Mental health needs of Undocumented Migrants

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List of abbreviations

EU = European Union
GGD = Municipal Health Authority
UM = Undocumented Migrant
PSO = psychosocial support (intervention Doctors of the World)
GGZ = mental health care (the Dutch association is: GGZ Nederland)
Summary

Introduction
There is an increase of undocumented migrants in the Netherlands and the limited existing literature suggests that mental health problems are common among this group due to i.e. their precarious health status and living conditions. Although UMs should be able to access mental health services in theory, this is not always the case in practice. This study aims to investigate what the needs are of UMs in terms of mental health and accessing mental health services. This is investigated by doing a needs assessment including a variety of stakeholders, including UMs.

Methods
The design of this study entailed a qualitative approach, including semi-structured interviews with 18 participants. The participants were categorized in three stakeholders’ groups: care providers, social support participants and UMs. A thematic analysis was conducted to analyse the needs.

Results
Results imply that there is an urgent need for long term mental health support for UMs, that includes long term, tailored mental health support due to the diversity of UM patients with a low threshold and focuses on trauma but addresses the healthy parts of the individuals as well. Moreover, in addition to treatment, social activities and a stable physical environment are needed in order for the treatment to be effective. Lastly, collaboration between stakeholders and case management and monitoring of individual cases is needed.

Discussion and conclusion
Although the needs for this group are hard to define, due to i.e. uncertain situations and power relations, it can be concluded that there is a need for improved access to mental health services and a need for a more suitable approach for mental health support. Strengths of this study were that it contributed to the little evidence on UMs and mental health and that it provided multiple perspectives on the needs. A remark that needs to be taken into account, is that there is still a hard to reach group among UMs that has to be included in a needs assessment as well and therefore, this challenge lies in future research. Another future research recommendation is to investigate the group dynamics and power relations within collectives of UMs and UMs in general, since the findings of this study suggest that these power relations affect the needs of UMs.
Chapter 1 Introduction

Over the past decade, international migration has risen due to factors such as conflict and wars, lack of employment and discrimination (Grit, den Otter & Spreij, 2012). These rising numbers of international migration, also include illegal migration, including undocumented migrants (UMs) (Karl-Trummer, Metzler, Novak-Zezula, 2009; Grit, den Otter & Spreij, 2012). It is estimated that there are approximately 20-30 million UM worldwide (Bhugra et al., 2014). These increasing numbers of illegal migration have also led to an increase of UM in a lot of Western countries (Grit, den Otter & Spreij, 2012). It was estimated in 2010 that there were 1.9 to 3.8 million UM living in Europe and in 2013, 35,500 in the Netherlands (Hamburg, 2010; Heijden, 2015). UM are often failed asylum-seekers and therefore, do not have a legal residence permit and are at risk of being deported by police because of their illegal immigration status (Grit, den Otter & Spreij, 2012).

The United Nations declared that the right to health care is a fundamental human right and thus states have the obligation to provide healthcare to each person, including UM despite their illegal immigration status (United Nations, 2000). UM are among the most deprived in the society and often have a precarious health status, including their mental health (Teunissen et al., 2014). Their mental well being is often perceived as low due to mental health problems, such as stress, anxiety and depression (Schoevers, van den Muijsenbergh & Lagro-Janssen, 2009; Yosofi & van den Muijsenbergh, 2009; Lahuis, Scholte, Aarts & Kleber, 2019). There are several factors contributing to this precarious (mental) health status, such as poor living conditions, homelessness, language problems, being in constant fear of deportation and social isolation (Ashcroft, 2005; Pollard and Savulescu 2004; Teunissen et al., 2014; ). According to a scoping review, UM experience difficulties accessing (mental) health care services, but no detailed conclusions can be derived from these studies, due to e.g. highly heterogeneous groups of UM and using different criteria for mental health problems (Woodward, Howard & Wolffers, 2014).

Although there are some indications that mental health problems among UM are common, there is a low record of mental health problems among UM by health care providers in the Netherlands (Van Oort, Kulu-Glasgow, Weide & De Bakker, 2001; Wolsink, Kuyvenhoven & van den Muijsenbergh, 2009; Teunissen et al., 2014). In order to understand the problems in accessibility, research that includes care providers, but also UM themselves is necessary, but is limited which might be due to the fact that UM are a hard to reach group (Schroevers, Loeffen, van den Muijsenbergh, Lagro-Janssen, 2010). Especially research with a focus on UM and their mental health is limited in the Netherlands (Teunissen et al., 2014).

In conclusion, it remains unclear what the mental health needs are of UM and to what extent (mental) health care in the Netherlands is responding to the mental health problems and the needs of UM.
Therefore, this study aims to improve the understanding of mental health needs of UM by providing insights from multiple perspectives on the mental health needs of UM and experiences regarding accessing mental health services in the Netherlands. These perspectives include UM, health care providers and individuals of organisations that work closely with UM. The main research question addressed in this study was: “What are the needs of undocumented migrants in terms of mental health support and access to mental health services?”
Chapter 2 Background

This chapter includes the contextual background, theoretical background and the conceptual framework used in this study. In the contextual background the following is discussed: UMs in the Netherlands, the mental health of UMs and access to mental health services, including barriers they face. Furthermore, the stakeholders in the field of providing services to UMs are presented. The theoretical background includes the needs assessment model and factors influencing mental health and well being of immigrants and refugees, including an explanation of the key concepts of these models. Lastly, the conceptual framework includes the model that is used and the corresponding main research question and sub questions.

2.1 Contextual background

The following paragraphs include the context of mental health and access to mental health services for UMs.

2.1.1 Undocumented migrants in the Netherlands

Due to the illegal status that UMs have, exact records on how many UMs reside in the Netherlands are hard to reach. However, from the estimated 35,500 UMs in 2013 that reside in the Netherlands according to registrations of the Police Suite Immigration Enforcement, some conclusions can be derived (van der Heijden, Cruyff & van Gils, 2015). First of all, it was estimated that 71% are men and 29% are female. Secondly, 78% of this population is younger than 40 years. Thirdly, most UMs originate from Asia (28%), Africa (20%), East-Europe (21%), Northern-Africa (10%), followed by Turkey, Surinam or with an unknown country of origin (van der Heijden, Cruyff & van Gils, 2015).

In addition, UMs in the Netherlands can be roughly categorized in three categories: failed asylum seekers, labourer workers (including victims of human trafficking) and people who came to the Netherlands because of family reunification (Schoevers, 2011).

2.1.2 Mental health of undocumented migrants

Mental health is defined by the WHO as ‘a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’ (WHO, 2001, p.1).

It has been reported that mental health problems occurred more often in groups refugees and asylum seekers than native Dutch and Western migrants (Gerritsen, van der Ploeg, Deville & Lamkaddem, 2005; Gerritsen et al., 2006; Toar, O’Brien & Fahey, 2009). Huijts et al. (2012) found that this high prevalence of mental health problems among this group might be due to pre migration factors, such as long-term
exposure to stress, war and trauma and post migration factors, such as a low quality of life when arriving in the new country. In comparison with migrants who are granted a residence permit, UM are in problematic conditions (e.g. homelessness) and are excluded from social and health services due to their legal status. The living conditions of UM can have a negative influence on their mental health status (Woodward, Howard & Wolffers, 2014).

There are some studies that have investigated the prevalence of mental health problems of UM in Europe and the Netherlands. In Europe, a survey among more than 1000 UM, revealed that a third of male UM and a quarter of female UM report their mental health as bad or even very bad (Chauvin & Simmonot, 2012). Another study conducted in the Netherlands among 100 female UM, concluded that psychological problems (e.g. sleeplessness and anxiety) were reported by 70% of the study population (Schoevers, van den Muijsenbergh & Lagro-Janssen, 2009). In addition, a study of 20 male UM in the Netherlands concluded that mental health problems were common among more than 80% of the participants (Yosofi & van den Muijsenbergh, 2009).

### 2.1.3 Access to (mental) health services

Compared to other Western countries, the Netherlands has quite a generous health care provision in theory (Teunissen et al., 2014). In practice, UM do not always receive the correct health care due to factors such as laws, costs of healthcare, knowledge and attitude of UM and health care providers (Cuadra, 2010). In the Netherlands, there is an insurance based system and every citizen with legal status needs to take out an insurance and in turn, can access health services (Cuadra, 2010). Since UM do not have a legal status, they are not allowed to take out an insurance due to the policies in the Netherlands regarding insurances. However, in 1998, the Dutch law ‘Linking Act’ was passed. The Linking Act included that although UM can’t take out a health care insurance, they could still access ‘medically necessary care’, which includes all care that is covered within the basic insurance (Grit, den Otter & Spreij, 2012). UM have to pay the costs of healthcare themselves, but if they can prove that they are not able to pay the costs, the health care providers can make an appeal to the CAK. CAK (Central Admission Office) can reimburse only 80% of the costs of directly accessible care (e.g. GP). For non-directly accessible plannable care (e.g. hospital, pharmacies, nursing homes and mental health care) 100% reimbursement is possible (Doctors of the World, 2018).

So although UM should be able to access (mental) health services, this is not always the case. On the one hand, health care providers are not always aware of their obligations and on the other hand, UM might face barriers in accessing these services due to fear of deportation, shame, language barriers and a lack of knowledge (Teunissen et al., 2014).
2.1.4 Stakeholders

There are several stakeholders in the field of delivering services to UMs that are relevant in this study. For purposes of this study, these stakeholders were categorized in three stakeholders’ groups: care providers, social support participants and UMs themselves.

First of all, the care providers include i.e. the GP, psychologists and psychiatrists that deliver health care to UMs. The GP delivers primary care to UMs and refers UMs to other health services. In order to go to mental health services, a referral of the GP is needed and therefore, most UMs will see the GP as well in accessing mental health services (Teunissen et al., 2014). After referral, UMs go to mental health services, similar to other patients, where they are treated by psychologists and psychiatrists. These include regular mental health care services, but also mental health care services that are specifically focused on intercultural mental health care, such as i-Psy. Moreover, Equator is a mental health care service that provides care to refugees, including UMs, with the aim to recover from post-traumatic experiences. There are also care providers working in organisations that include addiction treatment for UMs, such as Jellinek. Besides the regular mental health care services, there are organisations (including NGOs) that have developed interventions in which mental health support is provided to UMs. An example is the psychosocial support (PSO) of Doctors of the World, in which voluntary psychologists offer mental health advice to UMs.

Secondly, stakeholders working in the social group include employees and volunteers of organisations that provide social and/or legal support to UMs or are involved in shelter locations (such as ROS or SDNVU). These stakeholders often work closely with UMs. Furthermore, there is no free access to social advisors for UMs and the only social advisors UMs have access to are from NGOs (Teunissen et al., 2014). Therefore, this category also includes NGOs that provide services to UMs. Examples are the Dutch Council for Refugees, ‘Wereldhuis’, Red Cross Netherlands and LOS Foundation (‘Landelijk Ongedocumenteerden Steunpunt’). Since a lot of UMs are unaware of their rights, these NGOs support them in understanding their rights (Teunissen et al., 2014). Another stakeholder is the municipality that also provides social support to UMs, but also support on the health level, such as the Municipal Health Services (GGD), and therefore can be categorized in both group 1 and 2.

Thirdly, UMs themselves are an important stakeholders’ group. Their input is essential in improving mental health services for UMs. This because they have the best insights on what is needed and which barriers are experienced in accessing mental health services. Moreover, UMs should be included in developing i.e. mental health support interventions as well, so that these interventions are responding to the needs of UMs which in turn might influence the implementation of interventions positively (Schoevers, Loeffen, van den Muijsenbergh, Lagro-Janssen, 2010). Until now, research that includes UMs themselves is limited, but necessary (Teunissen et al., 2014).
In addition to the stakeholders mentioned above, policy-makers play a crucial role in access to mental health care services for UMs, because the limited access to mental health services can be partly explained by the current political climate (Teunissen et al., 2014). However, before transferring messages to the political and public agenda, it is important to first investigate what the needs are of this group (Teunissen et al., 2014). Therefore, policy makers are not included in this study.

2.2 Theoretical background

The following paragraphs include the model for conducting a needs assessment and the factors that influence the mental health and mental health needs of UMs.

2.2.1 Needs assessment model

The aim of this study was to investigate what the needs of UMs are in terms of mental health support and access to mental health services. Therefore, a needs assessment is most suitable in this study. In health care and policy, including mental health care, needs assessment models are widely used. The aim of these models are to gather information on the perceived needs of individuals and define gaps in order to anticipate on the gaps (Watkins, Meiers & Visser, 2012). This in turn will lead to delivering beneficial change to the target population and the health care system in general (Watkins, Meiers & Visser, 2012; Stevens & Raferty, 2018). In this study, the target population include UMs and beneficial changes include improved understanding in terms of access to mental health services and how to improve the mental well being of UMs. Kaufman and Rojas (1993) have created a needs assessment model, which is depicted in figure 1.

![Figure 1 Needs assessment model](image)

In this model, the needs assessment includes a process in which gaps between the current situation and desired situation are identified and prioritized. Moreover, the causes of the identified gaps need to be analyzed in order to investigate what is actually needed to anticipate on the gaps and resolve those (Kaufman & Rojas, 1993). This model entails the following concepts: current results and consequences, desired results and consequences, gap, means and needs. This model can be easily adjusted to the context of the study, is feasible and explores the needs explicitly, which makes this model suitable for this study and is therefore
used. In the following paragraphs these concepts are further elaborated and applied to the context of this study.

**Current results and consequences**

The current results and consequences entail the current situation and ‘where you are now’ (Kaufman & Rojas, 1993). In the context of this study, the current situation includes mental health, access to mental health services of UMs in the Netherlands and the current experiences, including barriers UMs face, regarding these mental health services. For purposes of this study, the current results and consequences are referred to as the current situation.

**Desired results and consequences**

The desired results and consequences are the situation ‘where you should and/or want to be’ (Kaufman & Rojas; 1993, Lee & Son, 2008). Within this situation, there might be feelings of urgency that there needs to be a change and/or opportunities, which can also be defined as possibilities in order to achieve the desired situation (Ghent, 2002). In this study, the desired situation is improved access to mental health services in order to improve mental health of UMs and meet the needs of UMs. For purposes of this study, the desired results and consequences are referred to as the desired situation.

**Needs**

The needs include the discrepancy between the current and desired situation (Kaufman & Rojas, 1993; Cobuild, 2014). By understanding the needs, structured interventions with suitable care can be developed (Mojetabai, Olfson & Mechanic, 2002). This also includes the perceived need, for example the perception that it is needed to seek help. Especially in terms of sensitive issues, such as mental health, individuals do not always recognize the urgency to seek help. Moreover, these perceptions can be influenced by the social context, for instance, fear of stigma (Mojetabai, Olfson & Mechanic, 2002). In this study, the needs include the perceived needs of UMs by UMs themselves and other stakeholders in terms of improvement on their mental health.

**Means**

Means include the necessary tools to close the gap between the current and desired situation. This can for example be methods, specific interventions and programmes (Kaufman & Rojas, 1993). In this study, an improved understanding on what is needed in terms of mental health support to UMs could contribute to closing the gap between the current and desired situation.
2.2.2 Factors influencing mental health needs of immigrants and refugees

There are specific factors which needs to be taken into account in terms of mental health needs of immigrants and refugees (including UMs). Therefore, the Winnipeg Regional Health Authority’s (WRHA) Immigrant/Refugee Working Group has developed a conceptual framework in order to optimize mental health and improve the emotional well-being of immigrants and refugees. These factors are of particular importance to immigrants and refugees (including UMs) and influence the mental health and emotional well-being of this particular group. The WRHA framework factors differ from natives and other migrants groups (WRHA, 2014). Therefore, it is important to understand the factors that specifically influence the mental health and well-being of refugees and immigrants and in turn, their mental health needs. Table 1 shows all factors.

Table 1 Factors influencing mental health and well being of immigrants and refugees

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<tr>
<th>Factor</th>
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<td>Age</td>
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<td>Gender</td>
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<td>Migration</td>
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<td>Personal health practices and coping skills</td>
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<td>Culture</td>
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<td>Income and social status, Employment and working conditions</td>
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<td>Education and literacy</td>
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<td>Physical environment</td>
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<td>Social support networks</td>
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<td>Access to health services</td>
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<td>Prejudice, discrimination and racism</td>
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<td>Healthy Child Development: Child Rearing, Parental Practices</td>
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<td>Biology and Genetic Endowment</td>
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In terms of this study, biology and genetic endowment and healthy child development have been excluded, because it is not feasible to investigate genetics due to the qualitative approach of this study and this study is not focused on parents and children. In the following paragraphs all factors are explained.

Age

According to Khanlou, age influences the prevalence of mental health problems. For example, refugee and immigrant adolescents are in the process of identity development and at the same time have to adapt to a new culture (Khanlou, 2010). For UMs, this situation is even harder due to the insecurity of staying in the country of residence and adapt to the new culture or having to return to their country of origin (Teunissen
et al., 2014). Moreover, people who migrate after the age of 65 might experience more mental health problems because they face difficulties in learning a new language and adapting to a new culture on this age (Diversity Task Group, 2009).

**Gender**

There are differences between women and men among refugees and immigrants regarding mental health problems. Women often migrate as dependents of their male partners or relatives and therefore, policies and interventions are merely focused on males (WRHA, 2014). This while women experience mental health problems differently and even to a larger extent, for instance due to exposure to sexual and domestic violence (Teunissen et al., 2014). Therefore, the mental health needs of women and men might differ as well.

**Migration**

Pre-migratory stress factors, such as trauma, war and torture, can result in an increased risk for mental health problems, including post-traumatic stress disorder (Diversity Task Group, 2009; Rasmussen, Rosenfield, Reeves & Keller, 2007). Moreover, the migration status influences the possibilities to access mental health services, especially for UMs, who do not have a legal status. As explained in the paragraphs above, UMs in the Netherlands face barriers in accessing mental health services due to the way the Dutch health care system towards UMs is arranged (Teunissen et al., 2014). This in turn leads to extra vulnerability for mental health problems for this particular group (Khanlou, 2010).

**Personal health practices and coping skills**

Resilience is defined as ‘the ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity’ (Health Canada, 2000, p8). The ways in which immigrants and refugees, including UMs, are able to cope with their mental health problems influences their mental health needs (Yakushko, Watson & Thompson, 2008).

**Culture**

The spiritual and cultural context construct mental health problems among immigrants and refugees differently. There is a discrepancy in beliefs on the origins of mental health problems. Some immigrants and refugees believe, for example, that it is a result of religious factors, while Western perceptions on mental health problems are based on a biomedical model (Chung, Bemak, Ortiz & Sandoval-Perez, 2008). Furthermore, cultural differences in health beliefs, especially mental health, are known to be barriers in accessing mental health services. This might be due to for example the stigma around mental health problems (van den Muijsenbergh, 2014). Therefore, it is important to understand the context and the ways in which UMs perceive mental health problems, in order to understand their mental health needs.
**Income and social status, Employment and working conditions**

There is a relationship between a low socioeconomic status (SES), financial insecurity, poverty and mental health problems. These problems are common among refugees and immigrants and especially among UMs, due to their legal status and barriers they face in accessing employment (Teunissen et al., 2014; Diversity Task Group, 2009). Immigrants and refugees often experience a difference in social status in their home country and country of residence and this might result in poverty. Furthermore, refugees and immigrants often face barriers (e.g. language problems) in getting an employment. These periods of unemployment might also result in mental health problems (CAMH Best Practice, 2012).

**Education and literacy**

Refugees and immigrants often face interruptions in their education, because they could not finish their education in their home country. Moreover, most refugees and immigrants are not familiar with the language in the country of residence and could therefore experience difficulties in expressing themselves and understanding advice of mental health professionals (WRHA, 2014). In terms of access to health care, literacy can also play a role. Illiterate UMs might face difficulties when trying to understand prescriptions or advice written down by health practitioners for example. But literacy can also play a role in the broader context, where written communication is important in the legal situation of UMs (e.g. trials), but also in the daily lives of UMs (e.g. reading a traffic sign) (Vieira, 2013).

**Physical environment**

Due to poverty, refugees and immigrants are more likely to live in poor areas and/or areas with poor housing stock. This in turn can increase the risk of mental health problems (Diversity Task Group, 2009). Moreover, homelessness is prevalent among UMs, which also results in a higher risk of mental health problems (Khanlou, 2010; Ashcroft, 2005).

**Social support networks**

When immigrants and refugees migrate, social support networks can be broken or lost. Family and social networks are important factors that promote mental and emotional well being. However, immigrants and refugees do not always have those networks and might experience social isolation (Devillanova, 2008). Social isolation, in turn, might lead to the development of mental health problems (Khanlou, 2010).

**Access to Health services**

Immigrants and refugees face many barriers in access to mental health services. In addition to the cultural barriers and the legal status of UMs as explained in the previous paragraph, there are also other barriers, such as a lack of knowledge regarding the rights of UMs, fear of deportation or prosecution, financial and
linguistic barriers (Teunissen et al., 2014; Dorn et al., 2011; Schoevers, Loeffen, van den Muijsenbergh & Lagro-Jansen, 2010; Rechel, Mladosvsky, Ingleby, Mackenbach & McKee, 2013). In order to improve access, it is important to understand what the exact barriers are that UMs face in accessing mental health services.

*Prejudice, discrimination and racism*

Systematic discrimination against refugees and immigrants is commonly experienced. UMs in particular, face discrimination in several dimensions (e.g. employment, health care and public spaces) due to their legal status, as is explained in the previous paragraphs as well (Teunissen et al., 2014). Khanlou (2010) states that there is a connection between systematic discrimination and mental health problems.

2.3 Conceptual framework

The aim of this study was to investigate what the mental health needs are of UMs. By understanding the mental health needs of UMs, mental health support can better respond to their needs. In order to investigate the mental health needs of UMs, the needs assessment model of Kaufman & Rojas (1993) was used. Since UMs are a vulnerable group and at risk for mental health problems, there are several factors influencing their mental health and well being and thus need to be taken into account in the needs assessment model. WRHA (2014) have investigated which factors influence the mental health and well being of immigrants and refugees in Canada. Although Canada and The Netherlands are western countries, those two could not be directly compared due to, for instance, different immigration policies. However, since there isn’t a framework yet for the Netherlands, the WRHA framework factors are still considered in this study to influence the mental health and in turn, the mental health needs of UMs in the Netherlands. Moreover, this study might reveal factors that are specific in the context of the Netherlands. All the factors of the WRHA (2014), except for biology and genetic endowment and healthy child development, study are combined with the Kaufman and Rojas (1993) needs assessment in figure 2.
The main research question of this study is: ‘What are the needs of undocumented migrants in terms of mental health support and access to mental health services?’ and the addressed sub questions are:

- **How is the current mental health and mental health support of UMs experienced?**

- **What factors influence the current situation in terms of mental health and mental health needs of UMs?**

- **How can current access to mental health services and current mental health services ideally be improved?**

- **What is needed to fill the gap between the current situation and the desired situation in terms of access to mental health services and mental health needs of UMs?**
Chapter 3 Methodology

In this chapter, the study design, the recruitment and sampling of participants, the data collection and analysis and the ethical considerations are presented.

3.1 Study design

The aim of the study was to investigate what the experiences and perceptions are of multiple stakeholders in terms of mental health needs of UMs. A qualitative design allows for in depth insights into the experiences and perceptions of individuals (Denzin & Lincoln, 2008; Green & Thorogood, 2014). Therefore, a qualitative approach suits this study best. The method that was used in this study were semi-structured interviews with UMs, care providers and social support participants in the Netherlands. The aim of the interviews was to gain a better understanding on mental health needs of UMs and the experiences in access of mental health services for UMs.

3.2 Participants

Purposive sampling was used to recruit participants for the interviews, in order to select the study population based on the objective of this study and inclusion criteria (Green & Thorogood, 2014).

The inclusion criteria for UMs included UMs who have been living in the Netherlands for at least one year. When UMs have recently (<5 years ago) received a legal status and have been living in the Netherlands without a legal status for at least five years, they were also included in this study. In addition, it was preferred that UMs had sufficient verbal English, Dutch or Arabic language skills for the interviews. The participants were recruited via the network of the researchers involved in this study and Doctors of the World, which was the most feasible way to include participants. Participants who met the inclusion criteria, were contacted via phone. UMs chose the location for the interview themselves, in order to create a safe environment for them, in which they could freely express themselves.

Care providers and potential social support participants were selected based on their experiences with providing (mental) health care to UMs and/or providing social support and their involvement and direct contact with UMs as is explained in the stakeholders analysis in chapter 2. They were asked to participate in this study via email. Moreover, participants who agreed to participate were specifically asked for snowballing which included that the invitation to participate in this study was sent to others potential participants as well, in order to reach more participants. Snowballing is a recruiting method that is often used for hidden groups (including UMs) (Beauchemin & Gonzalez, 2011).

In total 34 participants were approached, including 11 care providers, 14 social support participants and 9 UMs. A total of 18 participants (53%) agreed to participate.
3.3 Data collection and analysis

The interviews were semi-structured and based on the interview guide (see appendix 1). In total 18 interviews were held. Each interview lasted approximately 50 minutes and was held face-to-face. All the interviews were recorded and the interviews were transcribed verbatim. The transcripts of the interviews were analysed in Excel. In order to determine recurring themes and patterns, thematic coding was used to analyse the transcripts (Green & Thorogood, 2014). The main themes were based on the conceptual framework used in this study and within the main themes, sub themes and codes were found.

In order to ensure reliability, data triangulation and peer debriefing occurred during all phases of this study, since another researcher was involved in data collection and analysis as well. The data was not limited to only one source, but there were three stakeholders’ groups, in order to ensure that a wide understanding of the study subject was reached (Green & Thorogood, 2014). Moreover, in order to ensure validity, the interviews were allowed for recording and two other researchers were involved in all phases of this study as well (Green & Thorogood, 2014).

3.4 Ethical considerations

Verbal consent was asked from participants to participate in this study and record the interviews. The participants of this study were assured of anonymity, that their names would not be mentioned in the report. Moreover, since this study only included qualitative research and did not include experiments, approval of the medical ethical committee was not necessary.
Chapter 4 Results

First of all, the participants’ characteristics are explained, followed by the experienced mental health problems among UMs according to participants. Moreover, four main themes emerged from the analysis. The first theme includes the ‘Attitude towards mental health care and influence of culture’, the second theme ‘Physical environment’, the third theme ‘Daily activities, social support networks, group dynamics and power relations’ and the last theme ‘Experiences of mental health services’.

Within every main theme the subtheme ‘Current situation’ is explained which entails the answers on the following sub questions: “How is the current mental health and mental health support of UMs experienced?” and “What factors influence the current situation in terms of mental health and mental health needs of UMs?” In addition, within every main theme, the sub theme ‘Desired situation’ is elaborated which includes the answers on the following sub questions: ‘How can current access to mental health services and current mental health services ideally be improved?’ and ‘What is needed to fill the gap between the current and desired situation in terms of access to mental health services and mental health needs of UMs?’ Within the sub theme ‘Desired situation’ there is a division between suggestions for improvement that directly or indirectly benefit the mental health of UMs and directly or indirectly improve current mental health services. Direct mental health support include suggestions on improvement that include mental health care and improvements within mental health care and indirect mental health support include suggestions on improvement in addition to treatment that might benefit the well being of UMs.

Lastly, an overview of all needs addressed within all themes is presented.

4.1 Participant characteristics

In table 2 the function or characteristics of the participants, organisation and the group in which the participants are categorized are presented. A total of 5 care providers, 7 social support participants and 7 UMs were included. Some of the participants were categorized in two stakeholders’ groups, as presented in the table below.

Table 2 Participant characteristics

<table>
<thead>
<tr>
<th>No</th>
<th>Function and/or person characteristics</th>
<th>Organisation</th>
<th>Stakeholders’ group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Psychologist/ volunteer PSO (psycho-social support for UMs)</td>
<td>Doctors of the World</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Counsellor of UMs</td>
<td>ROS (shelter)</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Psychologist</td>
<td>Equator</td>
<td>1</td>
</tr>
</tbody>
</table>
The UMs included originated from a variety of countries and most of them were between 30 and 40 years old. The duration of stay in the Netherlands varied from 3 years to 17 years. Five out of the seven UMs had experiences with psychosocial support and/or are still under treatment, while one UM had no experiences but her husband had experiences and one UM had no experience at all. Furthermore, all UMs included in this study were failed asylum-seekers. In table 3, the specific characteristics of the UMs included in this study are presented.

Table 3 Characteristics UMs

<table>
<thead>
<tr>
<th>Corresponding participant number</th>
<th>Gender</th>
<th>Country of origin</th>
<th>Age (18-30, 30-40, 50-65)</th>
<th>Duration stay in Netherlands</th>
<th>Status</th>
<th>Experiences mental health care/support</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Male</td>
<td>Algeria</td>
<td>18-30</td>
<td>3 years</td>
<td>Undocumented</td>
<td>No experiences</td>
</tr>
<tr>
<td>10</td>
<td>Female</td>
<td>Afghanistan</td>
<td>30-40</td>
<td>3 years</td>
<td>Undocumented</td>
<td>Visited psychologist several times for</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Female</td>
<td>Nigeria</td>
<td>30-40</td>
<td>3 years</td>
<td>Undocumented</td>
<td>Visited psychologist at psychosocial hours of Doctors of the World, currently waiting to be accepted for a trauma treatment trajec</td>
</tr>
<tr>
<td>13</td>
<td>Male</td>
<td>Sudan</td>
<td>30-40</td>
<td>17 years</td>
<td>Documented since 5 months (undocumented for 16.5 years)</td>
<td>Followed a complete trajec at Equator (trauma treatment)</td>
</tr>
<tr>
<td>14</td>
<td>Female</td>
<td>Armenia</td>
<td>30-40</td>
<td>12 years</td>
<td>Documented since 4 years (undocumented for 8 years)</td>
<td>Visited none, husband visited psychologist for sleeping problems</td>
</tr>
<tr>
<td>17</td>
<td>Male</td>
<td>Guinea</td>
<td>50-65</td>
<td>14 years</td>
<td>Undocumented</td>
<td>Still visiting the psychologist for trauma and hallucinations</td>
</tr>
<tr>
<td>18</td>
<td>Male</td>
<td>Sierra Leone</td>
<td>30-40</td>
<td>16 years</td>
<td>Undocumented</td>
<td>Still visiting the psychologist</td>
</tr>
</tbody>
</table>

### 4.2 Experienced mental health problems

*Feelings of hopelessness and suicidal ideation*

There was unanimous acknowledgement among the participants that the illegal status of UMs had a huge influence on their mental health problems. One of the participants explained the following:

“They end up in limbo, where they can not go back to their country of origin and can not stay in the Netherlands either. And this by definition leads to mental as to somatic health problems.” - Participant 15 (care provider and social support participant)

These uncertain situations in which they live lead to hopelessness and even suicidal thinking, as noted by another participant:

“They share hopelessness; the past being terrible and the current situation being extremely difficult and the future being hopeless. A lot of people saying I don’t want to live anymore. This is not a life worth living. Why should I stay here?” - Participant 3 (care provider)
Post traumatic stress and comorbidities

Trauma and PTSD were mentioned as the most common mental health problem by all care providers, but also several social support participants and UMs themselves. Many UMs have suffered several traumatic events (in their home country as well as in the Netherlands) and therefore are suffering from complex PTSD, in the perspective of a psychologist. Furthermore, it was noted, according to several participants, that the mental health problems that they experience are multilayered, which means that comorbidities are experienced as well, such as anxiety, depression and hallucinations. Other mental health problems that were often seen among UMs are stress and sleeplessness, which was experienced by all UMs in this study as well. An UM explained the following:

“Of course everyone who is out of procedure has a lot of stress, you have a lot of disappointments, you have lost confidence in yourself.. you don’t even know if you have a future anymore.. each time you think about these things, you feel that something is wrong with you... some people are talking to themselves now, they are going crazy.. so if you have this stress in you and you don’t have good sleep.. it will become worse..”

Participant 11 ( UM, female, Nigeria)

Addiction

Another common mental health problem is addiction as it was identified as a huge problem by 8 participants. A social support participant explained that a lot of UMs drink and use drugs in order to forget their problems. It was mentioned that UMs are seen as an inconvenient group to deal with and treat because of the alcohol and drugs problems, but the underlying problems why people start drinking are not tackled.

4.3 Theme 1: Attitude towards mental health care and influence of culture

4.3.1 Current situation

The attitudes towards mental health care differed from individual to individual which might be (partly) due to cultural differences, according to participants. Recognition of mental health problems, trust and expectations and stigma, were all recurrent factors within this theme and are explained in the following paragraphs.

4.3.1.1 Current situation: recognition of mental health problems

It was noted by participants that work with UMs that there is often recognition and awareness among UMs that they are not doing well. It was also stressed by several participants, including UMs, that there were UMs who saw no other way but to receive mental health support, due to their deteriorated health status,
and asked advice where they could receive mental health support. For these UMIs this recognition of mental health problems and the need to do something about it was prioritized. However, it was also mentioned by several participants that some UMIs are so busy trying to survive, that they do not have the space to prioritize their mental well being. In addition, a care provider explained in his perspective, that it depended on what mental health problems were recognized. He further explained that it was easier for African men for example, to acknowledge that they have drinking problems instead of PTSD, which might be due to cultural differences in terms of acceptance of mental health problems. Furthermore, the recognition of mental health problems might also be explained by the several ways of coping by UMIs. Social support participants noted that some UMIs were resilient and therefore, did not want to seek help from others. In addition, an UM explained that there are always people having it worse than him and therefore, he does not see the need to search for mental health support.

4.3.1.2 Current situation: trust and expectations
There was unanimous acknowledgement among the participants that trust is a factor that strongly influences the mental health of UMIs and their experiences with mental health services. The factor trust consists of trust towards mental health practitioners and trust in effectiveness of mental health support, which also might impact the expectations of UMIs when entering mental health services.

Fear of police
It is experienced that UMIs do not always have trust towards the mental health practitioners because they fear that they might say something to the aliens’ police, as explained by a UM:

“Trust is the key to every undocumented migrant.. Once you are a undocumented migrant, you just believe that you are wanted by the police.. You do not know who to trust..” - Participant 11 (UM, female, Nigeria)

This was also confirmed by a psychologist, who mentioned that patients did not feel comfortable talking to a professional translator, due to fear for the aliens’ police.

Doubt about effectiveness and expectations of mental health services
It was mentioned by care providers, social support participants and UMIs that UMIs sometimes do not see the point of going to a mental health care provider, because they do not think that it really can help. An UM explained the following:

“I don’t believe that the psychologist is able to help me... It is impossible that I will be happy again. I want realistic things, not only talking to someone..” - Participant 7 (UM, male, Algeria)
A psychologist further explained in her perspective that when people with another cultural background eventually go to a psychologist, they have other expectations of the help they receive at the psychologist due to cultural differences:

“Many see you as THE doctor, you know everything. I tell you my story, I give you everything and now you fix me. Kind of opposite of how we work; we work mutually, so I give you this and I need this from you.. So it is back and forth.. A mutual thing.”- Participant 3 (care provider)

This cultural difference in expectations and trust in therapy, might be due to the individualistic way of living we have here in the Western world according to the psychologist. This was manifested in for example the way patients talk about themselves, as was experienced by a psychologist: they use the word ‘we’ instead of ‘I’ and give socially desirable answers, such as that they respect their parents while in fact they were beaten up by their parents.

4.3.1.3 Current situation: stigma

In the countries of origin of UM's in this study, mental health services do not exist or people only go there if they have the label ‘crazy’. One would go to the hospital whenever they feel ill, and not a mental health care provider, explained a social support participant. Among the participants stigma around mental health is still prevalent, as some UM's did not want to tell others that they visited a psychologist out of shame. In addition, in terms of culture and stigma, UM's were specifically asked on how religion influences their perceptions on mental health, but 4 UM's in this study mentioned that it was merely culture and not religion. However, it was mentioned by UM's that had experienced mental health support or are still under treatment, that it was experienced to be positive if mental health support had a low threshold. In addition, sharing experiences with other UM's was considered to be helpful. One UM, that did not receive mental health support, mentioned that he was willing to go to someone to talk about his problems, but as soon as the word ‘psychologist’ was mentioned, he did not want to go anymore.

4.3.2 Desired situation: low threshold (direct mental health support)

In the previous paragraphs factors were described that influence the attitude and/or acceptance of mental health services by UM's. Suggestions were made by participants to contribute to overcoming these barriers. These suggestions entailed improvement on direct mental health support that had a low threshold and included building a safe environment and having group sessions. It was also suggested to employ UM's who have received mental health support themselves as key persons to reach other UM's.
Need for low threshold mental health support
It was raised by three care providers and three UMs who had experiences of having group sessions and peer support, that there is a need for low threshold mental health support due to cultural barriers that are mentioned in the current situation. By having low threshold group sessions, UMs can share experiences with each other in a safe environment and it might help reduce loneliness as well as the lack of social networks, according to participants. Several participants, including UMs, stressed the importance of having a safe environment. Due to the distrust that a lot of UMs experience, the need to build trust by care providers is important in order to have effective treatment. An UM explained:

“The first and most important thing is: do you like the person you are talking to? If you do not trust that person, you will not listen to his advice. But if you trust this person, you will listen. Also, they have to build trust, but also do not force you to do things that you do not like. That is important.” - Participant 18 (UM, male, Sierra Leone)

In order to understand UMs better and to build trust, it was suggested that cultural diversity training should be given to all care providers working in the field of mental health support for UMs.

Key person
Although there is a need for mental health support, and some UMs recognize this need as explained in the above-mentioned paragraphs, there is still a hard to reach group that does not access mental health services. According to two UMs, two care providers and two social support participants, it is therefore important if UMs who have already received mental health support or were/are under treatment, are employed as key persons to reach this hard to reach group. A participant mentioned that it is more effective to have someone who looks similar to UMs, in terms of origin, culture, gender and experiences, to teach them psycho education instead of Dutch people who they might not trust. Another participant further suggests that, since the limited network that UMs have are religious networks, the church or the mosque could be a place where UMs can be reached by these key persons.

4.4 Theme 2: Physical environment

4.4.1 Current situation
A factor that had a huge influence on the mental health of UMs was the physical environment UMs live in (in other words the housing of UMs) according to participants. It was mentioned by several participants, including participants working in shelter locations, that the physical environment is not suitable for persons with mental health problems due to incitements and instability and that this environment leads to even
more stress. A social support participant that works closely with UMs that live in a collective, noted that groups who have a more stable place and do not have to move every 4-6 weeks, also have less addiction problems and conflicts within the group. Another social support participant noted that mental health support is provided to stable and official shelter locations of the municipality, while a large group UMs live in unstable conditions and are below the radar of institutions and therefore, do not access mental health services. An UM felt that their living conditions and physical environment negatively affects their treatment:

“\textit{It (the treatment) is not going to help.. You have received the treatment but return to the same living conditions..So it doesn’t make sense.. It gives even more challenges. It is like you give food to eat, but don’t give water to drink after you finish eating, so it does not have an impact. The water will help you to adjust.. it needs to go together.}”- Participant 13 (UM, male, Sudan)

\textbf{4.4.2 Desired situation: stable physical environment (indirect mental health support)}

As the unstable physical environment of UMs had a negative impact on the mental health of UMs and the treatment, it was suggested that UMs under treatment should have stable housing. This could indirectly benefit mental health support, according to participants. Care providers explained, in their perspective, that especially with trauma treatment, UMs need to return to their home with stability, in order to be able to process the treatment and have effective treatment. Therefore, there needs to be a lobby that every UM with mental health problems should have stable housing.

\textbf{4.5 Theme 3: Daily activities, social support networks, group dynamics and power relations}

\textbf{4.5.1 Current situation}

According to participants, a lack of daily activities and social networks influence the mental health of UMs negatively. In addition, it was mentioned that group dynamics and power relations need to be understood before reaching UMs. The following paragraphs elaborate on these factors.

\textbf{4.5.1.1 Current situation: (lack of) daily activities and social networks}

Firstly, a commonly mentioned factor was a lack of activities during the day, since UMs are not allowed to work and have limited to no social and/or educational activities during the day. Secondly, participants from all groups highlighted lack of social networks as an important factor. Two social support participants explained that the little network that some UMs only have are the church or the mosque for example. A lack of activities during the day in combination with a limited to no social network leads to isolation and loneliness, which in turn also affects their mental well being, in the perspective of an ex-UM who works in the social support group now. Another UM elaborates on that by the following quote:
“They came to this country with a lot of problems and if they do nothing all day long and are alone, they keep thinking about their problems and that influences their mental health and future perspective…”

Participant 7 (UM, male, Algeria)

However, some UMIs live in collectives of UMIs, such as the ‘We are here’ groups in Amsterdam, or stay in official shelters. Several care providers and a participant who supports the ‘We are here’ group explained that when UMIs are a part of a collective, they are more connected in the city and thus can find their way easier to mental health services. Six out of the seven UMIs in this study, were all connected to either an official shelter or a collective and had all received mental health support. One of the seven UMIs, which was not connected to either, mentioned that he had never visited health services before and had no knowledge regarding these services.

4.5.1.2 Current situation: group dynamics and power relations

Group dynamics

Despite the fact that living in a collective brings some advantages, as mentioned above, four participants of all groups mentioned that group dynamics are quickly changing within collectives due to the rising numbers of new UMIs arriving in the Netherlands. This in turn might result in conflicts within the group according to the participants. In addition, a participant working in the field of addiction treatment and a social support participant commented that addiction problems are hard to address within collectives due to strong peer pressure within these social groups.

Power relations

A social support participant raised power relations as an important factor that needs to be taken into account when trying to approach UMIs in order to support them. According to her, there are complex power relationships within the group that are very hard to understand as an outsider, which makes it complicated to understand the needs of UMIs. For example, the leaders are the first contacts of organisations and individuals that are willing to help UMIs, and therefore, they are also in charge of telling individuals and organisations what is needed. In this way, leaders of collectives can exercise control and power over what is offered to UMIs within the group. The participant further explained that being in control over the group forms the identity of the leaders:

“What is striking is that those leaders want to keep their positions so badly, while these functions are very stressful and a great responsibility. They always tell me ‘it is getting too much, I need to breathe’. But then I wonder, why are you fighting so hard to keep this position? My interpretation is that they have no
perspective left anymore and this might be the only identity they have left.. And if you give this up, what is left over?” - Participant 6 (social support participant)

Untold needs in exploitation relations
In addition, in terms of power relations, two social support participants, mentioned that some UMIs are caught up in illegal circuits, such as prostitution. Consequently, these UMIs, mostly females, are always accompanied by another male or female who are identified as their ‘bosses’, which makes it hard for the UMIs to express their true needs. Moreover, these ‘power holders’ of the circuits want these UMIs to stay anonymous and therefore, they are not always allowed to visit mental health services for example. Therefore, it was suggested by participants, that these power relations need to be understood first, in order to find out what UMIs actually need.

4.5.2 Desired situation: social activities (indirect mental health support)
All participants agreed on the importance of having social activities and working on a social network in addition to treatment. Therefore, it was suggested by participants, that improved mental health support should include social activities too and that this might indirectly benefit mental health support. Several UMIs mentioned how keeping yourself busy during the day and do social activities you like or that are relaxing, such as mindfulness or yoga, had a beneficial impact on their mental well being. Therefore, these UMIs wish to see other UMIs be socially active more in order to improve their mental health and have a more effective treatment.

4.6 Theme 4: Experiences of mental health services

4.6.1 Current situation
Knowledge of both UMIs and care providers, symptom treatment and lack of monitoring of individuals were all factors that influenced the access to mental health services and experiences with mental health services, according to participants. These factors are explained in the following paragraphs.

4.6.1.1 Current situation: knowledge of UMIs and care providers
A social support participant said that ‘there is a huge lack of knowledge both from UMIs as care providers regarding their rights’ and that ‘there is a lack of overview of all organisations and possibilities’. UMIs do not always have the correct knowledge on the possibilities in the field of mental health services. However, several social support participants and care providers expressed their concerns on the lack of knowledge that they have on these possibilities too. A participant, who works as a GP, mentioned that due to the lack of knowledge that care providers experience in addition with the limited access to mental health services for UMIs, GPs experience difficulties to connect physical symptoms to mental health problems:
Its from both (both GP as patient) sides.. Because if you ask it as a GP.. what will be the next step then? Sometimes you say A, but there is no B, due to limited access to mental health services. This while asking about their mental situation can sometimes be enough, that you confirm that they do not have brain cancer, but they have a hard life.. Which has an effect on their body too. But this remains hard to do, to really connect the stress to mental health problems..” - Participant 9 (care provider)

4.6.1.2 Current situation: symptom treatment
A participant, that used to be an UM, stressed that it takes long, in her opinion, until care providers acknowledge that there are serious mental health problems. According to her, care providers experience that UMs are all in difficult situations and ‘sometimes it is taken for granted that UMs are stressed’. Moreover, an UM stressed that it is necessary to find out as a care provider why, for example, UMs are not sleeping, so that the underlying mental problems are addressed instead of the ‘symptoms’. That the current mental health care that UMs receive mainly includes so-called ‘symptom treatment’ and is for the short-term was by several participants addressed as a problem. Consequently, UMs received medication instead of long-term trauma treatment for example, according to participants. All UMs in this study have acknowledged that even if they would receive a residence permit, that their mental health problems will stay and therefore, they are in need of continuous mental health support, which is not the case in the current situation.

4.6.1.3 Current situation: case management and monitoring
Another obstacle that was addressed multiple times by care providers and social support participants, was that there is no monitoring of individual UMs. This was due to the lack of collaboration between organisations and resulted in that organisations are not aware of what help an individual received or needed, according to participants. Moreover, a social support participant stressed that especially for minors, no monitoring worried her, because these young UMs were in very unstable circumstances. She also mentioned that especially for young UMs, no suitable mental health support is available, since most mental health services focus on older UMs.

4.6.2 Desired situation

4.6.2.1 Desired situation: long term (direct mental health support)
Since the need for continuous care was addressed by all participants, because their mental health influences returning to the country of origin and/or the procedure of getting legal papers, it is important to offer long-term trajecct mental health support to UMs. In addition, long term mental health support should focus on the following aspects: trauma treatment, focus on the healthy parts of the individual and be
patient tailored (including youth psychiatry and cultural differences).

**Trauma treatment**

All care providers suggested that every mental health service should include trauma treatment due to the experienced high numbers of UMs with trauma. In addition, a social support participant explained that ‘it is impossible for UMs to focus on their future or on self-reliance without addressing their traumas’. Moreover, a participant working in addiction treatment and a social support participant, explained in their perspective, that the huge addiction problems might be due to the fact that traumas are not treated and are consequences of not addressing trauma. Therefore, by addressing and treating trauma, the addiction problems among UMs might be declined which is also beneficial for the public order, according to participants.

**Addressing healthy parts**

A psychologist mentioned that every long-term mental health support traject should not only include trauma treatment, but also address the healthy parts of the individual:

“Stimulate to find activities to find friends and build a social network and address the healthy parts of a person’s life and not only being a victim. There are also strengths which are easily forgotten by them...when things are so difficult you kind of hyperfocus on them.. You forget your talents.. You forget your hobbies, you forget the stimulating things in life that you do enjoy.”— Participant 3 (care provider)

**A tailored approach to mental health services**

There is a wide range of diverse UM patients, which stresses the need for tailored mental health support, according to participants. As mentioned in the paragraphs on the influence on culture, cultural differences should be taken into account, but also patient tailored mental health support for minor UMs (including youth psychiatry) according to participants. Therefore, mental health services should respond to these individual needs.

4.6.2.2 Desired situation: outreach work (direct mental health support)

Ideally, all UMs should be reached for psycho-education and be provided with the opportunity to visit mental health services if necessary, but this remains hard, as explained in the above mentioned paragraphs as well. Therefore, several participants have suggested that outreach work of mental health care providers is needed. So instead of waiting for UMs to come to them, they ideally need to go to both official as unofficial shelter locations of UMs in order to reach them. According to participants, this might increase the access to mental health services.
4.6.2.3 Desired situation: monitoring and case management (direct mental health support)

It was addressed that there is a lack of monitoring of individuals. Therefore, collaboration between stakeholders could include monitoring of individual cases. This can be done by having one organisation that is in charge of an individual and by communicating that to other stakeholders, according to participants.

4.6.2.4 Desired situation: collaboration stakeholders (indirect mental health support)

Several participants suggested that there is a considerable potential in improving mental health services for UMIs by improving collaboration between all stakeholders. It was suggested that all the possibilities could be made visible by making flyers in which all the different routes to help and the possible reimbursement are depicted, for all stakeholders, including UMIs. This could also be made digitally visible, such as creating an app or a website, according to several participants. Moreover, it was suggested that communication between organisations could ideally be improved by having several yearly meetings and by also including and inviting UMIs to these meetings. This because UMIs themselves stressed the importance of always involving UMIs by developing an intervention or every other form of support for UMIs.

4.7 Overview of needs

In the paragraphs above it was mentioned that several needs have to be addressed in order to reach the ideal situation. The table below shows an overview of all the needs and how many times the needs were addressed and by who.

<table>
<thead>
<tr>
<th>Need</th>
<th>How many times addressed and by who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to build trust</td>
<td>All participants</td>
</tr>
<tr>
<td>Need to have tailor-made mental health support for diversity of UM patients (including cultural differences and including youth psychiatry)</td>
<td>All participants</td>
</tr>
<tr>
<td>Need for stable physical environment</td>
<td>15 participants (4 care providers, 5 social support participants, 6 UMIs)</td>
</tr>
<tr>
<td>Need for social networks and daily activities</td>
<td>All participants</td>
</tr>
<tr>
<td>Need to understand group dynamics and power relations</td>
<td>4 participants (3 social support participants, 1 UM)</td>
</tr>
<tr>
<td>Need to improve access to mental health services and reach UMIs to enter mental health services (including outreach work)</td>
<td>All participants</td>
</tr>
<tr>
<td>Need to raise awareness among UMIs, care providers and social support participants on mental health support for UMIs and all possibilities</td>
<td>All participants</td>
</tr>
<tr>
<td>Need for continuous care</td>
<td>13 participants (4 care providers, 4 social support participants, 5 UMIs)</td>
</tr>
<tr>
<td>Need for (more) peer support (including key persons)</td>
<td>11 participants (4 care providers, 2 social support participants, 5 UMIs)</td>
</tr>
<tr>
<td>Need for monitoring and case management of UMIs with severe mental health problems</td>
<td>6 participants (3 care providers, 3 social support participants)</td>
</tr>
</tbody>
</table>
Chapter 5 Discussion

In this chapter a summary of key findings is presented and consequently, compared to existing literature. Furthermore, the strengths and limitations and recommendations for future research and implications are discussed.

5.1 Key findings

5.1.1 Summary of key findings

The aim of this study was to investigate what the needs are of UMs in terms of mental health and access to mental health services. This study found that there was unanimous acknowledgement that UMs are in urgent need for mental health support as they suffer from several mental health problems, such as PTSD, stress and sleeplessness. Several needs were addressed by participants (see table 4: overview of needs). By addressing these needs, the desired situation should include the following direct and indirect mental health support (see table 5).

Table 5 Recommended direct and indirect mental health support for UMs

<table>
<thead>
<tr>
<th>Direct mental health support</th>
<th>Indirect mental health support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term trajectory mental health support that focuses on trauma, healthy parts of individual and is patient tailored (including youth psychiatry and cultural differences)</td>
<td>Collaboration stakeholders</td>
</tr>
<tr>
<td>Low threshold support (group sessions/ peer support/ key persons/ psycho-education)</td>
<td>Stable physical environment</td>
</tr>
<tr>
<td>Improved access to mental health services (including outreach work)</td>
<td>Social activities</td>
</tr>
<tr>
<td>Case management and monitoring</td>
<td></td>
</tr>
</tbody>
</table>

The most striking findings were that it remains hard to define needs of UMs. Although it is stressed that there is a need to reach UM, this study has also found that it is important to understand power relations within collectives and groups of UM and within illegal circuits of exploitation, before approaching UM. This in order to understand what is actually needed and how the needs can be met best, because UM who are caught up within power relations are not always able to express their actual needs. However, some conclusions can be derived from the findings of this study in terms of needs. First of all, a more suitable approach for mental health support for UM is needed, which includes continuity and addressing the underlying mental health problems instead of only treating symptoms that UM experience. In addition, a more suitable for approach includes a low threshold and patient-tailored mental health support due to the diversity of UM patients, in order to contribute to overcoming cultural barriers. In addition, there is a lack
of knowledge among UMs and stakeholders on the possibilities of mental health support for UMs, which stressed the need to provide information and improve collaboration between stakeholders. Furthermore, an improved access to mental health services is needed, which includes outreach work of care providers. Lastly, in addition to treatment, providing social activities and stable housing are important, in order for the treatment to be effective.

5.1.2 In comparison with existing literature

Mental health problems

In this study, it was recognized that UMs experience multi-layered mental health problems, which include complex PTSD in addition with comorbidities (e.g. depression and anxiety) and substance abuse. These findings are aligned with existing literature on mental health problems among UMs and refugees (Fazel, Wheeler & Danesh, 2005; Steel et al., 2009; Kirmayer et al., 2011; Lahuis, Scholte, Aarts & Kleber, 2019). These experienced mental health problems stress the need for mental health support (Lahuis, Scholte, Aarts & Kleber, 2019).

Reflection on WRHA framework and one truly novel factor: power relations

Reflecting on the WRHA framework that was used in this study, which included 11 factors that influenced the mental health of UMs, it can be concluded that the findings of this study are more interconnected and no clear distinction between the factors could be made. A total of 4 main themes emerged during analysis, which included a variety of factors within the main themes. In comparison with all factors of the WRHA framework, one truly novel factor was the presence of complex power relations within collectives and groups of UMs and UMs that are caught up in illegal circuits (e.g. exploitation and prostitution)(WRHA, 2014). While there is research on how collectives of UMs exercise power as a group in for example political decision making processes, there is no research on how the power relations within these collectives is manifested (Monforte & Dufour, 2013). Recent studies have also concluded that UMs have an increased risk of being a victim in the country of residence again, as female UMs have a risk of being caught up in illegal circuits in terms of sexual exploitation (Lund et al., 2010; Lahuis, Scholte, Aarts & Kleber, 2019)

Continuity and lack of knowledge of care providers and UMs

As the need for mental health support was stressed in this study, adequate and suitable mental health support for UMs is not always available, since a more suitable approach is believed to include continuity. This study found that due to the lack of continuity, current mental health support is merely focused on symptom treatment and thus, often solved with medication, instead of addressing the underlying mental health problems. This finding could be connected to the lack of knowledge of UMs in terms of connecting mental health problems to physical symptoms, which is aligned with previous findings that UMs, compared to documented migrants, present more somatization of mental health problems (Kulu, Bakker, Weide &
Khanlou, 2010; which includes housing, in addition to treatment, is in line with previous studies and what includes adequate treatment for this particular group. These findings are in line with the study of Teunissen et al. (2014) that included GPs and their perceptions on recognition, recording and treatment of UMs in the Netherlands. Teunissen et al. (2014) have concluded that there is a recognition among GPs that psychotropics are too soon prescribed and are not always the best solution, but that those were still prescribed because GPs felt that they only had limited options for treatment or referral, due to the uncertain situations of UMs (Teunissen et al., 2014). That uncertain situations restrain care providers to accept UMs and offer suitable treatment, has also been confirmed in a recent report of Pharos (Pharos, 2019). However, by providing continuity of care (including a long relationship with patient), a relationship of trust could be facilitated, which was stressed as a need in this study as well. This in turn might contribute to disclosure of mental health problems and the recording and diagnosis of mental health problems (Teunissen et al., 2014).

Patient-tailored mental health support
In addition to continuity, this study suggested that a more suitable approach includes mental health support tailored to the context of patients. A study among hard to reach groups concluded that patient-centered care by cultural competent care providers is necessary in order to reach the best care (Kovandzic et al., 2011). As tailored mental health support in this study and previous studies are stressed as important, it also remains important to provide low threshold mental health support (e.g. peer support) in order to contribute to overcoming barriers such as cultural differences. This is in line with previous studies that have concluded that peer support among hard to reach hidden populations seems to be effective. Employing key persons, similar to UMs, which was recommended in this study, is a way to reach hard to reach hidden populations (Turner & Shepherd, 2000; Lazdane & Lazarus, 2003; Sokol & Fisher, 2016).

Social activities and physical environment
This study indicates that only treatment is not sufficient and that social activities and a stable physical environment need to be offered, in order for the treatment to be effective. The need for social activities and social support networks that was addressed in this study, is also aligned with previous findings that concluded that having a social network is crucial in times of mental distress (Teunissen et al., 2014). Therefore, mental health support should include aspects of building social support networks and doing social activities as well. In addition to social activities, the need to have a stable physical environment, which includes housing, in addition to treatment, is in line with previous findings as well (Ashcroft, 2005; Khanlou, 2010; Lahuis, Scholte, Aarts & Kleber, 2019).
5.2 Strengths and limitations
This study is the first to investigate what is needed for UM's in terms of mental health and mental health support from a stakeholders’ perspective. Therefore, this study contributes to the limited evidence that is available on mental health needs of UM's. A variety of stakeholders were included which has resulted in different perspectives on the needs. Moreover, the results of this study were focused on access to mental health services in the Netherlands, but since access is also restricted in other countries, the recommendations made can be widely used (Chauvin & Simmonot, 2013; Strassmayr et al., 2012). However, there are a few remarks that needs to be taken into account by interpreting the results. First of all, since UM's are a hard to reach group, it was not possible to recruit participants purposively on origin and culture for example. Therefore, it was not possible to focus on cultural differences within the group of UM's, while UM's have a variety of different cultures. In addition, all UM's included in this study were failed asylum-seekers, while mental health needs might differ for example for the group labourer workers. Nevertheless, the UM's included were heterogeneous in terms of origin and experiences with mental health support. Another remark is that snowballing was used to recruit participants, which lead to the inclusion of UM's that were often familiar with organisations and services and this might have resulted in selection bias. Nevertheless, by including a wide range of stakeholders of different organisations that are in direct contact with UM's, their experiences include a reasonable representation of UM's in the Netherlands. Another remark is that UM's experience a lack of trust but due to the limited time frame of this study, it was not feasible to take the time to build rapport and trust before interviewing the UM's. However, all UM's talked openly about their experiences and mental health problems and all agreed to record the interview, which might be due to the fact that they trusted the interviewer. This can be explained by the migrant background of the researcher and for being fluent in three languages (Arabic, English and Dutch).

5.3 Implications and recommendations for future research

Future research
Although most UM's included in this study, were somehow connected to organisations that support UM's, official shelters or collectives of UM's, there was one UM included in this study that was not connected at all and who had no idea about the existence of mental health support. This implies that there are hidden UM's who need to be traced and included in studies on UM's and their needs in accessing mental health services as well. Challenges lie in future research on including these hidden UM's in research. Another recommendation for future research is to understand the complex power relations within collectives of UM's and UM's in general because to our knowledge there has not been a study investigating these relations. This in order to gain a better understanding on what is actually needed, especially among this group.
Implications

The results of this study imply that a low-threshold and continuous approach of mental health support is needed. This includes group sessions, peer support and a focus on trauma, but addressing the healthy parts of individuals (e.g. talents, future perspectives) as well and is patient-tailored (including age and culture differences). For care providers and organisations working in the field of (mental health) support, it is recommended that there is more communication and collaboration, in order to learn from each other and reach the best care for UMs. This also includes the involvement of UMs. Moreover, organisations could find ways on how individuals can be monitored best. In order to reach UMs, it is recommended that organisations include outreach work. Lastly, it is recommended, in addition to treatment, to organise social activities as well and to advocate for a stable physical environment on the public agenda for UMs who are under treatment.
Chapter 6 Conclusion

Although needs for UM are hard to define (due to i.e. uncertainty, power relations and UM being a hard to reach group), the following can be concluded: there is an urgent need for long term mental health support for UM, that needs to take into account patient-tailored mental health care with a low threshold, focusing on trauma treatment but addresses the healthy parts of individual as well. In addition to treatment, social activities and a stable physical environment are important. An improved access to mental health services could be reached by providing information to UM and stakeholders on the possibilities and that stakeholders include outreach work. When trying to reach UM for mental health support, power relations need to be understood. Moreover, more collaboration between stakeholders and monitoring of individual cases is needed.
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Literature


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Appendix 1a Interview guide stakeholders

My name is .. and I am an intern at Doctors of the World. We are currently investigating what the mental health needs are of UMls. This in order to write recommendations to several organisations working in the field of mental health support for UMls to improve their services and meet the needs of UMls. Your experiences in the field of providing mental health support and/or support for UMls are therefore very valuable. Moreover, the interview is anonymous, which means that no names will be included in the report. We would like to record the interview for purposes of this study, if you agree. I will delete the recordings after I have listened to those recordings again. You can stop the interview at any time. Do you have any questions?

Introduction of interviewee/ general questions:
- Background
- Current employment
- (Other experiences with UMls and/or mental health services)

Current situation
- How do you experience working with UMls?
- How do you experience communication with clients?
- What type of clients visit your organisation? What mental health problems do they experience?
- What advice/help do you give your clients? How do clients deal with your advice/help? Have you seen results so far?
- Do you experience difficulties in doing your work? If yes, could you elaborate more on that by giving some examples (also: what factors make the job easier?)
- What factors influence mental health and mental health needs of UMls according to you? (How do factors (such as literacy, stigma, culture, discrimination, lack of social networks, income and social status, gender, age) in your experience, influence mental health of UMls and/or access to mental health services for UMls?) Do these factors influence your experiences with the help you give? How do you deal with these factors?

Needs and desired situation
- What do you think UMls need in terms of mental health support?
- Which factors does the mental health practitioner need to take into consideration in order to reach the best care for UMls?
- What kind of mental health support would help UMls best in your opinion?
- What do you think would improve access to mental health services for UMls?
- What is the ideal situation in which you can offer the best mental health support? What do you specifically need in order to reach this situation?
- What needs to stay the same and what could be improved in terms of mental health support for UMs?

Closure
- Do you have other suggestions for improvement that were not mentioned before?
- Do you want to add something else?
- Thanking the participant
Appendix 1b Interview guide UMs

Introduction of interviewer and purpose of the study:
My name is .. and I am intern at Doctors of the World. We are currently investigating what the mental health needs are of UMs. This in order to write recommendations to several organisations working in the field of mental health support for UMs and anticipate better on your needs. Moreover, the interview is anonymous, which means that no names will be included in the report. We would like to record the interview for purposes of this study, if you agree. I will delete the recordings after I have listened to those recordings again. You can stop the interview at any time and this will never affect the help Doctor of the World provides you. Do you have any questions?

Introduction of interviewee/ general questions:
- Age
- Social context (housing)
- Migration (country, length of stay in the Netherlands, current situation)
- Social network
- Mental health (how would you describe your mental health)

Current situation
- Have you visited mental health services? (Why or why not)
- How often have you visited mental health services?
- How do you experience the communication with care providers?
- Did mental health services contribute to your mental health?
- What advice/treatment has care providers given to you (and do you agree with it)?
- Do these mental health services meet your expectations of what you had in mind before visiting mental health services? Are you satisfied? If yes, what makes you exactly satisfied?
- Have you been to other mental health services? Did you discuss mental health with your own GP (if you have a GP?) What makes it easy to go to those mental health services? What makes it hard to go to those mental health services?
- Do you experience that other UMs are in need of mental health support?
- (Probing question) How do factors (such as literacy, stigma, culture, discrimination, lack of social networks, gender, age) influence your perceived access (or other UMs perceived access) to mental health services? Do these factors influence your mental health? Do these factors influence your experiences with mental health services?
Needs and desired situation

- What do you think UMs need in terms of mental health support?
- Let’s say that your best friend, with the same culture as you, does experience mental health problems and wants to visit mental health services. How can this friend be helped best? Which factors does the mental health practitioner needs to take into consideration in order to reach the best care?
- What kind of mental health support would help you best?
- If you visit mental health services with psychological problems, what do you want them to do for you?
- What do you think would improve access to mental health services?
- What is the ideal situation for you in order to improve your mental health (or mental health of UMs)? What is needed to reach this situation?
- What is the ideal situation for you (or for UMs in general) in order to have improved access to mental health services? What is needed to reach this situation?

Closure

- Do you have other suggestions for improvement that were not mentioned before?
- Do you want to add something else?
- Thanking the participant