be included since they lack the personal identity code. The Finnish-born controls were matched by sex, age and the municipality of residence on 31 December 2010. The participants were followed until death, emigration or 31 December 2020. In the present study, the entire sample was used in the first part of the analyses to compare the time until the start of psychotherapy among migrants and Finnish-born participants.

For the second part of the analyses of the present study, investigating the number of psychotherapy visits, only individuals who had received reimbursements for rehabilitative psychotherapy from the Social Insurance Institution of Finland (Kela) during the follow-up were included. We had the information on reimbursements from 2007 to 2020 (overall, 1846 migrants and 8890 Finnish-born controls received reimbursements during this period), but only psychotherapies that were ongoing at the beginning of follow-up (1 January 2011) were included and therapies that began during 2020 were excluded. This selection yielded a sample of 1516 psychotherapies for migrants and 7258 psychotherapies for Finnish-born controls (migrants n=1459, Finnish-born n=6995, same individual could have more than one psychotherapy).

Background characteristics

The background characteristics of interest included age, sex, socioeconomic status (SES) and the diagnoses for which rehabilitative psychotherapy reimbursement was granted. For migrants, we were also interested in the region of origin and the length of residence in Finland. Information on SES was derived from Statistics Finland, information on age, sex, region of origin and length of residence was derived from the DVV and information on the diagnosis was retrieved from Kela's register. The SES was based on the occupation or main activity in 2010 and was classified into five groups: (1) entrepreneurs and farmers, (2) upper white-collar workers (such as leaders or experts), (3) lower white-collar workers (such as office workers), (4) blue-collar workers (manual work) and (5) any another status (people not in employment). Age at the beginning of follow-up was categorised into three categories: 15–29, 30–44 and 45 years or more. Region of origin was categorised into five groups: (1) the European Union/European Free Trade Association (EU/EFTA), UK, North America and Australia, (2) Eastern Europe (including Russia and the former Soviet Union), (3) the Middle East and Northern Africa, (4) sub-Saharan Africa and (5) Asia. There were so few migrants from other countries that no separate category was formed for them, and they were thus excluded in the analyses related to the region of origin. The length of residence in Finland was categorised into three groups: (1) less than 5 years, (2) 5–15 years and (3) over 15 years.

The information on diagnoses included in the register is retrieved from physicians' statements, which the client needs when applying for psychotherapy. Both main diagnoses and two secondary diagnoses were included. The psychiatric diagnoses were based on the 10th version of the International Statistical Classification of Diseases and Related Health Problems criteria, which has been used in Finland since 1996. They were categorised as follows: psychotic disorders (F20–F29), bipolar disorders (F30–F31), depressive disorders (F32–F33), other mood disorders (F34–F39), anxiety disorders other than PTSD (F40–F42, F44–F48), PTSD and other reactions to severe stress (F43), behavioural syndromes associated with physiological disturbances and physical factors (F50–58), disorders of adult personality and behaviour (F60–F68) and all other F-diagnosis.

Psychotherapies

Rehabilitative psychotherapy is usually started after a minimum of 3 months of usual treatment in public or private mental health services. Usual treatment may include psychotropic medication, short-term psychotherapy or less intensive psychosocial support. Rehabilitative psychotherapy is considered when there is a need for longer-term treatment and patient's study or work ability is threatened. Support from the social insurance system Kela is granted based on a recommendation by a psychiatrist at public or private health services. Psychotherapy is provided by private psychotherapists once or twice a week. Part of the expenses is reimbursed by Kela whereas the rest (typically €20–€50/session) is paid by the patient. The use of an interpreter is funded by Kela. Psychotherapy may last up to 3 years (maximum 200 sessions). If the need for psychotherapy is estimated to be clearly less than 1 year, it is usually organised as another type of services.

We had the information on the received psychotherapies as payment periods for each individual who had received reimbursements during the given time period. If there was a break longer than 365 days between two payment periods, they were considered belonging to two separate psychotherapies (as a break longer than a year will result in the termination of therapy). After terminating rehabilitative psychotherapy, it is possible to apply for a new treatment episode, but there usually has to be at least a 5-year break in between. There were 828 individuals who had two therapies, and 21 individuals who had three therapies during years 2007–2020. We analysed differences in the length of therapies so multiple therapies of the same individual could be included. We analysed the length of psychotherapy as the number of visits the therapy consisted of. It was categorised as follows: (1) 1–19 visits, (2) 20–40 visits, (3) 41–120 visits and (4) 121 visits or more.

Statistical analysis

The differences in background characteristics of the migrants and the Finnish-born participants were compared using χ^2 tests.

To explore how likely migrants were to receive psychotherapy when compared with the Finnish-born, Cox regression was used to study the effect of migrant status on the time until the start of therapy from the beginning of follow-up. For these analyses, we used the entire original sample including individuals who had not received reimbursements for therapy. Those who had begun their therapy before 2011 were excluded. The models were adjusted for sex, age and SES. The model including only migrants was adjusted with the length of residence in Finland and the region of origin. Adjusted HRs are reported. Both estimates for the entire sample and estimates stratified by migrant status were produced.

Multinomial logistic regression was used in the second part of the analysis to predict the effect of migrant status to the categorised number of visits. The model was adjusted for sex, age and SES. Adjusted ORs are reported. We excluded those who had died or emigrated within a year after the last therapy visit to ensure that the end of therapy was not explained by death or emigration. Both estimates for the entire sample and estimates stratified by migrant status were produced. The model including

Table 1 Descriptive characteristics of the sample by migrant status

	Sample used in the Cox regression (part 1)		Sample used in the multinomial logistic regression (part 2)		
	Migrant	Finnish-born	Migrant	Finnish-born	P value*
n	185 256	183 412	1516	7258	
Sex (female) (%)	90 694 (49.0)	89 248 (48.7)	1063 (70.3)	5377 (74.1)	**0.003**
Age (%)					0.188
15–29	57 133 (30.8)	56 371 (30.7)	697 (46.1)	3513 (48.4)	
30–44	72 450 (39.1)	71 576 (39.0)	652 (43.1)	3041 (41.9)	
45 or more	55 673 (30.1)	55 465 (30.2)	163 (10.8)	703 (9.7)	
SES (%)					**<0.001**
Entrepreneurs and farmers	11 449 (6.2)	10 162 (5.5)	73 (4.8)	245 (3.4)	
Upper white-collar workers	18 861 (10.2)	34 932 (19.0)	355 (23.5)	1905 (26.3)	
Lower white-collar workers	25 035 (13.5)	52 918 (28.9)	400 (26.5)	2480 (34.2)	
Blue collar workers	47 005 (25.4)	35 006 (19.1)	199 (13.2)	682 (9.4)	
Not in employment	60 425 (32.6)	44 843 (24.4)	399 (26.4)	1711 (23.6)	
Unknown	22 481 (12.1)	5551 (3.0)	86 (5.7)	234 (3.2)	
Number of visits (%)					**<0.001**
0–19			158 (10.4)	420 (5.8)	
20–40			236 (15.6)	947 (13.0)	
41–120			720 (47.5)	3327 (45.8)	
121 or more			402 (26.5)	2564 (35.3)	
Region of origin (%)					
Western	58 220 (32.1)		839 (57.3)		
Eastern	56 034 (30.9)		418 (28.6)		
Middle East and North Africa	22 972 (12.7)		103 (7.0)		
Sub Saharan Africa	16 025 (8.8)		37 (2.5)		
Asia	28 169 (15.5)		67 (4.6)		
Length of residence, years (%)					
<5	64 673 (38.5)		381 (27.1)		
5–15	62 977 (37.5)		537 (38.1)		
>15	40 491 (24.1)		490 (34.8)		

Bold typeface indicates statistical significance.
*Refers to the significance of differences in descriptive characteristics between migrants and Finnish-born among the psychotherapy recipients.
SES, socioeconomic status.

only migrants was adjusted with the length of residence in Finland. Due to low cell sizes in most categories, we could not use the region of origin as a predictor in this analysis.

RESULTS

The descriptive statistics of the sample are shown in table 1. Overall, Finnish-born individuals received considerably more psychotherapies (n=7258) than the migrants (n=1516). There were statistically significant differences in all background characteristics between the migrants and the Finnish-born who had received psychotherapy, except for age. The majority of psychotherapy recipients were women, who were particularly overrepresented in the Finnish-born sample. In both groups, almost half of the psychotherapy recipients were under 30 years old, and only around 10% were over 45 years old. In both groups, most of the psychotherapy recipients were either lower white-collar workers, upper white-collar workers or not in employment, but in general, migrants had slightly lower SES. In both groups, about half of the therapies consisted of 41–120 visits, but migrants consistently received therapies with less visits.

Sample used in the Cox regression includes the entire original sample except those with therapy visits during 2007–2010. Sample used in the logistic regression includes only individuals who received reimbursements for psychotherapy during 2011–2020, excluding those whose therapy began during 2020. Same individual can have multiple psychotherapies.

Most of the migrants were either from EU/EFTA, UK, North America and Australia or Eastern Europe. Only 7.0% of the psychotherapy recipients were from Middle East and Northern Africa, 2.5% were from sub-Saharan Africa and 4.6% were from Asia. Most migrants had lived in Finland from 5 to 15 years.

Table 2 shows diagnoses for the migrants and for the Finnish-born. In both groups, depressive disorder was the most common diagnosis with over 60% of the therapy recipients having this diagnosis. The second most common diagnosis was an anxiety disorder. For migrants, the third most common diagnosis was PTSD, which was significantly more common among migrants than among the Finnish-born. Disorders of adult personality and behaviour were relatively common among both samples. In addition, there were statistically significant differences in the frequency of other mood disorders and in the frequency of behavioural syndromes with physiological disturbances.

Table 3 shows the results of the Cox regression analysis. Overall, migrants were considerably less likely to start therapy in comparison to the Finnish-born (HR 0.27, 95% CI 0.25 to 0.28). In both groups, older individuals were less likely to start therapy and the effect increased with age. Women were considerably more likely to initiate therapy in comparison to men. In

Table 2 Mental disorder diagnosis

	Migrant	Finnish-born	P value
n	1516	7258	
Alcohol use disorder (F10)	4 (0.3)	37 (0.5)	0.285
Psychotic disorder (F20–F29)	25 (1.6)	106 (1.5)	0.664
Bipolar disorders (F30–F31)	55 (3.6)	245 (3.4)	0.679
Depressive disorder (F32–F33)	973 (64.2)	4556 (62.8)	0.315
Other mood disorder (F34–F39)	115 (7.6)	724 (10.0)	**0.005**
Anxiety disorder (excl. PTSD) (F40–F42, F44–F48)	741 (48.9)	3722 (51.3)	0.094
PTSD (F43)	204 (13.5)	546 (7.5)	**<0.001**
Behavioural syndrome with physiological disturbances (F50–F59)	37 (2.4)	329 (4.5)	**<0.001**
Disorder of adult personality and behaviour (F60–F68)	163 (10.8)	898 (12.4)	0.086
Other mental disorder diagnosis	50 (3.3)	210 (2.9)	0.446

One person may have several diagnoses.
Bold typeface indicates statistical significance (p<0.05).
PTSD, post-traumatic stress disorder.

comparison to upper white-collar workers, individuals from all other socioeconomic classes were less likely to initiate therapy. Migrants in the lowest socioeconomic classes were especially likely not to initiate psychotherapy.

When compared with migrants from EU/EFTA, UK, North America and Australia, all other migrants were less likely to initiate psychotherapy. HRs were particularly low for migrants from sub-Saharan Africa (HR 0.14, 95% CI 0.09 to 0.20) and for migrants from Asia (HR 0.17, 95% CI 0.14 to 0.22). S horter length of residence in Finland made initiating psychotherapy less likely.

Results of the multinomial logistic regression are presented in table 4. Migrants, compared with Finnish-born, were significantly more likely to receive therapy consisting of less than 20 visits (OR 2.31, 95% CI 1.85 to 2.88), therapy consisting of 20–40 visits (OR 1.65, 95% CI 1.37 to 1.99) and therapy consisting of 41–120 visits (OR 1.44, 95% CI 1.25 to 1.65) than therapy consisting of at least 121 visits. The odds of receiving therapy of less than 20 visits were also elevated by belonging to the oldest age group and by belonging to any socioeconomic class other than upper white-collar workers, whereas female sex decreased the odds of receiving less than 20 visits. Overall, lower-white collar workers had higher odds of receiving therapy consisting of 20–40 visits and therapy consisting of 41–120 visits in comparison to upper white-collar workers, and blue-collar workers had higher odds of receiving therapy consisting of 20–40 visits in comparison to upper white-collar workers. The estimates on the sample stratified by migrant status show that the effect of lower SES on odds of receiving psychotherapy consisting of fewer visits was particularly striking among the migrant sample. Migrants who had lived in Finland for less than 5 years had higher odds of receiving therapy consisting of 41–120 visits than therapy of over 120 visits when compared with migrants who had lived in Finland over 15 years.

Table 3 Part 1 of the analyses: results of Cox regression analysis predicting time until beginning of therapy from the beginning of follow-up (the entire original sample included: migrants n=162 775, Finnish-borns n=177 861, each individual can have only one event)

	All	Migrants	Finnish-born
	HR (95% CI)	HR (95% CI)	HR (95% CI)
Migrant (ref. Finnish-born)	0.27 (0.25 to 0.28)		
Age (ref. 15–29)			
30–44	0.57 (0.55 to 0.60)	0.52 (0.46 to 0.59)	0.58 (0.55 to 0.61)
45 or more	0.17 (0.16 to 0.19)	0.12 (0.10 to 0.15)	0.17 (0.16 to 0.19)
Female (ref. male)	2.76 (2.63 to 2.91)	2.28 (2.02 to 2.58)	2.90 (2.74 to 3.06)
SES (ref. upper white-collar workers)			
Entrepreneurs and farmers	0.51 (0.45 to 0.57)	0.37 (0.28 to 0.49)	0.56 (0.48 to 0.64)
Lower white-collar workers	0.66 (0.62 to 0.70)	0.65 (0.55 to 0.76)	0.66 (0.62 to 0.70)
Blue-collar workers	0.35 (0.33 to 0.38)	0.29 (0.24 to 0.34)	0.39 (0.35 to 0.42)
Not in employment	0.58 (0.54 to 0.62)	0.42 (0.36 to 0.50)	0.68 (0.63 to 0.73)
Region of origin (ref. EU/EFTA, UK, North America and Australia)			
Eastern Europe		0.46 (0.41 to 0.52)	
Middle East and Northern Africa		0.34 (0.28 to 0.43)	
Sub-Saharan Africa		0.14 (0.09 to 0.20)	
Asia		0.17 (0.14 to 0.22)	
Length of residence (ref. >15 years)			
<5 years		0.39 (0.33 to 0.45)	
5–15 years		0.66 (0.58 to 0.75)	

Those whose therapy started before 2011 were excluded.
EU/EFTA, European Union/European Free Trade Association; SES, socioeconomic status.

Table 4 Part 2 of the analyses: results of multinomial logistic regression predicting the categorised number of visits (ref. 121 visits or more) with migrant status and background characteristics

	All (OR (95% CI))			
	1–19 visits	20–40 visits	41–120 visits	≥121 (ref.)
Migrant (ref. finnish-born)	**2.31 (1.85 to 2.88)**	**1.65 (1.37 to 1.99)**	**1.44 (1.25 to 1.65)**	1
Female (ref. male)	**0.67 (0.55 to 0.82)**	**0.73 (0.63 to 0.85)**	0.96 (0.86 to 1.08)	1
Age (ref. 15–29)				
30–44	1.22 (0.99 to 1.50)	1.09 (0.93 to 1.27)	1.08 (0.97 to 1.20)	1
45 or more	**1.47 (1.08 to 2.01)**	1.03 (0.80 to 1.32)	1.00 (0.84 to 1.19)	1
SES (ref. upper white-collar workers)				
Entrepreneurs and farmers	**1.86 (1.18 to 2.94)**	1.18 (0.81 to 1.72)	0.97 (0.74 to 1.27)	1
Lower white-collar workers	**1.69 (1.31 to 2.18)**	**1.40 (1.17 to 1.69)**	**1.14 (1.00 to 1.29)**	1
Blue-collar workers	**2.08 (1.49 to 2.91)**	**1.40 (1.08 to 1.81)**	1.19 (0.98 to 1.43)	1
Not in employment	**1.34 (1.00 to 1.78)**	0.95 (0.77 to 1.17)	0.87 (0.75 to 1.00)	1
	Migrants (OR (95% CI))			
	1 to 19 visits	20 to 40 visits	41 to 120 visits	≥121 (ref.)
Female (ref. male)	0.79 (0.51 to 1.24)	0.81 (0.55 to 1.18)	0.92 (0.68 to 1.24)	1
Age (ref. 15–29)				
30–44	1.15 (0.73 to 1.82)	0.90 (0.60 to 1.33)	0.90 (0.67 to 1.22)	1
45 or more	1.45 (0.70 to 3.00)	1.35 (0.74 to 2.46)	0.95 (0.58 to 1.55)	1
SES (ref. upper white-collar workers)				
Entrepreneurs and farmers	2.28 (0.85 to 6.13)	1.65 (0.75 to 3.60)	0.75 (0.39 to 1.45)	1
Lower white-collar workers	**2.03 (1.03 to 3.98)**	1.41 (0.85 to 2.34)	1.03 (0.71 to 1.50)	1
Blue-collar workers	**2.90 (1.37 to 6.11)**	1.56 (0.86 to 2.84)	1.12 (0.71 to 1.77)	1
Not in employment	**2.98 (1.55 to 5.73)**	1.20 (0.72 to 2.01)	0.86 (0.58 to 1.26)	1
Length of residence (ref. >15 years)				1
<5 years	1.33 (0.76 to 2.33)	1.49 (0.94 to 2.37)	**1.46 (1.02 to 2.10)**	1
5–15 years	1.28 (0.79 to 2.08)	1.12 (0.74 to 1.69)	1.25 (0.91 to 1.71)	1
	Finnish-born (OR (95% CI))			
	1–19 visits	20–40 visits	41–120 visits	≥121 (ref.)
Female (ref. male)	**0.63 (0.50 to 0.79)**	**0.71 (0.60 to 0.85)**	0.97 (0.86 to 1.10)	1
Age (ref. 15–29)				
30–44	1.18 (0.93 to 1.50)	1.14 (0.96 to 1.35)	1.11 (0.98 to 1.25)	1
45 or more	**1.52 (1.07 to 2.17)**	0.98 (0.74 to 1.30)	1.05 (0.87 to 1.27)	1
SES (ref. upper white-collar workers)				
Entrepreneurs and farmers	1.68 (0.99 to 2.87)	1.00 (0.64 to 1.56)	1.01 (0.75 to 1.37)	1
Lower white-collar workers	**1.61 (1.21 to 2.13)**	**1.40 (1.15 to 1.71)**	**1.17 (1.02 to 1.34)**	1
Blue-collar workers	**1.85 (1.26 to 2.72)**	**1.35 (1.01 to 1.81)**	1.19 (0.97 to 1.46)	1
Not in employment	0.98 (0.70 to 1.38)	0.90 (0.72 to 1.14)	0.87 (0.75 to 1.02)	1

People who died or moved out within a year from the end of therapy, or with missing values in any variables, are excluded (migrants n=1411, finnish-born n=6993).
Bold typeface indicates statistical significance.
SES, socioeconomic status.

DISCUSSION

This study showed that migrants are less likely to receive psychotherapy than Finnish-born individuals. The differences between migrants and non-migrants were much larger than in our previous studies on the use of specialised psychiatric services or psychotropic medication.[17 22] Lowest likelihood of initiating psychotherapy was found among migrants from sub-Saharan Africa and Asia. Young people, women and people with high SES were more likely to initiate psychotherapy both among migrants and Finnish-born. The psychiatric disorders psychotherapy was targeting were also similar except for PTSD, which was clearly more common among migrants. Migrants, who received psychotherapy, had less sessions than Finnish-born participants. Among migrants, low SES was a strong predictor of receiving less than 20 sessions, which can be considered as an early termination of therapy. Among Finnish-born participants, SES was less strongly associated with the number of sessions received.

There are several possible explanations for the finding of migrants being less likely to receive rehabilitative psychotherapy. There could be a lower need for psychotherapy. Especially among labour migrants there might be so-called healthy migrant effect, the healthiest people being more likely to migrate. They may also more often use remote therapy in their native language. However, migrants from EU/EFTA and other regions with many labour migrants were most likely to use rehabilitative psychotherapy. In addition, there are migrant groups, which have shown higher levels of symptoms of anxiety and depression[23] and groups with higher incidence of psychiatric disorders compared with the Finnish-born population.[24] Of note, migrants have higher rates of PTSD,[24] for which psychotherapy is strongly

recommended.[25 26] Therefore, lower need is unlikely to explain such a large difference in psychotherapy use.

Migrants probably have more barriers to accessing psychotherapy than non-migrants. Fear of stigma, logistic and language barriers, cultural mismatch with service providers or lack of culturally sensitive practices have been found to prevent migrants from accessing mental health services.[27 28] The process of applying for rehabilitative psychotherapy and searching for a psychotherapist is complicated, especially for one who does not know the language or service system well. Health professionals may also underestimate the ability of migrants to benefit from psychotherapy and refer them to less intensive treatments instead. Many psychotherapists may have more negative attitudes towards patients with migrant background[29] or face practical barriers when working with an interpreter.[30] Even with the social insurance support, the cost of psychotherapy is high, which may prevent especially students and unemployed people from accessing it. Getting financial support from family or other sources might be less common among migrants. Our study showed that migrants with low SES are least likely to initiate psychotherapy and have the highest risk of early termination.

Social and cultural factors may affect the expectations for treatment. Psychotherapy is not the preferred source of help in all groups. It may be more common to seek support from informal sources, traditional healers or religious communities.[28] Talking about individual problems is sometimes seen as inappropriate way of dealing with difficulties.[31 32] In Germany, the lower motivation for psychotherapy among Turkish migrants was explained by stronger beliefs in supernatural causes of illnesses and higher fatalistic-external illness-related locus of control.[33] In a study conducted among traumatised migrants at a Swiss clinic, it was found that participants considered their suffering to be a consequence of long-term oppression and multiple negative life events.[34] They knew very little about psychotherapy and had negative prejudices but were nevertheless willing to enter a therapeutic process.[34]

Cultural factors can also affect the quality of the therapeutic relationship. It is important for migrants and other ethnic minority patients that the therapist understands the sociocultural context they are living and is open to different worldviews, religious beliefs and illness conceptualisations.[28 31] In a US study ethnic minority patients more often ended their therapy without informing the therapists than white patients.[35] Some psychotherapists were more likely to retain their minority patients than other therapists, which may suggest higher cultural competence among them.[35] Among asylum seekers and refugees in particular, mistrust in services is common and may decrease their willingness to access mental health services or share personal information in psychotherapy.[31 32 36 37]

The findings of this study have implications for the service system. Publicly supported long-term psychotherapy should be equally available to the whole population. Our study suggests that the current system of providing psychotherapy does not meet the needs of the migrant population or they have difficulties in accessing it. Health professionals should support migrant patients in accessing psychotherapy. For migrants who do not wish to receive psychotherapy, effective options for treatment should be explored and developed. Psychotherapists should become aware of the higher risk of early termination of psychotherapy among migrant patients, address possible barriers and pay attention to sociocultural issues.

The strengths of this study include the longitudinal design, large sample size and comprehensive register data with high quality. The study was limited by the fact that we could not control for the need for psychotherapy. Furthermore, we could only include the rehabilitative psychotherapy, which decreases generalisability because a comparable system does not exist in most other countries. The indicator of SES may be less reliable among migrants than among Finnish-born participants.

In conclusion, there is probably a high level of unmet need for psychotherapy among migrants in Finland. To ensure equitable access to effective, evidence-based treatments for mental disorders, healthcare systems must better consider the special needs of migrant populations.

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