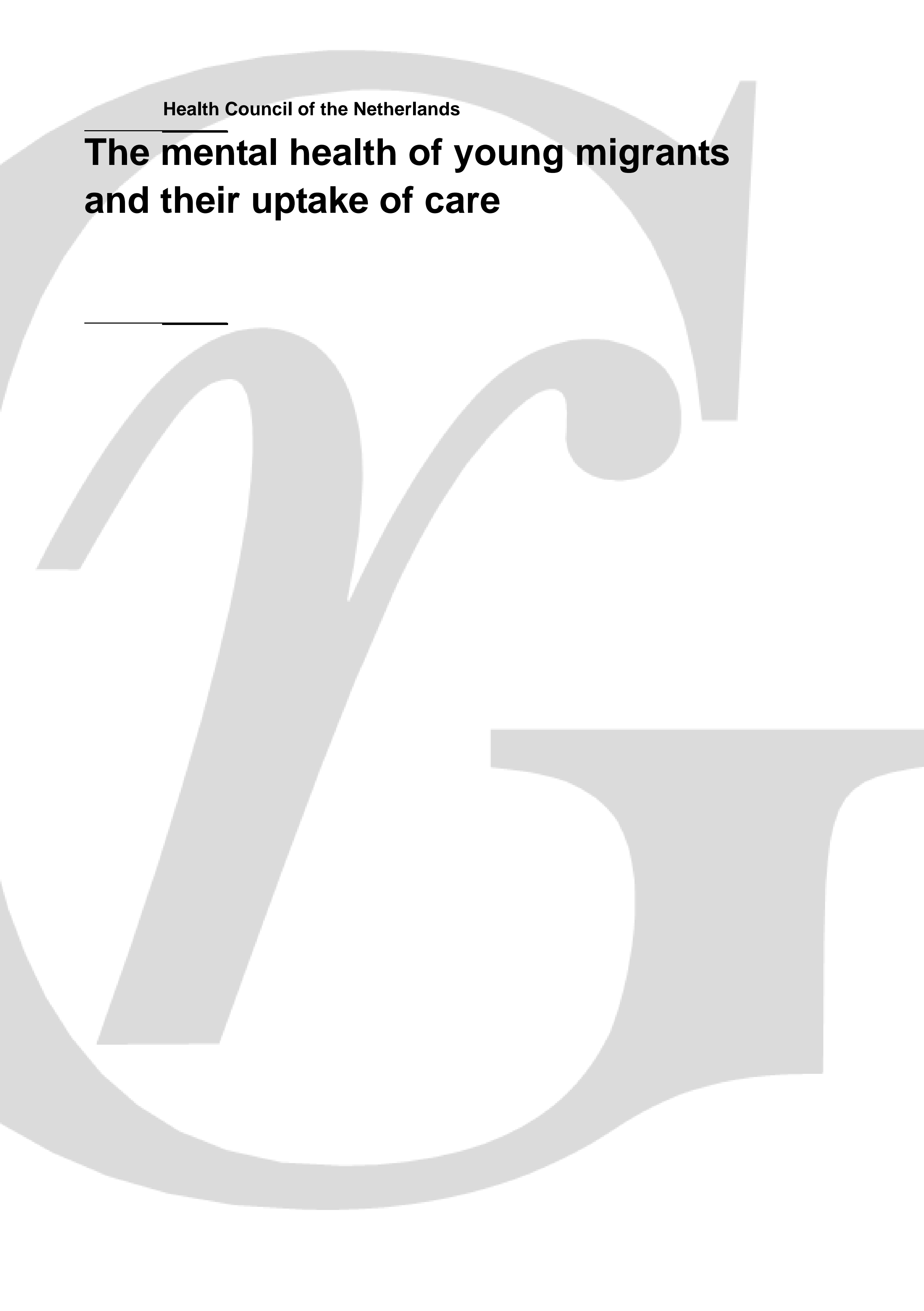

Health Council of the Netherlands

The mental health of young migrants and their uptake of care

Gezondheidsraad
Health Council of the Netherlands

To the Minister and State Secretary of
Heath, Welfare and Sport

Subject : presentation of advisory report *The mental health of young migrants and their uptake of care*
Your reference : CZ/CGG-2989643
Our reference : I-487-10/SK/bp/856-E
Enclosure(s) : 1
Date : September 13, 2012

Dear Minister and State Secretary,

I hereby submit the advisory report entitled *The mental health of young migrants and their uptake of care*. This advisory report was requested on 30 March 2010 by the then Minister for Youth and Families, the Minister of Health, Welfare and Sport, the then Minister for Housing, Communities and Integration, and the State Secretary for Education, Culture and Science. The reason for the request was the suspicion that migrant children are more likely to suffer from mental health problems than children with a native Dutch background, moreover, they do not always get the help they need to cope effectively with these problems. In preparation for this advisory report, a specially appointed committee of experts has examined the results of the published studies in this area. Their findings have been reviewed by the Standing Committee on Public Health and the Standing Committee on Medicine.

The Committee has focused on the available data for the four largest migrant groups in the Netherlands: Moroccan, Turkish, Antillean and Surinamese children and young people. Given the heterogeneity of migrant groups and differences in the way in which mental health care services are structured, the situation in the Netherlands is not comparable to those in other European countries. However, there is evidence to suggest that neighbouring countries are facing similar issues.

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The Committee notes that "young migrants" do not exist as a distinct group. Although data is scarce, the available literature shows that it is impossible to view "young migrants" as a homogeneous group. Accordingly, the advisory report paints a more nuanced picture. For instance, differences were found between migrant groups in terms of the incidence of mental health problems and in their healthcare consumption. This shows that young Moroccan males and Turkish children in particular and, to a lesser extent, Antillean children receive less care than would be expected based on their numbers as a percentage of the population as a whole and on the mental health problems that occur in these groups. It is also striking that some migrant groups do not differ from their native Dutch counterparts of the same age in terms of mental health problems and the uptake of care.

There is still a lack of hard data that might account for the differences that do exist. However, the differences can serve as a guideline for the policy of offering appropriate care to every child in the Netherlands who needs it. The Committee therefore recommends that there should be a specific focus on those groups of children which, according to the evidence, are not receiving the care they need. This will require a more detailed knowledge of these groups' care requirement and their uptake of care.

I endorse the Committee's recommendations.

This advisory report is also being submitted to the Minister for Immigration, Integration and Asylum and the Minister of Education, Culture and Science.

Yours sincerely,,
(signed)
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Vice President

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The mental health of young migrants and their uptake of care

to:

the Minister and State Secretary of Health, Welfare and Sport

the Minister of Immigration, Integration and Asylum

the Minister of Education, Culture and Science

No. 2012/14E, The Hague, September 13, 2012

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Executive summary

Mapping possible gaps in the provision of mental health care

There are signs that young migrants in the Netherlands are more likely to suffer from mental health problems, and do not always get the help they need to cope effectively with these problems. In other words, there may be a gap between the need for care in this field and the actual provision of care. Further data are required on this topic. The than Minister of Youth and Families therefore asked the Health Council of the Netherlands (*Gezondheidsraad*) to inventory the current state of affairs in order to pinpoint any gaps in the provision of care, since every child in the Netherlands who is suffering from mental health problems has the right to appropriate care.

Inhomogeneities in the target group

The expert Committee set up to study this problem observed first of all that young migrants up to the age of 23 in the Netherlands do not form a homogeneous group. It was therefore decided to study the four main groups – children and young people of Moroccan, Turkish, Antillean and Surinamese origin – separately. Where possible, the data was further broken down by age and gender, since the problems encountered and the uptake of care may vary in relation to these variables. A distinction was also made between emotional and

behavioural problems (i.e. mental health problems that are inwardly directed and those that concern relations with the outside world).

Data on mental health problems

On the basis of these criteria, an inventory was made of what is known about the prevalence of mental health problems in the four above-mentioned groups, in comparison with that among young people of Dutch origin. This study had to make use of reports by the parents of the young people concerned, the young people themselves and other people (such as teachers) who are involved.

It was difficult to get a clear picture on the basis of the information collected, since no objective diagnoses were available. Hard conclusions about the current prevalence of mental health problems in the above-mentioned four migrant groups cannot be drawn on the basis of scientific research in this field either. Nevertheless, a picture does emerge – and this picture suggests that the problems encountered vary from one group to another.

In certain respects, these groups show more problems than their Dutch counterparts. For example, there are more reports of behavioural problems among young males of Moroccan origin than among Dutch males of the same age, while young people of Turkish origin have more emotional problems. Young people of Antillean origin show a higher prevalence of both types of problems.

In other respects, the young migrants show fewer mental health problems than their Dutch counterparts, or no differences are observed. For example, young people of Moroccan origin report fewer emotional problems, and fewer suicide attempts are reported for young females in this group. Young people of Surinamese origin seem to have about the same prevalence of mental health problems as their Dutch counterparts of the same age, though more suicide attempts are reported for young females from this group.

Data on the uptake of care

The expert Committee then inventoried what is known about the uptake of care. Do young people from the four groups concerned (or their parents) request care for their mental health problems to the extent that might be expected? The Committee tried to estimate this by comparing the uptake of care with the prevalence of mental health problems (a group with more mental health problems would be expected to call on the services of care providers more often) and with the size of the group in relation to the population as a whole (a larger group would be expected to call on the services of care providers more often).

It was found on the basis of this approach that young people of Moroccan origin with behavioural problems appear to have a relatively low uptake of care: they are not seen by the child and youth mental health services (known as *jeugd-GGZ* in Dutch) as often as might be expected on the basis of the frequency of mental health problems in this group and the size of the group. Young people of Antillean origin show more mental health problems (both emotional and behavioural) and lower uptake of care than might be expected on the basis of the size of the group.

Young people of Turkish origin consult their general practitioner (GP) readily when they have emotional problems, but their uptake of youth mental health services is lower than might be expected on the basis of the size of the group. Young people of Surinamese origin show the same level of uptake of mental health care as their Dutch counterparts of the same age.

It may be noted that comparison with young Dutch people of the same age does not necessarily provide an accurate measure of whether uptake of care is at the ‘right’ level. It does however highlight the main differences in this field.

Bottlenecks in the mental health care supply chain

Is it possible to explain the observed differences in the uptake of mental health care? While hard data is not available in this field, some indications may be given.

Access to the GP does not seem to be a problem: young people from the four migrant groups considered consult their GP just as often as their Dutch counterparts, or even more often. However, the transition from primary health care to the youth mental health care services does not seem to run as smoothly as it should. Qualitative studies indicate that communication problems and lack of understanding of the position of young migrants on the part of care providers may play a role here.

It has been suggested that the overrepresentation of certain groups in the field of forensic psychiatry might be due to low uptake of regular mental health services. The Committee could not find any evidence of a direct link here, however. The available data does not support this conclusion – and there are other ways of ending up in the domain of forensic psychiatry.

Recommendations

One important conclusion that may be drawn from this report is that empirical evidence is often lacking, and that further investigation is therefore required.

Nevertheless, a picture does emerge that provides a basis for proposals for further action. It is important in this connection not simply to aim at increasing the uptake of youth mental health services by young people from the various migrant groups, but to ensure that *every* young person in the Netherlands gets the mental health care he or she needs. The specific characteristics of the various groups of young people of migrant origin must be taken into account if this objective is to be achieved.

Chapter 1

Introduction

1.1 A gap in child and youth mental health services?

As a society, we feel the need to help children who are at risk of being overwhelmed by mental health problems. Mental health problems arise when there is a shift in the balance between people's day-to-day worries (burden) and their ability to deal with them (ability to cope). If the symptoms are so severe that the individual's performance is affected (not attending school, or not going to work, avoiding friends, etc.), then they can be said to be suffering from a mental disorder. (American Psychiatric Association, 2000)

Among young people in particular there are many opportunities to identify mental health problems and to prevent them from developing into disorders. For this reason, the early detection and treatment of mental health problems in children and young people have become major pillars of youth care services in the Netherlands. Moreover, if (in spite of these efforts) young people are diagnosed with a disorder, then effective assistance should be readily available.

In this context, it is essential that the monitoring system in question be free of blind spots and that all children and young people have equal access to care. Nevertheless, people currently have the impression that the children of non-western migrants in the Netherlands are more at risk of mental health problems than their native Dutch counterparts of the same age, and that they do not always have timely access to the right sort of care. That might constitute just such a gap.

For the then Minister for Youth and Families, the Minister of Health, Welfare and Sport, the then Minister for Housing, Communities and Integration and the State Secretary for Education, Culture and Science this was sufficient reason to seek the advice of the Health Council. The ministers asked for recommendations on how this possible gap between the care requirements of young migrants of non-western origin and child and youth mental health services might be bridged. The text of the request for advice is given in annex A.

This material has already been examined by a Health Council committee specially appointed for the purpose. Details of the Committee's make-up are set out in Annex B. At an early stage it became clear that, before the request for advice could be properly answered, it would be necessary to determine whether the assumptions about an increased care requirement and reduced access to child and youth mental health services were indeed correct. To this end, the Committee has determined the current level of knowledge on this matter. Armed with that knowledge, it then tracked down possible gaps and made recommendations for improvement.

Age limit

The upper age limit used to determine who is or is not a "young person" varies from 18 to 23 in different parts of the youth care service. For the purposes of this advisory report we consider everyone aged from 0 to 23 to be a "young person". We have further subdivided this age range into the following groups: 0-11 (children), 12-18 (young people/adolescents) and 18-23 (young adults).[1]

1.2 Principles governing the advisory process

It is no easy matter to obtain a reliable picture of the care requirement in specific groups, and to compare this to their actual uptake of care in practice. Nevertheless, in order to be able to make scientifically substantiated statements on this matter, the Committee has incorporated a number of important principles into its approach.

Terminology

The request for advice refers to young migrants with a non-western background. For the purposes of this advisory report, the Committee has used variations of this term: young migrants, migrant children, young people of migrant origin. This refers to children and young people up to 23 years of age who were not themselves born in the Netherlands or whose parents (one or both) were not born in the Netherlands. This interpretation is consistent with the Statistics Netherlands' definition of "people with a foreign background" as "Someone who lives in the Netherlands (and whose name appears on their local authority's register of residents), and at least one of whose parents was born abroad. In this connection, a distinction is drawn between those who were themselves born abroad (first generation) and those who were born in the Netherlands (second generation: Statistics Netherlands 2005)."

The data is broken down by migrant group

Migrants differ considerably in terms of their cultural background, migration history, and social position in the Netherlands. Each migrant group has its own specific characteristics, which may affect their mental well-being. Accordingly, in terms of care requirement, the term "young migrants" does not represent a homogeneous group.[2,3]

In addition, overall figures for mental health problems among young people of migrant origin are scarce, and currently present an inconsistent picture.[4] A few examples. Statistics Netherlands' Permanent Quality of Life Survey shows no significant differences in psychosocial health between migrant children up to 12 years of age and children with a native Dutch background in the same age group.[5] In the large-scale Health Behaviour in School-aged Children study, however, migrant pupils aged 11-16 report nearly twice as many behavioural problems or problems with their counterparts of the same age – although this difference disappears after the figures are corrected for educational level and family prosperity. It also appears that migrant pupils experience fewer emotional problems than their native Dutch counterparts of the same age.[6,7] However, there are also studies showing that young people of migrant origin are more likely to

report emotional problems.[2,8] Native Dutch pupils, on the other hand, are more likely to report hyperactivity issues.

In short, within the large and diverse group of young people of migrant origin, it is essential to draw a distinction in terms of ethnic origin. As virtually all of the published research data relates to the four largest groups in the Netherlands, for the purposes of this advisory report the Committee has focused on young people in the Moroccan, Turkish, Surinamese, and Antillean communities.

Demographic information

Twenty-three percent of all young people in the Netherlands are of non-Dutch origin. This means around one million young people of migrant origin are currently living in the Netherlands.[9] Fifteen percent of this group are first generation people with a foreign background and eighty-five percent second generation people with a foreign background (as defined by Statistics Netherlands). The largest group are migrants of Moroccan origin (3.6% of the Dutch population), followed by young people with a Turkish background (3.4%). Young Surinamese people make up 2.4% of the Dutch population. Young people of Antillean and Aruban origin make up the smallest group (1.2%).[9]

Table 1 Absolute numbers of young people aged 0-20 in the Netherlands in 2010.

	Total	Men	Women
Total	3,928,334		
People with a native Dutch background	3,026,835	1,548,237	1,478,598
People with a non-western foreign background	638,221	326,620	311,601
People with a western foreign background	263,278	134,773	128,505
Morocco	140,994 (3.6%)	71,811	69,183
Neth. Antilles and Aruba	46,427 (1.2%)	23,584	22,843
Suriname	93,762 (2.4%)	47,979	45,783
Turkey	133,246 (3.4%)	68,549	64,697

Mental health problems serve as an indication of the care requirement

If you want to determine whether, at the population level, there is a care requirement that does not translate into the uptake of care that you might expect, it is first essential to find out how many people suffer from mental health problems or mental disorders.

This advisory report mainly restricts itself to statements about mental health *problems*, as little or nothing is known about the prevalence of mental *disorders*. This is because mental disorders can only be identified in personal interviews with a healthcare professional, such as a physician, psychiatrist, or healthcare psychologist, an approach that is seldom used in population studies. This information is obviously more readily available for those who are already receiving care. However, this still provides no understanding of the extent to which a given population as a whole has an increased or decreased risk of experiencing certain problems. Moreover, these are individuals who have managed to find the assistance that they need. This is not an effective way of locating blind spots.

Mental health problems are a different matter, as these can be identified before the individuals in question have had any contact with caregivers. Questionnaires (completed by parents, teachers, or the young people themselves), for example, can be used to identify the incidence of such cases.

To track down any gaps, the Committee used data on the prevalence of mental health problems. It draws a distinction between emotional problems (which mainly take the form of unpleasant moods and feelings) and behavioural problems (which are mainly expressed as actions that others find upsetting). This distinction is also widely used in child and adolescent psychiatry.

Emotional problems are seen as internalising in nature, which means that they are manifested mainly by internally perceived symptoms, such as depression and anxiety. Behavioural problems are described as being externalising in nature, as they are expressed in the form of behaviour that others can observe. The family and friends of affected individuals are more likely to find such problems upsetting. Overall, young females seem more likely to experience emotional problems, while young males are more prone to behavioural problems. To take account of these significant gender differences, where such an opportunity presents itself, the differences between problems in young females and young males have been included in this advisory report.

The care system as a whole

The focus is on child and youth mental health services as a type of care, nevertheless, the Committee has placed this in a broader context. Post-natal clinics, GPs, child and youth health care, and alternative forms of assistance are also included. Besides the accessibility of care, the Committee has also examined the data on through-flow and outflow.

The results provide indications, not certainties

These principles can give an impression of the match between the prevalence of mental health problems on the one hand and the uptake of care by young migrants on the other. Based on this data, it is difficult to make properly substantiated statements concerning the uptake of care by young migrants with medically objectifiable mental disorders.

We can, however, observe differences between groups (e.g. one group has more mental health problems than another), or we can identify the existence of a gap between the prevalence of mental health problems and the uptake of care (which does not correspond to prevalence-based expectations), assuming that a percentage of the individuals with such problems will go on to develop a disorder.

All things considered, it will be shown that this approach can generate a number of well-founded conclusions, which may point the way to improvement. In other cases, the Committee can only conclude that our knowledge of such issues is still less than complete.

1.3 Request for advice and design

Based on the principles used, the Committee has considered the specific questions contained in the request for advice - which are presented in four clusters (see annex A) - in their entirety. The questions have also been slightly rearranged. To ensure that these complex issues involved are tackled in an orderly way, the first questions to be dealt with are all those relating to the prevalence of mental health problems and to ways of measuring this. The Committee then addressed questions about child and youth mental health

services (admission, orientation, and use). Next the various sticking points that have identified are discussed. In brief, the key questions are as follows:

Summarise the mental health problems involved

1 How do the nature and extent of mental health problems among migrant children of Moroccan, Turkish, Surinamese, and Antillean origin relate to the nature and extent of mental health problems in other young Dutch people up to 23 years of age? What are the underlying causes of any differences?

Summarise the uptake of care

2 How do the nature and extent of care uptake in connection with mental disorders among migrant children of Moroccan, Turkish, Surinamese, and Antillean origin relate to the nature and extent of care uptake in connection with mental disorders in other young Dutch people up to 23 years of age?

Analysis of the relationship between mental health problems and care uptake

3 How large is the gap, if any, between care requirement and care uptake in the cited population groups? What are the underlying causes of any discrepancies?

Recommendations for improving the match between care requirement and the uptake of care

4 Are there any potential solutions that might lead to an improvement in the current situation in these population groups? What steps can be taken?

The structure of this advisory report reflects the sequence of these questions In Chapter 2, the first question in the request for advice is answered. This involves a summary of the prevalence of mental health problems among young migrants, compared to that in other children in the Netherlands. Chapter 3 is devoted to the uptake of child and youth mental health services. There is also a brief outline of how children obtain access to these services. In Chapter 4, there is an examination of what the two types of data can tell us about the possible differences in care requirement and care uptake among migrant children. This requires a comprehensive assessment of aspects such as the complications

involved in determining high-uptake or low-uptake in certain groups. Chapter 5 contains recommendations for the next steps.

Chapter **2**

Mental health problems among migrant children

The first step is to get an impression of the nature and extent of the mental health problems affecting the four groups of migrant children, and (where possible) to compare them with those affecting other young Dutch people. The Committee's approach here was to summarise all the available literature on mental health problems in these groups. The Committee also examined the explanations of any differences between the incidence of mental health problems.

2.1 Procedure used to prepare summary

Use of sources

A 2008 systematic review on the mental health of young migrants provided the starting point for a summary of the data. In this review, Stevens and Vollebergh examined all of the available international literature in the light of various selection criteria, such as the characteristics of the study group, and the way in which mental health problems and ethnic origin were assessed.

Although a large number of studies were initially found in the international literature, ultimately just 24 of them met these criteria.[3]

Within this group of studies, the Committee then examined Dutch studies that contained specific information about one or more of the four largest migrant groups in the Netherlands. The available data were then supplemented with more recently published studies, selected using the same criteria. Annex C contains an

extensive literature survey, which includes details of the methodological aspects involved.

The quantity of information available was found to vary from one group to another. Most of the studies in this area involve young people of Turkish and Moroccan origin. Much less data is available on young people of Surinamese and Antillean origin. The 2008 Rotterdam Youth Monitor has the largest study population. This provides information about each of these four groups among all children of school-going age in Rotterdam (aged 0 to 19), measured at five points in time.[10]

For each migrant group, the available data were divided into emotional problems (internalising) and behavioural problems (externalising). Any available data on suicidal behaviour and psychotic symptoms was also included. Any available data on differences in problems between young males and young females was also included.

There have been very few large-scale studies (using diagnostic interviews) into the prevalence of mental disorders in the population as a whole. However, those that have been carried out include the studies by Zwirs et al and Crone et al[11,12]. These have been used in the present report. The remaining studies gathered data by means of questionnaires that were completed either by the young people themselves, their parents, or their teachers. All of the studies examined both first and second generation young people of migrant origin.

Figures for all children in the Netherlands

In 2010, well over 4.5 million children and young people up to the age of 23 were living in the Netherlands. There is very little hard data on mental disorders in children and young people. It is estimated that approximately 5% of children and young people in the Netherlands have mental health problems of such severity that they are associated with impaired development and/or marked dysfunction in daily life.[13] A study by Verhulst in young people under the age of 18 combined the prevalence of disorders with marked dysfunction. It concluded that, on this basis, 5-6% of this group are eligible for secondary child and youth mental health care.[14] A cross-cultural study into behavioural problems reported by the parents of adolescents (aged 13-18) in twelve different countries revealed that the prevalence of serious mental health problems in the Netherlands is comparable to that seen elsewhere (79 per 1,000).[15] In the Health Behaviour in School-aged Children study, the welfare and happiness scores for young

Dutch people have, for many years, exceeded those of children in 38 other countries in Europe, as well as those in North America. Young Dutch people also routinely achieve high scores in terms of the support that children receive from their parents, the number of friendships that they have, and their positive feelings about school.[16]

2.2 Summary of mental health problems

This section sets out the Committee's main findings with regard to studies into the prevalence of mental health problems, broken down into the various groups of migrant children. Annex C contains a comprehensive list of all the relevant studies, together with the reporting methods used and the conclusions reached on a study-by-study basis.

Young people of Moroccan origin

Eight studies identified a category of young people with a Moroccan background. Of these, the studies by Stevens et al and Zwirs et al studied the largest experimental groups, followed by the study by Adriaanse et al.[2,11,17-22] Additional data was obtained from studies by the Rotterdam Youth Monitor.[10]

Emotional problems

The Rotterdam Youth Monitor shows that parents of Moroccan origin more often report emotional problems (crying, depressed, general impression of sadness) in their toddlers and preschool children than do the parents of native Dutch counterparts of the same age. The figures are 16% and 7% for toddlers, and 21% and 9% in preschool children. However, self-reporting by children in year 7 showed no difference at all. In the third year of secondary school, only 13% of young people of Moroccan origin report emotional problems, compared to 20% of their counterparts of the same age. Some studies reveal no differences, while others indicate a higher or lower percentage of emotional problems.

In the available studies, no clear evidence emerged for an increased prevalence of emotional problems among young Moroccan people, compared to their native Dutch counterparts of the same age.[2,10,11,19]

Behavioural problems

The situation is different with regard to behavioural problems. The teachers who took part in the various studies reported more behavioural problems among young people of Moroccan origin, especially young males. This was confirmed by the Rotterdam Youth Monitor, in which reports by parents and teachers, as well as self-reports, indicated a higher incidence of behavioural problems in children of Moroccan origin. The increased prevalence of behavioural problems in young Moroccan males was mainly reported by teachers, and much less so by their parents or by the young people themselves. Self-reporting by young Moroccan males in the various studies gave no clear impression. However, it did show that the incidence of problems in this group is either the same or considerably lower than in their native Dutch counterparts of the same age. [2,10,11,17-19]

Suicidal behaviour

Self-reports show less suicidal behaviour among young Moroccan females than among young Dutch females.[20,21] For young males and young females combined, the picture is also better. The Rotterdam Youth Monitor shows that 13% of the young people of Moroccan origin surveyed had experienced suicidal thoughts, compared to 19% of their native Dutch counterparts of the same age.[10] The number of reported suicide attempts among young Moroccan females (6.1%) is lower than in young Dutch females (8.8%).[21]

Psychotic symptoms

In the study by Adriaanse et al, children and adolescents of Moroccan origin more often reported delusional thoughts than their native Dutch counterparts of the same age.[19] In another study, young people/young adults (aged 19-30) of Moroccan origin in this group more often reported having hallucinations (21%) than did their native Dutch counterparts of the same age (3%). This difference was only found for men, not for women.[22] Another study has shown that young adult men of Moroccan origin are at greater risk than their counterparts of the same age of developing a psychotic disorder.[23]

Young people of Turkish origin

Ten studies separately investigated young Turkish people of migrant origin. [2,11,17-18,20,21,24-27] Stevens et al and Zwirs et al studied the largest experimental groups, followed by the Rotterdam Youth Monitor.[10]

Emotional problems

In most cases, self-reports and reports by parents reveal a higher prevalence of emotional problems in children and young people with a Turkish background, compared to their counterparts of the same age. According to the parents' reports analysed by the Rotterdam Youth Monitor, these differences are 22% and 7% in toddlers, and 27% and 9% in preschool children. In contrast, reports by teachers show no differences.[2,10,17,18,24-27]

Behavioural problems

Studies suggest that young migrants of Turkish origin may have a slightly higher prevalence of behavioural problems. However, their findings are not consistent. The available self-reports and parents' reports show that native Dutch counterparts of the same age exhibit just as much problem behaviour, if not more. Teachers do not feel that this migrant group causes more problems.[2,10,17,18,24-27]

Suicidal behaviour

Young females with a Turkish background report suicidal behaviour more often than their counterparts of the same age. The number of reported suicide attempts in this group was also significantly higher.[20,21] One study reported a rate of 14.8%, compared to 8.8% in young females with a Dutch background.[21]

A study into suicidal behaviour among young people in The Hague showed that young Turkish females (aged 15-24, data from care institutions) made significantly more suicide attempts than young Dutch females.[28]

Young people of Surinamese origin

Three studies separately investigated young Surinamese people of migrant origin.[17,18,21] Additional data was obtained from studies by the Rotterdam Youth

Monitor.[10] The studies by Zwirs et al and by the Rotterdam Youth Monitor investigated the largest study population.

In the interests of obtaining a better understanding, it is important to draw a distinction between the two largest groups of Surinamese migrants, the Hindustani Surinamese and the Creole Surinamese. However, the available studies seldom make any such distinction. Accordingly, in the present report, any allusion to young Surinamese people refers to the group as a whole. In those instances where a given subgroup is investigated separately, this is explicitly stated.

Emotional problems

The few studies based on self-reports, parents' reports and teachers' reports showed no difference between the prevalence of emotional problems in children and young people of Surinamese origin and their native Dutch counterparts of the same age.[10,17,18]

Behavioural problems

With regard to behavioural problems too, the three types of reports show no differences between children and young people of Surinamese origin and their native Dutch counterparts of the same age.[10,17,18]

Suicidal behaviour

The available research consistently indicates a slightly higher number of reported suicide attempts among young Surinamese people (9% compared to 6% among their counterparts).[10] They also have suicidal thoughts more often than their counterparts of the same age. The difference between young people with Dutch and Surinamese backgrounds is greater for young females than for young males. In a study that specifically investigated young Hindustani females, 19.2% of the subjects claimed to have attempted suicide, as opposed to 8.8% among their native Dutch counterparts of the same age.[21] A study into suicidal behaviour among young people in The Hague showed that young Surinamese females (aged 15-24, data from care institutions) made significantly more suicide attempts than young Dutch females.[28]

Young people of Antillean origin

Emotional problems

The Rotterdam Youth Monitor is the only source to provide details of the incidence of mental health problems among Antillean migrant children in the population as a whole. This source shows that the parents of Antillean toddlers (17%) and preschool children (19%) more often report emotional problems (tendency to cry, depressed, general impression of sadness) in their children than do the parents of Dutch toddlers (7%) and preschool children (9%). A larger proportion of Antillean children (33%) than Dutch children (25%). report having feelings of despondency.[10]

Behavioural problems

Parents and teachers estimate that toddlers and preschool children with an Antillean background have a higher incidence of behavioural problems than their counterparts of the same age. Schoolchildren themselves report a higher incidence of problem behaviour than their native Dutch counterparts of the same age.[10]

Suicidal behaviour

More young Antilleans in the third year of secondary school have had suicidal thoughts than their native Dutch counterparts of the same age (26% versus 19%).[10]

2.3 Discussion of the studies' findings

How much importance can be attached to the details of mental health problems reported in published studies? Does this group of studies give a good indication of the current state of affairs, or is it necessary to add various caveats? Here the Committee discusses various factors that affect the studies' outcomes and, by extension, their significance in terms of this advisory report.

Differences in the design of studies make comparisons difficult

The available studies appear to be very heterogeneous. They use different reporters (the children themselves, their parents, or teachers), different methods of comparing the study groups with native groups, and they involve different age groups. This sometimes makes it difficult to formulate a consistent picture, as it is not always clear whether the differences in the results obtained are associated with the designs of the studies in question.

As shown above, the choice of reporter affects the perceived scale of emotional and behavioural problems in the various groups of young people. Different reporters have a different perspective on children's problems, partly because they encounter the children in different situations, and partly because they vary in their awareness of what the children are going through.[29] For instance, it appears to be relatively common for teachers to be unaware that a given child in their class is suffering from emotional problems. The children and young people themselves do report these emotional problems, after all they are the ones directly affected by them, even though this does not always translate into behaviour that everyone is able to recognise. In this context, the relatively high number of self-reports of emotional problems made by young Turkish males and females certainly needs to be taken seriously.

Differences in reporting may also arise if children do not exhibit the same behaviour in every situation. For example, children may behave or respond differently at home than they do at school.

Another point is that differences in outcomes may be influenced by the fact that people use different frames of reference when formulating their answers. For instance, a child's parents may see certain behaviour as being normal or acceptable, while the teacher may take a totally different view.

There is also a difference between questionnaire-based studies and the relatively few studies that involved additional diagnostic testing (in the form of an interview with a healthcare professional).[11] That, too, will produce differences in outcomes. For instance, the study by Crone et al, which was partially diagnostic in design, showed that the incidence of mental health problems among Turkish and Moroccan children (aged 5-12) was no higher than among children with a native Dutch background. However, the parents' reports seemed to indicate that their children did indeed have a higher incidence of mental health problems. Yet, when these parents were directly asked whether they were concerned about their child's behaviour, their responses were found to be no different to those given by the reference group. Other studies show similar differences.[30,31] In this connection, a study by Bevaart et al indicated that the

perception of problems by Moroccan and Turkish parents did not correspond to the high level of reported problems that emerged from studies based on a validated questionnaire.

Finally, there may be some under-reporting, where certain reporters fail to report real problems.[32] It is also possible that the perceptions of certain reporters (e.g. teachers) may be influenced by the prevailing social image of certain population groups.

Relevant refinements are often missing

A second factor that makes it difficult to sketch a consistent picture is that certain refinements are lacking. In Chapter 1, the Committee formulated the main principles underpinning its advisory report. Naturally, the published studies were not designed to comply with these principles.

The biggest drawback is that studies which differentiate their subjects into the four largest migrant groups in the Netherlands are few and far between. This restricts the amount of data on each group to such an extent that there are occasionally large gaps in this information. For example, the Committee is aware of just one study on mental health problems in young Antillean people in the population as a whole.[10]

However, there is another study on this group (albeit with a preselected patient population), which tends to confirm the view that this particular group suffers from a greater incidence of mental health problems. This results from a study by Bongers et al among Antillean delinquents (aged 17-26), which shows that they report a greater incidence of emotional and behavioural problems than the reference group (young people held in a youth detention centre).[33,34]

In addition, few studies have been published on mental health problems in children of Surinamese origin. Only two of the studies cited in Stevens and Vollebergh's literature review separately investigated young Surinamese people of migrant origin. The only other data available is that given in the 2008 Rotterdam Youth Monitor. Moreover, no distinction is made between the two largest groups, the Hindustani Surinamese and the Creole Surinamese. This may cause people to lose sight of major differences.

Furthermore, in many cases no distinction is made between young males and young females, while the nature and prevalence of their mental health problems may differ considerably. There may also have been differences in the nature and severity of health problems, which were not reported in the studies in question.

2.4 Accounting for differences in mental health problems

The above analysis shows that the results of published studies are subject to certain limitations. Taking this into account, it nevertheless seems justified to conclude that children of Moroccan, Turkish, and Antillean origin in particular experience a higher incidence of mental health problems than their native Dutch counterparts of the same age. In the case of Moroccan children, this mainly seems to involve behavioural problems. Among Turkish children, the main issue is emotional problems, while Antillean children appear to have a higher incidence of both types of problems. What could be the cause of this?

The primary explanation of these differences involves a different distribution of risk factors. Some groups have more risk factors for developing mental health problems than others. However, it is also possible that certain groups have fewer protective factors. This too will affect the prevalence of such problems in those groups.[35]

Indeed, we know that some of the factors that may affect mental well-being are not present to the same extent in the migrant groups. For instance, many Antillean children grow up in single-parent families. In 2009, this was the case for 38% of these children, compared to 11% of native Dutch children.[9] However, whether or not this accounts for their higher incidence of mental health problems remains open to question. After all, the group of children of Surinamese origin is known to have only marginally more problems than their native Dutch counterparts of the same age, while about the same percentage as Antillean children grow up in single parent families.

In the case of children of Moroccan origin, growing up in a larger family may be a risk factor, and such families are relatively common in this group. [19] They have a lower incidence of protective factors such as perceived support from their mother and living in a good neighbourhood (determined by its liveability according to the Ministry of Housing, Spatial Planning and Environmental Management's liveability monitor) than do young Dutch people.[19]

Accordingly, risk factors are of great importance in accounting for the differences. But why do specific migrant groups have a greater incidence of certain risk factors and a lower incidence of protective factors? Studies have shown that the differences partly correspond to the differences in socioeconomic background of the children and their parents. [36] However, other factors may also be involved which specifically relate to the position in society of children and young people from migrant groups. Two examples of such factors are the degree of acculturation and the "ethnic density effect".[37-41]

A study by Veling et al demonstrated the impact of the latter factor. It showed that the risk of developing a psychosis depends on the ethnic density of the neighbourhood. In neighbourhoods where Turkish, Moroccan, and Surinamese migrants are less well represented (lower ethnic density), there is a higher incidence of psychotic disorders among these migrant groups.[39] Gieling et al investigated the effect of ethnic density in the classroom. They found that adolescents belonging to an ethnic minority in their classroom reported more behavioural problems.[38]

Furthermore, various studies have indicated that the degree of acculturation (in this case the individual's sense of connection with Dutch and Moroccan culture) affects the risk of developing mental health problems. [40,42-45] A study by Stevens et al showed, for example, that young Moroccan females with an average level of orientation to both the Moroccan and Dutch cultures reported more emotional and behavioural problems than young females who feel a strong sense of connection with the Moroccan culture (but not with the Dutch culture) or young females who feel a strong sense of connection with both the Dutch and Moroccan cultures. One explanation put forward to account for this was that young females in the former group tended to have more conflicts with their parents.[45]

2.5 Conclusion

In this chapter, an attempt is made to frame conclusions about the prevalence of mental health problems in the four groups of migrant children, based on the available literature. The heterogeneous design of these studies makes it difficult to interpret the results. So the differences in perspective (of the parents, the teachers, and the children themselves) play a major part, although the question of which findings are assigned greater weight cannot be answered with any certainty. As a result, it is difficult to construct a consistent picture for the four groups.

Nevertheless, it is certainly possible to derive a number of clear indications. For instance, young Moroccan males were consistently reported to have more behavioural problems than their native Dutch counterparts of the same age. This increased prevalence of behavioural problems in young Moroccan males was mainly reported by teachers, and much less so by their parents or by the young people themselves. Yet young Turkish people actually appear to have more emotional problems. Young Antillean people have a higher incidence of both emotional and behavioural problems.

In some groups of young migrants, mental health problems do *not* seem to occur more frequently than in young people with a native Dutch background. For instance, no clear differences were found between the incidence of mental health problems in young Surinamese people and in young people with a native Dutch background. It should be noted, however, that these findings are based on a very limited amount of data. Yet it does seem that there are a greater number of suicide attempts among young Surinamese females.

In the group of Moroccan origin, too, some problems seem to be less common than among native Dutch counterparts of the same age. Young Moroccan people report fewer emotional problems, and young Moroccan females report a lower incidence of suicidal behaviour.

Chapter 3

Uptake of child and youth mental health services by migrant children

In this chapter, the Committee reviews the uptake of mental health care by migrant children from the four groups. That is the second step towards answering the question of whether a gap exists between the prevalence of mental health problems and expectations regarding the corresponding uptake of care. Section 1 briefly outlines the structure of child and youth mental health services, and how children obtained access to these services. This is followed by a summary of care uptake. In the conclusion, the uptake of care per group of migrant children is discussed.

3.1 Types of care

The care provided for children and young people with mental health problems and disorders can be classified into three different levels (see Figure 1).

Zero line health care

Firstly, there is the “zero line”. This consists of the basic educational facilities encountered by all children and parents: schools, kindergartens, sports clubs, etc. While not part of the youth care system, these institutions can help to identify problems. In this way, they can be the first step towards obtaining appropriate care. Moreover, these are places that put great emphasis on prevention.

Primary health care

The next level involves primary health care. This includes child healthcare, parenting and childhood support, and “elementary” assistance. At this level, caregivers implement prevention programmes, early detection, and early childhood intervention. This group includes: post-natal clinics (children aged 0-4), school doctors, school nurses, and GPs. Many local authorities group these amenities together in Youth and Families Centres.

Secondary health care

As a next step, specialised secondary mental health care for young people (youth mental health care services) is available at nine child and adolescent psychiatric centres and at 32 children and young people's departments at child and youth mental health care institutions. In addition, intensive assistance offered by youth care institutions, for example, in the context of secure youth care and by means of youth probation. Within youth detention centres too, care is provided for individuals with mental health problems and disorders.

3.2 Procedure used to prepare summary

Availability of data

Ethnicity (based on the country of origin of patients or their parents) is not recorded consistently within the various types of care. This severely limits the usefulness of registration data in care. Such data as is available was obtained from surveys or from sporadic analyses of routinely collected data. This was then linked to data on ethnic origin, on a one-off basis.

Data on the uptake of care in primary health care was obtained from Statistics Netherlands’ StatLine.[5,9] This provides information about the number of young people from the various migrant groups that have visited their GP in connection with mental health problems. There are also figures on the number of cases of mental illness diagnosed by GPs. The Committee has examined the 2008 figures for children and young people aged 0-15.

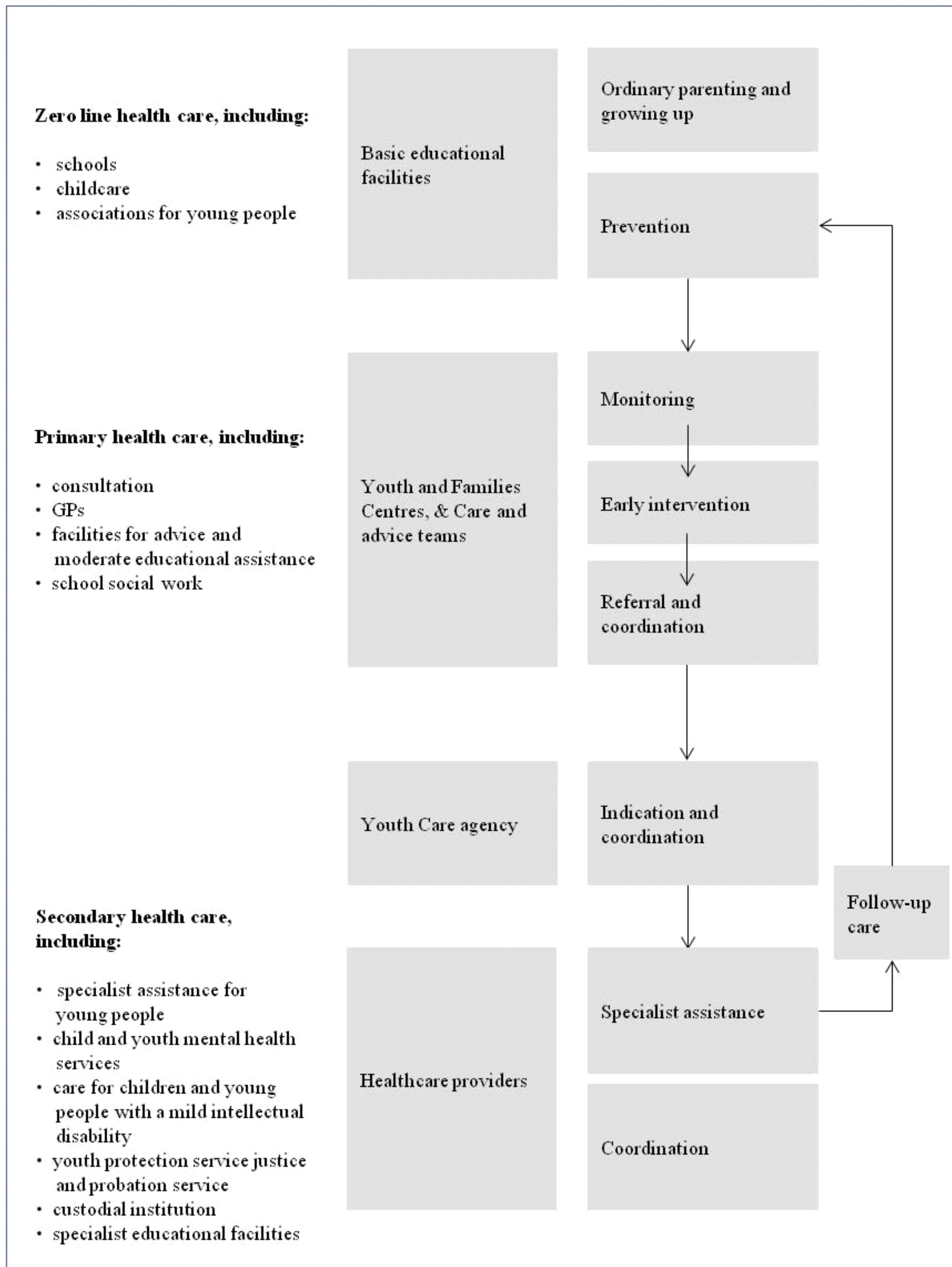

Figure 1 Schematic overview of the Dutch youth care system.

One limitation is that this data was obtained solely from GPs. While GPs, as a group, are indeed the largest referrer to child and youth mental health services (45%), referrals also take place through other channels, especially via the Youth Care Agency (15%). However, no reliable referral data for each migrant group is available for the latter referral channel.[9,46,47]

Absolute numbers

In 2009, 267,500 young people and parents were treated in child and youth mental health care institutions. The subgroup of individuals aged 0 to 17 involved a total of 140,600 cases: 66% of these were young males and 34% young females. The majority of clients (96%) received outpatient treatment, while the remaining 4% of cases involved part-time or clinical treatment. Relative to 2008, the number of clients increased by 8%, whereas there was a 17% increase from 2006 to 2007.[48]

The Committee had access to two extensive sources of information on care uptake within mainstream child and youth mental health services. One was the Rijnmond psychiatric case register and the other was data on the Haaglanden region.

The publication by Boon et al on the Jutters Foundation in the Haaglanden region gives a summary of the representation of migrant groups in different types of child and youth mental health services in relation to their numbers as a percentage of the population in each care institution's catchment area.[49] More specifically, these workers examined each institution's figures for 2008 and their relation to data on the population of the catchment area in question.[49] The *de Jutters* mental health care institution registers the country of birth of clients and their parents. Population data were obtained from Statistics Netherlands.[9]

The client group consists of all the young people who were registered with outpatient clinical services (or day-clinic services) and with the prevention department at *de Jutters*. Boon et al used two categories, young people up to the age of 14 and adolescents aged 15 and above. In 2008 they recorded a total of nearly 5,000 young people undergoing treatment. Sixty percent of these were people with a native Dutch background. In the catchment area in question, that percentage is around 50%.

The Rijnmond psychiatric case register shows the inflow of new clients over a period of three years. An analysis was made of the figures for all child and

youth mental health care institutions in the Rijnmond region, for the periods from 2001 to 2003 and from 2008 to 2010. In the period from 2001 to 2010, child and youth mental health services recorded a 33% increase in prevalence. In 2010, a total of nearly 5,000 young people were in care. Even as far back as 2001, this figure was still in excess of 3,500.[50-52] The Rijnmond psychiatric case register divides clients into two age groups, 0-11 and 12-18. Information on the make-up of the population in Rotterdam was obtained from the Centre for Research and Statistics (COS).[53,54] In the Rotterdam catchment area, about 38% of young people aged 0-18 in the study period had a native Dutch background. The corresponding figures for the migrant groups discussed in this advisory report are: Surinamese origin 12%, Antillean origin 6%, Moroccan origin 11%, and Turkish origin 13%.

3.3 Summary of data by type of care

3.3.1 In primary health care

Mental health problems registered by GPs

Like children with a native Dutch background, young males from the four migrant groups are more likely than young females to be registered by their GP as having symptoms of mental illness. The prevalence in young males with an Antillean/Aruban background is actually considerably higher than among young males with a native Dutch background.

The differences are smaller in the other groups. However, the prevalence among young Turkish and Antillean/Aruban females is higher than that seen in their native Dutch female counterparts of the same age.

Young Surinamese males are an exception. At 73 cases of mental health problems per 1,000 head of population, they score lower than young males with a native Dutch background (80 cases of mental health problems per 1,000 head of population).

The table below shows the number of 0-15 year-olds per 1,000 head of population who have been registered by their GP as having symptoms of mental illness.[5,9] The data relate to 2008.

Table 2 Number of individuals per 1,000 head of population registered by their GP with symptoms of mental illness.

	total	young males	young females
People with a native Dutch background	61	80	41
Morocco	64	80	45
Neth. Antilles and Aruba	87	121	53
Suriname	60	73	48
Turkey	69	82	54

Mental disorders diagnosed by GPs

The table below shows the number of cases (per 1,000 head of population) of 0-15 year olds diagnosed with mental illness by GPs, for children with a native Dutch background and for the four groups of migrant children.[5,9] Here too, it is noticeable that children of Antillean/Aruban origin are twice as likely to be diagnosed with a mental health problem than children with a native Dutch background. Children with a Moroccan or Turkish background are no more likely to be diagnosed with mental problems than children with a native Dutch background. Young Surinamese people are somewhere in the middle.

Table 3 Number of individuals per 1,000 head of population diagnosed by their GP with a mental disorder.

	Total
People with a native Dutch background	7
Morocco	6
Neth. Antilles and Aruba	14
Suriname	10
Turkey	5

3.3.2 *In secondary health care*

Data from mainstream child and youth mental health services

The following tables relate to the Jutters Foundation, in the Haaglanden region catchment area. They give details of client percentages for 2008.[49] This data indicates that children with a native Dutch background consume more care than would be expected on the basis of their numbers as a percentage of the population as a whole.

The opposite is true of children of Moroccan and Turkish origin, up to 15 years of age. Their presence in mainstream child and youth mental health

services is only about half of what would be expected on the basis of their numbers as a percentage of the general population in the catchment area.

Young Antillean people above the age of 15 are also under-represented in mainstream child and youth mental health services, relative to what would be expected on the basis of their numbers as a percentage of the population, although here the difference is smaller. In this group, there is no discrepancy with regard to children up to the age of 15.

Children and young people of Surinamese origin consume exactly the amount of care that might be expected on the basis of their numbers as a percentage of the population.

Table 4 Percentage of young people aged 0-14 in mainstream child and youth mental health services.

	% in the region (Haaglanden)	% Jutters clients mainstream
People with a native Dutch background	51.7	63.4
Morocco	7.5	4.3
Neth. Antilles/Aruba	2.6	2.7
Suriname	8.5	8.4
Turkey	8.2	4.1

Table 5 Percentage of young people aged 0-14 in mainstream child and youth mental health services.

	% in the region (Haaglanden)	% Jutters clients mainstream
People with a native Dutch background	52	60
Morocco	6.2	3.1
Neth. Antilles/Aruba	3.1	2.4
Suriname	11.1	11.5
Turkey	7.7	3.5

The following table also shows the prevalence rate for the Haaglanden region, here as the number of cases per 1,000 head of population.

Table 6 Number of young people in mainstream child and youth mental health care per 1,000 head of population in the Haaglanden region catchment area.

	child and youth mental health services aged 0-14	child and youth mental health services >15 years of age
People with a native Dutch background	36	32
Morocco	18	14
Neth. Antilles/Aruba	33	21
Suriname	30	29
Turkey	16	13

Data from forensic psychiatric care

The following table contains forensic client data for the Haaglanden region.[49] Young Antillean people above the age of 15 have more than double the representation in forensic psychiatric care than would be expected on the basis of their numbers as a percentage of the population as a whole. The same is true of young people of Moroccan origin. The representation of young Turkish and Surinamese people is almost entirely proportionate to their numbers as a percentage of the population as a whole. In this form of care, young people with a native Dutch background were seen less frequently than would be expected on the basis of their numbers as a percentage of the population as a whole.

Table 7 Young people below the age of 15 in forensic psychiatric care.

	% in the region (Haaglanden)	% Jutters clients forensic psychiatric	number per 1,000 head of population in catchment area
People with a native Dutch background	52	37	5
Morocco	6.2	14.5	18
Neth. Antilles/Aruba	3.1	6.5	17
Suriname	11.1	12.6	9
Turkey	7.7	7.3	7

Long-term incidence rates from child and youth mental health services

The Rijnmond psychiatric case register analysed the figures for the Rijnmond region from 2001 to 2010. It concluded that, in total, incidence increased by 23% during that period, and prevalence by 33%. Children and young people with a native Dutch background were mainly responsible for this increase, but increases were also seen in specific groups (among young Antillean males in particular).

Between 2008 and 2010, the three-year incidence rates for young Moroccan males aged 12 and above increased from 4 (the 2001-2003 rate) to 7 per 1,000 head of population. The incidence rates for young males and young females with a Turkish background remained virtually unchanged. From 2008 to 2010, young Surinamese males up to the age of 11 showed an incidence of 19 per 1,000 head of population, which was almost double that seen from 2001 to 2003 (10 per 1,000 head of population). Between 2008 and 2010, the incidence rates for young Antillean males aged 12 and above increased from 7 (the 2001-2003 rate) to 17 per 1,000 head of population.

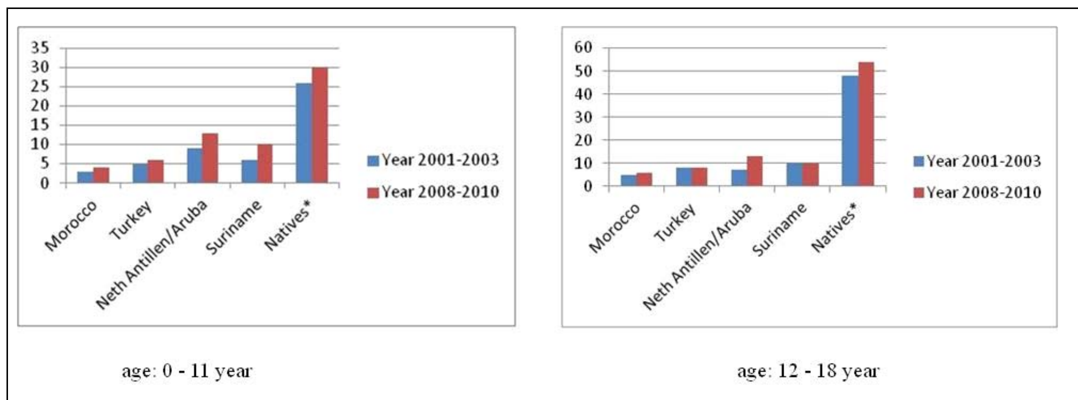

Figure 2 Shows three-year incidence rates in child and youth mental health services for the periods from 2001 to 2003 and from 2008 to 2010, expressed as the number of patients per 1,000 residents of Rotterdam.
* Natives = People with a native Dutch background

Figure 2 shows three-year incidence rates in child and youth mental health services for the periods from 2001 to 2003 and from 2008 to 2010 among children and young people (young males and young females).[51] The figures show that young people from the four migrant groups in the Rotterdam region are significantly less likely to be new users of care than young people with a Dutch background.

Data on patterns of care

The Rijnmond psychiatric case register carried out an exploratory analysis into patterns in the uptake of care by the various migrant groups. It examined the level of care (admissions versus outpatient contacts), the duration of care, the intensity of care (contact frequency per month) and the percentage of patients in care per month.

Well over 40% of all new patients remained in care for less than one month. The drop-out rate (less than one month of care uptake) did not vary significantly between the different migrant groups. However, the drop-out rate was higher among higher income patients. During the period in question, the average duration of care was 2.2 years. Young Antillean people remained in care for significantly shorter periods than their counterparts of the same age.

Over a period of twelve months after the initial contact, checks were made to see whether, in addition to outpatient care, patients had also been clinically

treated (either full-time or part-time). It was found that only 2.6% of all new patients received clinical care during the first year.

The contact frequency averaged one face-to-face contact every two to three weeks. Between 2008 and 2010 there were more monthly contacts than in the period from 2001 to 2003, particularly among the lower income groups.

From 2008 to 2010, the four migrant groups had a significantly lower contact frequency (adjusted for age and sex) than the native Dutch group.[52]

3.4 Findings per group of migrant children

What conclusions can be drawn from this data? The Committee discusses its main findings on care uptake on a group by group basis.

Young people of Moroccan origin

Children of Moroccan origin are just as likely to consult their GP about mental health problems as their native Dutch counterparts of the same age. However, their care uptake in secondary mental health care for children and young people is lower than that of children with a native Dutch background. It also remains below what would be expected on the basis of their numbers as a percentage of the population as a whole. In addition, the Rijnmond psychiatric case register shows that they are significantly less likely to be new users of care than young people with a Dutch background.

Young Moroccan people are more frequently represented in forensic psychiatric care than would be expected on the basis of their numbers as a percentage of the population as a whole.

Young people of Turkish origin

Young Turkish females in particular are more likely than young Dutch females to consult their GP about symptoms of mental illness. Despite this, their GPs do not diagnose mental problems in such cases any more often than with native Dutch counterparts of the same age. In child and youth mental health services, children of Turkish origin are less frequently represented than would be expected on the basis of their numbers as a percentage of the population as a whole. In addition, the three-year incidence rates recorded by the Rijnmond psychiatric case register for Turkish children were lower than those for their native Dutch counterparts of the same age. This group is by no means over-represented in forensic psychiatric care.

Young people of Antillean origin

Antillean children are more likely to visit their GP with mental health problems than their native Dutch counterparts of the same age. This is more true of young males than young females. GPs diagnose mental problems more frequently (twice as often) in this group. According to published studies, however, this does not translate into a higher uptake of care in child and youth mental health services. In this echelon, on the basis of their numbers as a percentage of the population as a whole, young people of Antillean origin are proportionally represented (or slightly under-represented).

The available three-year incidence rates for care uptake by young Antillean people are lower than for young people with a native Dutch background. As this group appears to have more mental health problems than young people with a native Dutch background, they might actually be expected to show a higher uptake of care.

Young Antillean people are more frequently represented in forensic psychiatric care than would be expected on the basis of their numbers as a percentage of the population as a whole.

Young people of Surinamese origin

GP registrations show that the percentage of children of Surinamese origin with symptoms of mental illness is just as large as that among young people with a native Dutch background. GPs tend to diagnose mental problems only slightly more often than they do for young people with a native Dutch background.

In the child and youth mental health care services, children of Surinamese origin are proportionally represented in terms of their numbers as a percentage of the population as a whole.

Three-year incidence rates in the child and youth mental health services are lower for the group of Surinamese migrant children than for young people with a native Dutch background. In forensic psychiatric care, young people of Surinamese origin are proportionally represented in terms of their numbers as a percentage of the population as a whole.

3.5 Conclusion

Based on the available data, the following conclusions can now be drawn. A degree of caution should be exercised in this regard, as there is only a limited

amount of numerical data, relating only to a single region, for example. Nevertheless, the impression obtained is likely to be indicative of the group as a whole.

The inflow at GPs' practices is the same or slightly larger

Details obtained from the available registration of symptoms of mental illness at GPs' practices show that all migrant groups at this level of care are no less well represented than their native Dutch counterparts of the same age. Young females with a Turkish background and children of Antillean origin present with symptoms of mental illness relatively often, compared to their Moroccan, Surinamese, and native Dutch counterparts of the same age. Moreover, in all four migrant groups, GPs do not diagnose mental problems any less often than in the native Dutch group. The Antillean group is more often diagnosed with mental problems than are young Dutch people.

Children of Moroccan and Turkish origin in particular are less well represented in the child and youth mental health services

Published studies show that Moroccan and Turkish children are less frequently represented in mainstream child and youth mental health services than would be expected on the basis of their numbers as a percentage of the population as a whole. This is less true for children of Antillean origin. However, young Surinamese people are proportionally represented.

Crude prevalence data from a major child and youth mental health care institution in Amsterdam shows a similar picture. There too, children with a Moroccan or Turkish background were found to be under-represented, while the care uptake of Antillean and Surinamese children was exactly what might be expected on the basis of their numbers as a percentage of the population as a whole.[55]

The inflow of children with a native Dutch background into child and youth mental health services is relatively high

Interestingly, data from the Rijnmond psychiatric case register reveals a relatively high inflow of children with a native Dutch background into mainstream child and youth mental health services, especially in low-income groups. Their uptake of care is also higher than might be expected on the basis of their numbers as a percentage of the population as a whole. On this basis,

however, it is not possible to conclude that the level of care uptake by young people of migrant origin is too low. It should be noted that children with a native Dutch background are not being used as a yardstick for measuring the uptake of care by others. For instance, the uptake of child and youth mental health care by young people of migrant origin might not be too low, it might just be that uptake by young people with a native Dutch background is relatively high. This can only be verified by studies in which mental health data is combined with care uptake data at the level of the individual. However, as shown in Chapter 2, no such study of young migrants in the Netherlands is currently available.

Young people of Moroccan and Antillean origin are more frequently represented in forensic psychiatric care

Institutional figures on forensic psychiatric care in the Haaglanden region show an increased rate for young Moroccan and Antillean people, relative to their numbers as a percentage of the population as a whole. This does not apply to young people of Turkish and Surinamese origin.

There is a difference in the number of treatment contacts, but not in terms of drop-out rates

Figures from the Rijnmond psychiatric case register show that the four migrant groups had significantly fewer treatment contacts per month than their native Dutch counterparts of the same age.

Although the drop-out rate (remaining in treatment for less than one month) for new patients was quite high (40%), there was no significant difference between children belonging to the four different migrant groups and children with a native Dutch background.

This suggests that the lower uptake of care among certain groups of migrant children is not so much the result of high drop-out rates, but that it is instead due to a relatively low inflow and to less frequent treatment contacts. In this connection, it should be noted that the choice of cut-off point (in this case, one month), strongly affects the outcome.[56] An examination of routine failure to attend appointments ("no-show") or patient deregistration, especially in cases where therapists are convinced of the need to continue therapy, would yield a more adequate picture of the drop-out rate.

Chapter **4**

Discrepancies between care requirement and the uptake of care

What impression can be gained from the data contained in Chapters 2 and 3. The Committee has identified various discrepancies between the potential care requirements of the four groups of migrant children and the care that they actually receive. The details are discussed below. These discrepancies may stem from a variety of causes. In this chapter, the Committee also discusses the possible underlying causes of such differences. This provides the basis for the recommendations made in the next chapter.

4.1 Identifying the discrepancies

Goldberg and Huxley's filter model (see Figure 3) provides a guiding principle that could be used to identify a possible gap between care requirement and care uptake.[57] In this model, level I relates to the prevalence of mental health problems in the population. If patients are to reach the most specialised care (level V) they need to pass through a number of filters (referral filters). Together, these "filters" represent a selection process in which some individuals proceed to the next stage in the care process, while others do not.

This also applies to children with mental health problems and disorders. It all starts with the individual in question acknowledging and recognising that something is wrong, or, in the case of younger children, with responsible parties who have a monitoring role. If there is a failure to act, then – even at this early

stage - the process may stagnate, and young people may, quite unjustifiably, not be admitted to care.

In many cases, the next step is to visit the GP. The GP can make a diagnosis and, where necessary, refer the individual to the child and youth mental health services. Furthermore, the monitoring activities of doctors in child health clinics, school medical officers and/or paediatricians can also result in young people being referred to the child and youth mental health services. That does not mean, however, that the child eventually gets the right care. The GP or other caregiver may wrongly decide not to refer the young person, or the individual may drop out, or the treatment offered may not be appropriate. Here too, there are potential sticking points that affect the relationship between care requirement and care uptake.

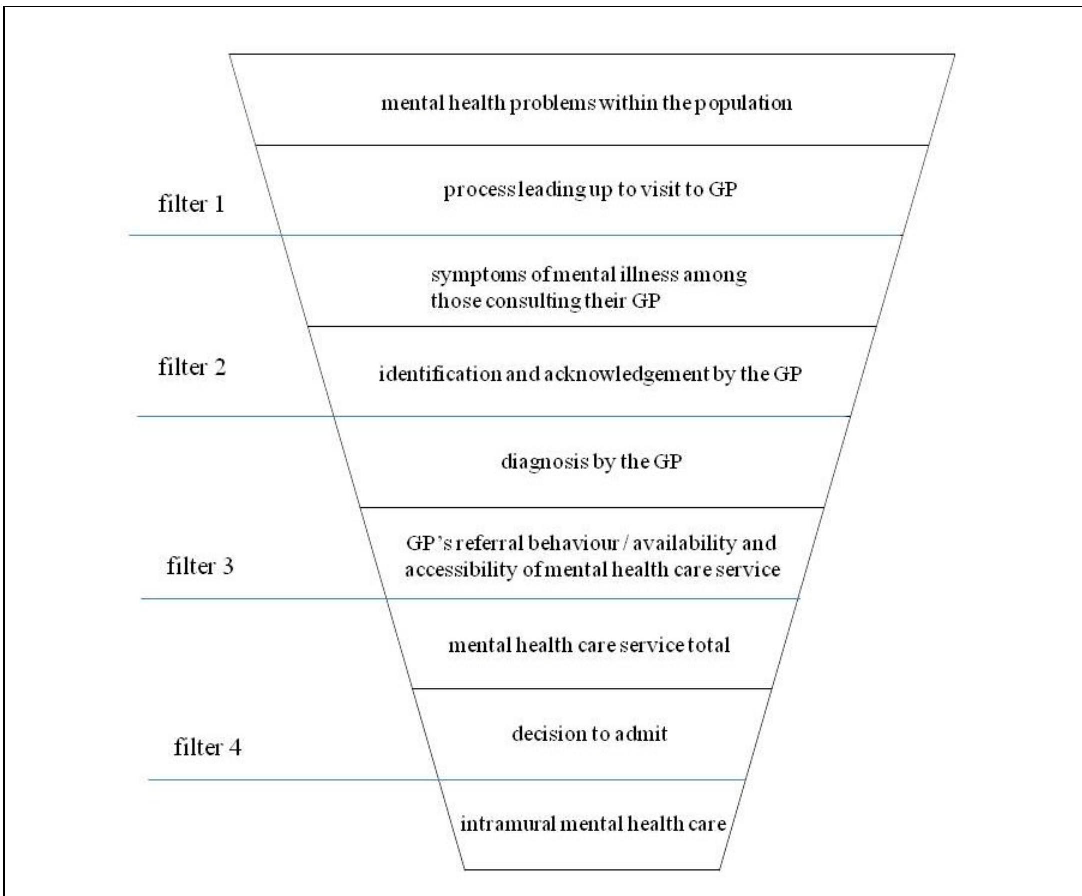

Figure 3 Goldberg and Huxley's filter model, completed in accordance with the Dutch model.

When the concept of a series of filters is applied to the material presented in Chapters 2 and 3, this gives an impression of potential sticking points and discrepancies. This is exactly what the Committee has done. In the tables below, an approximate indication is given of whether each group of migrant children is under-represented, over-represented, or proportionally represented at every stage of the care process.

In this connection, the monitoring process (carried out by those involved and by the school) uses the available comparisons with native Dutch counterparts of the same age, relative to whom the migrant children are assigned a +, -, or = (more, less, about the same).

With regard to its uptake of primary health care and diagnosis, each migrant group is designated by a +, - or = to show whether uptake is more, less, or about the same as that of native Dutch counterparts of the same age.

Their uptake of mainstream and forensic psychiatric care is compared with what might be expected on the basis of their numbers as a percentage of the population as a whole. Here too, a +, - or = is assigned for more, less or about the same uptake of care, relative to their numbers as a percentage of the population as a whole.

Table 8 Reporting by the young people themselves and by their parents on the one hand and monitoring by schools on the other, broken down by group of migrant children, compared to their native Dutch counterparts of the same age, based on various studies into the prevalence of mental health problems (no national screening).

	Young Moroccan people	Young Turkish people	Young Antillean people	Young Surinamese people
Reporting by young people/parents	-/=	+	+	=
Monitoring (school)	+	=	+	=

Table 9 Data from general practice registrations on the uptake of primary health care and the diagnoses made, broken down by group migrant children, compared to their native Dutch counterparts of the same age.

	Young Moroccan people	Young Turkish people	Young Antillean people	Young Surinamese people
Uptake of primary health care	=	+	+	=
GP’s diagnosis	=	=	+	=/+

Table 10 Data on the uptake of mainstream and forensic psychiatric care, broken down by group of migrant children relative to their numbers as a percentage of the population as a whole.

	Young Moroccan people	Young Turkish people	Young Antillean people	Young Surinamese people
In care (mainstream child and youth mental health care services)	-	-	-/=	=/-
In care (forensic psychiatric)	+	=	+	=

Stage 1: Recognition of problems by parents and children

An initial sticking point may be that children and their parents are not sufficiently aware of the mental health problems, and that they are therefore less inclined to seek help. This seems to be an issue in the group of Moroccan origin, as shown in Table 8. This shows that reporting by parents and children lags behind reporting by schools. This is not an issue in the other groups. In the group of Turkish descent, the parents and children actually perceive more problems than do the schools.

Before the Committee explores possible explanations for what may or may not be a relative inability to recognise problems in the group of Moroccan descent, it will first attempt to verify the finding itself.

For instance, it is conceivable that a poor command of Dutch may make questionnaires less reliable.[26] An unintentionally different interpretation of questions can also introduce a degree of bias. Some measuring tools do not appear to be valid, in terms of cultural sensitivity.[58] Accordingly, this could introduce a degree of bias, in the sense that young Moroccan people and/or their parents may indeed be more likely to recognise problems, but that the measuring tools used are not able to detect this.

The full impact of this potential bias cannot yet be determined. However, several studies have indeed shown that there is a discrepancy between the problems perceived by migrant parents and their children and the diagnosis made by healthcare professionals.[11,31,42] [30,59] This suggests that a relative inability to recognise problems may indeed be an obstacle in the process of seeking help, and that it is not simply a consequence of the research method used.

What might account for the fact that the parents and children of Moroccan origin themselves perceive fewer mental health problems than teachers? Their cultural background may be partly responsible for this. The culture in a particular group can affect its standards regarding what might be labelled as abnormal behaviour. Behaviour that one individual parent finds normal or acceptable, can be seen as problem behaviour by a parent with a different background.[60]

It may also be the case that the problems are indeed perceived as such, and that there is a genuine need for care, but that parents and young people themselves fail to recognise this (or lack the courage to do so). This is quite commonly seen in cases of mental health problems, but it may be more pronounced in certain groups. In such cases, shame and uncertainty in

childrearing, as well as fear of exclusion and stereotyping would lead to under-reporting.[2,8,61,62] It is certainly possible that this might affect the Moroccan group, for example, in response to the fear of discrimination.[63]

Furthermore, it may also be the case that the parents and children are not under-reporting, but that the teachers and doctors in child health clinics/school medical officers are actually seeing too many problems, as a result of over-attribution due to ethnic bias. When people from a minority group experience problems, others have a tendency to attribute that to the characteristics (or supposed characteristics) of that particular group. However, in the case of people from majority groups, problems are more readily associated with individuals.[60]

Stage 2: Detection and diagnosis by GPs

In many cases, when parents and/or children perceive that a mental health problem is involved, the next step is to visit the GP. Accordingly, it may be worthwhile to check for possible obstacles.

As shown in Table 9, none of the four groups shows a low uptake of primary health care. In children of Turkish and Antillean origin, uptake is actually somewhat higher than in the native Dutch population. However, it is striking that fewer diagnoses are made in the group of children of Turkish origin than might be expected on the basis of problems reported by Turkish parents and children.

This picture is entirely consistent with the Committee's findings regarding the pattern of health problems in the various migrant groups. In other words, if a population group tends to have a higher incidence of mental health problems, these are more likely to be diagnosed as such by the GPs in question. Accordingly, the various groups appear to have full access to primary health care. Yet it is still unclear why the disproportionately high reporting of problems by young Turkish females in particular, compared to their native Dutch counterparts of the same age, does not translate into more diagnoses of mental problems by GPs.

In addition, it is still unclear exactly what follow-up procedures are used once migrant children have been seen by their GP. Does this involve referral to a more specialised type of care? Do the parents and children feel that such referral is useful, or is it enough simply to have their problem diagnosed by the GP? Moreover, if their GP refers them to a specialist, do people actually take the next step in the care process?

A qualitative study was carried out in the Netherlands into GPs' experiences of referrals to child and youth mental health services. In general, this showed that GPs encountered various sticking points in this area, such as poor

communication and cooperation with youth mental health care services, and a level of accessibility that left much to be desired.[64] Various studies carried out in other countries tend to confirm that picture.[65,66]

In addition, surveys of adult clients demonstrate that GPs may experience problems in their contacts with Turkish and Moroccan clients, for example. For instance, GPs may find it more difficult to convey information about the mental health care service to patients of Turkish and Moroccan origin. As a result, the care these patients eventually receive does not live up to their expectations. [67,68]

Stage 3: Inflow into child and youth mental health services

Patients may encounter yet another obstacle during their transition to child and youth mental health services. The findings suggest that children of Moroccan and Turkish origin, and (to a lesser extent) children with an Antillean background, are under-represented relative to their numbers as a percentage of the population as a whole.

Where there is easily accessible healthcare, a higher prevalence of mental health problems in a particular group of migrant children should actually result in a higher uptake of child and youth mental health care in that group.

How should we interpret this? This discrepancy may indicate that these groups have limited access to child and youth mental health services. The literature contains descriptions of various models that can be used to study the accessibility of care and to identify contextual factors that can affect the uptake of care.[69] The model developed by Andersen [70,71] states that care can be regarded as accessible if a group's health needs match their actual care uptake. If it is to be used effectively, however, this model requires unambiguous information about the medical necessity of care in relation to actual use. As has been stated on several occasions, such knowledge is not available. This is due to a lack of care requirement data on one hand, and of care uptake data on the other, for the same individual. Even in the absence of such data, it seems reasonable to assume that there is restricted accessibility for young Turkish and Moroccan people. After all, their lower uptake of care can only be consistent with their care requirement if these groups also have considerably fewer mental health problems than is the case among young people of native Dutch origin. In view of the data discussed in Chapter 2, however, this is not a plausible scenario.

What might account for the more limited access to child and youth mental health care services experienced by young Turkish and Moroccan people?

One possible explanation is that this is a result of parents' attitudes to care for mental health problems. A study carried out by Fassaert et al shows that the care

requirement for mental health problems, as perceived by Moroccan adults, is lower than that perceived by adults with a native Dutch background.[72] Given the importance of parents in helping their children make the transition to care, this fact may also be partly responsible for the low uptake of care by children of Moroccan origin in the mental health care system.

Secondly, there is evidence that, rather than call in the mental health care service, parents of Moroccan and Turkish origin tend to seek other solutions.[73,74] For instance, they seem more inclined to link problems to environmental factors, and to seek solutions in that area. They are also more inclined to seek help at school.[30,75] The latter indicates a need for more primary care, which can be provided through the school. Furthermore, they may more readily turn to alternative forms of assistance. This might involve someone in their own circle, the use of alternative and/or complementary therapies, or seeking help in their country of origin.[76-78] This evidence will need to be examined further before definitive conclusions can be drawn about the causes of this phenomenon.

Thirdly, it may be that child and youth mental health services are ill-equipped to provide adequate care for young Turkish and Moroccan people. While there is little scientific knowledge on what constitutes appropriate care for groups of migrant children, there is nevertheless some evidence of sticking points. This derives from studies (including some small-scale studies), case histories, and from accounts by individual caregivers. Various knowledge institutes are currently working to identify these sticking points, mainly using reports by clients and caregivers. Some factors cited in that context are an inadequate knowledge of Dutch child and youth mental health services, a lack of confidence in the assistance available, and the inadequate quality of care.[79] However, there is no empirical evidence to show how issues of this kind affect the uptake of care.

Fourthly, it is not inconceivable that the general organisational problems currently affecting child and youth mental health services may have a detrimental effect on high-risk groups. The report entitled *An assessment of the Youth Care Act* takes a critical look at the sticking points in youth care services in general.[80] It concludes that: “The youth sector is fragmented, responsibilities are divided among many different parties, and widely diverse funding streams are involved. In addition, there is insufficient coordination between the various healthcare providers.”

Higher proportion of certain groups in forensic psychiatry

Finally, it is also important to address a form of over-representation, more specifically that of young Moroccan and Antillean males in forensic psychiatric

care. It has been suggested that this is a direct result of the low uptake of mainstream child and youth mental health care, but there is no data to support this view.

However, the Committee feels that there is unlikely to be a direct link between the low uptake of mainstream child and youth mental health care and over-representation in forensic care. After all, under-representation in mainstream care is not the only possible explanation for an over-representation in forensic psychiatric care. Two other possible explanations are discussed here.

Firstly, there may be other reasons why people enter the forensic psychiatric system, such as criminal behaviour, or to protect them against self-harming behaviour, or against individuals who want to abuse them.[81] Accordingly, the path that led them to forensic psychiatry needs further investigation.

Incidentally, even if a given group has a higher representation in the forensic care system as a result of criminal offences, this does not necessarily mean that the group in question is more prone to criminal behaviour. This is because there appear to be differences in the punishment meted out to juvenile offenders.[82] For example, a study by Veen et al showed that the nature and seriousness of the offenses for which young Moroccan people are sentenced are less extreme than those committed by their native Dutch counterparts of the same age.[83]

Secondly, the fact that these young people are over-represented in forensic psychiatric care might also be related to the involuntary nature of their participation. Within the child and youth mental health system there are other departments where admissions are on a non-voluntary basis but where criminality is not involved. These are departments where people are admitted under the Psychiatric Hospitals (Compulsory Admissions) Act, mainly due to severe psychosis and suicidality. In child and youth mental health institutions, a relatively high proportion of such cases also involve young people of migrant origin. The fact that these individuals do not voluntarily seek assistance but instead have it imposed upon them, may therefore be an explanatory factor.

4.2 Conclusion

The analysis in this chapter shows that there are certain sticking points in the care process which may affect the uptake of care by individuals from the four groups of migrant children who are suffering from mental health problems or disorders.

For instance, parents and children of Moroccan origin seem to be less able to recognise problems. This might make them less inclined to take the first step towards care. In primary health care, accessibility does not seem to be an issue in quantitative terms, although there are indications that communication between

GPs and migrants and the through-flow to child and youth mental health services both leave something to be desired. The lower inflow of migrant children into secondary health care may have something to do with this, but there is currently no evidence to support this hypothesis. However, there is evidence to suggest that these groups are more inclined to make use of alternative forms of assistance. Another factor might be a lack of appropriate care in mainstream health services.

In conclusion, the Committee feels that this over-representation in forensic care is unlikely to be a direct consequence of the low uptake of mainstream child and youth mental health care. This is because there may be other reasons why people enter the forensic psychiatric system.

Chapter 5

Conclusions and recommendations

5.1 Differentiated picture

An important conclusion, at the end of the advisory process is that migrant children of Moroccan, Turkish, Surinamese and Antillean origin differ in the degree to which they suffer from mental health problems and in the extent of their uptake of care. There is no such thing as “young migrants”, as migrant children and young people are not a homogeneous group. Accordingly, when attempting to identify the mental well-being of young migrants, it is essential to distinguish between them in terms of their origin. In addition, there are important distinctions to be made within ethnic groups, such as gender.

The outcomes of this advisory report reaffirm the importance of the choice that the Committee made at the very beginning, which was to examine the four groups of migrant children individually. In subsequent steps, too, it is important to examine specific groups. This advisory report’s findings can be used to locate problems more accurately, and to focus on them.

5.2 Request for advice 1: prevalence of mental health problems

How do the nature and extent of mental health problems among migrant children of Moroccan, Turkish, Surinamese, and Antillean origin relate to the nature and extent of mental health problems in other young Dutch people up to 23 years of age? What are the underlying causes of any differences?

In a number of cases there are more problems, in others just as many or fewer

The available empirical data on the prevalence of mental health problems is very limited. In addition, those studies that are useful also tend to be rather heterogeneous in terms of their design. For this reason interpretation can be very challenging, and it can be difficult to form a consistent picture.

Nevertheless, this research has yielded some evidence. For instance, there were consistent reports of more behavioural problems in young males of Moroccan origin than in their native Dutch counterparts of the same age. Yet young people with a Turkish background actually appear to have more emotional problems. Young Antillean people have a higher incidence of both emotional and behavioural problems.

In other cases, reports indicated that there were actually fewer problems. For instance, young people of Moroccan origin themselves reported fewer emotional problems, and reports by young females from this group indicated less suicidal behaviour. No clear differences were found between the incidence of mental health problems in young Surinamese people and in young people with a native Dutch background. It should be noted, however, that these findings are based on a very limited amount of data. Yet it does seem that there are a greater number of suicide attempts among young Surinamese females.

A combination of causes

Why do some groups of migrant children suffer more mental health problems than others? There is still a great deal of uncertainty in this area. In general, the reasons for health inequalities are ascribed to a different distribution of risk factors, or to more or fewer protective factors. Similar explanations can also be put forward with regard to the mental health problems in the groups of migrant children surveyed.

For instance, a lack of protective factors may be involved in the case of young people of Moroccan origin. Some examples are the quality of residential life (liveability) in their neighbourhood, and the perceived support that they receive from their mother. This gives rise to another question. Why do specific migrant groups have a greater incidence of certain risk factors and a lower incidence of protective factors? This appears to be partly related to these groups' socioeconomic background. There are also indications of factors whose role is

specific to their origins in ethnic minority groups, such as the ethnic density of the residents of a given area, and their cultural orientation.

5.3 Request for advice 2: uptake of care

How do the nature and extent of care uptake in connection with mental disorders among migrant children of Moroccan, Turkish, Surinamese, and Antillean origin relate to the nature and extent of care uptake in connection with mental disorders in other young Dutch people up to 23 years of age?

Less uptake of care at different stages of the care process

Children of Moroccan origin consult their GP about mental health problems just as often as their native Dutch counterparts of the same age. However, their uptake of secondary child and youth mental health care is lower than might be expected on the basis of their numbers as a percentage of the population as a whole.

Young Turkish females in particular are more likely to consult their GP about symptoms of mental illness than young Dutch females, but this is less likely to result in a diagnosis. In child and youth mental health services, children of Turkish origin are less frequently represented than would be expected on the basis of their numbers as a percentage of the population as a whole.

Antillean children are more likely than their native Dutch counterparts of the same age to visit their GP with mental health problems. This is more true of young males than young females. As a result, GPs diagnose mental problems twice as often in this group. However, this does not translate into a higher uptake of child and youth mental health care.

GP registrations show that the percentage of children of Surinamese origin with symptoms of mental illness is about the same as that seen among young people with a native Dutch background. GPs do tend to diagnose mental problems in this group slightly more often than they do in young people with a native Dutch background.

Children of Surinamese origin are proportionally represented in the child and youth mental health services.

Institutional figures on forensic psychiatric care in the Haaglanden region show an increased rate for young Moroccan and Antillean people, relative to their numbers as a percentage of the population as a whole. This does not apply to young people of Turkish and Surinamese origin.

5.4 Request for advice 3: low uptake of care and sticking points

How large is the gap, if any, between care requirement and care uptake? What are the underlying causes of any discrepancies?

Some groups are relatively under-represented in healthcare, especially in the area of child and youth mental health care

Certain groups show clear discrepancies between the scale of mental health problems in that group, and the level of uptake of child and youth mental health services. For instance, published studies have reported more behavioural problems among children of Moroccan origin than among their native Dutch counterparts of the same age, but their representation in child and youth mental health care is actually lower than that of the latter group.

A similar picture, albeit less pronounced, can be seen in children of Antillean origin, who have a somewhat higher prevalence of mental health problems, and a lower care uptake of child and youth mental health care than you might expect based on these prevalence figures.

Yet children with a Turkish background show a higher incidence of emotional problems. They do visit their GPs, but their uptake of child and youth mental health services is less than might be expected.

However, children of Surinamese origin do not show an increased prevalence of mental health problems, even though their uptake of child and youth mental health services is in line with what might be expected of a group of this size.

The main sticking points affect the through-flow to child and youth mental health services

What could account for these differences? Is there a problem with the accessibility of care, or are there other reasons? In scientific terms, little can be said about this matter with any certainty. Nevertheless, the figures on care uptake do offer a few clues.

For instance, parents and children of Moroccan origin seem to be less able to recognise problems. This might make them less inclined to seek care. In primary health care, accessibility does not seem to be an issue in quantitative terms. Children from the four migrant groups consult their GPs about symptoms of mental illness just as often as children with a native Dutch background, sometimes more so, as in the case of young females with a Turkish background

and children of Antillean origin. However, it remains unclear exactly what follow-up procedures are used once migrant children have been seen by their GP. There are indications that their through-flow to child and youth mental health services is generally less than ideal. The lower inflow of migrant children into secondary health care may have something to do with this, but there is currently no data specific to these groups that might help to clarify the situation. However, there is evidence to suggest that these groups are more inclined to make use of alternative forms of assistance. A lack of appropriate care in mainstream health services might also be involved.

Over-representation in forensic psychiatry

Finally, it is also important to address a form of over-representation, more specifically that of young Moroccan and Antillean males in forensic psychiatric care. It has been suggested that this is a direct result of the these groups' under-representation in mainstream child and youth mental health care. However, there is no data to support this view. Under-representation in mainstream care is not the only possible explanation for an over-representation in forensic psychiatric care. There may be other reasons why individuals enter the forensic psychiatric system, such as criminal behaviour. Also, some young people are admitted to a secure setting to protect them against self-harming behaviour, or against individuals who want to abuse them. In addition, the fact that these young people do not voluntarily seek assistance but instead have it imposed upon them may be an explanatory factor.

5.5 Request for advice 4: potential solutions

Are there any potential solutions that might lead to an improvement in the current situation? What steps can be taken?

Focus on appropriate care, rather than on quantity

The limited availability of data has given this advisory report a primarily agenda-setting quality, the Committee has nevertheless proposed a number of potential solutions. It feels that an important starting point here is that the goal should not be formulated in quantitative terms, such as “more migrant children in care”. Every child with mental health problems is entitled to care, but that care must be appropriate. This applies just as much to young people with a native Dutch background.

Take account of differences

General organisational improvements in youth care services will benefit all vulnerable groups, including specific migrant groups. This alone is not enough. While there is little scientific knowledge on what constitutes appropriate care for groups of migrant children, there is nevertheless some evidence of sticking points. This derives from studies (including some small-scale studies), case histories, and from accounts by individual caregivers and clients. On that basis alone it is recommended that both organisations and caregivers be given the competencies needed to provide effective care to patients from a wide range of ethnic groups. Various initiatives launched by existing knowledge institutes and care institutions can be useful in this regard.

Need for focused research

One of this advisory report's major themes is the limited availability of empirical data. While a picture has certainly emerged that provides some initial points of reference for improvement, a greater understanding is needed. To this end, it is vital to focus effectively on the issues at hand. We must spotlight children that we suspect are not receiving the care they need. The findings of this advisory report provide points of reference for this purpose. The Committee has made the following recommendations.

Research into prevalence and explanatory factors

Firstly, additional and more focused research is needed into the prevalence of mental health problems. For instance, the research needed could involve comparing reports by children, parents and teachers with the outcomes of diagnostic interviews with healthcare professionals. The outcomes that are currently available are often difficult to interpret.

This is particularly applicable to the determination of behavioural problems among young Turkish and Moroccan people, and of emotional problems among young Turkish and Surinamese females. Knowledge from a variety of sources, about the same individuals, can then be used to identify any discrepancies with their actual uptake of care.

It is recommended that further studies be conducted into the protective factors and risk factors involved. This could provide insight into the development of mental health problems in certain vulnerable groups (including vulnerable

migrant groups). This, in turn, could provide control points for preventive measures.

Research into care uptake

Based on currently available sources, it is difficult to make general statements about the uptake of care by various migrant groups in the Netherlands. More detailed conclusions could be drawn if there were better uniform registration, and if data from many more institutions and regions was available than is presently the case.

In addition to monitoring the inflow into care, there should be an examination of drop-out rates. There should also be a focus on the relatively high uptake of care (and especially on the large inflow into care) of children and young people with a native Dutch background.

Research is also needed into the effects of possible differences in care uptake, in terms both of the prognosis in certain disorders and of care uptake in other segments. This would involve the identification of treatment processes (longitudinally), to identify any sticking points. A specific examination would be needed of a number of screening points in the care process, such as monitoring at schools and referral to primary and/or secondary care, and referral by GPs.

A retrospective study could also help to identify potential sticking points in care, especially among clients in forensic psychiatric care. This would facilitate an exploration of differences between groups in terms of mental health problems and of completed care programmes. The main focus will need to be on young people of Moroccan and Antillean origin, compared to children with a native Dutch background and to other groups of migrant children.

Studies of clients' experiences in the care system

Finally, it is important to encourage qualitative studies among migrants (both young people and parents), with a focus on client satisfaction, relevance, and diversity competence among caregivers.

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A Request for advice

B The Committee

C References concerning prevalence rate in the general population

Annexes

Annex **A**

Request for advice

On 30 March 2010, the then President of the Health Council was asked to prepare an advisory report on young migrants and child and youth mental health services. This request was made by the then Minister for Youth and Families, the Minister of Health, Welfare and Sport, the Minister for Housing, Communities and Integration and the State Secretary for Education, Culture and Science. The Minister wrote (letter CZ/CGG-2989643):

Dear Prof. Knottnerus,

The Minister of Health, Welfare and Sport, the Minister for Housing, Communities and Integration, the State Secretary for Education, Culture and Science, and I would like to draw your attention to the following:

There is evidence that young migrants of non-western origin are about three times as likely to develop mental disorders as their native Dutch counterparts of the same age. They appear to be under-represented in early-stage outpatient mental health care. However, this group is over-represented in specialist and forensic mental health care.

In the case of these young people, it seems that it is difficult to identify (at an early stage) problems that may indicate a mental disorder, and to effectively refer them for further diagnosis and treatment. Timely care can solve these problems, or at least prevent them from becoming more severe.

So why is it that young migrants with mental health problems are admitted to the mental health care system at a late stage (possibly too late) or are never admitted at all? This may result from the way in which monitoring and care are organised, from the procedures followed by the various institutions involved, and from cultural factors. The next question is how can the availability and accessibility of mental health care services for young people of migrant origin and their parents be enhanced? What are the implications for the way in which monitoring and care are organised? What changes are needed in institutional procedures? What does that mean for professional practitioners working in the mental health care services, in terms of the development of their knowledge and skills? What steps need to be taken? What parties would this involve? These are the central questions on which I would appreciate your Council's advice.

To reach young people with a non-western background who are suffering from mental health problems sooner and more effectively, I am requesting the Health Council to advise me on how to develop a better mental health care service for these young people. I would also like the Council to answer the following questions.

The specific questions for your Council are:

1 Can you summarise the results of studies (including recent studies) into the prevention of mental health problems among young migrants, differentiated by origin, age, gender, and socioeconomic status, and compared to young people of Dutch origin (or those from another western country) with the same characteristics? Can you also indicate the percentage that have been diagnosed or are in care, and give an estimate of the true prevalence? What can be concluded at this stage about the cause of the observed differences in mental health, and which areas require further research?
2 Given the under-representation of young migrants in the child and youth mental health care system and their later over-representation in those parts of the mental health care service that specialise in more serious cases, I would like you to clarify at which moment, in which domain (family, school, care, or judicial care), and by whom, the problems of young migrants are identified. I would also like to know how and by whom these young people and their parents are referred? With regard to these points, are there any observable differences between young people with western and non-western backgrounds, allowing for their socioeconomic status?
3 What sticking points can be identified in the processes of monitoring, referral, and diagnosis, and in keeping these young people in care during their treatment? What is the nature of these sticking points? This could involve infrastructure, professional practitioners' intercultural competences and expertise (including intercultural expertise), sufficiently (or insufficiently) culturally-sensitive diagnostic and curative tools, as well as sticking points in cooperation between various sectors. In this connection, please be sure to address the sticking points perceived by the clients themselves.
4 What type of approach, and what activities, will be needed to resolve the sticking points that have been identified? In what ways should the organisation and procedures of institutions

involved in the mental health care service be improved to ensure that young migrants are reached just as effectively as young people with a native Dutch background? In the context of this process, what are the roles and responsibilities of the government and the various parties involved? What potential solutions have been put forward by clients and professional practitioners, and which of these are feasible in practice? Are any effective examples available?

As this request for advice involves potential solutions in a range of different domains, I would ask you, where necessary, to make use of the expertise of the Education Council of the Netherlands and the Netherlands Council for Social Development in your investigation. I would also refer you to the "Diversity in Youth Policy" programme that was launched by the Ministry for Youth and Families and the Ministry of Housing, Communities and Integration at end of 2008. This programme is being implemented by the Netherlands Organisation for Health Research and Development. Its main goals include improving the availability and accessibility of general amenities for young people and parenting support for migrant groups. Other targets for those working in the field are the development of intercultural knowledge and greater professionalism.

Given the urgency of the problem and the need to tackle sticking points that have been identified in the very near future, please submit your advisory report to me in the spring of 2011.

Yours faithfully,
The Minister for Youth and Families,
A. Rouvoet

Annex **B**

The Committee

- Prof. K. Stronks, *Chairperson*
  Professor of Social Medicine, Academic Medical Center, Amsterdam
- Prof. M.H.J. Bekker
  Professor of Clinical Psychology, Tilburg University
- Prof. F. Boer
  Emeritus Professor of Child and Adolescent Psychiatry, Bascule and Academic Medical Center, Amsterdam
- Prof. M.C.H. Donker, (*until January 2011*)
  Chief Science Officer, The City of Rotterdam, and Professor of Public Health and Policy, Erasmus University, Rotterdam
- Prof. H. Ghorashi
  Endowed Professor of Management of Diversity and Integration at VU University Amsterdam
- Dr. A.E. Kunst
  Social Epidemiologist and Medical Demographer, Social Medicine, Academic Medical Center, Amsterdam
- Prof. Ch. van Nieuwenhuizen
  Endowed Professor of Forensic Mental Health Care,
  Tilburg University
- Prof. W. Shadid
  Emeritus Professor of Intercultural Communication, Tilburg University and University of Leiden

- Dr. G.W.J.M. Stevens
  General Social Sciences, Utrecht University
- Dr. W. Veling
  Psychiatrist and Epidemiologist, Parnassia, The Hague
- Prof. F.C. Verhulst
  Emeritus Professor of Child and Adolescent Psychiatry, Erasmus Medical Center, Rotterdam
- E. Memeo, *observer*
  Ministry of Health, Welfare and Sport, The Hague
- Dr. C.A. Postema, *scientific secretary*
  Health Council of the Netherlands, The Hague
- Dr. S.J.W. Kunst, *scientific secretary*
  Health Council of the Netherlands, The Hague

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For the purposes of this advisory report, Dr. André I. Wierdsma and Dr. Astrid M. Kamperman of the O3 Research Centre at the Rijnmond Mental Health Care Institute and the Department of Psychiatry, Erasmus MC have performed a number of exploratory analyses using data from the Rijnmond psychiatric case register.

The Health Council and interests

Members of Health Council Committees are appointed in a personal capacity because of their special expertise in the matters to be addressed. Nonetheless, it is precisely because of this expertise that they may also have interests. This in itself does not necessarily present an obstacle for membership of a Health Council Committee. Transparency regarding possible conflicts of interest is nonetheless important, both for the chairperson and members of a Committee and for the President of the Health Council. On being invited to join a Committee, members are asked to submit a form detailing the functions they hold and any other material and immaterial interests which could be relevant for the Committee's work. It is the responsibility of the President of the Health Council to assess whether the interests indicated constitute grounds for non-appointment. An advisorship will then sometimes make it possible to exploit the expertise of the specialist involved. During the inaugural meeting the declarations issued are discussed, so that all members of the Committee are aware of each other's possible interests.

Annex **C**

References concerning prevalence rate in the general population

Young Moroccan people

author, year of publication	population (incl. reference group)	sampling characteristics	age
Zwirs et al, 2006 [17]	792 Moroccan (M), 768 Dutch (D)	ADEON study, *cluster sample* in areas of Utrecht and Amsterdam with large migrant populations of low socioeconomic status	5-11
Wissink et al, 2006 [18]	84 Moroccan (M), 319 Dutch (D)	all secondary schools at the lowest level of secondary education with a migrant population of between 10% and 45% in medium-sized and major cities in the Netherlands	12-16
Stevens et al, 2003 [2]	819 Moroccan (M), 2,227 Dutch (D)	random sample of children from the registers of residents kept by The Hague and Rotterdam. For Dutch children, 89 local authorities were chosen at random. Within each of these local authorities, a random sample of children was then selected (= nationally representative)	4-18
Crone et al, 2010 [11]	156 Moroccan children (M), reference group (RG) 1,831 children from industrialised countries	random sample of 15 child and youth care institutions (multistage stratified) involving a random sample of children from each institution. In addition, a sample of 200 Moroccan children (2002-2003) was selected from two major cities in the Netherlands	5-12 (5-6 and 8-12)
Adriaanse et al, 2011 [19]	408 Moroccan children and young people (M), 693 Dutch (D)	screening (2009) involving 8 primary schools and 10 secondary schools throughout the Netherlands, with the maximum possible distribution in terms of school level	9-16 (9-12 and 13-16)
van Bergen et al, 2010 [21]	female secondary school pupils, 557 Moroccan (M) and 3,090 Dutch (D)	Rotterdam Youth Monitor, 85% of all secondary schools in Rotterdam took part (2003-2006)	14-16
van Bergen et al, 2008 [20]	39 Moroccan (M), 142 Dutch (D)	random sample from the Utrecht register of residents (249 adolescents) (1996-2001)	12-18
van Heusden et al, 2008 [22]	67 Moroccan (M) and 1,634 Dutch adolescents (D)	cross-sectional population survey (random sample of 35 local authorities) in the south-west of the Netherlands (2004-2005)	19-30
Rotterdam Youth Monitor, 2008 [10]	toddlers 241 (M) and 1655 (D), group 2 465 (M), 1685 (D), group 7 335 (M) and 949 (D), Sec. Sch. yr 1 491 (M) and 2042 (D), Sec. Sch. yr 3 467 (M), and 2032 (D)	all children of school-going age in Rotterdam using 5 measurements at given points in time: toddlers 30 months, young children in year 2, children in year 7 and in the first year of secondary school, adolescents in the third year of secondary school (in collaboration with post-natal clinics and schools from 2004-2006)	0-19

generation, 1st and 2nd	method	reporter	prevalence of problem behaviour
both	SDQ and 5 ADHD/ODD DSM IV items	teacher report	M>D (young males) M=D (young females)
both	YSR: aggressive and delinquent behaviour	self report	aggressive and delinquent behaviour M=D
both	CBCL, YSR, TRF	parent report, self report and teacher report	self M<D (ext) M=D (int) parent M=D ext/int) teacher M=D (int) M>D (ext)
both	CBCL, parental concerns questionnaire, diagnosis by professional practitioner (heteroanamnesis and physical examination)	parent report and diagnosis by a professional practitioner	M>RG (ext) M>> RG (int), concerns about behaviour M<RG, diagnosed psychosocial problems M<RG
both	SDQ and SAHA	self-report and teacher report	Emotional issues: SDQ self-report both young males and young females to M<D, SAHA young males M>D young females M<D; teachers' reports on both young males and young females M<D. Behavioural problems SDQ and SAHA self-report young males and young females M>D, teacher report SDQ M>>D
both	YMR questionnaire	self-report (anonymous)	rate of suicide attempts M(6.1%)<D (8.8%)
both	health questionnaire by mail	self report	suicidal behaviour young males M=D, young females M(13%)<D(20%)
both	ASR	self report	number of men who reported hallucinations M (21%)>D(3%), women M=D (approx. 3%)
both	Rotterdam Youth Monitor questionnaire with several nationally validated measuring tools (including KIPPI 1-2, KIPP 5 and SDQ)	parent report, teacher report, self report	parent report of emotional problems in toddlers M(16%)>D(7%) and preschool children M(21%)> D (9%), behavioural problems toddlers and preschool children M(8%)>D(4%) teacher report toddlers behavioural problems M>D self report gloomy feelings children M=D; behavioural problems M>D self report emotional problems young people M(13%)<D(20%) number young people with suicidal thoughts M(13%)<D (19%), behavioural problems M>D

Young Turkish people

author, year of publication	population (incl. reference group)	sampling characteristics	age
Zwirs et al, 2006 [17]	434 Turkish (T), 768 Dutch (D)	ADEON study, cluster sample in areas of Utrecht and Amsterdam with large migrant populations of low socioeconomic status	5-11
Wissink et al, 2006 [18]	106 Turkish (T), 319 Dutch (D)	all secondary schools at the lowest level of secondary education with a migrant population of between 10% and 45% in medium-sized and major cities in the Netherlands	12-16
Janssen et al, 2004 [26]	379 Turkish (T), 1,039 Dutch (D)	random sample of Turkish children from the registers of residents kept by The Hague and Rotterdam. For Dutch children, 89 local authorities were chosen at random. Within each of these local authorities, a random sample of children was then selected (= nationally representative)	11-18
Crijnen et al, 2000 [24]	524 Turkish (T), 1,625 Dutch (D)	see Janssen 2004	4-18
Bengi-Arslan et al, 1997 [25]	833 Turkish (T), 2,081 Dutch (D)	see Janssen 2004	4-18
Stevens et al, 2003 [2]	833 Turkish (T), 2,227 Dutch (D)	see Janssen 2004	4-18
van Oort et al, 2007 [27]	168 Turkish (T) young people, 486 Dutch (D) young people	random sample from the Rotterdam and The Hague registers of residents for young Turkish people (1993) and a random sample from the South Holland register for young Dutch people (1987)	11-15
Crone et al, 2010 [11]	150 Turkish children (T), reference group (RG) 1831 children from industrialised countries	random sample of 15 youth care institutions (multistage stratified) involving a random sample of children from each institution. In addition, a sample of 200 Turkish children (2002-2003) was selected from two major cities in the Netherlands 2002-2003	5-12
van Bergen et al, 2010 [21]	female pupils; 614 Turkish (T), 3,090 Dutch (D)	Rotterdam Youth Monitor, 85% of all secondary schools in Rotterdam took part (2003-2006)	14-16
van Bergen et al, 2008 [20]	22 Turkish (T), 142 Dutch (D)	random sample from the Utrecht register of residents (249 adolescents) (1996-2001)	12-18
Burger et al, 2009 [28]	Turkish women (T), Dutch women (D)	data from care institutions in The Hague 2002-2004 (psychiatric departments general hospitals, emergency psychiatric departments, and municipal coroners)	15-24
Rotterdam Youth Monitor, 2008 [10]	toddlers 198 (T) and 1655 (D), year 2 510 (T) and 1,685 (D), year 7 386 (T) and 949 (D), Sec. Sch. yr 1 467 (T) and 2,042 (D), Sec. Sch. yr 2 545 (T) and 2,032 (D),	all children of school-going age in Rotterdam, using 5 measurements at given points in time: toddlers 30 months, young children in year 2, children in year 7 and in the first year of secondary school, adolescents in the third year of secondary school (in cooperation with post-natal clinics and schools from 2004-2006)	0-19

generation, 1st and 2nd	method	reporter	prevalence of problem behaviour
both	SDQ and 5 ADHD/ODD DSM IV items	teacher report	T<D (young males) T=D (young females)
both	YSR: aggressive and delinquent behaviour	self report	aggressive behaviour T>D delinquent behaviour T=D
both	YSR	self report	T>D (int) T=D (ext)
both	TRF	teacher report (Dutch teacher)	T=D (int/ext)
both	CBCL	parent report	T>D (int and ext)
both	CBCL, YSR, TRF	parent report, self report and teacher report	self T>D (int) parent T>D (int/ext) teacher T=D (int/ext)
both	YSR	self report	young females T>D (int/ext), young males T>D (int) and T=D (ext)
both	CBCL, parental concerns questionnaire, diagnosis by professional practitioner (heteroanamnesis and physical examination)	parent report	T=RG (ext) T>>RG (int), concerns about behaviour T<RG, diagnosed psychosocial problems T=RG
both	YMR questionnaire	self-report (anonymous)	rate of suicide attempts T (14.8%)>D (8.8%) (non-fatal)
both	health questionnaire by mail	self report	suicidal thoughts/ considering making an attempt young males T(30%)>D(15%) young females (46%)>D(20%)
both	number of suicide attempts/ number of actual suicides	data from healthcare institutions	suicide attempts T (545 per 100,000 person-years)>D (246 per 100,000 person-years), no successful suicide attempts among Turkish women
both	Rotterdam Youth Monitor questionnaire with several nationally validated measuring tools (including KIPPI 1-2, KIPP 5 and SDQ)	parent report, teacher report, self report	parent report emotional problems toddlers T(22%)>D(7%) and preschool children T(27%)>D (9%), behavioural problems toddlers and preschool children T>D teacher report behavioural problems in preschool children T(7%)>D(4%) self report gloomy feelings children T=D; behavioural problems T>D self report emotional problems young people T=D(20%) number of young people with suicidal thoughts T=D

Young Surinamese people

author, year of publication	population (incl. reference group)	sampling characteristics	age
Zwirs et al, 2006 [17]	409 Surinamese (S), 768 Dutch (D)	ADEON study, cluster sample in areas of Utrecht and Amsterdam with large migrant populations of low socioeconomic status	5-11
Wissink et al, 2006 [18]	33 Surinamese (S), 319 Dutch (D)	all secondary schools at the lowest level of secondary education with a migrant population of between 10% and 45% in medium-sized and major cities in the Netherlands	12-16
van Bergen et al, 2010 [21]	female pupils; 266 Hindustani (H) and 3,090 Dutch (D)	Rotterdam Youth Monitor, 85% of all secondary schools in Rotterdam took part (2003-2006)	14-16
Burger et al, 2009 [28]	Surinamese women (S) and Dutch women (D)	data from care institutions in The Hague 2002-2004 (psychiatric departments general hospitals , emergency psychiatric departments, and municipal coroners)	15-24
Rotterdam Youth Monitor, 2008 [10]	toddlers 162 (S) and 1,655 (D), group 2 489 (S), 1,685 (D), group 7 337 (S) and 949 (D), Sec. Sch. yr 1 555 (S) and 2,042 (D), Sec. Sch. yr 3 517 (S), and 2,032 (D)	all children of school-going age in Rotterdam using 5 measurements at given points in time: toddlers 30 months, young children in year 2, children in year 7 and in the first year of secondary school, adolescents in the third year of secondary school (in collaboration with post-natal clinics and schools from 2004-2006)	0-19

generation, 1st and 2nd	method	reporter	prevalence of problem behaviour
both	SDQ and 5 ADHD/ODD DSM IV items	teacher report	S=D (young males) S=D (young females)
both	YSR: aggressive and delinquent behaviour	self report	aggressive behaviour S>D, delinquent behaviour S=D
both	YMR questionnaire	self-report (anonymous)	rate of suicide attempts H (19.2%)> D (8.8%)
both	number of suicide attempts/number of actual suicides	data from healthcare institutions	suicide attempts S (421 per 100,000 person-years)>D (246 per 100,000 person-years), no successful suicide attempts among Surinamese women
both	Rotterdam Youth Monitor questionnaire with several nationally validated measuring tools (including KIPPI 1-2, KIPP 5 and SDQ)	parent report, teacher report, self report	parent report of emotional problems in toddlers S=D(7%) and preschool children S=D (9%), behavioural problems toddlers and preschool children S=D teacher report behavioural problems in preschool children S=D self report gloomy feelings children S=D; behavioural problems S=D self report emotional problems young people S=D (20%), number young people with suicidal thoughts S (23%) versus D (19%) behavioural problems S=D

Young Antillean people

author, year of publication	population (incl. reference group)	sampling characteristics	age	generation, 1st and 2nd	method	reporter	prevalence problem behaviour
Rotterdam Youth Monitor, 2008 [10]	toddlers 84 (A) and 1,655 (D), year 2 231 (A) and 1,685 (D), group 7 135 (A) and 949 (D), Sec. Sch. yr 1 198 (A) and 2,042 (D), Sec. Sch. yr 3 178 (A), and 2,032 (D)	all children of school-going age in Rotterdam using 5 measurements at given points in time: toddlers 30 months, young children in year 2, children in year 7 and in the first year of secondary school, adolescents in the third year of secondary school (in collaboration with post-natal clinics and schools from 2004-2006)	0-19	both	Rotterdam Youth Monitor questionnaire with several nationally validated measuring tools (including KIPPI 1-2, KIPP 5 and SDQ)	parent report, teacher report, self report	parent report of emotional problems in toddlers A (17%)>D (7%) and preschool children A (19%)> D (9%), behavioural problems toddlers and preschool children A (15%)> D (4%) teacher report behavioural problems in preschool children A>D self report gloomy feelings children A=33% versus D=25%; behavioural problems A>D number young people with suicidal thoughts A (26%) versus D (19%) behavioural problems A>D

VO = secondary education, SDQ = Strengths and Difficulties Questionnaire, YSR = Youth Self Report, CBCL = Child Behaviour Checklist, TRF = Teacher's Report Form, SAHA = Social and Health Assessment, ASR = Adult Self Report, JMR = Rotterdam Youth Monitor Questionnaire.