Roma and mental health: the role of discrimination

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What stands out from the interviews collected by Associazione 21 luglio while exploring the conditions of the Roma minors living in the "institutional village" on Via Salone in Rome is a 32-year old man saying: "*I don't want my children to live here. They will have mental problems when they grow up if they stay here, that's for sure. Many people here have mental problems [...] it's dangerous for the children, there is sadness, depression, schizophrenia*" and he goes on "*I'm scared they're going to suffer from a mental illness as grown-ups. My children have no future here*" (Anzaldi and Stasolla 2010, p. 35).

Introduction

Wishing to give an overview, albeit general, of the state of mental health of Roma people across Europe, we inevitably need to highlight the issues and hurdles encountered, first and foremost choosing the methodology, so to be able to accurately analyse (Geraci et al 1998) communities with different demographic, socio-economic and cultural characteristics. For example, the main communities in Italy are 22: Italian Roma not recently migrated who are divided into 5 groups; Sinti including 9 groups; Balkan Roma recently migrated including at least 5 groups; Bulgarian Roma; Romanian Roma; *caminanti*. Not all Roma individuals and households residing in Italy are socially vulnerable. As a matter of fact, according to a census conducted on 180,000 Roma people by the Council of Europe, only 20,000 of them are faced with emergency housing conditions and are experiencing poverty and social exclusion (Associazione 21 Luglio 2018). This survey intends to focus on those subgroups of the Roma "universe" who live in informal and institutional slums as aconsequence of poverty, social marginalization and policies generating "ghettoes" and discrimination. So, to avoid generalizations, the wording "Roma" or "Roma community" used herein depicts specifically this portion of a larger and more diversified context.

Moreover, to carry out epidemiological research and collect reliable data results to be complex given that these people access the National Healthcare Service (SSN) in a limited way (or do not access it at all). This happens despite of the fact that the Roma communities often perceive illness as a matter of concern and constantly talk about it as a severe crisis phase not only for the individuals who are ill but also for their families and broad circle of relatives. In this regard, illness becomes a personal – but also and above all a social – issue (Sutherland 1992). Many studies emphasize that the

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Roma minority primarily suffers from chronic diseases, among which mental disorders (Goward et al 2006; Parry et al 2004) whilst research into mental disorders within Roma groups is rare compared to that concerning non-Roma people (Pereira et al. 2016; Cemlyn et al 2009; Filadelfiová et al 2007; Parry et al 2004). Most analyses carried out suggest that mental health problems are closely related to social health determinants (Robles-Ortega et al 2017; Voko et al 2009). A number of studies investigates the existing discrimination, prejudice and racism at various levels (of policies, media, services, neighbourhood, school) (EUFRA 2017; Izsak-Ndiaye 2017; Associazione 21 Luglio 2015; Piasere 2015; Francis 2013; Lloyd&McCluskey 2008). A 2016 European survey points out that between 14% and 48% of the Roma interviewed in the various European countries were subject to discrimination in the previous 12 months (EUFRA 2017).

The surveys assessing the direct association between racial discrimination and mental health point out the impact discrimination has on triggering reactions in the various stages of life, which may lead to the development of psychopathologies. (Heard-Garris et al 2018; Priest et al 2013; Astell Burt et al 2012; Pachter et al 2009).

Mental health risk factors

Research into incidence and prevalence of mental disorders in marginalized Roma communities compared to non-Roma emphasizes a higher prevalence of chronic conditions, among which mental disorders (Goward et al 2006; Parry et al 2004). Much of this research takes into consideration general health, chronic diseases (including mental disorders), their risk factors and influence over the **quality of life** (Pappa et al 2015; Zelko et al 2015). A study conducted in Serbia stresses that the Roma people examined are not satisfied with their own life and unhappier than non-Roma (Cvjetkovic et al 2017). In a 2015 survey regarding a Roma community in north-eastern Slovenia, Zelko et al assess the quality of life of Roma suffering from chronic conditions by using a self-report scale (EQ-5D). The findings indicate that the existence of chronic mental disorders negatively affects the subjective perception of the quality of life, which is in turn associated with higher anxiety and depression.

Most publications taken into consideration by this report suggest that mental health problems in the same way as the quality of life are closely related to **social health determinants,** and so are bad housing conditions, low educational attainment, unemployment, the low socio-economic level, material deprivation and unhealthy lifestyles, issues that sometimes coexist among Roma (Robles-Ortega et al 2017; Voko el al 2009).

Among the factors that may intensify the incidence of chronic diseases, it is worth mentioning on one hand, components that we can define as internal in the Roma communities referred to by our report, and on the other, external elements affecting health. These risk conditions do not stand alone, rather they are articulated with synergic effect. The so-called internal factors are women, hereditary diseases, a low educational level, the socio-economic level, some specific cultural features that impact living habits and a different approach to health and healthcare services. The latter are closely related to "external" elements such as social and housing policies, discrimination emerging from the media, at school, the neighbourhood and healthcare and non-healthcare services, the lacking cultural competence within the healthcare service system (Pappa et al 2015; Carrasco-Garrido et al 2011).

That **education** has an impact on the quality of life was broadly demonstrated (Voko et al 2009). This co-relation is significantly strong among the Roma population where low educational attainment ranks second among the health risk factors and is preceded only by socio-economic and housing conditions. The young going to school report better health conditions, education is in fact a crucial condition also for the future well-being, to find a good job and earn a decent salary (Pappa et al 2015).

Literature reviews concerning the **socioeconomic impact** on Roma's health are manifold. Some scholars argue that there is a direct association between the two and that a prominent role in the development of mental disorders is played by economic and social conditions of Roma communities (Pappa et al 2015). On the contrary, others remark that the interaction between these factors is not so influential that it determines a difference in the mental health state of Roma against non-Roma (Kolarcik et al 2009). An in-depth analysis about the **housing conditions** will be outlined later in this report. The latter exercise considerable influence over the quality of life: stable housing solutions like those applying to all other citizens boost the well-being perceived by Roma (Pappa et al 2015).

Lifestyles stand out as being one of the elements that may affect Roma's mental health, namely the so-called "internal" factors. Habits such as alcohol consumption, smoking cigarettes, inadequate nutrition associated with bad housing conditions and social exclusion expose individuals to ongoing stress, thus triggering the onset of a chronic disease or awakening latent symptoms (Sivic et al 2013; Pappa et al 2015).

Some studies conducted among the Roma communities in Greece and Spain report that **gender gaps** are important health risk factors (Carrasco-Garrido et al 2011; Pappa et al 2015). In this regard, a relevant role is played by socio-economic factors, which further increase gender disparities and the gap in terms of health conditions. Women have a lower quality of life than men, probably

due to their role in the community, to cultural aspects and different lifestyles. Roma women do less physical activity, consume considerable amounts of alcoholic beverages and use healthcare services less than men (Carrasco-Garrido et al 2011). Some studies highlight that the young age and to have a partner are protective factors that exercise a positive effect on the quality of life (Pappa et al 2015).

An interesting basis for reflection on the matter is the gradual tendency to women's empowerment, which sets a change in the role women play in the typical Roma family. Cemlyn et al (2009) suggest that such a condition in some families can cause domestic violence to increase due to the hurdles men encounter when they try to adjust to a new situation and to reshape their own role. It is worth considering such a topical and constantly evolving issue, which would deserve to be delved into properly. Despite the key role women play in looking after the family, or as intermediaries when dealing with healthcare services, for example concerning their children, scientific research does not sufficiently explore their health (Francis 2013). Current literature emphasizes that they are subject to double discrimination by reason of both cultural background and gender (Surdu and Surdu 2006).

Mental disorders

To provide a sufficiently comprehensive overview of mental health conditions of Roma, we need to analyse the European research scenario of merit.

A report on the health conditions of Roma in Slovakia underlines that a tenth of the Roma population would suffer from mental disorders – a much higher proportion compared to non-Roma (Filadelfiová et al 2007). From the analysed studies it emerges that the most common disorders are anxiety, depression, attempted suicide and suicide, drug and alcohol abuse, and psychotic symptoms.

A British study including the so-called Travellers (nomadic Roma groups) identified that the incidence of **anxiety-related symptoms** is 3 times higher than in the general population, the incidence of **depression-related** symptoms is twice as high, while the risk women run to develop a mental illness is twice higher than men (Parry et al 2004). A survey carried out in Italy about primary health care delivered in the area of Milan revealed that 20% of the total symptoms reported are **non-specific disorders** such as distress, fatigue, dizziness, inappetence, sadness and headache, which account for 9% of the total number of the diagnoses made (Colombo et al 2011). The noteworthy incidence of the reported symptomatology can be related to chronic stress Roma are subject to due to environmental and social conditions, as well as discrimination, which might in some cases evolve into a mental illness when underrated or misdiagnosed. As part of the evidence for that, among those who have no health insurance in Portugal and so, no access to medical care, Roma

show to suffer predominantly from depression, anxiety, and **psychotic symptoms** (Pereira et al 2016). Poor access to medical care hinders prompt diagnosis and treatment, and increases the risk that a disease will onset, flare up and become chronic.

A higher incidence in anxiety and depression was also detected in the Roma communities examined in the United Kingdom in comparison with most people. In particular, research stressed that in such a context, **suicidal ideation** and attempted suicide (Cemlyn et al 2009) increase as a consequence of non-treated depression. The factors that contribute to worsening a depressive disorder to the extent that it could evolve into suicidal ideation are social exclusion, experienced cases of racism, stigma relating to sexual orientation and significant changes in life such as divorce and **bereavement** that has never been resolved.

The life conditions of some of the Roma communities whose main feature is that their members live in close proximity most of the time, often cause so high emotional intensity when a relative or a neighbour dies that some told about resolving bereavement as a hard process that may last for a lifetime (Cemlyn et al 2009; Van Cleemput et al 2007; Parry et al 2004). In some cases, depression as a reaction to bereavement may cause self-injurious behaviours that might eventually lead individuals to commit suicide.

Moreover, to tackle the grief for the loss, drugs and alcohol are sometimes used as self-medication (Van Cleemput et al, 2007), thus exacerbating the depressive symptomatology and generating addiction, a condition for which a way out is hard to find.

As a result, addiction can cause deviant behaviours, such as theft and violent behaviours (including domestic violence), crimes that may lead to **imprisonment**. The depressive condition is made worse by living in prison: the fact that drugs can be easily found here may intensify addiction and more likely develop suicidal ideation (Cemlyn et al 2009). In United Kingdom, the incidence of Roma prisoners committing suicide is high (Cemlyn et al 2009; Parry et al 2004). The Roma who have never been affected by disorders related to drug abuse before imprisonment could possibly start using drugs in prison where they can end up after committing petty crimes e.g. theft (Cemlyn et al 2009).

Alcohol and drug consumption is wider-spread among the Roma communities than the general population (Cemlyn et al 2009). In particular, alcohol is consumed by those who live in degraded housing conditions, who have no job and suffer from depression (Parry et al 2004). Like in the case of bereavement, alcohol is often used in large quantities as self-medication to help lessen depression or anxiety symptoms (Van Cleemput et al 2007). Self-medication as a therapy for psychological problems occurs also when the prescribed **medications** are wrongly taken. It is not rare that

psychopharmacological treatments are self-dosed or handed out to the other members of the community without medical indication, who end up becoming addicted (Castagnone et al 2015).
Mental disorders, as well as addiction in Roma can be worsened by a double difficulty: on one hand, they do not call for help because they feel ashamed and believe that having a mental problem means that they are mad; on the other, it is difficult for them to access the dedicated services, an issue that we will explore hereinafter (Cemlyn et al 2009; Parry et al 2004).

Discrimination

The 2017 EUFRA report confirms that Roma are subject to persisting levels of marginalization and discrimination, which are risk factors for mental health. Although the great deal of research into discrimination, prejudice and racism against Roma demonstrates that the influence of these factors over these people's lives is pervasive (EUFRA 2017; Izsak-Ndiaye 2017; Associazione 21 Luglio 2015; Piasere 2015; Francis 2013; Lloyd&McCluskey 2008), this issue is paid minimum attention by the media and society, who, on the contrary, boost bias against them (Francis 2013).
Whereas racism against foreign people, migrants and religious minorities has been addressed by political media and institutions over recent years, the issue of discrimination against Roma has never been delved into very much. Significant is how Sir Trevor Philips commented this phenomenon before the *Commission for Racial Equality* in 2004, that is "the last respectable form of racism" (CRE 2004). Racism against Roma occurs at various levels such as politics, media, neighbourhood, school and services.
The European Parliament expressed concern for the forms of discrimination Roma are victims of in the areas of education, housing, occupation and equal access to the healthcare systems and public services (Colombo et al, 2011).

As mentioned above, **media** often nurture bias against Roma. Not rarely, TV shows or newspaper articles encourage discrimination by providing incomplete or inexact information that casts a detrimental image upon Roma. They frequently disseminate merely negative news that contribute to raising fear and/or hate among the citizenship. Also at the level of a **neighbourhood** racism may result in exclusion or even violence (Cemlyn et al 2009) - that is what happened in Rome when the City Council moved a Roma group to a reception centre in Torre Maura (Internazionale 2019).
A particularly sensitive field where discriminatory behaviours can develop and be engaged in is at **school** and in some cases, we can even speak of "institutional racism" (Lloyd&McCluskey 2008). The classmates can perpetrate exclusion, bullying and racist abuse but apparently, the school system can commit prejudice too. A study carried out in the United Kingdom stresses that teachers get

angry more easily when dealing with Roma children, punish them more severely and give them lower grades. This institutional attitude can foster discriminatory or bullying behaviours by the classmates also via social media (Lloyd&McCluskey 2008). Such a school environment raises the risk of lowering school performance and encouraging early school leaving. Poor performance associated with the risk factors for mental health listed above, such as insecure housing conditions, the low socio-economic level, material deprivation, unhealthy lifestyles of the household of origin, may unleash high stress levels and depressive reactions (Lee et al 2014). Experiences with discrimination are so pervasive that they trigger physical reactions in the human body by increasing the levels of cortisol and other stress hormones, which might cause improper conduct such as drug abuse, smoking cigarettes and risky sexual conduct. The onset of a mental illness is substantially more likely to happen when an individual is in such a fragile psychological and physical state in co-existence with these social risk factors (Pascoe and Richman 2009).

Racism can be also an indirect experience because the discriminatory event a person is subject to might **vicariously** impact another one. Children along their development can be negatively affected by the discrimination their parents have been subject to. To live in one's own and others' perception of a hostile external environment influences the vision a child has of the world, reduces self-confidence and the trust built with others, makes us gradually estranged from social relations. If such a process is not curbed, it could lead to the development of a mental illness as adolescents or adults (Heard-Garris 2018).

Access to services

Article 32 of the Italian Constitution establishes that "The Republic protects health as a fundamental right of the individual and collective interest, and guarantees free medical care to the most deprived people." So, the right of all citizens and - before that - of all human beings to health cannot be set aside and access to services is the precondition for ensuring it tangibly.

A great deal of research and studies carried out in Europe, including Italy, show that Roma can hardly access healthcare services, and specific action is needed, which has to take into account the variables and hurdles that currently interfere (Francis 2013; ERRC 2006; EUMC 2003).

We can distinguish between internal and external factors also in the case of the access to services. The internal factors, such as the low educational level, cultural aspects and life habits, together with the "external" factors such as issues relating to red tape and issuing of documents, geographical isolation of some settlements, the location of the local facilities delivering services, no information

and communication tools in the Roma settlements, prejudice and the lacking cultural competence of health workers, negatively impact access. The aforementioned barriers hindering access to healthcare services determine that the latter are improperly used. The Roma surveyed herein can hardly benefit from the prevention and screening programmes the national healthcare system delivers and advises for the most common diseases to the general population. In addition, they have no sufficient vaccination coverage in many cases and use emergency services most of the time (Castagnone et al 2015; Francis 2013; ERRC 2006).

Among the factors affecting the access to services we will focus on the existing relationship between health workers and Roma: in this regard, we intend to stress that discrimination plays a role if Roma do not resort to health care, thus acting as a risk factor for the development of mental disorders.
The lack of **cultural competence** about the Roma people and of **intercultural mediators** within the healthcare services is emphasized by much research (Mc Fadden et al 2018; Ricordy et al 2014; Francis 2013). Health workers are not adequately trained and as a result, their approach often takes into no account cultural differences, so, they take for granted in their clinical practice that Roma patients observe the usual rules of conduct and the provided indications, that they need no additional explanation compared to Italian patients and that they understand what they have been told. A health worker frequently reacts out of anger when a patient misses an appointment, does not arrive on time for the doctor's visit or comes to a visit with the entire family, does not take medications in the correct way or even interrupts a treatment when the symptoms disappear – these are the typical conditions that may occur with some Roma patients – because he or she considers these attitudes to be demeaning for his or her own role. Moreover, the fact that being able to establish a relationship with these patients is difficult is generically and inappropriately attributed to the "Roma culture" by health workers, who do not consider that these patients' behaviour is influenced by their *gagé* cultural background (Castagnone et al 2015; Ricordy et al 2014).
In addition, health workers are more or less knowingly influenced by the cultural context they live in, which - as it was said above - casts negative stereotypes and boosts **prejudice** against Roma. So, racism lurks also in the healthcare system and can generate a different form of institutional discrimination.
Two forms of discrimination lie within the healthcare services, namely one that occurs with higher frequency and can be defined as **indirect**, which liaises with the stereotypes concerning the Roma rooted in our culture, while the other is unfortunately **direct** and constitutes a deliberate breach of the right of Roma to health (Ricordy et al 2014; EUFRA 2013).

According to the European Union Agency for Fundamental Rights' (EUFRA) 2009 survey, 17% of Roma declared to have been subject to healthcare discrimination in the previous 12 months. This data was confirmed by other studies, which argue that a shorter length of time is dedicated to Roma during a doctor's visit while the symptomatology, the treatments to undergo and the progress of a disease are not accurately outlined to these patients (Van Cleemput 2010).

The 2006 ERRC report conducted in Hungary, Bulgaria and Spain underlines that severe direct discrimination at the detriment of Roma exists in the healthcare context. Health workers would change behaviour according to where the beneficiaries come from and to their cultural background, and would offer inadequate treatment to Roma from both a professional and humane viewpoint (Ricordy et al 2014). In particular, the most alarming approaches to treating these patients consist of providing them with inadequate and lower quality treatments compared to the other patients. The report points out that the unequal treatment consists in separating them from the other patients, delivering hasty and incomplete check-ups with shorter visits, during which health workers avoid physical contact with these patients - visits to Roma patients are more often carried out by trainees or medical students than in the case of non-Roma patients – as well as providing no expert advice concerning the patient's problem. In some cases, Roma patients are verbally abused also by using racist language (Castagnone et al 2015; EUMC 2003; ERRC 2006).

Health workers' exclusionary attitude raises mistrust with the result that the Roma communities do not refer to the available services and do not follow the established clinical pathways. As a result, diseases are treated when they have already flared up, and this is the reason why these communities more frequently call to the emergency services e.g. ER and ambulance service. Sometimes, these services are misused and subsequently overburdened, which generates frustration in the health workers and worsens the exclusionary attitude against Roma. This might lead - in the worst case scenario - to ignoring the requests for assistance with an ambulance, thus breaching the right to health once again (EUMC 2003; ERRC 2006).

In the light of the above, given that the Roma examined in our report find it difficult to benefit from the public healthcare system, they often seek different assistance to that the rest of the population refers to, such as the outpatient care offered by private non-profit-making entities, volunteering organizations, self-medication, and so on (Ricordy, Motta e Geraci, 2014; Van Cleemput et al., 2007; Parry et al. 2004).

Clinical treatment of Roma with psychiatric disorders is affected, in a significant manner, by both the lack of cultural competence within specialised medical services and the discriminatory attitudes

mentioned above. We were witnesses into situations in which, for example, doctors prescribed antidepressants in a superficial way when they were asked for psychological help or counselling (Richardson et al 2007). Moreover, it is easier that psychiatrists or psychologists with no cultural competence end up making a wrong diagnosis. On one hand, they might interpret the signs of a psychiatric disease as "culture-related" and fail to diagnose and treat a disease, which then risks becoming chronic. On the other, they might mistakenly classify as "pathological" elements what truly characterizes habits, lifestyles, ways Roma use to communicate or express themselves, and diagnose a disease that has never existed.

All this leads those who have had direct and indirect experiences of this kind to lose trust in mental health workers and as a result, to refer to public psychiatric facilities with lesser and lesser frequency. Nevertheless, the Roma interviewed do not expect to be offered *ad hoc* services for mental health problems nobody else would access, rather they prefer to refer to the same locations of healthcare provision as all other citizens. But they state that health workers should be less discriminating in such facilities (Cemlyn et al 2009; Van Cleemput et al., 2004).

It is noteworthy that marginalized Roma communities very rarely benefit from psychiatric services due to the stigma of mental illness. In this regard, when they speak about a problem, they use wording such as "nerves", "nervous", while "mental" is not pronounced for fear of being associated with madness. Fear and shame attached to mental illness can be amplified by the discriminatory experiences demeaning them. So, a well-founded fear of being double-stigmatized because of their illness and the fact that they are Roma increasingly prevent these people from accessing the healthcare facilities and from exploiting any chance to treat their illness. Roma suffering from a mental illness are subject not only to double discrimination from society (due to both their cultural background and condition) but also to discrimination within the group by reason of the stigma of mental illness.

Closing remarks

Based on the findings of our study, racism affects mental health at various levels. Discrimination is constantly present in Roma's life stemming from politics, media, the institutions, and society, pervades their daily life and worsens marginalization. Constant discrimination can trigger different reactions: aggression and above all self-harm, impulsiveness, social isolation, anxiety, and depression. As outlined above, the most at-risk groups are women and children. The reason for this lies in the fact that women tend to isolate more from society and are also subject to gender discrimination

(double discrimination) (Surdu & Surdu 2006), whilst children are exposed to vicarious racism (Heard-Garris 2018) and are discriminated, attacked and bullied at school, which can cause early school leaving, stress and depression, and increase the risk of developing a mental disorder (Pereira et al. 2016; Cemlyn et al 2009).

The fact that a child who is born in a frustrated community constantly subject to racism and social exclusion, and is exposed to a rejecting and hostile environment where he or she is regarded as an inferior being, can trigger reactions during the process of growing up, thus leading the child to develop an inferiority complex. Because when a person is constantly demeaned, the ego gradually comes apart, and such a reaction - if extended over time - can unleash a mental disorder.

Much research stressed how prejudice against Roma creeps into these people so deeply that they end up behaving in such a way that complies with the stereotype itself (Goffman 1975). This mechanism results in a vicious circle where action and reaction take place symmetrically and make it difficult to identify the baseline to understand and solve the problem (Ricordy et al 2014).

Sometimes, some try to come out of the vicious circle by standing up against the stigma. Some succeed after great difficulty and assert their own identity, and as a result they improve their performance at school, find a job, integrate in society (in this regard, these people often avoid any possibility of disclosing the truth about their background just not to be subject again to those discriminatory attitudes they managed to lift out of so painstakingly). On the contrary, most of them fail to emancipate from prejudice and react out of anger and aggression, and sometimes develop anti-social behaviours, which thoroughly fall under the common stereotype.

Some psychological studies (Rosenthal & Jacobson 1968) observe that the expectation of others becomes central in the life of an individual who struggles to meet this expectation. People tend to conform to the image other individuals cast on them, whether it be a positive or a negative image. To give a practical example, we will outline the experiment carried out by Rosenthal and his team. Some children in a primary school underwent an intelligence test, at the end of which the teachers were made to believe that some of the children - at random - had above-average intelligence. The following year, Rosenthal observed that the performance of the selected children improved as a result of the teachers' positive attitude towards them.

All this works the other way round too, in the event negative expectations are implied. On one hand, a person conforms to, internalises and adapt to these beliefs by clinging on them thoroughly, and on the other, the external environment (society as a whole in the case of Roma) conforms to these expectations and contributes to effectively making them become real (Associazione 21 luglio 2016).

Being unable to oppose constant discrimination due to the lack of tools, strength and resources, may lead people to adjust to social prejudice: as a result, some Roma communities who live on the fringes of society tend to exploit prejudice, so to take advantage from it ("*retour du stigmate*" Goffman 1975 cit. in Ricordy et al 2014). This is also the case of healthcare. The Roma in Italy referred to by our report often ask the volunteering healthcare associations visiting their settlements for medical support because of previous experiences with discrimination they personally had or were told about, which some health workers perpetrated. This method for - surely necessary – assistance may result in the risk that the community increasingly turns in upon itself. Roma may be closed off public healthcare by reason of adjusting to this "comfort" situation (Alunni 2017). To adjust to the discrimination that stems from the institutions, they "adapt" by exploiting what is offered to them. This way, prejudice against marginalized Roma groups, who are already considered as social "parasites", becomes stronger while the vicious circle mentioned above is reinforced (Ricordy et al 2014).

It can be said that notwithstanding the above, discrimination does not directly cause psychiatric disorders but it constitutes a factor capable of making manifest, re-exacerbating and turning an illness into a chronic disease. An individual subject to repeated racism and discrimination can fall ill if he or she has not developed a sufficiently solid identity and a valid relational capacity during his or her own development. So, discrimination can act as a risk factor for the development of mental disorders in vulnerable individuals.

If on one hand, racism can act as a contributing factor to the pathogenesis of a mental disorder, on the other, it is surely involved in the access to services. Discrimination has a considerable impact on exclusion and the poor use of prevention programmes and early detection of illnesses on the part of the Roma community involved, with subsequent delays and hurdles in approaching clinical treatment of a mental illness. Bias present within the healthcare services are complicit of the exclusion of Roma from public health campaigns and programmes (European Communities 2003). So, we can deduce that the highest incidence of anxiety, depression, drug abuse and other illnesses emerging from the studies conducted on the Roma people is liaised, among other factors, with the hurdles they encounter when accessing psychiatric services against the general population.

Recommendations

From the examined literature, important recommendations have been identified at various levels i.e. politics, media, society, school, services and Roma communities, in order to protect mental health of the Roma groups who cannot easily access core services.

Various competences should be defined at political level, in particular at national or general level, at level of the territorial application of the general policies and eventually, at level of delivered service. Such actions should be directed to improving on one hand, housing conditions, education and access to healthcare services, and on the other, to identifying and addressing health needs of the vulnerable populations. Moreover, epidemiological and descriptive research into the psychiatric diseases affecting the vulnerable Roma communities is desired, which healthcare reforms can focus on, thus allowing for evidence-based interventions (Cook et al 2019).

The need to train the world of media by focusing on prejudice-free communication, which could substantially improve society's attitude towards Roma, is identified.

Primary prevention can be implemented in schools by means of training courses dedicated to teachers, as well as of meetings with the pupils and their families to talk about the psychological consequences of bullying and racism. The early detection of bullying would be of great relevance, and so would the promotion of secondary and tertiary prevention e.g. helpdesks providing psychological support in schools with the assistance of experts, who can identify the initial signs of a disorder and inform, guide and possibly take the children and their families by the hand along a clinical pathway.

Concerning healthcare, seeing the hurdles – explored above - encountered by the surveyed Roma groups when accessing public services, our remark is that the work carried out by the volunteering associations is of key importance. But such organizations should encourage Roma to access healthcare services - serve as a bridge and not replace the latter - in order to avoid ghettoizing them further and to allow for better integration (Alunni 2017).

Training healthcare workers is crucial to combat prejudice and the subsequent discriminatory attitude within the healthcare services. A survey in the utilisation rate of mental health services by foreign patients would be useful to substantiate the actual need for training programmes directed to health workers (Cook et al 2019). With particular reference to mental health services, initiatives aiming at implementing cultural competence of health workers and medical teams should be carried out, in order to enable them to treat Roma patients at the best and distinguish the clinical signs of a mental illness from the cultural elements. Moreover, appropriately training intercultural mediators operating within the services and the health workers working with the mediators is crucial. In addition, building health workers' cultural competence and involving intercultural mediators would encourage marginalized Roma to access services because they would feel like their health needs are addressed. Managing and organizing mental health services according to these methods would help avoid overprescription and the subsequent abuse of medications and would favour appropriate psychotherapeutic treatments (Francis 2013).

The delivery of *ad hoc* services dedicated to the Roma groups does not seem to be useful and may increase the stigma of mental illness (Francis 2013).

Healthcare education initiatives must be implemented within the communities, so to help raise awareness of mental health and the effects racism has on it and, at the same time, to reduce the stigma and to stress how important early diagnosis and prompt and ongoing medical care are (Goward et al 2006).

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