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Access and utilization of Portuguese mental healthcare services by migrant children and adolescents: perceptions and experiences of families

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ABSTRACT

This study explores the perceptions and experiences of migrant families regarding access and utilization of mental health services for children and adolescents in Portugal, addressing a critical gap in national research. A qualitative, exploratory approach was adopted, involving focus groups (FG) with migrant families recruited through non-governmental organizations. Participants included parents or caregivers from diverse cultural and migratory backgrounds. Five FG were conducted, stratified by shared linguistic and cultural characteristics, with 4 to 8 participants per group. Discussions were audio-recorded, transcribed, and analyzed using thematic analysis to identify patterns of utilization, barriers to access, and sources of support. Results revealed that migrant families face significant barriers, including bureaucratic obstacles in obtaining healthcare user numbers, economic constraints, geographic challenges, and language barriers. Emergency departments were frequently used as the main entry point to mental health care due to difficulties accessing primary care. Despite these challenges, formal support from NGOs and schools, as well as informal networks and technological tools such as translation apps, were identified as key facilitators in overcoming barriers. Participants emphasized the need for more culturally sensitive practices and better dissemination of information about the healthcare system. The findings highlight the urgent need for systemic changes to improve access to mental health services for migrant children and adolescents. Addressing institutional barriers and integrating community support mechanisms are critical to promoting equity in healthcare and ensuring better outcomes for vulnerable migrant populations in Portugal.

1. Introduction

Migration is a social determinant of health (Spagnoli et al., 2020). The number of international migrants has been growing rapidly over the last few years. The United Nations currently estimates that there are around 281 million international migrants worldwide, corresponding to 3.6 % of the global population (International Organization for Migration, 2024). According to UNICEF, of these 281 million migrants, 36 million are children, of which 17 million are refugees or asylum seekers (Inácio, 2023). An increasing number of people are being displaced, both inside and outside their country of origin because of conflicts, human rights violations, climate change, political oppression and changes in economic cycles (Khalifeh et al., 2023). Portugal has seen a very significant increase in its migrant population in recent years, with the arrival of immigrants from new origins and with new migratory experiences. In 2022, 143 081 residence permits were issued to foreigners, representing an increase of 28.5 % from the previous year, with migrants of nationalities traditionally less common such as India, Pakistan and Bangladesh accounting for 12.3 % of the permits issued (INE I. Estatísticas Demográficas, 2022).

The migration process is also a mental health determinant (Stevens and Vollebergh, 2008), since most mental health problems begin in childhood and adolescence, and their development is related to the interaction between the maturation of the central nervous system and the early experiences to which it is exposed (Wittchen et al., 2011). Despite the variations associated with each migration process, children and adolescents are a vulnerable group due to factors such as lack of legal, socioeconomic and financial status, as well as cultural and

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language barriers that mean they are often neglected in the health system (Chan et al., 2009). Other risk factors for mental health problems associated with migration are also a reality, such as family separation, unstable care, abuse, discrimination or bullying (Belhadj Kouider et al., 2014).

The specific barriers to access and utilization of health systems by migrant population have been described, as have the inequalities in the health care received by this population (Morgan et al., 2005). Overall, migrant children have lower rates of participation in prevention and health surveillance programs. Studies exploring migrant families' perceptions of services emphasize a lack of knowledge and understanding of the system and mistrust based on different cultural perspectives on illness and treatment (Curtis et al., 2018; Bjerneld et al., 2018). Barriers to accessing care can occur at various levels, related to the individual migrant, such as gender, socioeconomic status, social support network or length of stay in the host country (Scheppers et al., 2006); but also to the characteristics of the health services themselves, such as responsiveness and organization or the attitudes and perceptions of health professionals towards migrant populations and knowledge of the cultural factors that affect their state of health (Dias et al., 2008). In terms of utilization, it is well known that the emergency service is often used as the first point of contact with the health system, particularly when it comes to accessing mental health care for children and adolescents (Gill et al., 2017); and this is even more evident in the case of the migrant population (Saunders et al., 2018). However, the emergency departments are not the ideal environment for young people to begin their process of contact with mental health services, as it is associated with worse outcomes, including longer duration of untreated illness and a higher rate of acute care services use in the future (Bhui et al., 2014).

In Portugal, there are no studies that directly explore the perceptions of migrant children and families regarding access and utilization of health services, particularly mental health services. Therefore, the aim of this study is to understand the perceptions and experiences of migrant families in accessing and using mental health services in Portugal.

2. Materials and methods

2.1. Approach and study design

The primary objective of this study was to investigate the general perceptions, attitudes, and experiences of migrant families regarding access to children's mental health services in Portugal. To this end, a qualitative and exploratory approach was utilized, allowing for a more descriptive and in-depth understanding of the participants' perspectives. Focus groups (FG) were conducted with immigrant families to gather data, as they allow for rich, interactive discussions and enable participants to share diverse perspectives.

FG have been widely employed in qualitative research involving populations experiencing vulnerabilities, including immigrant groups, and have proven successful in an intercultural context (Seven et al., 2021; Asanin and Wilson, 2008). They are also frequently used in studies addressing mental health issues in both pediatric and adult populations (Curtis et al., 2018; Fellmeth et al., 2015; Sime, 2014).

2.2. Study participants and recruitment

The participants were selected through a collaborative effort with various non-governmental organizations (NGOs) that support migrant families in different regions of Portugal. The researchers employed theoretical and/or purposive sampling strategies, including snowball sampling that facilitated reaching individuals from different community networks. The final number of participants was determined when no new data relevant to the study objectives emerged, indicating that data saturation had been reached (Saunders et al., 2018).

2.3. Inclusion criteria

For the purposes of this study, 'migrant families' are defined as those in which both adults have been born outside of Portugal and have entered the country with the intention of residing there for at least 1 year, with at least one child or adolescent under the age of 18 in their care, living in Portugal. There were no restrictions on the immigration status of the participants.

- Inclusion criteria: Parents or caregivers of legal age (≥18 years old) included in the definition of migrant families. Having a child or adolescent with an established mental-health diagnosis or ongoing treatment was not required.
- Exclusion criteria: age under 18, inability to communicate in a common language with the other participants of the FG, and cognitive limitations that prevent informed consent.

2.4. Implementation of the FG

The FG were designed to elicit a broad spectrum of experiences from migrant families living in Portugal. To this end, the researchers made concerted efforts to include a diverse array of migrant groups, reflecting the latest migration trends in Portugal, as well as diverse origins and migration histories.

To promote an effective FG dynamic and enable linguistic and cultural understanding the participants were grouped by culturally similar backgrounds, defined primarily by shared nationality or regional origin, language, and common sociocultural norms (e.g., Latin American Spanish-speaking countries, or South Asian countries such as Nepal and Bangladesh). In some instances, the participants were already acquainted through their involvement in non-governmental organization initiatives or within the local community.

Guided by these principles, five FG were conducted: two with immigrants from Portuguese-speaking countries (Portuguese-speaking African Countries and Brazil), one with immigrants from Latin America (Spanish speakers), one with immigrants from Asian countries (Nepal and Bangladesh, conducted in English, which served as a common working language for all group members) and one with refugees from Syria and South Sudan (speaking Arabic as a common language).

The FG consisted of 4 to 8 participants, which facilitated the inclusion of diverse perspectives while ensuring that all members had the opportunity and felt comfortable to actively participate.

Fieldwork was conducted between 30 November 2022 and 8 September 2023. Each focus group was held in person at facilities provided by the partnering NGO that had recruited the participants.

Prior to the FG sessions, the collaborating NGOs distributed informative materials to the participants. These materials outlined the study's objectives, the data collection procedures, the format of the FG, and the voluntary nature of participation. Despite these preparatory measures, at the start of each focus group, the moderator reiterated all relevant details. Participants were given ample time to review the materials, clarify any doubts, and provide written informed consent. Once the consent forms were collected, a brief sociodemographic questionnaire was administered, gathering information on the participants' gender, age, family structure, and migration background.

The FG discussions were approximately 60 min in duration and were facilitated by a member of the research team. In some instances, a mediator from the local community also participated in the focus groups to help mitigate potential cultural barriers between the moderator and the migrant families. All focus group sessions were audio recorded to optimize data collection and enable the subsequent transcription of the discussions for further analysis.

2.5. Data collection

Drawing on a literature review and input from the research team, the

researchers developed a semi-structured script to guide the FG discussions. In addition to an introductory question, the guide included several questions designed to elicit more detailed information. The topics covered in the questions included:

1. Perceptions about the vulnerability of migrant children and adolescents to mental health problems, perceptions about mental health problems and previous experiences
2. Factors associated with mental health problems among migrant children and adolescents
3. Experiences with childreńs mental health services in Portugal

For the purposes of this study, only the answers related to the pattern of access and utilization of mental health services were considered in the data processing.

2.6. Ethics approval

The study procedures were carried out in alignment with the ethical standards for human research. The research protocol was reviewed and approved by the Ethics Committee at NOVA School of Public Health. Participation was voluntary, and written informed consent was secured from each participant to ensure confidentiality and respect for the information provided. Furthermore, this manuscript was prepared in accordance with the COREQ (Consolidated Criteria for Reporting Qualitative Research) guidelines (Tong et al., 2007).

2.7. Data analysis

The data was analyzed using a Thematic analysis approach (Braun and Clarke, 2006), with all authors of the study contributing to this process.

The dataset consisted of transcripts from the FG discussions, field notes, and brief demographic questionnaires. The two researchers who served as moderators for the respective focus groups transcribed the discussions verbatim. An initial review of all the data was conducted to identify relevant text fragments and meanings. Nearly all spoken content was transcribed and analysed. Only segments affected by excessive background noise or clearly off-topic side conversations were excluded, ensuring that the thematic analysis reflected the full scope of participant contributions. After the transcription process was completed, the data was imported into the qualitative data management software Taguette.

The qualitative content analysis employed a combination of deductive and inductive approaches to identify categories and subcategories. The deductive categories were developed based on the research questions and the semi-structured script. In contrast, the inductive categories were generated from the data itself to capture new perspectives that were not previously considered.

The research team thoroughly discussed the categories and subcategories, and the material was reviewed multiple times. All of the codes were applied to relevant text segments using the qualitative data management software Taguette. Following the completion of the coding process, the entire dataset was scrutinized to ensure comprehensibility and thoroughness.

3. Results

The sociodemographic characteristics of the participants are presented in Table 1. While no specific variable on living environment was collected, it is relevant to note that participants in 4 FG were primarily living in urban settings (Lisbon and Coimbra), whereas those in the other FG resided in rural or semi-rural areas from the municipality of Figueira da Foz.

The analysis identified three main themes: patterns of service utilization, barriers to access, and sources of support/facilitators. Each of these themes was further divided into subcategories, as outlined below.

Table 1
General sociodemographic data (n = 30).

Gender – n (%)	
Female	28 (93.3 %)
Age (years) – n (%)	
18 – 24	1 (3.3 %)
25 – 34	11 (36.7 %)
35 – 44	13 (43.3 %)
45 – 54	3 (10.0 %)
>55	2 (6.7 %)
Geographic origin – n (%)	
Africa	10 (33.3 %)
South America	8 (26.7 %)
Central and Southeast Asia	8 (26.7 %)
Middle East	4 (13.3 %)
Place of birth – n (%)	
Cape Verde	7 (23.3 %)
Nepal	6 (20 %)
Syria	4 (13.3 %)
Brazil	3 (10 %)
Bangladesh	2 (6.7 %)
Colombia	2 (6.7 %)
South Sudan	2 (6.7 %)
Venezuela	2 (6.7 %)
Argentina	1 (3.3 %)
São Tomé and Principe	1 (3.3 %)
Time of residence in Portugal – n (%)	
<3 months	1 (3.3 %)
3 – 6 months	3 (10 %)
6 – 12 months	10 (33.3 %)
1 – 3 years	4 (13.3 %)
3 – 6 years	12 (40.0 %)
Transit in another country before Portugal – n (%)	
Egypt	5 (16.7 %)
Malta	2 (6.7 %)
Panama	2 (6.7 %)
Chile	1 (3.3 %)
Poland	1 (3.3 %)
Greece	1 (3.3 %)
Number of dependent children – n (%)	
1	7 (23.3 %)
2	10 (33.3 %)
3	7 (23.3 %)
4	5 (16.7 %)
5	0 (0.0 %)
>6	1 (3.3 %)
Relationship with the child – n (%)	
Mother	27 (90.0 %)
Father	2 (6.7 %)
Brother/Sister	1 (3.3 %)
Reasons for immigration – n (%)	
Economic	11 (36.7 %)
War, conflict or security	15 (50.0 %)
Education	11 (36.7 %)
Family reunion	6 (20.0 %)
Other	7 (23.3 %)

Fig. 1 summarizes the interplay between the different themes.

3.1. Patterns of service utilization

Patterns of service utilization encompassed two key subcategories: previous experiences and entry points into the healthcare system.

Regarding their previous experiences, some participants reported

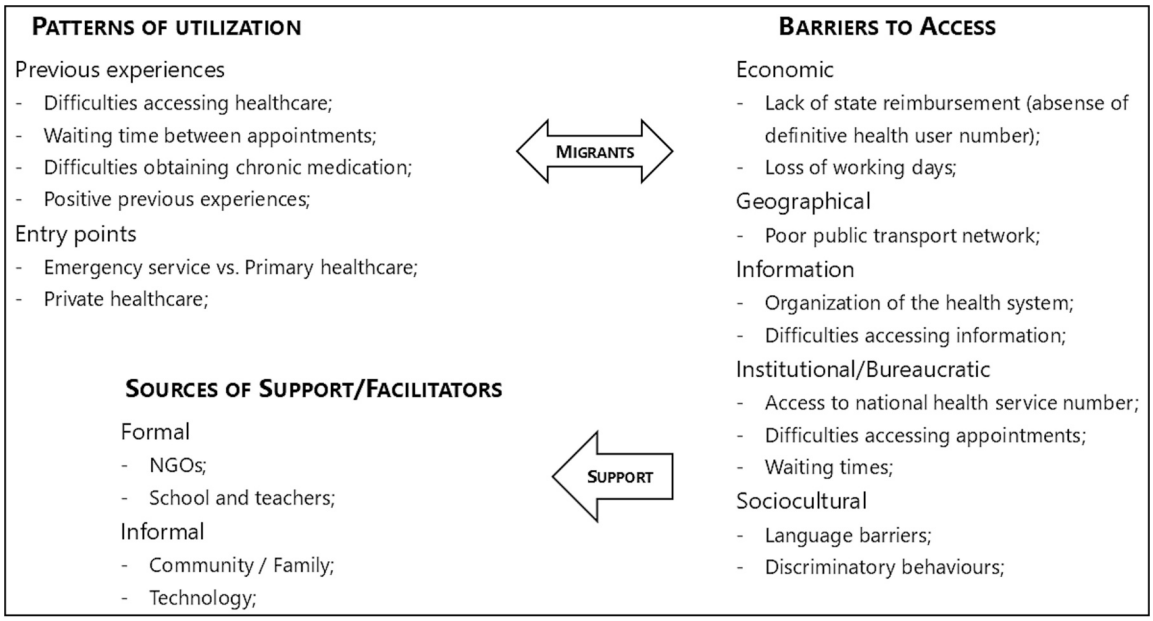

Figure 1. Interaction between themes

Fig. 1. Interaction between themes.

difficulties accessing healthcare, particularly making appointments in primary care. One participant summarized their experiences:

Participant from Cape Verde, Lisbon: "*We have to call. They don't answer the phone. Then they give you the number to leave a message. You leave a message and they don't answer. You don't know if it's been recorded or not. I went to the counter twice. The security guard said: "You have to go home to try to get an appointment". I got very angry and said to her: "I've had enough of calling here". The phone rings, rings, nobody answers. I send messages and there's no reply.*".

The participants also noted the long waiting times between appointments as an issue.

Participant from South Sudan, Coimbra: "*She says she had a consultation with a hospital doctor to help, but they never called her back…*".

Participant from Syria, Coimbra: "*She hasn't seen a doctor in over a year… since November last year… But she has therapy three days a week…*".

In contrast, some participants reported positive experiences with mental healthcare. As two participants summarized:

Participant from Cape Verde, Lisbon: "*Everything was always quick for him. Always normal. I needed to make an appointment. I went there, made the appointment and then he was registered too. Now we have a family doctor. Thank God.*".

Participant from Brazil, Lisbon: "*So, when we decided to come here, my children were already receiving psychological support in Brazil. When we arrived, I chose not to continue the follow-up remotely. I thought it wouldn't be necessary because we had done this before. But later I realised they needed it, and I even spoke to Participant 1 and said, 'I'm going back.' And then they resumed their mental health treatment here in Lisbon.*".

According to the participants, the consensus was that accessing the healthcare system through emergency services was more straightforward than going through primary care.

Participant from Brazil, Lisbon: "*I… When I didn't have a document, I would go to the emergency room and they would see my children without any problem. And I haven't paid anything yet, because I haven't been able to pay.*".

Participants also mentioned using the private healthcare system, particularly to access mental health care, as a way to continue therapies that had been started in their country of origin.

Participant from Brazil, Lisbon: "*I never tried. I went straight to private. I asked some friends, they said, look, it takes a while, and since he was already doing this therapeutic process in Brazil, I opted not to take so long, and then he continued here in private.*".

3.2. Barriers to access

Several barriers to accessing health services in general and mental health services in particular were identified during the FG, and this was the topic with the most information gathered. Economic, geographical, information, institutional/bureaucratic and sociocultural barriers were identified.

As for economic barriers, participants highlighted the high prices of medicines without government subsidies in outpatient pharmacies as a significant barrier, greatly impacting family budgets.

Participant from Syria, Coimbra: "*At the pharmacy they ask if you have a pharmacy card, but I don't… When I buy syrup for my children* (antipsychotic)*, I pay the full price, there's no discount… All together 35 euros!*".

Participant from Colombia, Coimbra: "*If you can't go for a consultation, you can't get a prescription. The medicines in pharmacies are very expensive, because it's like you're a foreigner who doesn't work here.*".

In line with the previous point, one of the issues that inevitably came up was the lack of state reimbursement and the need to pay for all medical procedures used in the absence of a definitive health user number. One participant described the challenge of accessing mental health care for her child under these conditions:

Participant from Cape Verde, Lisbon: "*My son needed to see a psychologist at the hospital, but because he only had a provisional number, they told me we would have to pay everything, consultation, evaluations, everything. I couldn't afford it, so we just waited and tried through the school instead.*".

The participants also highlighted the economic impact of taking time off work to attend medical appointments during working hours as a significant concern. Two participants, including a father, discussed this issue.

Participant from Nepal, Figueira da Foz: "*The problem is that I work… I can't be waiting all day, I can't be absent all day, and then the next day for something else… The boss fires me or the mother if we're always absent!*

Participants in one FG extensively discussed geographical barriers, highlighting the difficulties of traveling to another city to access healthcare, with a particular emphasis on the inadequate public

transportation network.

Participant from Nepal, Figueira da Foz: *"Yes, they always say "we can't do anything here, only in Figueira* (da Foz)*, you have to go there…" And it's hard to get to Figueira* (da Foz)*…..… There are only a few buses every now and then, there's no other way to go... and they tell you "you have to go", but they don't tell you how!"*.

Participant from Nepal, Figueira da Foz: *"It's not easy at all! You don't have a car, you have no way of getting around… the transportation is very bad…"*.

Regarding information barriers, participants across all FG discussed the difficulty in understanding the organization of the Portuguese healthcare system upon arrival in the country, particularly regarding the concept of a family doctor. One participant provided an illustrative example of this challenge.

Participant from Cape Verde, Lisbon: *"I spoke to him and said I needed to speak to the doctor. He asked what about. I explained that it was to get the pills, that I couldn't buy the pills without a prescription* (Attention-Deficit/ Hyperactivity Disorder medication)*. He then said that I had to speak to the family doctor. I said: "Family doctor? What do you mean? I don't know what a family doctor is!"*.

Participants reported difficulty accessing information about the Portuguese healthcare system as a fundamental problem, particularly due to the discrepant information they received from different sources.

Participant from Saint Tome and Principe, Lisbon: *"I don't think it's that difficult, but it is difficult because there's no information. It's very difficult to get information on how to do things, where to go. And every hour someone gives you different information. I think it's a bit lost."*.

Institutional and bureaucratic barriers were extensively discussed across the different FG. Access to the national health service user number, and the challenges associated with not obtaining it, emerged as a widely discussed topic that caused significant discomfort and difficulty for the participants. Several participants shared their experiences, with the accounts of two participants standing out.

Participant from Syria, Coimbra: *"The hardest thing for me was getting the documents so that I could then go to the health center and see a doctor…. … Sometimes it's difficult for people to get documents so that they can buy medicines at the pharmacy, because they don't have a card, for example, they don't have documents from Portugal, only a refugee card, so they can't buy medicines..."*.

Participant from Argentina, Coimbra: *"I also had to push a lot, I asked, I asked, I had to talk to the social worker, I myself asked for an appointment with the social worker, it had been more than 8 months with emails urgently asking for the user number, I even said that at school they were urgently asking me for the user number to enrol the child…"*.

Participants also highlighted difficulties in accessing appointments, both at the primary healthcare level to see a family doctor and at the hospital level for specialty appointments.

Participant from Syria, Coimbra: *"That's a difficulty here in Portugal, people can't get service at the health center easily and then they get to the hospital and have to go to the health center again… It's very difficult with all the problems, but even more with mental health problems, having to talk to so many different doctors…"*.

Participant from Brazil, Lisbon: *"When we actually went to register, it was quicker. But when it came to my daughter, I really found it more difficult because I'd make an appointment, miss it by a day and they'd cancel it. Before it was scheduled and then there was no more room."*.

Participants also discussed the bureaucratization of the healthcare system, including the associated chaos of lengthy queues and waiting times, as a significant issue.

Participant from Argentina, Coimbra: *"Yes, health care here is a bit difficult…..… There's a lot, a lot of bureaucracy, isn't there? (all the participants nod) For example, we need an appointment and when we go to book it, the doctor doesn't have an opening for another three months! It's something I don't understand..."*.

Participant from Brazil, Lisbon: *"And I had a shock of reality. The huge queues, the lack of people to guide you. And even if you go to get the password they ask for, you can't get it because there are so many people. And you realize that there are people who really need it more than you do. And you end up giving them space, which is what happened to me. So I was scared. Very scared."*.

Sociocultural barriers, particularly communication and language difficulties, emerged as a prominent theme across the FG. This issue was seen as a significant barrier, especially among participants from Nepal, Bangladesh, Syria, and South Sudan, who grappled with overcoming language barriers to access healthcare services.

Participant from Syria, Coimbra: *"In Egypt I had syrup to take* (anti-psychotic)*, but it ran out and here I don't have any more…..… It's difficult here... because I can't speak Portuguese and I don't know... I don't know what to do... But the boy is very ill, he hurts himself..."*.

On the other hand, participants from Latin American or Portuguese-speaking African countries did not consider the language barrier a significant problem.

Participant from Cape Verde, Lisboa: *"I think they can understand what we're saying. Because we may not speak Portuguese correctly, but you can understand it."*.

The availability of different healthcare professionals, such as doctors and nurses, was also highlighted as a key theme in supporting migrants to understand information and access healthcare services. These healthcare providers were described as available and willing to offer assistance and support.

Participant from Syria, Coimbra: *"The hardest thing! Because the language is very different, the way of understanding things too (laughs), but the doctors are always very nice to the children, just like in Syria… that's one of the same things about the culture of Portugal and Syria, respect for mothers, respect for children…"*

Participant from Syria, Coimbra: *"It's hard for me to speak Portuguese well, but my* (family) *doctor also helps, she says very simple things and always asks if I understand and when I don't, she helps and puts it on the computer… It was very important for me to speak Portuguese well!"*

In contrast, participants reported that other professional groups, such as security guards or administrative staff, exhibited less favorable attitudes, reduced willingness to provide assistance, and some discriminatory behavior.

Participant from Cape Verde, Lisbon: *"In the way they treat people! Because I've noticed that doctors always treat patients well. But the ones who treat them badly are the security guards, the other people, the administrators. They talk badly, arrogantly. When they explain something, they always treat you badly. Both in the emergency room and in the hospital. I've noticed that. And not the doctor, the doctor speaks well to people."*

Participant from Venezuela, Coimbra: *"I think they see us and immediately think that we're going to give them more trouble! (laughs) Because we speak another language, even if it's similar, or because they know they're going to have some more bureaucratic problem with us, or because we don't know the system and we ask more obvious questions, you know?"*

Participant from Colombia, Coimbra: *"Wow, I think that's a really good point, because for me the people at the reception, who are the first ones you face when you walk in, right? I feel like they're a big problem… I mean, that's where I really felt discrimination for being an immigrant, with those people, because I try to go in and start talking to them and they act like they don't understand…"*

Participants did not report any significant barriers related to cultural or religious aspects in accessing healthcare services.

Participant from Nepal, Figueira da Foz: *"Diseases, health problems are the same for everyone, anywhere in the world, I think, no? (laughs) We're all human. So it doesn't matter what your religion or culture is, the issue here is just your health and that of your children…"*

Participant from Bangladesh, Figueira da Foz: *"I don't think religion or culture influence health… You go to the doctor and you don't talk about your religion, that's not important…"*

3.3. Sources of support/facilitators

Finally, the theme of sources of support and facilitators of access to healthcare revealed both formal and informal facilitators.

Across the FG, the role of NGOs emerged as a prominent formal facilitator, with numerous participants reporting substantial support from these organizations (Portuguese Red Cross, Associação Girassol Solidário, Cáritas Diocesana Coimbra, AMI – Centro Porta Amiga, Associação Lusofonia, Cultura e Cidadania).

Participant from South Sudan, Coimbra: *"But after six months help came, the Portuguese Red Cross helped me, gave me a house and it gave me work too… But then I started to understand and speak a bit of Portuguese and now I speak a lot, a lot, now I translate for others, imagine!"*

Participant from Nepal, Figueira da Foz: *"Yes, the hardest part was getting the children into school… But then we spoke to Ana* (fictious name) *and Caritas* (Diocesana) *and they found a place for us! After being in school they have lots of friends, Portuguese, Nepalese, Bangladeshi, Uzbek."*

Participants also highlighted the role of schools and class teachers as facilitators of access, particularly to mental healthcare services.

Participant from Venezuela, Coimbra: *"I would say that the school is one of the areas where we can ask if we feel our children need a psychologist, given my particular experience… I would talk to the teachers or head teacher!"*

The community was highlighted as playing a crucial role as an informal facilitator in participants' experiences of accessing and utilizing health services.

Participant from Syria, Coimbra: *"I also found people who helped me, neighbours, now they're almost like my family! So it was easier (smiles)."*

Participant from Nepal, Figueira da Foz: *"Friends, family… I think we all knew someone here before we came (laughs). And it's these people who explain to us how things work here, and also how the doctors and the health system work…"*

Participants also emphasized the pivotal role of family in facilitating access to mental healthcare, particularly teenage children who had a stronger command of the Portuguese language and a greater capacity to adapt to diverse contexts.

Participant from South Sudan, Coimbra: *"My daughter is now 15 and helps with the translation, she speaks Portuguese very well because she studied most of her schooling here… She always translates or if there's a problem with her brother I get her on the phone…"*

Participants also discussed the role of technology and the internet in facilitating access to healthcare services. One participant highlighted how they used their cell phone to support translation during consultations with healthcare providers.

Participant from Nepal, Figueira da Foz: *"I use the cell phone… (several laugh and agree) The doctor writes on the cell phone and shows it, I write and show it…"*

4. Discussion

This qualitative study sought to investigate and characterize the perceptions and experiences of migrant families regarding access to and utilization of healthcare services in Portugal, with a specific focus on mental health services. Overall, the participants reported a range of barriers and facilitators to accessing and using mental healthcare services in Portugal, with several common themes emerging across the FG.

4.1. Patterns of utilization

Migrant children frequently report unsatisfactory experiences when accessing healthcare services (Chang et al., 2022). They may encounter challenges and delays in registering with primary care providers, obtaining medical appointments, and attending follow-up visits (Yu et al., 2004; Lorek et al., 2009). Participants in our study reported previous negative experiences in using health services, consistent with the existing literature. Key difficulties included challenges in accessing healthcare, particularly primary healthcare, long wait times between appointments, and obstacles in obtaining previously prescribed chronic medications due to limited access to medical prescriptions in a timely manner. Existing literature has documented disparities in the utilization of mental health services among migrant children and adolescents compared to their non-migrant peers. Readily available and accessible health services are key factors in promoting the health, well-being, and integration of migrant populations (Ferrari et al., 2015; Fauk et al., 2021). Due to the difficulties in accessing primary healthcare, participants reported that the emergency service was seen as the easiest entry point into the health system. The existing literature indicates that most of the youth who first seek emergency care for mental health concerns had not previously received outpatient treatment for a mental illness, and this trend is particularly pronounced among the migrant population (Gill et al., 2017; Saunders et al., 2018; Cloutier et al., 2010; Liu et al., 2014; Durbin et al., 2015; Lebano et al., 2020). Research indicates that factors such as limited access to primary care, diminished English proficiency, stigma, challenges in navigating the healthcare system, or more severe illness are key contributors to the use of emergency services as an alternative entry point, which is associated with poorer long-term outcomes (Bhui et al., 2014; Fiscella et al., 2002). Participants also described leveraging the private healthcare system as a supplementary option for accessing mental health services, particularly when the patient had initiated treatment in their country of origin. These alternative care-seeking pathways highlight the barriers encountered by economically vulnerable populations, including migrant families (Tulli et al., 2020).

4.2. Barriers to access

The participants extensively outlined the range of barriers they encountered when trying to access healthcare services, encompassing economic, geographical, informational, institutional/bureaucratic, and sociocultural barriers. Institutional and bureaucratic barriers emerged as a central theme, as the difficulty in obtaining a national health service beneficiary number was closely linked to other themes such as economic barriers and prior utilization experiences. Without a valid national health service number in Portugal, individuals are required to pay in full for both outpatient prescriptions and inpatient procedures, without any state co-payment or reimbursement. Additionally, the participants cited the challenges in accessing primary and hospital-based consultations, as well as the excessive bureaucratization of the healthcare system, characterized by lengthy queues and wait times. These institutional barriers were closely intertwined with the difficulties the participants had reported in terms of their previous experiences and patterns of healthcare utilization. Prior research has documented the psychosocial and physical consequences of lengthy wait times, as well as other significant impacts such as loss of employment, increased reliance on over-the-counter medications, and reductions in income, all of which may disproportionately affect low-income households or individuals with part-time or hourly-based employment, a common circumstance among migrant populations (Harrington et al., 2014). Furthermore, participants highlighted the economic barriers stemming not only from the need to pay the full cost of healthcare services, but also from the loss of income due to taking time off work to attend appointments and therapies, as well as the risk of termination due to absenteeism. The literature has consistently demonstrated the link between employment status and healthcare access. Unemployed individuals face significant challenges in regularly utilizing healthcare services and are more likely to have unmet healthcare needs compared to their employed counterparts (Lee et al., 2015). Existing research has also identified a lack of financial resources and the cost of services as key barriers to accessing care, particularly among vulnerable populations like migrants and low-income communities (Njagi et al., 2020).

A central issue discussed across all FG was the sociocultural barrier of language. This was particularly significant for participants who did not

speak Portuguese as their primary language. Insufficient language proficiency hinders effective communication with healthcare providers and navigating the healthcare system, leading to misunderstandings, difficulty in expressing symptoms, and suboptimal care experiences. Language barriers are widely documented as a significant obstacle to accessing and utilizing healthcare services, especially among migrant populations, as they can impede accurate diagnosis, appropriate treatment, and patient engagement in their own care (Pandey et al., 2021; Al Shamsi et al., 2020). For mental health care, the language barrier plays an especially crucial role. Unaddressed language barriers can hinder patients at multiple junctures of the healthcare pathway, from the initial stages of seeking information and accessing care, to adhering to prescribed treatment plans. When language support is unavailable, these linguistic obstacles can adversely impact the early identification and diagnosis of mental health issues, which then has downstream effects on the subsequent stages of the care process (Krystallidou et al., 2024). Our data also suggest that the organization of primary care matters: Family Health Units and other health-center teams that operate on a list-based, continuity-of-care model can maintain closer contact with users, enabling physicians to invest time in simplified explanations and iterative checks of comprehension, thereby reducing language-related barriers for migrant families. Furthermore, participants discussed geographical and informational barriers, highlighting the challenges in navigating the healthcare system. The main difficulties included the inability to comprehend the organization of the Portuguese health system, the lack of centralized and coherent information about the system, and the difficulty in traveling to other cities due to the country's limited public transportation network. Navigating healthcare systems often proves challenging due to their inherent complexities, encompassing factors such as insurance plans, provider networks, referral procedures, and medical billing. The absence of clear and user-friendly information about how to effectively navigate these systems creates substantial barriers, particularly for those unfamiliar with healthcare processes or facing language barriers. This can result in delays in accessing care, missed appointments, and difficulties in obtaining necessary services (Vernon et al., 2007).

4.3. Sources of support/facilitators

The participants further discussed and identified sources of support and facilitators that assisted them in accessing and utilizing mental health services. These included both formal and informal sources of support. Among the formal sources, the participants highlighted the important roles played by NGOs and schools. NGOs were cited as key providers of information, support, and direct assistance in navigating the healthcare system, especially for newly arrived or migrant families experiencing vulnerabilities. Research indicates that local non-profit organizations supporting immigrant integration can enable collaborative initiatives to enhance migrant access to mental health and healthcare services (Papademetriou and Institute, 2014). These organizations can support access to primary healthcare by partnering with community health providers, linking clients to health services and providers, advocating for immigrant health, offering educational programs, and engaging in community development, mobilization, and advocacy to promote healthcare access. Integrating these local immigrant settlement organizations into healthcare planning and service delivery may enable more responsive and inclusive approaches to reach marginalized, high-need immigrant populations (Ratnayake et al., 2022). Additionally, the participants emphasized the crucial role of schools in identifying and referring children and adolescents with mental health issues, as well as in providing counseling and support services. Schools can serve as an important entry point to the healthcare system, particularly for migrant children and adolescents, as they are often the first institutional setting where mental health concerns may be identified and addressed (Zhang et al., 2023). Moreover, school-based mental health services and referral networks can be especially beneficial for overcoming barriers such as language difficulties, lack of information, and cultural stigma surrounding mental health care (DeSilva et al., 2014; Hoover and Bostic, 2021).

The participants also discussed the role of informal support networks, such as family, friends, and religious/cultural communities, in facilitating access to mental health services. Interestingly, participants also noted the importance of using technology, particularly online translation services, as a source of support in the process of overcoming language barriers. These informal networks often provide crucial emotional, practical, and informational support, which can be particularly valuable for newly arrived migrant families (Merry et al., 2019; Stewart et al., 2018).

4.4. Strengths and limitations

Several limitations of the study should be noted. The FG format, while intended to reduce stigma and facilitate collective discussion on migration, may have restricted the expression of minority perspectives given the sensitive nature of the topic. Additionally, while participants communicated in a common language with the aid of translators, some did not convey their views in their native tongue, potentially limiting the depth of the insights shared. Furthermore, the sample exhibited a gender imbalance, with the majority being female, which reflects the global trend of mothers as primary caregivers, though future research should recruit a more diverse pool of participants, including fathers and other caregivers, to gain a comprehensive understanding of potential differences. All participants were recruited through NGOs, suggesting they may have had access to the resources and services provided by these institutions, whereas immigrants without such institutional support may have experienced divergent opportunities and challenges. Our snowball sampling through NGO networks, while effective for reaching families facing the greatest structural vulnerabilities, resulted in the underrepresentation of several large European-origin communities (e.g., Romanian, Italian, Spanish, Ukrainian migrants) that seldom rely on NGO support. Consequently, the final sample disproportionately reflects non-EU and refugee populations and may not capture the potentially different experiences of EU citizens who, by virtue of freedom of movement, often navigate Portuguese health and social services with fewer bureaucratic hurdles. This recruitment pathway therefore limits the generalisability of our findings to the broader migrant population. Future studies should employ alternative channels, such as consular registers, social media, or community associations, to include EU migrants and thereby offer a more comprehensive picture of access to mental-health care across all migrant groups in Portugal. Finally, since data saturation was assessed globally rather than within each cultural subgroup, subtle subgroup-specific nuances may have been inadvertently missed. Future work could more comprehensively explore these differences by conducting multiple focus groups within each subgroup.

This study demonstrates notable strengths despite the limitations identified. The researchers recruited a diverse sample of migrant families from various organizations and communities across Portugal, encompassing participants with diverse ages, family structures, and durations of residence in the country. This diversity enables a more nuanced understanding of the perspectives and experiences of migrant families living in Portugal. The presence of a cultural mediator in the Arabic-speaking group played a key role in shaping the interaction, especially by enabling linguistic access and cultural resonance. In contrast, the informal support provided by NGO staff in other groups underscores the value of community-based trust and proximity in qualitative research with migrant populations. To the researchers' knowledge, this is the first Portuguese study to directly explore the perceptions and experiences of migrant families in accessing and utilizing mental healthcare services. Consequently, this work establishes a foundation for future research essential for expanding knowledge about the mental health of migrant children and developing effective interventions. Moreover, the findings of this study can inform the

development of policies and programs aimed at promoting the mental health of children by addressing the primary factors identified by the families.

5. Conclusions

This study provides novel insights into the perceptions and experiences of migrant families regarding access to and utilization of mental health services for children and adolescents in Portugal. By employing a qualitative approach, the research identified significant barriers (bureaucratic, economic, sociocultural, and geographical) that hinder equitable access to care. It also highlighted the reliance on emergency departments as the primary entry point for mental health services, reflecting systemic challenges in primary care accessibility.

Despite these barriers, the study identified critical facilitators, including the role of NGOs, schools, informal networks, and technological tools, such as translation apps, in bridging gaps in access and utilization. These findings underscore the importance of culturally sensitive practices and systemic reforms to promote equity in healthcare delivery for vulnerable migrant populations.

From a broader perspective, the study's implications extend to policy and practice. Addressing institutional barriers, improving the dissemination of information about the healthcare system, and fostering community-based support mechanisms are critical for enhancing the mental health outcomes of migrant children and adolescents. Schools and NGOs emerge as pivotal partners in this process, offering opportunities for early identification of mental health needs and ensuring timely access to care.

Future research should further explore the long-term outcomes of interventions designed to address these barriers and evaluate their effectiveness in different contexts. By contributing to the global discussion on health equity and the mental health of migrant populations, this study lays the groundwork for policies and practices that promote inclusive, responsive, and sustainable healthcare systems.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

Data will be made available on request.

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