SUMMARY
There is widespread concern about the accessibility and quality of mental health care for non-western ethnic minority groups in relation to depression and/or anxiety (also referred to as common mental disorders, or CMD). However, there are various methodological shortcomings of the scientific literature on ethnic inequities in mental health care. For example, studies tend to compare the ethnic composition of patient populations of mental health care institutions to the composition of the general population in the related catchment areas, while ignoring the fact that differences may exist between ethnic groups regarding their need for mental health care (e.g. the prevalence of mental disorders). An additional problem is that ideas about ethnic minority groups, and how they may have limited access to mental health care, are strongly influenced by studies from the U.S. and the U.K.. Yet, these studies have limited generalisability to the situation in the Netherlands, where other ethnic groups are represented, and where health care is organised differently. Finally, the evidence currently available on differences between ethnic groups with respect to accessibility of good quality mental health care, is more heterogeneous than is often suggested. Considering these and other limitations presented in the introduction in Chapter one, the aim of this study was essentially twofold. Firstly, it aimed at providing better insight in the association between ethnic background and the need for mental health care in relation to CMD (section 1, chapters 2, 3, 4 and 5). Secondly, its aim was to determine whether differences exist between ethnic groups regarding their access to good quality mental health care for CMD in the Netherlands (section 2, chapters 6, 7 and 8).

Ethnicity and mental health care need
The first section of this thesis focused on possible differences between ethnic groups regarding their mental health care need. Chapters in this section were based on data from the Amsterdam Health Monitor, a population-based study which primarily aimed at estimating the prevalence of CMD in different ethnic groups in the general population of Amsterdam. Chapter two focused on the question whether anxiety and depression can be established reliably and validly in different ethnic groups (i.e. ethnic Dutch, Turkish, and Moroccan) by the Kessler psychological distress scale (K10). The results suggested that the K10 is indeed appropriate for that purpose. That is, the results indicated the existence of a solid single factor structure with virtually absent item bias, suggesting that the non-specific psychological distress as measured by the K10 is negligibly biased towards the ethnic groups examined in this study. Addition-
ally, sensitivity and specificity of the K10 with respect to a one-month diagnosis for CMD were good in all subgroups. Finally, the results suggested that the K10 is as good in predicting disability among Turkish and Moroccan respondents as it is among ethnic Dutch. However, it was also concluded that higher cut-off scores are necessary for Turkish and Moroccan patients to achieve comparable sensitivity and specificity compared with ethnic Dutch patients.

Next, chapter three explored the complex relation between acculturation and psychological distress, with acculturation defined as the extent to which respondents participate in Dutch society, and on the other hand maintain their heritage culture and identity. The results indicated that a lack of skills for living in Dutch society, largely related to poor mastery of the Dutch language, was associated with more psychological distress among both Turkish and Moroccan subjects. Other aspects of acculturation showed a more heterogeneous relationship with psychological distress. That is, traditionalism was related to less distress only among Moroccan respondents, and more conservative norms and values seemed to be related to distress only among Turkish men, not Turkish women.

Chapter four focused on possible differences between ethnic groups regarding their perceived need for mental health care. The study was guided by the presumption that among patients with a CMD, non-western ethnic minority patients would be less likely than ethnic Dutch patients to have a perceived need for mental health care. In addition, the study aimed to assess the extent to which perceived needs were met. Finally, the chapter aimed to study potential differences in perceived barriers to mental health care. The findings showed that the perceived need for mental health care was much higher in the Turkish population, which was explained by a higher prevalence and higher symptom levels for CMD in the Turkish group. When we took these differences into account, Moroccan respondents actually perceived less need for mental health care than ethnic Dutch, thus partially supporting our prior hypothesis. The results did not support the hypothesis that, in case of similar prevalence and symptom levels, migrants’ needs were less often met than needs of ethnic Dutch. In case of a (partially) unmet need, self-reliance was the most frequently mentioned barrier to health care in all ethnic groups. Pessimism about the effectiveness of mental health services and lack of knowledge of (Dutch) mental health care were important barriers to care that appeared more specific to migrants.
Finally, chapter five focused on differences between Turkish, Moroccan and ethnic Dutch respondents regarding their attitudes towards self-reliance and (in)formal help seeking in relation to mental health problems, because (negative) attitudes may act as a barrier to mental health care utilisation. Ethnic Moroccan and Turkish subjects reported more positive attitudes than ethnic Dutch towards being self-reliant when a need for mental health care was present. In addition, they displayed more positive attitudes regarding help from family. Moroccan ethnic background was also associated with a negative attitude towards sharing problems with friends, in which respect they differed from both ethnic Dutch and Turkish respondents. Surprisingly, attitudes towards formal types of care were similar across ethnic groups. Even more surprising, there was no relation between attitudes and actual uptake of mental health services.

**Ethnicity and access to good quality mental health care**

The second part of this thesis focused on the question how ethnic background may be related to accessibility and quality of Dutch mental health care in relation to common mental disorders. First, chapter six presents the results of a study on differences between ethnic groups regarding their self-reported uptake of (mental) health care services in Amsterdam. Of all the subjects with a CMD in the past six months, 50.9% had received some form of professional help for mental problems in that period. Only 35.0% said to have contacted specialised services. In relation to the presence of CMD, which was defined as an objective need, ethnic groups were equally likely to have accessed both primary and specialised (mental) health services. Since the purpose of specialised mental health services may be defined as the treatment of more severe mental health problems (or “cases” of CMD), this lead us to conclude that there was fairly equal uptake of specialised mental health services across ethnic groups. However, uptake of primary care services is primarily guided by self-referral of patients, and therefore subjective health status was considered to be more relevant. In relation to this subjective health status, Moroccan migrants were less likely than ethnic Dutch to report uptake of primary care services.

Chapter seven presented a comparison between ethnic groups regarding the prevalence of CMD in general practice in urban areas in the Netherlands, and in the extent to which general practitioners (GPs) in these practices adhered to treatment guidelines for both conditions. Data were derived from the Netherlands Information Network of General Practice (LINH). It was found that 4.4% of a selected general practice population in 2007 was diagnosed with a CMD. The prevalence was highest among Turkish
patients (5.2%), but not as high as was expected from the population-based prevalence estimates derived from Amsterdam. Of all patients diagnosed with a CMD, 42.9% received guideline-concordant treatment. Only Surinamese/Antillean patients were less likely than ethnic Dutch patients to be treated according to guidelines, particularly with respect to psychotropic drug prescriptions. It was concluded that, despite the latter finding, the results of this study did not support the general idea that non-Western ethnic minority patients are less likely to receive guideline-concordant care for CMD.

Finally, **chapter eight** contains the results of a study on outpatient mental health treatment for depression. A sample was taken from a nationally representative registration database (ZORGIS), gathered between January 2001 and January 2006. Information was available about timeliness of the initial treatment contact (indicating absence of delay in receiving needed services), treatment intensity, dropout, and early re-registration. Taking into account depression severity and demographic characteristics, it was found that, among clients with Moroccan, Turkish, and other non-Western ethnic backgrounds, timeliness of the first treatment contact was less favourable, and treatment intensity was lower compared to the ethnic Dutch reference group. Still, these differences were small. Surprisingly, differences were mostly absent regarding dropout and early re-registration, and in fact more favourable when Surinamese and Antillean clients were compared to ethnic Dutch. It was therefore concluded that the data did not support the idea that mental health treatment is generally less favourable for clients from ethnic minority groups.

The thesis finished with a general discussion in **chapter nine**. On the association between ethnic background and the need for health care, it was concluded that - in agreement with the elevated prevalence of CMD - the perceived mental health status (K10) of Turkish and Moroccan subjects was also significantly worse compared with the ethnic Dutch population. Correspondence between perceived and objective mental health status is important, for example in the context of screening for these disorders. However, compared with ethnic Dutch, higher cut-off scores for the K10 were found for the Turkish and Moroccan groups to obtain optimal sensitivity and specificity for detecting CMD. This result underlines the importance of studying the cross-cultural validity of instruments. In addition, when differences in subjective mental health status were taken into account, Moroccans perceived less need for mental health care than ethnic Dutch. The latter finding is important in the context of health behaviour and help-seeking, and therefore has clinical relevance.
With respect to the second research question, the results suggested that primary care utilisation for mental health problems was relatively low among ethnic Moroccan respondents when compared with ethnic Dutch. A lower perceived need for mental health care, as a key-factor in the help-seeking process, was considered as a possible explanation for this difference. Yet, utilisation of specialised mental health care (GGZ) was comparable between ethnic Dutch, Turkish and Moroccan groups. This result was supported by the finding in chapter four that, in case of similar mental morbidity, migrants’ needs were equally often met as needs of ethnic Dutch. Regarding quality of care, the results were mixed as well. There was evidence for underdiagnosis of CMD by GPs in urban areas, and some indications that this was particularly the case among Turkish patients when compared with ethnic Dutch. Furthermore, there were indications for lower quality of care for Antilleans/Surinamese patients with CMD in general practice (i.e. they were less likely to receive treatment with a relevant psychotropic medication), but outpatient depression treatment characteristics (based on findings from a nation-wide case-register) were more favourable for these groups. On the other hand, Turkish and Moroccan patients with CMD were as likely as ethnic Dutch to receive guideline concordant treatments in general practice, while outpatient treatment characteristics for depression were less favourable compared with ethnic Dutch.

In sum, taking into account the major concerns that were put forward in the introduction of this thesis, it can be argued that differences between ethnic groups regarding access to good quality care for CMD were markedly smaller than anticipated. Put differently, only to a limited degree did the results in this thesis support the idea that treatment of CMD may be less favourable for clients from ethnic minority groups than for ethnic Dutch patients. Nevertheless, the results were mixed, thus hampering a straightforward answer to the question whether or not access to good quality care for CMD is inherently worse for non-western ethnic minority groups. More specifically, various problem areas were identified, for example in relation to help-seeking behaviour (e.g. perceived need for care) and primary care (i.e. both uptake for mental health problems as well as quality of care in general practice). It is evident that, regardless of the more favourable results in this thesis, these issues need to be addressed.