Chapter

GENERAL DISCUSSION
Table 1. Newspaper articles from the past 10 years on ethnic/migrant groups in mental health care *

<table>
<thead>
<tr>
<th>Title</th>
<th>Source</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Racism is rife in NHS, says study †</td>
<td>The Guardian</td>
<td>19 Jun ‘01</td>
</tr>
<tr>
<td>2  Disparities Seen In Mental Care For Minorities No holding back:</td>
<td>The New York Times</td>
<td>27 Aug ‘01</td>
</tr>
<tr>
<td>3  The inquiry into the death of David ‘Rocky’ Bennett at a secure</td>
<td>The Guardian</td>
<td>11 Feb ‘03</td>
</tr>
<tr>
<td>unit will tomorrow report on the ‘festerings abscess’ of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>institutional racism in NHS mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4  Migrant complains about general practitioner; Patient receives</td>
<td>BN/De Stem</td>
<td>20 Feb ‘03</td>
</tr>
<tr>
<td>insufficient attention’.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5  Migrant fails only in specialised health care.</td>
<td>Trouw</td>
<td>6 Nov ‘03</td>
</tr>
<tr>
<td>6  Black tears – white words; to what extent must psychotherapy</td>
<td>Vrij Nederland</td>
<td>3 Jan ‘04</td>
</tr>
<tr>
<td>become migrant-friendly?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7  Shortage of mental health support for migrants.</td>
<td>Utrechts Nieuwsblad</td>
<td>14 Feb ‘04</td>
</tr>
<tr>
<td>8  Mental health campaign; psychiatric use of force ‘is racist’.</td>
<td>The Independent on</td>
<td>15 Feb ‘04</td>
</tr>
<tr>
<td>organisation.</td>
<td>Sunday</td>
<td></td>
</tr>
<tr>
<td>9  Mental health care demands more colour in ‘white’</td>
<td>Eindhoven’s Dagblad</td>
<td>4 May ‘04</td>
</tr>
<tr>
<td>10 Move to end race bias in mental health care</td>
<td>The Guardian</td>
<td>12 Jan ‘05</td>
</tr>
<tr>
<td>11 Mental health care for migrants fails short.</td>
<td>Provinciale Zeeuwse</td>
<td>7 May ‘05</td>
</tr>
<tr>
<td>Courant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Racial Disparities Found in Pinpointing Mental Illness.</td>
<td>The Washington Post</td>
<td>28 Jun ‘05</td>
</tr>
<tr>
<td>The struggle for cultural competence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Explaining Away Mental Illness; Many Immigrants Face Cultural</td>
<td>The Guardian</td>
<td>12 Apr ‘06</td>
</tr>
<tr>
<td>14 Barriers, Other Obstacles to Psychiatric Treatment Is it culture</td>
<td>The Washington Post</td>
<td>4 Sept ‘07</td>
</tr>
<tr>
<td>or just ADHD?†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Health care workers in The Hague claim that diagnoses are</td>
<td>Trouw</td>
<td>14 Apr ‘08</td>
</tr>
<tr>
<td>often incorrect.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 County must help improve Latino health; more than half uninsured.</td>
<td>Washington Post</td>
<td>26 Jun ‘08</td>
</tr>
<tr>
<td>17 Race bias in mental health admissions.</td>
<td>Guardian Unlimited</td>
<td>27 Nov ‘08</td>
</tr>
<tr>
<td>18 Can Hackney’s Mellow organisation help the borough’s black</td>
<td>The Guardian</td>
<td>18 Feb ‘09</td>
</tr>
<tr>
<td>and minority ethnic men recover from their mental health problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Mental health care sector pays insufficient attention to ethnic</td>
<td>Nederlands Dagblad</td>
<td>31 Mar ‘09</td>
</tr>
<tr>
<td>background patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Migrants contact mental health care only after criminal conviction.</td>
<td>AD/Groene Hart</td>
<td>17 Apr ‘10</td>
</tr>
<tr>
<td>Mental health care often too late.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Results of a non-systematic search in LexisNexis (http://www.lexisnexis.com) using combinations of the key-words migrant(s), ethnic minority/minorities and mental health (care).
† ‘rife’ means ‘common’
GENERAL DISCUSSION

There is widespread concern about access to good quality mental health care for non-western ethnic minority groups. This concern is expressed not only in a large number of international scientific publications, but in various popular media as well. As an illustration of the latter, I took a sample of foreign (American and British) and domestic newspaper articles from the past 10 years, the results of which are summarised in table 1. There is no doubt that this overview is incomplete, yet it provides a general impression of the way news media pay attention to this subject.

Without going into detail about the specific contents of each article, one can see quite easily how headings suggest that ethnic minority groups are being disadvantaged, for example with respect to interpersonal treatment (‘fester abscess of institutional racism’) or quality of care (‘diagnoses often incorrect’ or ‘mental health care sector pays insufficient attention to ethnic background patients’). Some headings are more explicit than others. For example, terms like ‘fester abscess’, ‘struggle’ and ‘bias’ have a negative meaning and clearly warn readers that something is not right. By stating the questing “black tears - white words; to what extent must psychotherapy become migrant-friendly?” the author more implicitly suggests that present-day psychotherapy is not (or at least not enough) culturally sensitive. Another subtle question (“Can Hackney’s Mellow organisation help the borough’s black and minority ethnic (BME) men recover from their mental health problems?”) implies that mental health problems among BME men (i) are an important health problem, (ii) are insufficiently addressed by health care providers, and (iii) demand a specific treatment or service. Yet, the author seems to doubt the outcome of the announced method or procedure by the Mellow organisation, because the heading is written in question-form.

At least as far as common mental disorders (CMD) are concerned, the introductory chapter of this thesis presented a number of methodological shortcomings of the scientific literature on ethnic inequities in mental health care. First and foremost, studies in this field 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 area, and derive conclusions about unequal access to health care from disparities between both population compositions [1,2]. Yet, as we have seen in the introduction, this approach ignores important differences that may exist between ethnic groups regarding their need for mental health care, if for example the prevalence of
mental disorders or the perceived need for care varies between those groups [3-5]. An addi-
tional problem that was mentioned in chapter one is that ideas about ethnic mi-
nority groups and how they have access to mental health care are strongly influenced
by studies from the U.S. and the U.K.. However, the results of these studies have lim-
ited generalisability to the situation in the Netherlands, where different ethnic groups
are represented, and where health care is organised differently. Finally, the scientific
evidence on differences between ethnic groups with respect to accessibility of good
quality mental health care is more heterogeneous than the above table suggests [6]. For
example, the RVZ reports [1,2], mentioned in the introduction, suggested that already
at the start of the new millennium it was clear that access and quality of outpatient
mental health care had improved in larger urban areas, especially for Turkish and
Moroccan subgroups.

Considering these and other limitations presented in this thesis, the aim of this study
was essentially twofold. Firstly, it aimed to provide 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 differ-
ences exist between ethnic groups regarding their access to good quality mental health
care for CMD in the Netherlands (chapters 6, 7 and 8). This final chapter will provide
a brief summary of the main findings presented in this thesis, and give an overview of
the various strengths and limitations of this study. Taking into account these methodo-
logical considerations the results will then be discussed. The chapter will finish with a
general conclusion and some implications of these findings.

**PRINCIPAL FINDINGS**

**Ethnicity and need for mental health care**
The first section of this thesis focused on the question whether there are possible dif-
fferences 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 anxiety and de-
pression in different ethnic groups in the general population of Amsterdam. Chapter two focused on the question whether anxiety and depression can be reliably and validly established in different ethnic groups (i.e. ethnic Dutch, Turkish, and Moroc-
can) by a well-known screening instrument like the Kessler psychological distress
scale (K10). The results suggested that the K10 is appropriate for that purpose. 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. Additionally, sensitivity and specificity of the K10 with respect to a one-month CIDI-diagnosis for depressive and/or anxiety disorders were good in all subgroups, as areas under the curves (AUCs) greater than 0.80 indicated good validity. 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, our study shows that Turkish and Moroccan respondents obtained higher scores on the K10 than ethnic Dutch respondents, regardless of whether a diagnosis for anxiety and/or depression was present. As a consequence it was suggested that different cut-off scores are necessary to achieve comparable sensitivity and specificity across ethnic groups.

Next, chapter three explored the complex relation between acculturation and psychological distress, with acculturation being on the one hand the extent to which respondents participated in Dutch society, and on the other hand maintained 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 more 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 non-western ethnic minority patients with a CMD would be less likely than ethnic Dutch patients with a common mental disorder to have a perceived need for mental health care. In addition, the study aimed to assess the extent to which perceived needs were met, and to provide potential explanations for possible ethnic differences. Finally, the chapter aimed to study potential differences in perceived barriers to care. The findings showed that the perceived need for mental health care was initially much higher in the Turkish population. Differences were highly related to a higher prevalence of CMD and to higher symptom levels for anxiety and depression. When we took these differences in mental morbidity into account, it appeared that Moroccan respondents had a relatively low perceived need for mental health care, thus supporting our prior hypothesis. The results however did not support the hypothesis that in case of similar
mental morbidity, needs of migrants were less often met than needs of ethnic Dutch. Notably, differences between ethnic groups could generally not be accounted for by the lower socioeconomic position of migrants. In all ethnic groups, self-reliance was most frequently mentioned as a barrier to care. Pessimism about the effectiveness of mental health services and lack of knowledge of (Dutch) mental health care were important barriers to care that appear more specific to migrants, and which may provide entries for prevention strategies.

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, for such (negative) attitudes may act as barriers to mental health care utilisation. Moroccan and Turkish subjects reported more positive attitudes than ethnic Dutch towards being self-reliant in case 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 against 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 contained three studies which describe how ethnic background is 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 Dutch, Turkish and Moroccan groups regarding their self-reported uptake of (mental) health care services in the general population of Amsterdam. It was determined whether differences in access were in accordance with the principle of “equal access for equal need” [7]. For that matter, two different types of need factors were taken into account, namely objective need (presence of a CMD diagnosis) and subjective need (self-reported psychological distress). Of all the subjects with a CMD in the past six months, 50.9% had received any professional help for mental problems in that period. Only 35.0% said to have contacted specialised services. In relation to the presence of CMD (i.e. objective need), ethnic groups were equally likely to have accessed both primary and specialised (mental) health services. Since it is the purpose of specialised mental health services to treat more severe mental health problems (or “cases” of CMD), this lead us to conclude that there was fairly equal uptake of spe-
cialised mental health services across ethnic groups. However, uptake of primary care services is primarily guided by the self-referral of patients, and therefore subjective need factors are highly relevant. In relation to psychological distress (i.e. subjective need), Moroccan migrants were less likely than ethnic Dutch to report uptake of care services. From that perspective, it was concluded in chapter six that the results indicated lower uptake of primary care services by Moroccan migrants.

Second, chapter seven presented a comparison between ethnic groups regarding the prevalence of anxiety and depression in general practice in urban areas in the Netherlands, and in the extent to which general practitioners (GPs) adhered to treatment guidelines for both conditions. Family practitioners in the Netherlands play a role as gatekeepers, meaning that they need to refer patients to specialized health services. As a consequence, family practitioners are the most important caregivers to those who seek medical care and have a crucial role in the recognition of mental health problems and need for mental health. It was found that 4.4% of a selected general practice population in 2007 (data derived from the Netherlands Information Network of General Practice, or LINH) was diagnosed with anxiety and/or depression. The prevalence was highest in Turkish patients (5.2%), but not as high as was expected from the population-based prevalence estimates derived from the AHM. Of all patients diagnosed with 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.

Chapter eight, finally, presents the results of a study on a comparison between ethnic groups regarding characteristics of 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 clients with Moroccan, Turkish, and other non-Western ethnic backgrounds had less favourable timeliness of the first treatment contact as well as a lower treatment intensity compared with ethnic Dutch. Yet 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. As in the previous study, 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 main findings are summarised once more in table 2.

Table 2. Summary of main results: differences and similarities between ethnic groups, given a certain level of common mental health problems *

<table>
<thead>
<tr>
<th></th>
<th>Turkish</th>
<th>Moroccan</th>
<th>Surinamese</th>
<th>Antillean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived need for mental health care</td>
<td>=</td>
<td>-</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Uptake primary care for mental health problems</td>
<td>=</td>
<td>-</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Detection CMD in general practice</td>
<td>-</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td>Guideline concordant treatment in general practice</td>
<td>=</td>
<td>=</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Uptake specialised mental health care</td>
<td>=</td>
<td>=</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Quality outpatient depression treatment</td>
<td>+/-</td>
<td>+/-</td>
<td>+/=</td>
<td>+/-</td>
</tr>
</tbody>
</table>

1. ethnic Dutch are the reference group
- less favourable position than ethnic Dutch
+ more favourable position than ethnic Dutch
= (about) equally favourable position compared with ethnic Dutch
x not studied in this thesis

METHODOLOGICAL CONSIDERATIONS

As emphasised earlier in the introduction of this thesis, and earlier in this chapter as well, the existing body of research dedicated to the issue of ethnic differences in access to good quality mental health care has a number of methodological shortcomings. In various chapters of this thesis we were able to address a number of them, which considerably strengthened our findings. Yet, the results should be viewed in the light of a number of remaining limitations as well. As strengths and
limitations have also been discussed elaborately in each chapter, only the major methodological aspects will be discussed in this paragraph.

**Strengths**
A major strength of this thesis is that it contains studies that were based on different types of data. For example, the AHM was one of the first population-based studies among two major European migrant groups to address inequalities in mental health care for common mental disorders. As a result of various measures that were taken to limit the non-response (including the recruitment of well-trained bilingual interviewers, with ethnic backgrounds that could be matched to the background of respondents) the principal researchers were able to include respondents who were not fluent in the Dutch language. This is in contrast with most other large-scale epidemiological studies in this area, which tend to exclude respondents who do not sufficiently master the dominant language(s) of the host country on beforehand. The remaining databases (LINH and ZORGIS), both provided longitudinal registration data from a representative network of family practices in urban areas, and outpatient mental health care, respectively. As a result, we were able to include large numbers of patients with anxiety and/or depression, and consequently had large sample sizes to work with in the analyses. Thus, we were able to conduct a detailed analysis of differences and similarities between ethnic background, which to a large extent contributed to the differentiated picture presented in this thesis. Moreover, data from the LINH database could be linked to the population register, which is kept by Statistics Netherlands, so that we had additional information about family income and country of birth. These variables (indicators of socioeconomic status and ethnic background, respectively) are quite often missing in studies that focus on this subject. Although the ZORGIS database did not have this advantage, it does contain longitudinal data, and covers the larger part of general mental health care consumption in the Netherlands. Since the central research question (i.e. whether there are ethnic differences regarding access to good quality mental health care) could be analysed in different ways, it was possible to present a balanced picture. What is more, the application of registration data partly compensated for the fact that the self-report data gathered among patients with a CMD, on health care utilisation in Amsterdam, may have been biased. That is, anxiety and depression are both motivational disorders that may result in negative thinking and views among patients about the care they received. Registration data do not have this limitation. Yet, on the other hand, registration data on quality of care do not necessarily correspond with consumer derived indicators of quality of care, and may lack validation.
Limitations

Despite all measures that were taken to prevent (systematic) non-response, it should be noted that the generalisability of the findings presented in this thesis (particularly those related to the AHM and the ZORGIS databases) are limited by considerable non-response and incompleteness of data. Although non-response and incompleteness were elaborately investigated in both studies, and appeared to be non-selective, selection may have occurred nonetheless on one or more unknown variable(s). There are some indications that this is the case for the Moroccan subgroup. For example, the prevalence of CMD among Moroccan citizens of Amsterdam was surprisingly low, and the gender distribution that is typical for anxiety and depression (i.e. a significantly higher prevalence among females than among males) could not be replicated [8]. Additional evidence for possible selection is provided by Kadri et al. [9], who recently conducted a study in the general population in Morocco to establish the prevalence of CMD. They found disorders to be much more common than is suggested in the AHM; 40.1% of the general population in Morocco had at least one current mental disorder, which included mood, anxiety, substance, and alcohol abuse disorders, and disorders were more frequently present among females [9]. Findings from the general population in Turkey [10], but also for Turkish and Moroccan migrants in Belgium [11,12], also suggest that the prevalence estimates for Turkish migrants in Amsterdam are more accurate than for Moroccan citizens.

Secondly, an important restriction is the cross-sectional design of the AHM. As a result, no conclusions are allowed on the directionality of our findings. As discussed in chapter 3, for example, it is conceivable that the experience of psychological distress is able to limit the ability of a person to participate in a new culture. On the other hand, inability to participate in the host culture may cause psychological distress. The same reasoning may be followed for perceiving a (partially) met need for mental health care (chapter 4). In relation to this limitation, one should keep in mind that psychological distress and common mental disorders can be characterized by motivational problems and negative thinking. In other words, more distress might result in a disproportionately negative evaluation of one’s acculturation or mental health care utilisation. An example of this may be the finding among Moroccans that feelings of loss (in relation to one’s cultural background) were highly related to feelings of psychological distress, which may in fact be an expression of a depression.

Thirdly, one might argue that some constructs in this thesis were not optimally defined or measured. Possibly the most obvious example in this respect is ethnic background,
which was defined according to the country of birth of the respondent and his/her parents. As explained earlier in the introductory chapter of this thesis, country of birth should be regarded as a proxy measure of similarities between people regarding their language, religious background (or absence thereof), migration history, genetic predisposition for (mental) illnesses and/or geographic origin [13,14]. Thus, ethnic background is a very crude measure, and although the definition based on country of birth is widely adopted in the Netherlands, other definitions are very well possible. In the UK, for example, it is very common to define ethnicity by a mix of cultural factors, including language, diet, religion and ancestry. In the USA, ‘ethnicity’ is often used as a synonym for ‘race’ [14]. An additional complicating factor is that ethnic differences in health and health care utilisation tend to be confounded by socioeconomic factors [15]. We were aware of this from the start of our study, and we attempted to disentangle ethnic background and socioeconomic factors from each other as much as possible. Socioeconomic factors, or status (SES), was indicated in most of our studies by educational level, type of health insurance and/or income - but it should be acknowledged that the concept of SES may encompass more than these three characteristics.

Finally, an important limitation of this study is that some ethnic minority groups received less attention than others. That is, only Turkish and Moroccan ethnic background were represented compared with ethnic Dutch in all studies. Various researchers in the Netherlands have recommended that more attention should go out to the other major ethnic groups in the Netherlands, namely Surinamese and Antillean groups. Additionally, it was not possible to make distinctions between ethnic subgroups, such as between Hindustani and Creoles within the Surinamese population. On the contrary, Surinamese and Antillean subjects even had to be merged into a single ‘ethnic’ category, so that comparisons could be made between data from the Amsterdam Health Monitor and registration data from general practice (chapter 7). Such combinations of ethnic groups may mask relevant differences between those groups. For example, previous studies have established important differences within the Surinamese population (i.e. between Hindustani (Indian descent) and the Creoles (African descent) regarding health and health care behaviour (e.g. with respect to psychiatric morbidity and suicidal behaviour [16-18]).
Chapter 9

INTERPRETATION OF FINDINGS

This thesis aimed to address the questions whether there are differences between ethnic groups in the Netherlands regarding (i) the size and type of mental health care need in relation to CMD, and (ii) their access to good quality mental health care for CMD. In both questions ‘need factors’, which according to the Behavioural model are the most important determinants of health care utilisation [3-5], play a central role. Before these research questions can be addressed, some more attention should be paid to these need factors.

Health status, need for care and care utilisation

First, it is important that need for care is clearly distinguished from both health status and health care utilisation, although these three concepts are strongly correlated. This correlation is illustrated by the traditional approach in psychiatric epidemiology to derive a population’s need for mental health care by measuring the prevalence of mental disorders in that population, or by measuring the extent to which mental health services are used [19]. In other words, prevalence of mental disorders and mental health care utilisation are used as proxy-measures of mental health care need. However, as we have seen in the introduction, persons with a psychiatric disorder do not necessarily consider themselves to be unhealthy, nor do all patients view themselves to be in need for mental health care. Similarly, not all persons who use mental health services need them, and not all persons who are in need for health services use them. Thus, the presence of a psychiatric disorder is not the only aspect that is to be valued in determining health status or mental health care need [20]. Additional aspects that should be considered are, for example, levels of distress and disability. In conformation with this, diagnosis is nowadays regarded as being suggestive of treatment at best, not prescriptive [21]. In the field of psychiatric epidemiology, this notion has resulted in various attempts to define and measure need for mental health care more directly.

Objective and subjective aspects

Another distinction that should be highlighted is the difference between objective and subjective aspects of both health status and need for care [22]. That is, objective health status typically refers to a professional judgement or estimation of a patient’s health status. Instead, subjective health status refers to the individual perspective, expressed in the extent to which a person indicates to be suffering from mental health symptoms. Likewise, need for care has both objective and subjective aspects. Although arguably
not the same, objective need for care was considered to be equal to objective health status in this thesis. This was done based on the notion that, in present-day Dutch mental health care, a diagnosis is closely related to the kind and amount of treatment that will be provided to a patient. That is, Diagnosis-Treatment-Combinations (Dutch abbreviation: DBCs) 6 play a central role in financing. In short, a DBC consists of all activities of a health care professional that arise from the request for care of a patient. In determining this request for care, a DSM-based diagnosis plays a central role [23]. Subjective need for care (or perceived need for care), however, is different from subjective health status, as it refers to the actual need for (in)formal care a patient experiences. In this study, a CIDI-based diagnosis for anxiety and/or depression was used as a proxy-measure for objective health status, while scores on instruments such as the Kessler Psychological distress scale (K10) and the Symptom Checklist (SCL-90-R) were used as indicators of subjective mental health status.

**Objective health status: prevalence of CMD**

The information above is summarised in **figure 1**, which is partly derived from an earlier edition of the Public Health Status and Forecast by the National Institute for Public Health and the Environment (RIVM) [24], and might by interpreted as an extremely simplified version of the Behavioural model by Andersen et al. [3-5]. Starting from the overview in **figure 1**, the primary difference between ethnic Turkish, Moroccan and Dutch groups was that, in terms of CMD, the objective mental health status of ethnic minority groups in Amsterdam tended to be worse compared with

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**Figure 1. A simplified Behavioural model**

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5 The term ‘objective health status’ may be somewhat misleading, in that the estimation whether a person is unhealthy and/or in need for care is the outcome of a diagnostic process with subjective elements, and thus diagnoses may vary between professionals. For example, psychologists and psychiatrists may value and notice different aspects than a general practitioner and a social worker

6 http://www.dbconderhoud.nl/Over-de-DBC-systematiek/Information-in-english.
ethnic Dutch. This has been described elaborately by de Wit et al. [8], and is therefore not a result of this thesis per se. More specifically, de Wit et al. [8] found that Turkish women had the highest risk for a current depressive or anxiety disorder, and that the risk of a current disorder was also increased for Turkish and Moroccan men compared to Dutch men, although not statistically significantly.

**Subjective health status: distress**

In addition, there was a strong association between the objective health status (CIDI diagnosis for CMD), and subjective health status (K10 and SCL-90-R), regardless of ethnic background of respondents. The strength of this relationship is important. A weak association would for example imply that instruments like the K10, that are normally used for screening for mental disorders, are not suitable for this purpose among ethnic minority groups. Instead, findings like these imply that ethnic minority patients are, too, quite able to make an adequate estimation of their (mental) health status. Thus, the initial results of our study were quite favourable, and - as suggested in chapter two - might indicate that depression and anxiety are not so different across cultures [25,26], although cultural variations in clinical expression of depression and anxiety may exist [27]. Support for this hypothesis might be found in recent findings from the same dataset, reported by Schrier et al. [28], who showed similarities in symptom profiles for depressive disorder among ethnic Dutch, Turkish and Moroccan participants.

**Perceived need for care**

What is more, there was a strong relation between objective/subjective mental health status on the one hand, and perceived need for care in three ethnic groups. The findings showed that the perceived need for mental health care was much higher in the Turkish population, and that this difference corresponded with them showing the highest prevalence of, and symptom levels for, anxiety and depression. A strong association between health status and (perceived) need for care is important in the light of health behaviour and help-seeking; as was explained in chapter four, greater perceived need for care is associated with higher use of services, less dropout and better compliance with treatment [29,30]. Conversely, the disbelief that problems require treatment (i.e. no perceived need for care) is an important reason for people not to seek help [31,32]. Moreover, the association between health status and (perceived) need for care has clinical relevance. For example, van Beljouw et al. [33] recently reported that patients with a CMD who also expressed a need for care tended to suffer from the severest consequences of anxiety and depression: compared with patients without
a perceived need for care, they reported more severe symptoms of their disorders, greater disability, more loneliness, and less social support [33].

However, there was a differences between ethnic groups regarding the strength of the aforementioned associations. Although the correlation between objective and subjective health status was strong in general, it was somewhat weaker among migrants. Similarly, it was explained that the association between subjective health status and perceived need for care was weaker among Turkish and (especially) Moroccan migrants. That is, in case of comparable subjective health status, the perceived need for mental health care was relatively low among non-Western migrants, especially among those with a Moroccan background. In line with this finding, Kamperman & de Wit [34] commented that, generally speaking, worse levels of subjective mental health status within the Turkish and Moroccan population do not necessarily correspond with or translate into a higher prevalence of mental disorders. To this I would like to add that higher levels of subjective mental health status do not necessarily correspond with a higher perceived need for mental health care either. Such findings are highly relevant in the light of the on-going discussion about the lack of research focusing on cross-cultural validity of psychometric instruments [35-38]. That is, although it was shown in chapter two that anxiety and depression can be detected among non-western population groups using a ‘western’ screening tool like the K10, more conservative cut-off points for Turkish and Moroccan respondents were recommended to achieve comparable sensitivity and specificity as found in the ethnic Dutch population.

Uptake of mental health care

There is an additional reason why it is important to make a clear distinction between different types of health status and different types of need for care, which can be derived from the following. One of the key-components of the Dutch health care system is its referral system, meaning that patients cannot directly consult a medical specialist, but have to visit a general practitioner (GP) first. GPs subsequently acts as gatekeepers, which means that they have to recognise a potential disorder. Only on certain conditions will a GP refer a patient to specialised mental health care. Although referral rates vary greatly between GPs, and there is a lack of consensus about what an appropriate referral is [39], most reasons for a referral seem to fall into three categories. These are (i) investigation/diagnosis, (ii) treatment, or (iii) advice/reassurance for the patient and/or GP [40]. For this study, we decided to define an appropriate referral on basis of the traditional purpose of specialised mental health services, which is the diagnosis and treatment of mental disorders [41]. The need for specialised mental health
care was defined accordingly, i.e. by the presence of a mental disorder (or ‘caseness’). Strikingly, this study shows that, given the presence of a diagnosis for CMD, Turkish and Moroccan migrants did not differ in the uptake of specialised mental health services compared to ethnic Dutch. This result is fairly surprising, given that various authors have previously argued that mental health care utilisation among Turkish and Moroccan migrants is lower than among ethnic Dutch. Yet it is supported by the finding in chapter four that in case of similar mental morbidity, migrants did not perceive their need for mental health care to be met less often than ethnic Dutch. Later in this chapter, this result will be elaborated upon.

**Uptake of primary care**

However, the principle of ‘caseness’ applies less to primary care services, which mainly consist of GP care. These are typically the services to which patients are self-referred when they perceive a health problem and/or a need for care. Therefore, subjective (mental) health status is (or should be) the most important initiator of professional help seeking. In that context it is noteworthy that, given a certain level of subjective mental health problems, Moroccan migrants were less likely to report uptake of primary care for mental health problems.

The distinction between primary care in general and primary care for mental health problems is important. That is, previous studies have suggested that Turkish and Moroccan migrants are generally frequent visitors of general practice [7,42,43]. A post-hoc analysis (data not displayed here) within the sample used for this study indicated that the level of primary care utilisation in general was comparable in all three ethnic minority groups. After correction for objective and subjective mental health status, there were still no statistically significant differences between ethnic Turkish, Moroccan and Dutch respondents regarding primary health care utilisation.

One explanation for the finding that primary health care utilisation for mental health problems was low among Moroccans is the relatively low perceived need for care in that group. For example, Verhaak et al. [44] reported that the odds of mental health treatment in primary care are higher for people who perceived themselves as having a mental problem. The suggestion that a lack of perceived need may explain the lower use of primary care for mental health problems among Moroccans is further supported by the finding in chapter four that the levels of unmet and/or partially met perceived need for care were comparable in all ethnic groups. After all, in case of a lack of perceived need for mental health care, not paying a visit to primary health care for mental
health problems is unlikely to result in a partially met/unmet need for mental health care. A possible explanation for the relatively low perceived need for care among Moroccans may be found in the concept of self-reliance. In chapter four it was suggested that there were high levels of self reliance in general, regardless of patients’ ethnic background, which agrees with findings from other studies. For example, Sareen and colleagues [45] reported that ‘I wanted to solve the problem on my own’ was among the most frequently mentioned barriers in surveys conducted in the United States, Ontario, and the Netherlands. Evidence that self-reliance is relatively more important in the Turkish and Moroccan population was presented in chapter five. There it was presented that Moroccan and Turkish respondents displayed more positive attitudes regarding help from family. However, Moroccan respondents differed from ethnic Dutch and Turkish respondents in that they had more negative attitudes against sharing problems with friends. Although attitudes were not directly associated with actual uptake of mental health care, this finding at least partially supports the assertion that self-reliance is more prominent as a barrier to care for Moroccans than for Turkish.

Yet, it might also be that by relying on instruments like the K10 without taking into account that cut-off scores may differ between ethnic groups, one might run the risk of overestimating the prevalence of CMD among certain ethnic minority groups, and thereby overestimate the need for mental health care among ethnic minority patients. Such overestimation may be the result of response biases like acquiescence or extreme responding [46], or of cultural variations in clinical expression of CMD [27]. Indeed it was shown in this thesis that certain levels of subjective mental health did not necessarily correspond with levels of perceived need for care (chapter four), and that the K10 may be used for screening for CMD among Turkish and Moroccan patients with similar psychometric qualities, provided that higher cut-off scores are applied (chapter two).

Possible underdiagnosis of CMD in general practice
Additional indications for disparities between ethnic groups were provided in chapter seven. That is, in chapter seven the large discrepancy between the prevalence of CMD in the population of Amsterdam [8] and the prevalence of CMD in an urban general practice population was highlighted. This discrepancy is likely to be caused by the subsequent filters in the Filter model (see introduction). That is, only some individuals who have a mental illness will notice symptoms, may (or may not) interpret these as mental health problems, perceive a need for care, decide to seek help and go to see a GP. These individuals, or cases, then have to be detected and diagnosed as such by the
GP, and diagnosed cases will have to be registered in a database [4,47]. Compared with ethnic Dutch, Turkish citizens of Amsterdam were almost twice as likely to have had CMD in the previous year [8], while the difference between Turkish and ethnic Dutch patients in urban general practice was much smaller (see figure 2). It was concluded in chapter seven that this may indicate underdiagnosis of CMD among Turkish patients. Following the same reasoning, no indications were found for underdiagnosis of CMD within the Moroccan and Surinamese/Antillean subpopulations.

![Figure 2. 1-year prevalence of CMD: a comparison between two populations [8,48]](image)

Underdiagnosis of CMD in primary care is a commonly studied subject in general, extensively described in other studies. According to Nuyen et al. [49], depression is often poorly recognized and diagnosed by GPs, with most studies reporting a rate of underdiagnosis falling in the 60-70% range [50,51]. The significance of underdiagnosis is evident, as it may be indicative of underdetection, while underdetection is likely to result in under-treatment [52]. Furthermore, diagnosing and subsequent recording of
the diagnosis for CMD in the patient’s record appears to be an important prerequisite for the provision of guideline-concordant care for CMD in general practice [53].

Plenty of reasons for not diagnosing CMD have been reported in other studies [52]. For example, factors that most likely complicate the diagnosis of depression primary care are (i) severity, (ii) complexity of fitting the continuous variation in depression severity into a categorical diagnosis (more-severe cases of depression are diagnosed more reliably than less-severe forms), (iii) uncertainty about the diagnosis, (iv) uncertainty about implications of the diagnosis (what should be the next step?), (v) limited consultation time and resources (psychological or even structured self-help programmes are often not available, and medical treatments are frequently not the first choice for patients), and (vi) comorbidity with other disorders (which might complicate the identification of depression symptoms from other symptoms). In the light of these factors it is interesting to note that Schrier et al. [54] found a higher amount of CMD comorbidity among Moroccan migrants compared with ethnic Dutch, and the highest comorbidity rate among Turkish subjects. Yet, based on these data it is not possible to conclude which - if any - of the other aforementioned factors might explain possible underdiagnosis of CMD among Turkish patients.

Quality of mental health care

This thesis also focused on the matter of quality of mental health care for those who contacted professional help and who were identified as patients with CMD. The main outcomes were summarized at the start of this chapter. In short, it is clear that there were both similarities and differences between ethnic groups. While similarities are positive in general, some of the differences suggested favourable outcomes for ethnic minority groups as well. For example, timeliness of the initial outpatient contact for depression treatment was better for Surinamese and Antillean clients than for ethnic Dutch clients. Furthermore, the clinical importance of statistically significant differences that hinted at an unfavourable position for patients with ethnic minority backgrounds (e.g. Turkish outpatient clients had 0.4 contact per month less than ethnic Dutch) was sometimes questionable.

In combination with the finding that uptake of specialised mental health care for CMD was comparable between ethnic groups, the findings on mental health care quality provide quite an optimistic picture for ethnic minority groups. Similar findings have been reported before, although previous studies typically did not take into account ethnic differences in mental health care need. That is, mixed results lead the Nether-
lands Organization for Health Research and Development (ZonMw) to conclude that not all ethnic minority groups are as unhealthy as often is hypothesized, and neither are health services generally less accessible to them, or provide care of less quality [6]. The results presented in this thesis suggest that a similar conclusion may apply to (mental) health care for CMD. This is further supported by the most recent report on Dutch mental health services by the Netherlands Institute of Mental health and Addiction (Trimbos) 7. In this report it is concluded that ethnic minority groups are increasingly able to find their way to mental health care. The positive development that is described in the report, however, applies mainly to (young female) Turkish and (male) Moroccan clients in outpatient mental health care [55,56]. According to the Trimbos institute, Surinamese, Antillean, and (elderly female) Moroccan clients are catching up as well, but in 2004 their share in outpatient mental health care utilisation was still lower compared with the ethnic Dutch population. In another Dutch study, Schrier et al. [57] suggested that migrants in Amsterdam are catching up in access to and use of outpatient mental health services.

In fact, similar observations (i.e. mixed results and/or results which indicate that ethnic minority groups are increasingly able to find their way to mental health care) have been done abroad. In the U.S., for example, Mayberry and colleagues [58] reported that “[as] with some other disease categories, studies of the use of mental health services by racial and ethnic minorities have yielded mixed results. Racial and ethnic disparities have been noted in outpatient services, inpatient admissions, and drug therapy, although the findings have not been consistent and their implications are not understood. Stockdale et al. [59] even wrote that racial and ethnic differences regarding “treatment of common mental disorders, disparities in counselling/referrals for counselling, antidepressant medications, and any care vastly improved or were eliminated over time in psychiatric visits”. In addition, Stockdale et al. [59] stress that recent studies have raised questions about whether formerly documented ethnic disparities in care for common mental disorders in primary and specialty care settings still remain [59].

**Possible explanations for differences and similarities**

In the introduction it was described which explanations exist for differences between ethnic groups regarding their access to good quality mental health services such as

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7 Please note that the Trimbos-report is actually partly based on the results presented in this thesis.
described in this thesis, and that both the Behavioural Model and the Filter Model may be used as a framework for these explanations. As for the reach of health care services for CMD, it was suggested earlier in this chapter that differences in primary health care utilisation for mental health problems might be explained by differences in perceived need for mental health care. Alternatively, it was suggested that by relying on instruments like the K10, the prevalence of psychological distress is overestimated in certain ethnic minority groups.

There were also indications for lower quality of care for Surinamese/Antillean clients with CMD in general practice, and for Turkish/Moroccan clients regarding outpatient depression treatment. That is, GPs were less likely to adhere to treatment guidelines for CMD if patients were Surinamese/Antillean. Regarding outpatient depression treatment, timeliness and treatment intensity were somewhat less favourable for Moroccan and Turkish patients compared with ethnic Dutch. A straightforward explanation, such as limited Dutch language proficiency among migrants, was not possible. That is, Surinamese and Antillean clients are generally considered to have better Dutch language proficiency than (first generation) Turkish and Moroccan migrants, as they are former residents of Surinam and the Dutch Antilles, which have a historic connection with the Kingdom of the Netherlands (the Antilles are still a part of it). Instead, better language proficiency was associated with better well-being/mental health (chapter three), in confirmation with other studies. Thus, other explanations for differences in health care quality had to be considered.

In a number of cases, the results in this thesis suggested that differences between ethnic groups were absent, or that ethnic minority groups held a more positive position compared with ethnic Dutch. There is no straightforward explanation for these findings. However, in terms of enabling factors, there was virtually no evidence for socioeconomic status (SES) acting as a barrier in obtaining access to good quality health services. That is, in subsequent chapters, SES was taken into account by including various indicators (income, educational level, type of health insurance), each one with its own limitations. Yet, in none of the studies were these proxy-measures identified as possible confounders in the relationship between ethnic minority background,

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mental health care utilisation and mental health care quality. Verhaak [44] also found that income, together with other enabling factors (i.e. the perceived accessibility of services nor the factual presence of services) made no difference between respondents receiving treatment for CMD and those who did not. According to Verhaak et al. [44] this may be typical for the Dutch situation, where access to care is not dependent on income, and geographically within the reach of everyone. Kamperman [60], too, noted that there are few indications for low SES to be acting as a barrier to obtaining health care, although it was suggested that SES may influence the type of health care that is received.

Apart from individual factors, the full Behavioural Model includes contextual factors, which were added to the model during the final phase of its development [61]. According to Andersen, contextual characteristics are measured at an aggregate level, and divided in the same way as individual characteristics have been divided. That is, Andersen distinguishes between contextual factors that predispose (e.g. community age structure), enable (e.g. supply of medical personnel and facilities), or suggest need for individual use of health services (e.g. mortality, morbidity and disability rates). Contextual factors were not included in this study, because they act at a different level and are difficult to measure. Still, some of the more favourable results presented here may have to be interpreted in the light of contextual developments. One of these developments is the process of interculturalisation in mental health care [62,63]. That is, in the past 25 to 30 years numerous efforts have been made to adapt mainstream (mental) health services in the Netherlands to suit clients from different cultures, also referred to as the process of ‘interculturalisation’ [62,64-66]. Examples of such efforts included consultation hours outside mental health care institutions and the development of peer education programs by members of ethnic minority groups [67-69].

In addition, the possibility that minority populations in western countries have advanced in terms of, for example, acculturation, education, and health literacy, should not be excluded [70]. As a consequence of these developments, the role of traditional barriers in help-seeking behaviour, like stigma and taboo, may have become smaller than is usually suggested [71]. At least for Turkish and Moroccan migrants in the Netherlands, the latter is supported by findings from Knipscheer & Kleber [72]. As an illustration, the results in chapter five indicated that attitudes regarding professional help for mental health problems were quite favourable among Turkish and Moroccan respondents compared with ethnic Dutch. Although it was shown in the same chapter that attitudes were not directly associated with health care utilisation, it is known from
literature that the decision to consult specialized mental health care is strongly related to the patients’ confidence in professional help and their distrust of lay help [44].

CONCLUSION

The studies in this thesis were primarily based on a number of concerns regarding non-western ethnic minority groups in the Netherlands and their supposedly disadvantaged position in terms of access to good quality mental health care for anxiety and/or depression (or common mental disorders; CMD). Amongst others, these concerns include non-western ethnic minority patients with CMD being less likely (i) to seek professional help for a mental health problem, (ii) to have access to (mental) health care, (iii) to be detected and diagnosed with CMD and (iv) to receive treatments for CMD that are in agreement with treatment guidelines. Hence, guided by the principle of “equal access for equal needs”, this thesis aimed to address two questions, namely:

1. Are there differences between ethnic groups regarding their mental health care need in relation to CMD?
2. Taking into account possible differences in mental health care need in relation to CMD, are there differences between ethnic groups regarding their access to good quality mental health care?

For several reasons, the answer to the first question should be affirmative: there were indeed differences between ethnic groups regarding their mental health care need. First and foremost, in terms of the prevalence of CMD, the objective mental health status of Turkish (female) and Moroccan (male) inhabitants of Amsterdam was worse compared with the ethnic Dutch population. Second, 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.
IMPLICATIONS

The implications of the results presented in this thesis will be divided into recommendations for research and recommendations for policy and practice.

Implications for further research
First, the results support the notion that mental health status and need for care may vary between ethnic groups, and that taking into account these variations can have implications for conclusions about accessibility and quality of mental health care for these groups. On various occasions the recommendation has been done that more research should be conducted on the prevalence of mental disorders in separate ethnic groups in the general population (see for example the report by the Dutch Council for Public Health and Health Care [1,2]). This information is considered to be vital as a starting point for mapping ethnic differences in mental health care utilisation. Nevertheless, researchers have insufficiently been able to follow this recommendation, even though approximately 11% of the Dutch general population to date has a non-western ethnic minority background (in a city like Amsterdam this is as much as 35%). The Amsterdam Health Monitor (AHM) of 2004/2005 contains proof that including ethnic minority groups is not only difficult and time consuming, but also feasible, worth the effort, and necessary. It is therefore recommended that more is done to include ethnic groups in epidemiological studies.

A second recommendation would be that more effort should be put in studying the cross-cultural validity of instruments that are commonly used in research in general. Like the previous recommendations, this one has been done before as well. That is, already in 1990 it was concluded that some instruments are probably not suitable for research in ethnic minority groups [38], and comparable comments have been done by others ever since [35-37]. Still, there is a lack of cross-cultural validation of measurement instruments that are applied both for epidemiologic and clinical purposes. In this thesis, it was suggested that, among non-western population groups too, anxiety and depression can be detected by a ‘western’ screening tool like the K10. This finding is important, as it indicates that a western psychometric instrument like the K10 is not necessarily useless for application among non-western populations. However, more conservative cut-off points for Turkish and Moroccan respondents were proposed to limit the rate of false-positives in these groups, thus confirming the importance of cross-cultural psychometric research.
Third, more research should be conducted on the quality of mental health care for CMD for different ethnic groups. Although quality of care was an important subject in this thesis, the indicators that were used to measure quality of care (e.g. guideline concordant treatment in general practice) represented a rather instrumental and narrow definition of quality. For example, GPs nowadays have a considerable number of psychological interventions at their disposal [73], but the provision of such treatment options was not included as a quality indicator. In addition, quality indicators in this thesis did not include an appreciation of the quality of the doctor-patient relationship, which is also an important aspect of culturally sensitive care [62]. The quality of this relationship is to a large extent determined by the quality of communication between doctors and their patients [62,74-76]. In other words, the extent to which treatment guidelines were adhered to by GPs is an important aspect of quality of care, but it does not tell the whole story.

At this point, it is also important to underline that neither equal accessibility of mental health care, nor equal quality of care - although both necessary as conditions for equal opportunity to health - can guarantee equal outcomes [77]. For example, Lugtenberg et al. [78] showed that evidence-based clinical guidelines can be effective in improving the process and structure of care in general practice, but effects of guidelines and guideline adherence on patient health outcomes have been studied less often and data are less convincing. On the contrary; there is evidence available from the U.S. suggesting that deviations from treatment guidelines by practitioners are in fact medically appropriate in many cases [79]. Thus, not only do we need to put more effort into studying the effects of guidelines and guideline adherence on patient outcomes, the applicability of these guidelines for different ethnic groups needs to be studied as well.

A similar reasoning can be followed for culturally sensitive care. That is, although our knowledge about what is (or should be) culturally sensitive mental health care has advanced considerably, it is less clear to what extent this type of care is more effective than regular care. The importance of answering this question has been highlighted before [57], but it appears that not much progress has been made yet. As Colijn & de Jong [80] note, the influence of evidence-based medicine in transcultural psychiatry and psychotherapy is relatively small in comparison to the field of psychiatry and medicine in general. An example of an initiative to invest in the evidence-base of mental health treatment of Moroccan and Turkish patients is the evaluation of an intercultural module added to the standard treatment guidelines of depressive and anxiety
disorders. Studies like these may be useful in the discussion about, for example, the necessity of taking into account ethnic background in the development of treatment guidelines [81-84]. More information about the effects of culturally sensitive care might also be helpful in the debate raised by the seemingly growing popularity of institutions that have specialised in (mental) health treatment for ethnic minority groups. That is, more information about the effectiveness of culturally sensitive care compared with ‘regular care’ would help in determining if and how existing treatments and programs in regular mental health care institutions would need some form of adjustment, or not.

Implications for policy and practice
As far as the inclusion of ethnic minority groups in research is concerned (see previous paragraph), this may be stimulated by improved rules and legislation. To illustrate this, a parallel may be drawn between epidemiological surveys and the issue of clinical trials in medicine. That is, it has been argued that clinical researchers have been insufficiently able to provide a representative image of (dis)advantages of medical treatments among those subgroups who have the greatest burden of the morbidity [85,86]. Consequently, some have asked for “changes in the conduct of clinical trials which are needed to reduce disparities of age, sex, race, and comorbidity” [87,88]. Several recommendations have been made to achieve this, including the change of rules and regulations concerning clinical trial design, funding and conduct, and publication policies of scientific journals [88]. It appears that nowadays legislation has been introduced in the U.S. which stimulates that minority groups are included in trials, and that trials are designed so that they also supply valid and reliable information about these minority groups [89]. It should be investigated whether such measures are feasible in the Netherlands as well.

In relation to the previous point, it should be noted that there are still insufficient data available in the Netherlands about the ethnic composition of patient populations in various medical settings, including mental health care [89]. This was one of the major limitations to the study presented in chapter eight, on outpatient depression treatment. Taking into account the ethnic background of patients can be important to provide good health care [90], and for this reason registration of ethnicity is lawful under certain conditions [91]. Therefore, more measures should be taken to stimulate registration of ethnic background in medical files.

9 http://www.emgo.nl/research/mental-health/research-projects/
In accordance with recent recommendations [92], it is concluded that the evidence base for primary prevention of CMD among ethnic minority groups should be improved. Previous studies have shown that primary prevention of CMD - especially depression - is possible, but that the reach of prevention programs in the general population remains limited [92,93]. Moreover, prevention programs have been insufficiently evaluated for application among ethnic minority groups [93,94]. In terms of secondary prevention, more should be done to support GPs in terms of recognition, diagnosis, and treatment of CMD among ethnic minority patients, especially patients with a Turkish or Moroccan background. That is, Turkish and Moroccan individuals are known to be frequent visitors of general practice, but it was suggested that Moroccan subjects with a CMD are less inclined to visit a primary care professional for mental health problems in the first place [95]. This would decrease the chance that mental health problems are discussed during a regular consultation. In addition, chapter seven provided evidence to suggest that recognition of CMD by GPs is relatively more difficult among Turkish patients [48]. In terms of supporting professionals in recognising and diagnosing CMD among ethnic minority patients, this thesis provides evidence that the K10 may be helpful for that purpose on certain conditions. As for treating CMD, peer counsellors (i.e. migrants educating migrants) have traditionally had an important role in that process [94,96]. Yet, despite various positive evaluations of peer counselling in improving health care accessibility and quality in the past, this type of services is still not structurally financed [6,68,69,97]. As such, the example of peer counselling may be illustrative of a much broader critique that is often heard in the context of policy on interculturalisation, namely the lack of structural and coherent funding for measures that should improve interculturalisation in health care [63,66,98]. Policy makers should be aware of the possible negative effects that discontinuity of financial resources may have on quality of care.
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