Mental health problems in undocumented and documented migrants: a survey study

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Abstract

Background. Undocumented migrants (UM) frequently report mental health problems. It is unknown to what extent these migrants seek help for these problems in general practice and how these issues are explored, discussed, registered and treated by GPs.

Objective. To gain insight in the registration and treatment of mental health problems in general practice of UM compared to documented migrants (DM).

Methods. A survey study of general practice patient records of UM and DM in nine general practices in the Netherlands. Consultation rates, registration of mental health problems, prescription of psychotropic medication and referrals to mental health care institutions of UM and DM patients were compared.

Results. A total of 541 migrants were included (325 UM and 216 DM). UM consulted a GP significantly less than DM (3.1 versus 4.9 times per year). Only 20.6% of the UM had at least one mental health problem diagnosis registered compared to 44.0% of the DM. In both groups, ~10% mentioned at least one main mental health complaint during the consultation that was not coded in the record. No significant differences were found in the prescription of psychotropic medication between the two groups. UM were referred less to mental health care institutions but more often to psychiatrists than to psychologists.

Conclusion. UM had less consultations with their GP, and in these consultations, less mental health problems were registered. UM were referred less to psychologists but more often to psychiatrists. GPs are advised to explore and register mental health problems more actively in UM.

Key words: General practice, health records, illegal migrants, mental health, migrants and transients, personal survey.

Introduction

In the European Union, between 2.8 and 6 million people do not possess a legal residence permit for their country of residence (1). These so called undocumented migrants (UM) include visa ‘overstayers’, rejected asylum seekers and individuals who have entered a country illegally (2). In the Netherlands, the number of UM from non-European countries is estimated to be between 60,000 and 120,000 and from European countries between 12,000 and 70,000. The largest group of UM in the Netherlands consists of men under 40 years of age originating from Africa, Asia and Eastern Europe; between 11% and 33% of these UM are rejected asylum seekers (3). Many of them live in difficult circumstances, characterized by difficult working and living conditions (4). Detailed information about their socio-economic situation is difficult to get, due to the large variety in UM characteristics and their illegal status (3). But in general, their socio-economic status is low (4).
In the Netherlands, UM have no free access to social advisors, except to advisors from non-governmental organizations. UM have to pay for all health services, and when they are not able to pay, physicians are obliged to provide all necessary medical care. The costs of this care can be reimbursed by a special fund installed by the government (5,6).

GPs are the main health care providers, and they can reimburse 80% of the consultation fee of UM (5,6). UM receive usual care by GPs, and this includes mental health care. All this care is based on available evidence-based guidelines (7). After referral, UM have access to all secondary care services, including mental health care services. Psychiatrists in mental health care institutions receive 100% reimbursement, but psychologists are not reimbursed at all. UM also have access to pharmaceutical care, including psycho-farmaca but have to pay a fee of 5 euro for every prescription (8). Pharmacists receive 100% reimbursement as well (8).

UM bring problems from their country of origin with them—including their (medical) life history and legal, political, financial and cultural issues. It is likely that these problems contribute to the uncertainty of their future and will lead to high prevalences of mental health problems.

Several studies have confirmed that mental distress is prevalent among UM (4,9,10). From this, it can be inferred that access to professional care for mental health is a priority for UM. However, it is unclear to what extent it is possible to respond to these needs: their illegal status in society is in itself an important barrier to access care. And culture and language are likely additional barriers to present mental health problems, when access to health care has been realized. GPs in the Netherlands play a coordinating role in the provision of health care, including the recognition and treatment of mental health problems (11,12). Provisions have been made for UM to contact general practice, in case they need health care (5) and there are some data available of their actual use of primary care: mental health problems are frequently presented (13), but the prevalence of psychiatric diagnoses and prescribing rates of sedatives were low (14). For that reason, we explored the mental health problems of UM recorded in general practice.

Insight in the care of mental health problems of UM is of growing importance, given the impact of immigration, and its related health problems, for the countries of Europe. This issue has grown in importance in the light of ongoing changes in immigrants’ and health care policies in different countries in Europe.

In summary, there seems to be a gap between the high occurrence of mental health problems among UM and their actual registration rate in patient files in the Netherlands. This study aims to give a more detailed insight in the diagnosis and treatment of mental health problems of UM by GPs, using migrants with a documentary status as a reference.

Method

Cohort selection

People without a legal status in society are difficult to identify under the prevailing social-political circumstances. To identify general practices with UM on their practice list, we used a snowball method. We contacted non-governmental organizations as well as general practices directly: these practices were involved in the care of UM and/or located in areas where many UM were residing (Amsterdam, Utrecht, the Hague, Rotterdam, Leiden, Breda, Nijmegen and Deventer). Using the procedure described above, we approached general practices for participation in the study, with a letter with information of the research project.

Selection of UM

UM were identified in two ways: either through the electronic medical records in practices that had listed UM as such in their system or through their health insurance status. In the Netherlands, health insurance is compulsory for all citizens and the insurance company is registered in the patients’ files (15). UM however are not entitled to health insurance. In practices, patient files of uninsured patients were identified.

Identified patients’ files were included, when (i) the patient was a migrant from outside the European Union, (ii) there had been at least one contact with the GP during 2010 and (iii) the patient was ≥18 years of age. Migrants whose status changed from undocumented to documented or vice versa during 2010 and 2011 were excluded from analysis. We searched their medical records for mental health problems during a time frame of the 2 years preceding the study (1 January 2010 to 31 December 2011). Of each patient, gender, age and geographical region of origin was established. If geographical region was not registered in the practice file, GPs and general practice assistants were asked to identify the region of origin of the patient. If they did not know, the region of origin was marked as unknown. No migrants from the European Union were included, because the group of UM was, after the expansion of the EU in 2004 and 2007, rather small and they could not be identified as undocumented as most had a legal health insurance (16).

Control group

On basis of the provided list of UM, a list of documented migrant patients (DM) was composed matched for age and gender, consisting of patients who visited the practice at least once. The patient files were checked for the region of origin. If the background was Western or unknown, the patient was excluded and the next patient file was selected till a patient was found of migrant origin whose region matched with the region of origin...
of the UM. If no match was found, the first non-western immigrant with known region of origin was selected.

**Data collection**

We extracted and anonymized data from patients’ records in the general practices on: date of birth, gender, country of origin (if available), date of first consultation, date of registration in the practice, number of contacts in 2010 and 2011 (consultations, telephone consultations, home visits, e-mail consultations), referrals for mental health care (to psychiatrists, psychologists or other mental counselors), prescriptions and recorded diagnoses. Most diagnoses were coded by the GPs, following the International Classification of Primary Care (ICPC) and we specifically looked for P (psychological)-ICPC codes (17). If the GP had not added an ICPC code, the researcher coded the described diagnosis into an ICPC code. All diagnoses in the problem list were included in the analysis. Main mental health complaints noted in the record but not recorded as a psychological problem were registered as ‘tags’ and analyzed separately.

Medication was registered by the researcher following the Anatomical Therapeutic Chemical Classification System (ATC) and all prescribed psychotropics were registered (18).

**Data analysis**

Data were analyzed using SPSS 16.0. Chi-square tests were used to compare the patient characteristics between the two groups. Time at risk, average number of consultations and average amount of medications were compared between the two groups using independent samples T-test. For migrants who had been in contact with their GP for the very first time in 2010, the date of registration in the practice was listed, so the number of consultations per month could be corrected for the period patients were registered (time at risk).

The following ICPC-P codes were clustered for further analysis: Sleeping disorders (ICPC code P06), addiction problems (ICPC code P15, P17–P19), psychotic disorders including bipolar disorders (P72–P73, P98), depression (P03, P76), anxiety problems (P01, P74) and Posttraumatic Stress Disorder (PTSD) (P02.01).

We used a logistic regression model to analyze whether having a P-code (one or more P-codes registered) was influenced by co-variates resident status, gender, age group, region of origin and time at risk.

**Results**

Of the general practices approached, nine responded that they provided care for UM and were able and willing to participate.

These practices were located in Amsterdam, The Hague, Rotterdam, Utrecht, Nijmegen and Leiden. One practice (GP7) was a solo-practice, whereas the others were group practices consisting of two (GP3, GP4, GP6, GP9), four (GP1, GP5, GP8), and eight GPs (GP2). One practice was a leading academic practice with a regional role in the care of UM (GP1).

A total of 325 UM were included, and it was possible to identify 216 DM, matched for gender, age and region of origin (Table 1).

Most UM were men aged 31–50 years and main regions of origin were Sub-Saharan Africa and Turkey/Middle East/Northern Africa. The group of UM included more men and more patients from Sub-Saharan Africa, Middle and South America and of unknown origin.

Corrected for the shorter period of time registered, UM contacted their GP significantly less often than DM (monthly 0.26 versus 0.41, yearly 3.1 versus 4.9 times a year) (Table 2).

<table>
<thead>
<tr>
<th>City</th>
<th>Number of UM included n (% of total study population undocumented)</th>
<th>Number of DM included n (% of total study population documented)</th>
<th>Total n (% of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP1 Nijmegen</td>
<td>63 (19.4)</td>
<td>58 (26.9)</td>
<td>121 (22.4)</td>
</tr>
<tr>
<td>GP2 Utrecht</td>
<td>29 (8.9)</td>
<td>27 (12.5)</td>
<td>56 (10.4)</td>
</tr>
<tr>
<td>GP3 Amsterdam</td>
<td>63 (19.4)</td>
<td>47 (21.8)</td>
<td>110 (20.3)</td>
</tr>
<tr>
<td>GP4 Rotterdam</td>
<td>31 (9.5)</td>
<td>33 (15.3)</td>
<td>64 (11.8)</td>
</tr>
<tr>
<td>GP5 Utrecht</td>
<td>3 (0.9)</td>
<td>5 (2.3)</td>
<td>8 (1.5)</td>
</tr>
<tr>
<td>GP6 Leiden</td>
<td>35 (10.8)</td>
<td>17 (7.9)</td>
<td>52 (9.6)</td>
</tr>
<tr>
<td>GP7 Amsterdam</td>
<td>26 (8.0)</td>
<td>0 (0)</td>
<td>26 (4.8)</td>
</tr>
<tr>
<td>GP8 Den Haag</td>
<td>60 (18.5)</td>
<td>15 (6.9)</td>
<td>75 (13.9)</td>
</tr>
<tr>
<td>GP9 Amsterdam</td>
<td>15 (4.6)</td>
<td>14 (6.5)</td>
<td>29 (5.4)</td>
</tr>
<tr>
<td>Total</td>
<td>325 (100.0)</td>
<td>216 (100.0)</td>
<td>541 (100.0)</td>
</tr>
</tbody>
</table>
Mental health problems diagnosed

Of all mental health diagnoses registered in the patient records, 12% had not been ICPC-coded by the GP and were coded by the researcher for further analysis. Twenty-one per cent of the UM had at least one mental health problem registered in comparison to 44% of the documented control group.

The most common mental health problems encountered were: sleeping disorders, addiction and psychotic disorders, anxiety, depression and PTSD (1.5%, 3.1%, 1.8%, 3.1%, 8.0% and 3.4% of UM, respectively). These diagnoses had been less often encountered than in DM (Table 3).

Tags

Eleven per cent of UM had main psychological complaints mentioned in the records (of consultations) that were not recorded as mental health problem diagnoses by the GP. For DM, this percentage was 8.3% (Table 3).

Sub-analysis: mental health diagnoses

By using a logistic regression model, we found that when a patient was registered in the practice for a longer period of time (time at risk), the patient was more likely to have a mental health problem registered. Gender and age did not make a statistically significant difference in the chance to have been coded with at least one P-diagnosis. Migrants from Middle and South America were significantly less often diagnosed with a mental health diagnosis (Table 4).

Referrals

Of the UM, 8% was referred to mental health care services—for DM, this was 11.2%. Of the undocumented group, 0.3% was referred to a psychologist, 2.5% to a psychiatrist and 5.2% to a mental health care institution, in comparison with 5.1%, 0.5% and 5.6% of the DM.
Prescriptions

The average number of prescriptions per patient in 2010 and 2011 was 3.8 for UM and 5.3 for DM. No significant difference was found in the prescription of benzodiazepines, antidepressants or antipsychotics between UM and DM (Table 5).

Discussion

Summary of main findings

This study analyzed GPs’ diagnoses and treatment of mental health problems in UM and compared these with migrants of the same age, gender and region of origin, but who had a legal status in Dutch society. UM can be characterized as a group that is largely invisible in their social engagement (19) but with substantial (mental) health needs (4,9,10). The findings of this study should be seen against this background.

We have opted for an explorative retrospective study design because we were facing a number of uncertainties at the start of the study: we did not know if GPs recorded the problems of UM, if UM accepted recording of their problems in a patient record and if GPs were willing to give permission to access the data of their undocumented patients. That was also the reason to focus on mental health problems alone. We recruited practices from areas in the country where it was known that many UM reside.

A first finding was that it was possible to access data of primary care for UM, through a carefully planned study design and through collaboration with practitioners and organizations who were focused on UM. This resulted in data of >300 UM—to the best of our knowledge, the largest survey of mental health care of this group. In addition, it was possible to relate the findings of this group to mental health care of otherwise highly comparable individuals with a legal status in society.

Comparison with existing literature

It is known that UM perceive their own health as (very) poor and mention many mental health problems. A survey among 1100 UM in Europe showed that almost a third of undocumented men and a quarter of undocumented women perceived their health as bad or very bad; 16% spontaneously reported psychological problems like anxiety, stress or depression (4). A descriptive study of 100 female UM in the Netherlands showed that almost two-thirds reported their health as poor, and psychological problems like anxiety, sleeplessness and agitation were mentioned by >70% of the women, but often not spontaneously (9). Three-quarter of a group of 20 male UM in the Netherlands reported their health as bad: mental health problems like sleeping problems and anxiety were mentioned by >80% of the respondents (10).

GPs are highly aware of these problems, and this comes forward in this study: GPs and their practices are actively involved in the care of (mental) health problems of UM: in diagnosis, counselling, prescription of psycho-pharmaca and referral to

Table 4. Risk of having at least 1 mental health diagnosis recorded (2010–2011)

<table>
<thead>
<tr>
<th>Odds ratio (95% confidence intervals)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident status: DM (UM reference)</td>
<td>2.65 (1.69–4.15)</td>
</tr>
<tr>
<td>Gender: male (Female reference)</td>
<td>0.92 (0.58–1.47)</td>
</tr>
<tr>
<td>Age group</td>
<td></td>
</tr>
<tr>
<td>18–30 years</td>
<td>Reference</td>
</tr>
<tr>
<td>31–50 years</td>
<td>1.01 (0.59–1.72)</td>
</tr>
<tr>
<td>&gt;50 years</td>
<td>0.90 (0.46–1.74)</td>
</tr>
<tr>
<td>Time at risk</td>
<td>1.17 (1.09–1.27)</td>
</tr>
<tr>
<td>General practice</td>
<td></td>
</tr>
<tr>
<td>GP (1)</td>
<td>Reference</td>
</tr>
<tr>
<td>GP (2)</td>
<td>1.04 (0.48–2.22)</td>
</tr>
<tr>
<td>GP (3)</td>
<td>0.37 (0.17–0.81)</td>
</tr>
<tr>
<td>GP (4)</td>
<td>2.12 (1.03–4.34)</td>
</tr>
<tr>
<td>GP (5)</td>
<td>0.41 (0.07–2.31)</td>
</tr>
<tr>
<td>GP(6)</td>
<td>0.59 (0.26–1.37)</td>
</tr>
<tr>
<td>GP (7)</td>
<td>4.29 (0.35–52.93)</td>
</tr>
<tr>
<td>GP (8)</td>
<td>1.26 (0.57–2.76)</td>
</tr>
<tr>
<td>GP(9)</td>
<td>0.49 (0.17–1.45)</td>
</tr>
<tr>
<td>Region of origin</td>
<td></td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>Reference</td>
</tr>
<tr>
<td>Turkey/Middle East/Northern Africa</td>
<td>0.88 (0.47–1.65)</td>
</tr>
<tr>
<td>Afghanistan/Iran/Iraq/Pakistan</td>
<td>1.90 (0.79–4.58)</td>
</tr>
<tr>
<td>Eastern Europe (non EU/former Union of Soviet Socialist Republics/former Yugoslavia)</td>
<td>0.92 (0.37–2.33)</td>
</tr>
<tr>
<td>Asia</td>
<td>0.62 (0.21–1.86)</td>
</tr>
<tr>
<td>Middle and South America</td>
<td>0.32 (0.12–0.86)</td>
</tr>
<tr>
<td>Surinam</td>
<td>2.42 (0.50–11.58)</td>
</tr>
</tbody>
</table>

Table 5. Number of total prescriptions and number of prescriptions of psychotropics UM and DM (2010–2011)

<table>
<thead>
<tr>
<th></th>
<th>Undocumented</th>
<th>Documented</th>
<th>P (&lt;0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of prescriptions per patient (SD)</td>
<td>Total 3.78 (±3.99)</td>
<td>5.31 (±4.80)</td>
<td>0.00* (T-test)</td>
</tr>
<tr>
<td>Average number of prescriptions per patient per month (time at risk) (SD)</td>
<td>Total 0.17 (±0.18)</td>
<td>0.23 (±0.21)</td>
<td>0.00* (T-test)</td>
</tr>
<tr>
<td>At least one benzodiazepine, n (%)</td>
<td>29 (8.9%)</td>
<td>15 (6.9%)</td>
<td>0.23</td>
</tr>
<tr>
<td>At least one antidepressant, n (%)</td>
<td>36 (11.1%)</td>
<td>19 (8.8%)</td>
<td>0.34</td>
</tr>
<tr>
<td>At least one antipsychotic, n (%)</td>
<td>13 (4.0%)</td>
<td>13 (6.0%)</td>
<td>0.28</td>
</tr>
</tbody>
</table>

* Significant (P < 0.05).
specialized services (13). These interventions should be seen against the major restrictions individuals without a legal status encounter in their daily functioning. Yet, the frequency of mental health problems is lower, when comparing their care with that of migrants with a legal status. And in comparison to the overall Dutch population, this difference is even bigger when correcting for the sex and age composition (28%) (20).

Intuitively one would assume that the mental health needs of UM are high, as they live in difficult circumstances. Some studies have found this (4,9,10), while others confirmed our lower levels (14). There seems to be a gap between the assumed high mental health needs of UM and the low actual recording of these mental health problems in general practice. Possible explanations for this gap are varied and may concern the health care system itself (access and finance), the UM (language and cultural factors) and the providers (time and their ability to cope with different cultural backgrounds) (4–6,9,21,22).

All these factors have a negative effect on the provision of health care in general, but especially on mental health. The taboo and stigma around mental health problems will play a role for this group, while UM may have other priorities when accessing care (burden of physical and social problems related to their undocumented refugee status) (4,6,9). And UM may be unaware that the GP can be approached for mental illnesses as well. The establishment of a relation of trust is an important precondition for effective health care and this plays in particular around precarious issues as mental health problems (23). And the status of UM will hamper in particular the establishment of a relation of trust with a GP and other primary care professionals. In UM who had consulted their GP more often, more mental health problems had been identified and treated. This finding may point to the importance of continuity of care for UM, and the fact that it is possible for GPs to establish a professional relation with UM.

Our study showed that UM were referred less to mental health care, but more often to psychiatrists. As referral patterns to mental health care might be influenced by other confounding factors (financial, organisational), we have to be careful to draw conclusions on this (24,25). One explanation might be that their mental health problems, when registered by the GP, were more severe, another might be the fact that consultations of UM with psychiatrists can be reimbursed whereas consultations of psychologists often cannot (5).

Another finding was that prescribing of benzodiazepines and antidepressants was the most common intervention and higher than in another Dutch primary care study of UM (14). A possible explanation for this could be that the UM in our study received more prescriptions in general (3.8 versus 2.7). An explanation for the high prescription rate of psychotropics in our study could be that because of the status of UM, prescribing of psychotropics seems the best possible treatment option.

**Strengths and limitations of the study**

A strength of the study was that we were able to gain access to detailed patient data of UM in a variety of different practices in different parts of the Netherlands. Therefore, we were able to cover data of mental health care of a representative group of UM in the Netherlands with all main sub-groups involved (3). By our research methodology, we were able to investigate a variety of record keeping procedures and systems used in primary care, including files on paper. This was a valuable way of limiting the loss of data.

Due to the chosen research methodology, this explorative study has some limitations as well. As the study was performed in a selected group of GP practices with relatively large groups of UM on their practice list, it is as yet unclear how representative these data are for UM in Dutch general practice.

As UM are a very dynamic group of patients, as their region of origin may rapidly fluctuate, it is as yet unclear how representative these data are for other settings and for the near future (3). On the other hand, we are confident that we accessed information that reflected the generic UM status.

We also realize that there are UM who do not have any contacts with a GP at all (9,10). It would be important to gain insight in the (mental) health status and their access to care, of this group.

**Implications for future research and clinical practice**

This analysis of care for mental health problems of UM leads to a number of conclusions. As we were able to gain access to detailed data of UM, we can conclude that a prospective study is well applicable. Therefore, now we recommend this for future research.

UM and GPs and their practices are engaged in active interactions around mental health problems. However, the large needs of this group are difficult to respond to, given the restrictions that the UM status imposes. Further qualitative research on reasons for under-disclosure and under-recording is highly recommended, in order to develop best practices and to create facilities for optimal response to the needs of this group. As this will require an intimate understanding of the needs, expectations and cognitions of UM towards (mental) health problems and the role of primary care, UM should be involved as stakeholders in this research.

As long as the gap between the assumed high mental health needs and the low recording is not clarified, we suggest GPs to explore and register mental health problems more actively in UM.

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Declaration

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Ethical approval: this project was submitted for ethical approval and was waved by the Ethical committee of the Radboudumc.

Conflict of interest: none.

References


