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ORIGINAL ARTICLE

Mental health problems of undocumented migrants in the Netherlands: A qualitative exploration of recognition, recording, and treatment by general practitioners

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Abstract

Objective. To explore the views and experiences of general practitioners (GPs) in relation to recognition, recording, and treatment of mental health problems of undocumented migrants (UMs), and to gain insight in the reasons for under-registration of mental health problems in the electronic medical records. **Design.** Qualitative study design with semi-structured interviews using a topic guide. **Subjects and setting.** Sixteen GPs in the Netherlands with clinical expertise in the care of UMs. **Results.** GPs recognized many mental health problems in UMs. Barriers that prevented them from recording these problems and from delivering appropriate care were their low consultation rates, physical presentation of mental health problems, high number of other problems, the UM's lack of trust towards health care professionals, and cultural differences in health beliefs and language barriers. Referrals to mental health care organizations were often seen as problematic by GPs. To overcome these barriers, GPs provided personalized care as far as possible, referred to other primary care professionals such as social workers or mental health care nurses in their practice, and were a little less restrictive in prescribing psychotropics than guidelines recommended. **Conclusions.** GPs experienced a variety of barriers in engaging with UMs when identifying or suspecting mental health problems. This explains why there is a gap between the high recognition of mental health problems and the low recording of these problems in general practice files. It is recommended that GPs address mental health problems more actively, strive for continuity of care in order to gain trust of the UMs, and look for opportunities to provide mental care that is accessible and acceptable for UMs.

Key Words: General practice, mental health, Netherlands, qualitative research, transients and migrants

Introduction

In the European Union, between 2.8 and 6 million migrants reside without a legal staying permit [1]. Most of these so-called undocumented migrants (UMs) live in difficult circumstances, characterized by poor living and working conditions and problems in accessing health care services. These difficult living conditions coupled with uncertain future perspectives lead to mental distress: mental health problems are highly prevalent amongst UMs [2–4].

Between 60 000 and 133 000 UMs reside in the Netherlands, mainly men under 40 years of age originating from Africa, Asia, and Eastern Europe. Between 11% and 33% are rejected asylum seekers [5]. The Netherlands is one of the few EU member states where UMs are entitled to health services access beyond emergency care [1,6]. They have the right to receive “medically necessary care”, which means that UMs have the right to receive the same normal care according to the same professional

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Mental health problems are highly prevalent amongst undocumented migrants (UMs), and are often part of their consultations with general practitioners (GPs). This study shows that GPs experience barriers in meaningful engagement with UMs in mental health problems, which hampers delivery of appropriate care. Barriers are: low consultation rates, physical presentation of mental health problems, high number of competing problems, UMs' lack of trust towards health care professionals, time pressures, and difficulties in referring to mental care. GPs mention the following solutions to overcome these barriers:

- Provide personalized care as far as possible. This will help to gain trust in respect of the UMs' need for disclosure of their mental health problems.
- Refer UMs to other primary care professionals such as social workers or mental health care nurses in the practice, instead of to mental care.

standards and guidelines as other patients [7]. However, UMs do not have the right to health care insurance. If UMs are not able to pay for health care provision themselves, health care professionals and institutions can gain reimbursement for their costs. As general practitioners (GPs) and primary care have a gatekeeping or navigation function in the Dutch health care system [9], primary care is the main health care provision for UMs. In this, GPs provide comprehensive care that includes prevention and all physical and mental health problems [8,10]. In the Netherlands, GPs have a fixed practice list and every insured patient is enlisted with one general practice. UMs are not officially part of this practice list, and have the right to visit every GP. GPs have the opportunity to make an electronic medical record of the UMs and to register them as uninsured patients.

Given their uncertain socio-economic situation and difficult personal experiences [4], it is a reasonable assumption to expect poor health status among UMs, and in particular poor mental health [2–4]. This may underline the need for access to health care for this group. However, despite the above-mentioned rights of UMs to obtain health care and the possible reimbursement for health care professionals (8), there are contradictory reports of the levels of mental health problems presented, recorded, and treated in primary care [11–13]. While one study showed that mental health problems were frequently presented in primary care [11], other studies showed low recording rates of mental health

problems and low prescription rates of psychotropics [12,13]. These studies indicate a gap between the high prevalence of mental health problems presented by UMs and the low recording of these problems by GPs. A number of reasons could play a role here: structural aspects of the health care system itself (access and finance issues), the complexity of interactions between UMs and GPs who have different language or cultural backgrounds, and also the GPs as providers (a minority of GPs considered emergency care only as part of their responsibilities for UMs. These GPs did not consider non-emergency care, for example care for mental health problems, as one of their tasks) [2,4,10,14–17]. However, this requires further empirical investigation and this qualitative study was designed to address this gap in knowledge. This study is part of a larger research project, including research where UMs were interviewed about their mental health problems, mental health needs, and their experiences with primary care [18]. The aim of this study was to gain insight into the way GPs approached mental health in UMs and barriers they encountered in the consultations that impacted on recognition, recording, and treatment.

Material and methods

Recruitment and sampling

To recruit GPs with UMs on their practice list we contacted general practices in seven cities involved in the care of UMs and/or located in areas where many UMs were residing. These areas were identified based on estimations from migrant organizations and from a previous study on UMs in the Netherlands [5]. Sampling of GPs was purposive [19], striving for maximum diversity in terms of age, practice location, and practice organization. Using the procedure described, we approached general practices for participation in the study, using a letter giving information on the research project.

Data collection

An interview topic guide was developed based on a review of the available literature and on the basis of expert opinions (MvdM, EvWB). Topics included barriers and facilitators in the GPs' work in these consultations with specific attention to recognition, recording, and treatment of mental health problems of UMs. In order to gain more insight into the specific impacts of consulting with UMs, the topic guide also included barriers and facilitators regarding consultations with documented migrants (DMs). Additionally, socio-demographic questions were included

such as GP and practice characteristics. As per the iterative process in qualitative research, this topic guide was adjusted and fine-tuned throughout the research process according to insights gained during the interviews [20].

All GPs were interviewed in their own practices by two medical students (EvB, LvdB), who were trained by two senior researchers, an experienced GP with expertise in UMs (MvdM) and a GP specialized in communication skills (EvWB). All interviews were audiotaped with the permission of the participating GPs. The interview was semi-structured in nature, allowing the interviewers to tailor the questions to the context of the participant. Interviews were conducted until no new information was imparted, and theoretical saturation had thus been reached [21].

This project was submitted for ethical approval and was waived by the Ethical committee of the Radboud University Medical Centre (Nijmegen, The Netherlands) on the grounds that analysis of health care professionals into the quality of their care – in this case of UMs – was an integral part of their professionalism [22].

Data analysis

Interviewees were assigned codes and all interviews were processed anonymously and transcribed verbatim. Analysis was based on a constant comparative method [23]. The first four interviews were read and re-read to gain an overall impression of the material and were analysed line-by-line and open coded by two individual researchers (EvB and ET). A list of themes was generated and conflicting thoughts and interpretations regarding these concepts were discussed with other team members (LvdB, MvdM, FvDM, and EvWB). When consensus was reached on the themes, they were categorized into a more sophisticated scheme by combining themes that were conceptually related.

Once a provisional coding scheme with overarching themes was developed, researchers EvB and ET coded the other 12 interviews and started to move to axial coding, in which they looked for relationships between categories. Finally, a more selective coding was applied from which the core categories emerged, looking for plausible explanations to enable the drawing of conclusions.

We attempted to develop theoretical insights and during all stages of the analysis close attention was paid to deviant cases. Coding and analysis were performed with Atlas.ti (atlasti.com) and relevant citations were selected and translated into English for the purpose of this article.

Results

Characteristics of the study population

Sixteen GPs participated in our study; they were aged between 30 and 64 years and nine were male. Their practices were located in Nijmegen, Amsterdam, Utrecht, Rotterdam, The Hague, and Deventer. The GPs estimated the percentage of migrants on the practice list, documented as well as undocumented, to comprise between 6% and 95% of the total practice list. The total number of UMs ranged from five to 600 per practice list, with an average of 141. Three GPs were unable to estimate the number of UMs on their practice list, and made an estimation of the number of UMs who consulted them in one month. Two of them estimated seeing 1–2 UMs per month, and one estimated seeing 15 UMs per month. These characteristics, and further characteristics of the practice (practice organization, practice list, and number of documented migrants), are presented in Table I.

Results from the interviews

Disclosure of mental health problems by UMs

Although the GPs believed that almost every UM must have mental health problems, they had the impression that UMs waited longer, compared with DMs, before consulting them and presenting mental health problems. GPs assumed that lack of knowledge concerning the right to medical care, feelings of shame about illegal residency, fear of reporting to authorities, and other priorities of UMs were contributing factors. The presumed medical role of the GP and the lack of friends or relatives who could encourage the UM to visit a GP for mental health problems were also mentioned as possible reasons.

A few GPs explained that rejected asylum seekers were an exception to the rule: this group of UMs presented mental health problems at an earlier stage than other UMs. GPs assumed that rejected asylum seekers were, more than other UMs, familiar with the coordinating role of GPs in the recognition and treatment of mental health problems, because they became acquainted with Dutch GP care in the asylum seeker centre.

In general, UMs presented their mental health problems more often through physical symptoms than DMs. GPs thought that a physical presentation of distress happened more in UMs than in DMs because UMs more often lack the necessary trust in the GP to present mental health problems. The following quote illustrates that lack of trust plays an important role:

Table I. Characteristics of the GPs, location of the practice, practice organization, practice list, number of documented migrants in practice, and number of undocumented migrants in practice.

General practitioner	Gender (M = male, F = female)	Age	Location of practice	Practice organization	Practice list	Number of documented migrants in practice	Number of undocumented migrants in practice
GP1	F	55	Nijmegen	Group practice	Shared	265	180
GP2	F	39	Amsterdam	Duo practice	Own	2363	400
GP3	M	44	Amsterdam	Duo practice	Own	1733	200
GP4	M	46	Utrecht	Group practice	Own	510	20
GP5	F	64	Utrecht	Group practice	Own	680	1–2 per month
GP6	F	50	Utrecht	Group practice	Own	465	5
GP7	M	55	Rotterdam	Special practice*	n.a.	n.a.	n.a.
GP8	M	55	Leiden	Group practice	Own	162	15 per month
GP9	M	60	Amsterdam	Group practice	Shared	2210	600
GP10	F	49	Amsterdam	Group practice	Own	840	10
GP11	M	55	The Hague	Group practice	Shared	4500	140
GP12	M	30	The Hague	Group practice	Shared	4320	140
GP13	F	56	Utrecht	Group practice	Own	1750	20
GP14	F	53	Utrecht	Group practice	Own	2120	25
GP15	M	50	Deventer	Group practice	Own	352	1–2 per month
GP16	M	37	Deventer	Group practice	Own	132	5

Note: *Special general practice for homeless patients.

It is complicated to discuss mental health issues with UMs. Sometimes you have to deal with people who are extremely distrustful and fearful, so they don't tell you many things. (GP1)

According to the GPs this has to do with a general lack of trust in professionals among UMs and with the lack of continuity of care for them in general practice: many UMs are not enlisted with one GP, but visit different GPs on different occasions. They also thought that the attendance of volunteers from local non-governmental organizations who supported the UMs in visiting a GP contributed to more physical presentation of distress as UMs felt embarrassed to present mental health issues in front of the volunteer.

Recognition of mental health problems by GPs

Most GPs reported that they recognize mental health problems in the large majority of UMs in the consultation room. They did not report evident barriers in the recognition of these problems, even though these problems were often not presented by the UMs as such. In general, these problems were recognized by the way in which the UM presents himself in the consultation room (often depressed or anxious), and through the presentation of symptoms (often physical problems caused by symptoms of distress). The following quote illustrates this:

They often come with a complaint like stomach pain or pain somewhere else, that's what they come with, but you immediately recognize it's psychological, you see it in their faces.... (GP6)

GPs thought that UMs, even more than DMs, are prone to develop mental health problems because of their difficult social situation. Also, GPs considered the fact that the UMs have no hope for a better future could contribute to persistence of mental health problems. While reflecting on the reasons for the high prevalence of mental health problems in UMs one GP said:

The uncertainty of UMs about what is going to happen in the future is the main problem. They are not allowed to work, actually their life stands still, that makes them very passive. (GP10)

A minority of GPs thought that a few UMs exaggerated their mental health problems but they believed this was done out of desperation, in order to receive legal status for medical reasons.

Discussing mental health problems by GPs with UMs

According to most GPs, an important problem affecting any discussion of a mental health problem was lack of time to discuss mental health issues. UMs attended less frequently and often presented other more urgent problems as well. Sometimes, because of time pressures in the practice, GPs ignored mental health problems and focused on these other problems they could more easily help the patient with. Reflecting on the reasons why these problems were not discussed one GP said:

Discussing mental health problems with the UMs takes so much time, and I don't have 45

minutes for a consultation. Sometimes it is more important to arrange some practicalities for the UMs first. (GP10)

Another problem mentioned by GPs as a reason why mental health problems were not discussed was the lack of options in treatment. For many of the UMs' mental health problems, GPs had the feeling that they could not help these patients. Therefore they often decided not to bring up these mental health issues at all. They also mentioned cultural and language barriers that hampered discussion (and recording) of mental health problems in consultations with UMs as well as DMs. Cultural health beliefs, and especially a taboo on mental illness, were often mentioned:

Yeah, it is difficult to discuss these problems, especially when it is about psychosis or depressions. They react differently. Sometimes they have the idea that they are demonized, that this is the cause of their problems. They often have magical thoughts. (GP8)

Language barriers played an important role as well. In this respect some GPs considered it necessary to use phone interpreting services to discuss mental health problems with migrants, but since 2012 GPs no longer receive compensation for this service in the Netherlands, and many GPs have stopped using this service. One of the GPs said:

I haven't used the interpreter phone any more since 2012, but I think it is necessary, especially for mental health problems. (GP3)

Instead of professional interpreters, GPs needed to rely on family and friends who can help to translate. For UMs this is often a friend or relative, often from a church or mosque; for DMs this is often a family member.

Recording of mental health problems by GPs

According to the GPs, the main reasons for under-recording of mental health problems were the previously mentioned problems in disclosure of mental health problems by UMs and the barriers in the discussion of these mental health issues with UMs. Some GPs also stated not recording these mental health problems as they could be considered as "a normal reaction to an abnormal situation". Labelling and recording these problems as psychological could easily lead to a situation in which UMs feel stigmatized.

The following quote shows an example of why GPs do not always discuss and record mental health problems:

When a UM presents many physical symptoms, there is a significant chance that he is depressed. But if you say you are gloomy and you have a depression, that is way outside their system. (GP5)

The lack of treatment options in mental health care was also mentioned as a reason why mental health problems were not labelled and coded as such. According to GPs, labelling of mental health problems without adequate treatment options was not very useful, and did not contribute to the mental well-being of the patient and that is why they did record them as such.

GPs did not mention authorities (like the police) as a barrier to recording UMs' (mental) health problems, and also the recording procedure itself was not the main cause for under-recording: almost all GPs recorded the consultations with UMs in their electronic medical records (EMR); only one recorded the consultations of UMs on paper. In general, GPs thought they recorded the consultations for UMs as accurately as for DMs, and attach a code following the International Classification of Primary Care (ICPC) to almost every diagnosis. Only one GP said that she was less precise in giving ICPC codes to UMs in the EMR; she considered this less necessary because UMs visited her practice less often than DMs. One GP did not use ICPC codes at all for any consultations in the EMR.

Treatment of mental health problems by GPs

Most GPs reported no difference in their practice of prescribing psychotropic drugs for UMs and DMs. Other GPs, however, prescribed fewer psychotropic drugs because they believed that good continuity of care was needed to prescribe these drugs safely. As many UMs do not reside in one place and change doctors frequently, GPs felt unable to provide good continuity of care for this group. Reflecting on the treatment with psychotropic drugs one GP said:

To treat UMs with mental health problems appropriately, you have to see the patient more frequently. As a GP, I do the best I can which is mostly talking with them. (GP12)

Other GPs stated that they prescribed psychotropics more easily because they had the feeling they had nothing else to offer:

Yeah, I prescribe medicines regularly. Psychotropics to make them sleep better for example.... In documented migrants I often talk about their traumas as well.... But it is not very useful to

talk about your traumas when you are homeless.
(GP4)

GPs stated that they referred UMs less often to mental health care institutions than DMs. Reasons given were: their own unfamiliarity with the possibilities for UMs to access this care, and the required financial contributions by patients, which they thought UMs could not afford. Besides, GPs reported that referrals to mental health care organizations often failed; these organizations often did not consider care for the mental health problems of the UMs as medically necessary and for that reason access was refused. GPs who encountered this problem repeatedly stopped making such referrals.

Solutions to overcome barriers in treatment

GPs described a number of solutions to cope with treatment barriers in order to provide optimal mental health to UMs. From the perspective of the GPs, the most important solution was to establish trust in the relationship with the UMs. This trust was essential to facilitate disclosure of mental health problems, and could only be gained in a long-term relationship with the patient. GPs explained that they tried to establish more continuity of care by being very accessible for UMs and by concentrating the consultations with UMs with one of the GPs in the practice. One of the GPs, who worked part-time in a group practice with four other colleagues, said:

We try as much as possible that UMs come to me or to R. (colleague), also because for reasons of expertise ... I think that 90% of the consultations of the UMs, who I consider to be my patients, are done by me. (GP1)

They also explicitly asked the UMs to visit this one GP for all their health complaints, and to come back to them. One GP said:

There is a group of illegal patients who come to me with complaints I can't solve, back pain for example, and they tell me that they visit another GP as well. I explain to them: it is not good to shop around. You need to stay with one doctor, because this doctor has a good overview of your situation. (GP9)

Problems in referrals were solved by using the resources available in the practice, for example by referring the UM to other primary care colleagues such as social workers and practice nurses who were specialized in mental health. Sometimes GPs referred UMs to psychiatrists who, they knew, would not charge the UMs.

As mentioned earlier, some GPs deliberately decided to be less restrictive in the prescription of psychotropics, although they acknowledged that psychotropics often were not the best solution, nor were advised in guidelines.

Discussion

Summary of principal findings

This paper reports a qualitative study of GPs' experiences with mental health problems of UMs. They recognized, recorded, and treated mental health problems of UMs as far as possible and in the same way as they did for other patients. GPs recognized many mental health problems in UMs, but at the same time experienced barriers that prevented them from comprehensively recording these problems and from delivering appropriate care: UMs consulted a GP less frequently, waited longer to present these mental health problems to the GP, and when they did it was mainly through physical symptoms. GPs mentioned the high number of other problems (physical and social) competing for the available time as well. They were aware of the fact that UMs often distrusted them and other professionals, partly due to a lack of continuity of care, and felt they had limited treatment options. Cultural differences in health beliefs and language barriers were experienced by the GPs with DMs as well.

GP explained that these barriers – low consultation rate, somatic presentation, lack of continuity, lack of treatment options, cultural differences and language problems, and above all lack of trust – were the reasons why mental health problems were often not labelled as such. They explained that these barriers hampered the ability to find with the UMs the common ground needed to treat mental health problems appropriately. They appeared to be well aware of the danger that labelling psychological problems under these circumstances, without mutual agreement and without adequate treatment options, could easily lead to further stigmatization.

GPs described a number of solutions to cope with these barriers and to provide optimal mental health care for their UMs, under the prevailing circumstances. They strive to provide continuity of care as far as possible in order to enhance a relationship of trust, which might facilitate disclosure of mental health problems. It seemed that only when this is possible will GPs be confident to label and record more mental health problems.

GPs also described different strategies to overcome problems in referrals. Although GPs acknowledged that psychotropics were not always the best solution, some of them would prescribe

these more easily to UMs as they felt they had nothing else to offer.

Strengths and limitations of the study

As far as we know, this is one of the first studies in Europe focusing on GPs' experiences with UMs' mental health problems. A strength of this study was that we were able to gain access to a group of GPs who had significant experience in the care of UMs and who were able to provide a lot of detailed information concerning the levers and barriers in the recognition, recording, and treatment of UMs' mental health problems. As they all practised in the main areas where many UMs were residing, we think the findings of this study are representative of the Dutch context. The majority of these GPs participated in an earlier survey study [13], and in this study we showed that their undocumented patients represented the general UM population in the Netherlands.

However, we should stress that this was a qualitative study with a small sample exploring the field for the first time. There might be a bias in information caused by the inclusion of GPs who are most engaged and experienced in UMs' problems. On the other hand, the richness of their information and the fact that theoretical saturation was obtained suggests a robust analysis of the issues.

Another strength of the study was that GPs were very open and willing to share their experiences of the provision of mental health care for their undocumented patients. This is positive as the study took place at a time when in the Netherlands legal action was considered against those who supported UMs. GPs described how they felt a large responsibility for the mental well-being of UMs. Because of their openness and responsibility, we were able to capture a number of solutions in coping with the difficulties in providing care for UMs. As GPs operate in a political context that changes rapidly, and UMs are a very dynamic group of patients, it is as yet unclear how representative the findings of the GPs are for the near future. On the other hand, we are confident that most of the GPs' experiences reflected generic problems in the mental health care of UMs.

Findings in relation to other studies

The GPs in our study were very engaged in efforts to provide good care for UMs. This is in line with prevailing medical ethics to provide care for all, and take responsibility for vulnerable and excluded groups despite their difficult legal, financial, and social circumstances [24]. The GPs in our study

mentioned that they recognized many mental health problems amongst UMs. This is in line with survey studies showing that UMs reported many mental health problems in general practice settings [3,4]. The patient delay in consulting GPs reported in this study was also mentioned in a previous Dutch survey amongst a representative group of almost 250 GPs, where a quarter of the GPs observed that the health complaints of UMs were more serious than the health complaints of DMs [17].

Barriers mentioned by GPs, such as unawareness among UMs of their right to medical care, their lack of knowledge of the health care system, shame at being undocumented, and fear of visiting officials, as well as other conflicting priorities, are well-known barriers for UMs [2,14,25], and have a large impact on the accessibility and availability of healthcare for undocumented patients. For instance, 70% of a group of 100 undocumented female migrants reported problems in accessing care and half of them were not registered with a GP at all [14]. The impression of the GPs in this study, that a lack of knowledge of and trust in GPs' competencies regarding mental health played an important role as well, was confirmed in a recent study amongst UMs in the Netherlands [18].

The impression of our GPs that UMs more often than DMs present physical complaints, probably as a symptom of distress, is in line with the finding in the previously mentioned survey amongst GPs, in which half of them stated that UMs presented more somatization of distress than DMs [17]. A study of patient records in general practice confirms the impression of the GPs of a high number of competing demands in their consultations with UMs: in almost a third of the consultations with UMs more than one reason for encounter was recorded [11]. The presented problems were, on average, more urgent than those of regular patients, and GPs recorded longer consultation times in the group of UMs [11].

Cultural differences in health beliefs and language barriers are well known obstacles in providing adequate mental health care to migrants in general [26]. However, one can imagine that these barriers are more profound in migrants who are less integrated in Dutch society [4].

The lack of continuity of care for UMs as mentioned by the GPs in our study is a well-known problem that impedes good quality of care [7], especially in the case of mental health problems [27]. The experienced problems in referrals to mental health care organizations are in line with findings from the previous mentioned survey amongst GPs which reported that more than one-fifth of the referrals of UMs to secondary care failed [17].

All these barriers explain why there is a gap between the high mental health needs and the relatively low recording of these needs in general practice files. The solutions GPs provide to overcome the barriers in treatment and referral – by striving for more continuity of care and thus building a relationship of trust, referring to social workers and practice nurses specialized in mental health in their own practice, and sometimes applying guidelines for prescribing medication a little less strictly – illustrate the way GP care is patient-centred, tailored to the context of the patient [28]. This patient-centred approach by culturally competent GPs (29) is essential to create more equal access and quality of care for this “hard-to-reach” group [30].

Meaning of the study and implication for clinicians and policy-makers

This study provides insight into the reasons why there is a gap between the high prevalence of mental health problems in UMs and the low recording of these problems in general practice. To narrow this gap, we recommend GPs to strive for continuity of care as far as possible. This can be achieved by improving the accessibility to the practice for UMs, by concentrating the UMs’ care on one GP, and by explaining the importance of continuity of care to UMs.

We also recommend that GPs address UMs’ mental health problems more actively and look for creative solutions in order to provide patient-centred, cultural sensitive mental health care for UMs of equal quality to that offered to other patients.

Ethical approval

The study was performed as part of the Dutch contribution to the EU project RESTORE (REsearch into implementation Strategies to support patients of different Origins and language background in a variety of European primary care settings (no. 200310014). This project was submitted for ethical approval and was waived by the Ethical Committee of the Radboud umc.

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Declaration of interest

There are no conflicts of interest in connection with the paper. The authors alone are responsible for the content and writing of the paper.

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