Inequalities in mental health care and social services utilisation by immigrant women

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Background: The basic assumption of public health policy for immigrants is that they ought to have equal access to health services compared to other population groups in Dutch society. However, little research is done on the actual use of mental health services by immigrants and literature seems to indicate inequalities in services utilisation by immigrant women. Methods: This study was conducted in Amsterdam, The Netherlands. Data on service utilisation were drawn from patient registers and came from care providers who were asked to keep up registration for some time to count the number of immigrant women referred to and in treatment. Results: Surinamese, Antillean, Turkish and Moroccan women made considerably less use of mental health care services than native-born women. On the other hand, immigrant women more frequently used social work facilities and women crisis intervention centres. Overall, they consulted the latter organizations nearly 1.5 times more frequently than mental health care services. The differences in service utilisation between the four immigrant groups are also discussed. Conclusions: This study explores the reasons for the ethnic differences in service utilisation. It argues that cultural and supply factors are largely responsible for the ethnic differences in use of mental health services. The differential use of social services is mainly ascribed to the socioeconomic status of the women concerned. The results imply that a care policy may improve the accessibility of mental health services for immigrant women. The most promising measure is by employing more ethnic and bilingual care providers.

Key words: ethnicity, mental health care, socioeconomic status, utilisation, women

A major objective of mental health policy in The Netherlands is equal accessibility to mental health services for immigrants in comparison to other groups of the population. However, in The Netherlands little research has been done on the actual use of mental health services by immigrants. In the past 15 years, three national and two regional studies have been conducted and the results of these studies are not conclusive. Differences in design and scope complicate the interpretation of the results. Four of the studies covered only access to one type of mental health service: three psychiatric hospitals and one Regional Institution of Ambulatory Mental Health Care (RIAMHC). The fifth study did not distinguish between male and female immigrants, despite indications for sex differences in the use of health services. The study presented here extends previous research in two ways. Firstly, it covers almost all mental health services as well as social services used by inhabitants of Amsterdam, a sizeable city with a large and growing population of immigrants. Secondly, it focuses on the service use of immigrant women. Specific attention to women is rare, despite the recent growth of research on the mental health needs of subpopulations and the knowledge of sex differences in the use of mental health services. These differences are relatively small in the use of residential mental health services, but they are considerably larger in the use of non-residential mental health services and the number of visits to a general practitioner about mental health-related problems. Moreover, sex differences in the use of mental health services can differ between ethnic groups. This study was conducted in Amsterdam during 1994–1995. The main objective was to investigate differences in use of mental health services and social services by immigrant (Surinamese, Antilleans, Turks and Moroccans) and native-born women.

BACKGROUND INFORMATION

Surinamese, Antilleans, Turks and Moroccans

Surinamese, Antilleans, Turks and Moroccans are the four largest immigrant groups in The Netherlands. More than 40% of them live in the four largest cities: Amsterdam, Rotterdam, Utrecht and The Hague. Turks, Moroccans and, to a lesser extent, Surinamese and Antilleans are over-represented in the lower socioeconomic status groups. They are on average less well educated, are often unemployed and more frequently live in poorer-quality housing in more deprived neighbourhoods than most native borns. A major factor responsible for the unfavourable social position of immigrants is a poor command of the Dutch language. The vast majority of Turks
and Moroccans have difficulties with the Dutch language. Among Surinamese and Antilleans, less than 20% have difficulties with Dutch.15

Mental health care and social services in The Netherlands
Mental health care in The Netherlands covers a wide range of services to which people with psychiatric problems can apply for help. All psychiatric and social help is publicly financed and obtaining help is usually free of charge. Dutch mental health care is customarily divided into three sectors: residential, semi-residential and non-residential. Residential services include both psychiatric hospitals and psychiatric departments of general and university hospitals. Semi-residential services include the Regional Institutions for Sheltered Living and psychiatric day-care. Among the non-residential services are the RIAMHCs, the out-patient clinics of psychiatric hospitals, psychiatric departments of general and university hospitals and private psychiatrists and psychotherapists. Residential social services include the women crisis intervention centres, which provide short-term accommodation for physically or sexually abused women and their children. Women in trouble because of pregnancy or the raising of their children may also be included in the target group of these centres. The activities of general social work consist of (non-residential) psychosocial treatment and practical support to people with social problems.

Mental health care and social services in Amsterdam
Table I contains quantitative data on Amsterdam services in size (number of beds/places) and number of admissions/contacts in 1993.

METHODS
Data on the use of residential and semi-residential mental health services were drawn from the Amsterdam Psychiatric Case Register. Data on the use of social services came from the registers of the Medelpunt Vrouwenopvang Amsterdam (Women Crisis Intervention Centres Amsterdam) and the Stichting Ondersteuning Gezondheidszorg en Maatschappelijke dienstverlening (Foundation in Support of Health Care and Social Services). The data concern the number of incident and prevalent female cases by ethnic group in 1993. In all three registers, ethnicity is determined on the basis of the patient’s country of birth and their parents’ country of birth. This is the best method, which is also used in the Amsterdam population register.

In non-residential mental health care, the registration of ethnicity of patients is not compulsory. Therefore, we could only use the registers of three RIAMHCs for this study. Within the other two RIAMHCs and the eight psychiatric out-patient clinics in Amsterdam, care providers were asked to keep up patient registration for a time. One RIAMHC recorded the ethnicity of the referred female patients from September to November 1993 (incidence). Both RIAMHCs and all out-patient clinics counted the average number of adult women in treatment by ethnicity during 1 week in October/November 1993 (prevalence).

Service use is related to census data from the Amsterdam Bureau voor Onderzoek en Statistiek (Amsterdam Bureau for Research and Statistics)16. More details about the materials and methods used can be found in Ten Have et al.17

RESULTS
Residential and semi-residential mental health services
Immigrant women made considerably less use of residential and semi-residential mental health services than native-born women. In 1993 the percentage of Surinamese, Antillean, Turkish and Moroccan women who were admitted to these services was 8.5% of all admitted women. Their proportion in the female population of Amsterdam was 18.4%. In total, 132 admissions of immigrant women were counted. Immigrant women were hardly referred to institutions for sheltered living: in 1993 this was done only five times. Furthermore, immigrant women spent less time in treatment than native-born women.17 There were major differences in service utilisation between the four immigrant groups (figure 1). Turkish women made considerably less use of the services: on a yearly basis not even 1 per 1,000 Turkish women living in Amsterdam was admitted to a (semi-) residential mental health service. The annual incidence rate of Surinamese, Antillean and Moroccan women who made use of these services was on average 3 per 1,000. Compared to native-born women, all four groups of immigrant women together had approximately three times less probability of being admitted to a (semi-) residential mental health service in Amsterdam.

Non-residential mental health services
Of all women who contacted the RIAMHCs in 1993, 18% were from Surinam, The Netherlands Antilles, Turkey and Morocco; this is in line with their proportion in the materials and methods used can be found in Ten Have et al.17

Table 1: Capacity and patient admissions/contacts (men and women) referred to mental health care and social services in Amsterdam, 1993

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number of Institutions</th>
<th>Beds/places</th>
<th>Admissions/contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>General psychiatric hospitals</td>
<td>3</td>
<td>1,418</td>
<td>1,978</td>
</tr>
<tr>
<td>Psychiatric departments of hospitals</td>
<td>2</td>
<td>160</td>
<td>913</td>
</tr>
<tr>
<td>Institutions for sheltered living</td>
<td>2</td>
<td>310</td>
<td>161</td>
</tr>
<tr>
<td>Institutions for ambulatory care</td>
<td>5</td>
<td>na</td>
<td>10,215</td>
</tr>
<tr>
<td>Out-patient clinics</td>
<td>8</td>
<td>na</td>
<td>6,581</td>
</tr>
<tr>
<td>Private psychiatrists and private psychotherapists</td>
<td>260</td>
<td>na</td>
<td>nk</td>
</tr>
<tr>
<td>Women crisis intervention centres</td>
<td>5</td>
<td>425</td>
<td>725</td>
</tr>
<tr>
<td>General social work</td>
<td>11</td>
<td>na</td>
<td>10,747</td>
</tr>
</tbody>
</table>

nk: Not known
na: Not applicable

The private psychiatrists and psychotherapists are counted in numbers of care providers.
Utilisation of care by immigrant women

Figure 1 The proportion of immigrant and native-born women who made use of residential and semi-residential mental health services in Amsterdam during 1993

Figure 2 The proportion of immigrant and native-born women who made use of RIAMHCs in Amsterdam during 1993

Figure 3 The proportion of immigrant and native-born women who made use of women crisis intervention centres in Amsterdam during 1993

Figure 4 The proportion of immigrant and native-born women who made use of residential mental health care services in Amsterdam during 1993

Figure 5 The proportion of immigrant and native-born women who made use of non-residential mental health care services in Amsterdam during 1993

the female population of Amsterdam (18.4%). Altogether it concerned 1,078 immigrant women. Moreover, immigrant women had a relatively short treatment duration compared to native-born women. There were major differences in service utilisation between the four immigrant groups (figure 2). Moroccan women made the least use of RIAMHCs: in 1993, 19 per 1,000 Moroccan women contacted these services. The annual incidence rate of Turkish women who made use of RIAMHCs was 23 per 1,000 and the incidence rate of Surinamese, Antillean and native-born women was, on average, 27 per 1,000 in 1993.

At the psychiatric out-patient clinics, immigrant women were strongly underrepresented. The percentage of Surinamese, Antillean, Turkish and Moroccan women under treatment at these clinics at the end of 1993 was 9.6%; that is 7.9 per 1,000 immigrant women. Altogether it concerned 356 immigrant women. Almost two-thirds (65%) of these women were under treatment in four clinics, which were responsible for approximately 30% of the production of all out-patient clinics in Amsterdam. Not surprisingly, these four clinics were specialized in serving immigrants.

Residential social services
Immigrant women made considerably more use of residential social services than native-born women. In 1993, 28.7% of all admitted women to crisis intervention centres were from Surinam, The Netherlands Antilles, Turkey and Morocco; more than 10% of what might be expected based on their proportion in the female population of Amsterdam (18.4%). There were 208 admissions of immigrant women; that is approximately 1.5 times their admission rate to a (semi-) residential mental health care service in Amsterdam.

Almost all groups of immigrant women frequently used women crisis intervention centres (figure 3). As a group, Turkish women made less use of these services: in 1993 not even 2 per 1,000 Turkish women in Amsterdam were admitted to a women crisis intervention centre. However, the annual incidence rate of Moroccan women was 8 per 1,000; that is approximately three times the incidence rate of native-born women. Prevalence data showed on average a longer stay of immigrant women compared to native-born women.

Non-residential social services
Immigrant women were also frequent users of social work facilities. In 1993, 30.2% of all women who consulted these services were immigrants. Altogether it concerned 2,378 immigrant women. That is more than twice the number of women who contacted the RIAMHCs, so social work is a very important care provider for these women.

Compared to native-born women, the four groups of immigrant women had a 1.5 times higher probability of being referred to an institution of social work. The incidence rate of Surinamese and Antillean women was the highest; in 1993, 59 per 1,000 and 53 per 1,000, respectively. The incidence rate of native-born women was much lower: in 1993, 32 per 1,000 (figure 4).

A summary of the findings is shown in table 2. From this we can see that 5.8% (i.e. 75) of all women admitted to a general psychiatric hospital or psychiatric department in
1993 were from Surinam. From the last row it can be seen that their proportion in the female population of Amsterdam was much higher: 9.5%.

DISCUSSION

This study focused on two non-residential mental health services: RIAMHCs and outpatient clinics. However, private psychiatrists and psychotherapists also belong to this sector. There are, at best, indications that in Amsterdam immigrant women make considerably less use of private services than native-born women. The private care providers consulted by immigrant women are usually specialized in the treatment of immigrants and have a personal history of migration. It is not known how many immigrant women these specialists treated in 1993. Because reliable data were lacking, our study did not analyse sociodemographic characteristics. However, these might explain some of the ethnic differences in service utilisation. For example, some age groups are more likely to seek mental health care than others. Since immigrant women are on average younger than native-born women, age can be a confounding variable. They also differ in household composition and employment status, which can both influence their use of mental health care and social services.

<table>
<thead>
<tr>
<th>Table 2 Admissions to and contacts with mental health services and social services of women in Amsterdam. By ethnic group and age 18–64 years, 1993 (numbers and percentages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Residential</td>
</tr>
<tr>
<td>Clinical admission</td>
</tr>
<tr>
<td>1,288 100 75 5.8 13 1.0 4 0.3 29 2.3 121 9.4 1,022 79.3 145 11.3</td>
</tr>
<tr>
<td>Semi-residential</td>
</tr>
<tr>
<td>Psychiatric daycare</td>
</tr>
<tr>
<td>162 100 4 2.5 0 0.0 1 0.6 1 0.6 6 3.7 152 93.8 4 2.5</td>
</tr>
<tr>
<td>Sheltered living</td>
</tr>
<tr>
<td>97 100 3 3.1 0 0.0 1 1.0 1 1.0 5 5.2 90 92.8 2 2.1</td>
</tr>
<tr>
<td>Non-residential</td>
</tr>
<tr>
<td>Ambulatory care</td>
</tr>
<tr>
<td>5,988 100 594 9.9 106 1.8 181 3.0 197 3.3 1,078 18.0 4,074 68.0 836 14.0</td>
</tr>
<tr>
<td>Outpatient clinic</td>
</tr>
<tr>
<td>3,724 100 nk nk nk nk 356 9.6 3,182 85.4 186 5.0</td>
</tr>
<tr>
<td>Social Services</td>
</tr>
<tr>
<td>Residential</td>
</tr>
<tr>
<td>Crisis intervention centre</td>
</tr>
<tr>
<td>725 100 93 12.8 22 3.0 11 1.5 82 4.2 208 28.7 401 55.3 116 16.0</td>
</tr>
<tr>
<td>Non-residential</td>
</tr>
<tr>
<td>General social work</td>
</tr>
<tr>
<td>7,863 100 1,371 17.4 196 2.5 339 4.3 472 6.0 2,378 30.2 4,734 60.2 751 9.6</td>
</tr>
<tr>
<td>Population figures</td>
</tr>
<tr>
<td>243,382 100 23,124 9.5 3,674 1.5 7,826 3.2 10,256 4.2 44,880 18.4 147,641 60.7 50,861 20.9</td>
</tr>
</tbody>
</table>

nk: not known
a: The Surinamese, Antillians, Turkish and Moroccan women together
b: Estimation
c: Estimation
d: Clientsystems
patient mental health users, although they were probably not over-represented among the higher socioeconomic classes. Other factors are apparently responsible for the ethnic differences in the use of residential mental health services, such as sociodemographic differences (for example, living conditions), cultural differences, differences in the behaviour of gatekeepers (GPs), particularly practitioners assigning diagnostic labels and referring patients and differences in the accessibility of care services.

In the literature, cultural factors are most often mentioned as an explanation for the infrequent use of residential mental health services by immigrants. Authors like Mesch and Van Mens-Verhulst referred to a greater taboo on mental illness and admission to a psychiatric hospital by immigrant women, less acquaintance with the available services and less faith in the benefit of mental health care by immigrant women and more social support provided by family and friends in cases of mental illness compared to native-born women. At the same time, these authors acknowledged that differences in the accessibility of mental health services can also stem from the inability of care providers to communicate adequately with immigrant women due to language and cultural barriers. Residential and semi-residential mental health services in The Netherlands have, so far, given little priority to the care of immigrants.

In accordance with these authors, we conclude that cultural factors in particular and, to a lesser extent, supply factors underlie the less frequent use of residential mental health services by immigrant women. It is unlikely that this use is related to fewer psychiatric disorders of immigrant women compared to native-born women, because persons with a lower socioeconomic status in particular, among which are relatively many immigrants, have a higher risk of psychiatric disorders.

Use of non-residential mental health services
RIAMHCs are the most important mental health care providers for immigrant women. This was certainly not the case 10 years ago. One important explanation for this change is the relatively greater effort which the RIAMHCs in the larger cities of The Netherlands have made to make care more accessible to immigrants. In Amsterdam the activities range from flexible office hours particularly for immigrants, to simplifying the intake procedure, creating more short-term treatment possibilities and educating Turks and Moroccans to familiarize them with the care provided by RIAMHCs. These and other efforts have been fairly successful in adapting care to the needs and the expectations of immigrant patients. However, this still occurs too rarely and is not always integrated into the organization structure, but it has resulted in almost equal service use between immigrant and native-born women. Under the assumption that these immigrant women are on average in a less advantageous socioeconomic situation, this result is not consistent with what might be expected from literature on socioeconomic status. International studies have shown that people of lower socioeconomic status are less likely to use out-patient mental health services and national research has demonstrated that this category made relatively less use of RIAMHCs, but had a higher probability of being referred to psychiatric out-patient clinics. On the other hand, relatively more persons of higher socioeconomic status make use of RIAMHCs and private physicians.

Our results show different patterns of utilisation: immigrant women contacted the RIAMHCs quite frequently but they were hardly seen at psychiatric out-patient clinics. However, Dieperink and Wierdsma also found low visiting rates at out-patient clinics for immigrants in Rotterdam. An interesting finding of our study was a relative over-representation of immigrant women at four, rather small out-patient clinics. A closer look at these clinics revealed that their policies were especially aimed at improving the accessibility of care to immigrants and succeeded in employing a proportional amount of immigrant care providers.

At the RIAMHCs, immigrant women’s length of treatment was relatively short and in the opinions of care providers they appealed more frequently for help in crisis situations than did native-born women. This is in accordance with two other studies, which showed that patients who were referred to a RIAMHC due to a crisis situation were less well educated than patients who regularly contacted a RIAMHC.

Cultural factors and supply factors were likely to be responsible for the differences in out-patient service use between immigrant and native-born women. Padgett et al. arrived at the same conclusion when they found that the use of out-patient mental health services by immigrant women lags behind native-born women, even when sociodemographic and socioeconomic factors were controlled.

Use of social services
This study demonstrated that social services are very important care facilities for immigrant women. The everyday worries of many immigrant women explain to a large extent their intensive use of general social work, a low threshold service organization which gives concrete assistance to people with psychosocial as well as financial problems. According to care providers in Amsterdam, their higher use of women crisis intervention centres is also linked to the socioeconomic situation of the clients concerned: immigrant women, particularly Moroccan women, make more use of these services because they are less frequently economically independent than native-born women. These results are consistent with two studies, which found that persons with a lower education tended to use social services more frequently than higher educated people.

Implications
Our findings are relevant for the current policy of mental health services, particularly residential services, of increasing their accessibility for immigrant women. To improve accessibility, three measures are proposed. The first measure concerns the staffing policy of mental health
services. All mental health services should employ more ethnic and bilingual care providers, because this is an effective way of making services more 'psychologically' accessible to immigrants who consider seeking professional assistance (see e.g. De Jong and Neighbors et al.30). However, mental health services should not only aim at employing a proportional amount of immigrant care providers. They should also extend their staffing policy by training personnel in treating immigrants, to prevent the too frequently observed situation that the care of these people is the exclusive task and responsibility of care providers with an ethnic background.

The second measure concerns collaboration between mental health services and social services. A suitable means to facilitate the referral of immigrant women to residential mental health services and, consequently, lowering the threshold of these services for them is by intensifying collaboration with non-residential mental health services and social services which have more experience in the treatment of immigrant women.

A third measure we advocate is conducting patient surveys among immigrant women. Studying their needs and expectations of mental health care is not customary. However, it can give useful information in what way care can match the real needs of immigrant women better.

An important finding of our study is the variety in utilisation rates between the different groups of immigrant women. Policy-makers must be aware of these differences in (social, cultural and economic) background and services use if they want to improve the accessibility of mental health care services for immigrant women.

In the near future we foresee a diminishing of ethnic differences in the utilisation of mental health services by women. We find support for our view with Leclere et al.31 who reported a positive relationship for the US between the duration of residence in the country and the use of health services for immigrants. Changes in the supply side as well as in the demand side will promote this process. Firstly, we notice increasing efforts in matching mental health care to the needs and expectations of all groups of patients, immigrants included. Secondly, there is an ongoing integration of immigrant women in Dutch society, resulting in an greater emancipation and changing roles of these women.

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