Dealing with the mental wellbeing of refugees in a Dutch context

A study about prevention and mental health care to refugees in the region Gelderland-Zuid.

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Summary

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Abbreviations

AZC	Asylum Centre
COA	Central Agency for the Reception of Asylum Seekers
GGD	Regional Public Health Service
GGZ	Mental Health Care
GP	General Practitioner
IND	Dutch Immigration and Naturalisation Service
ISK	International Transitional Class
POH-GGZ	Mental Health Nurse Practitioner
PTSD	Posttraumatic Stress Disorder
PVT	Participation Declaration Trajectory
VNG	Association of Dutch Municipalities
VWN	Dutch Council for Refugees
VWON	'East-Netherlands' department of the Dutch Council for Refugees

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1. Introduction

This is a study about barriers to the mental wellbeing of refugees during their integration in the Netherlands, as well as the challenge to organise prevention and mental health care during the increased refugee influx since 2015. This research was conducted within the framework of an internship at the GGD Gelderland-Zuid, a Dutch regional Public Health Service[1].

1.1 Research problem

Even though conflicts and refugees have existed over the centuries – and will probably do so in the future – the past three years are characterized by what the international community calls the 'European refugee crisis.' In 2015, approximately 1.25 million asylum seekers asked for protection in a EU-country, which is twice as many as in 2014 (Vluchtelingenwerk Nederland, 2016). With the number of asylum requests doubled to almost sixty thousand, the Netherlands is housing a substantial number of refugees as well.

Crossing borders: from the residence permit to societal integration
As soon as a refugee crosses the Dutch border into the Netherlands, he or she starts on a trajectory with the objective of becoming a Dutch citizen. During this process, the refugee must cross more borders, albeit of a non-physical kind. These 'paper-made' borders are actually the hardest to cross (Van Houtum & Lucassen, 2016). When entering the Netherlands through the physical border, the refugee becomes an asylum seeker upon recognition by the Dutch government according to the refugee convention (Van der Hel, 2016). He or she then awaits the approval of a temporary residence permit for five years, while normally being accommodated in a Dutch Asylum Centre (AZC) or emergency shelter. The approval of a temporary residence permit usually takes fourteen days, but can take up to six months, depending on the need for prolongation (i.e. extra investigation time). When the temporary residence permit is granted by the Dutch Immigration and Naturalisation Service (IND), the asylum seeker becomes a status- or permitholder and will be moved to housing in a municipality.

The statusholder is then obliged to successfully integrate into Dutch society within five years, after which he or she can apply for a permanent residence permit to become a fully recognized Dutch citizen through naturalisation. In order to do so, a statusholder must comply with two conditions. Since the 1st of July 2017, a statusholder is obliged to sign the participation declaration, in which he or she takes note of Dutch rights, duties and fundamental values and is willing to respect them (Rijksoverheid, 2016). A statusholder is also obliged to pass his or her civic integration exam within the first three years (DUO, n.d.). To pass this exam, the statusholder is personally responsible to follow integration and language courses. When a statusholder fails to comply with one of these conditions, he or she may be fined and the government may eventually decide to reject the permanent residence permit. This master thesis focuses primarily on this last symbolic border: the period of five years allowed for integration.

[1] A 'Gemeenschappelijke of Gemeentelijke Gezondheidsdienst (GGD)' or Dutch regional (literally communal or municipal) Public Health Service is a decentralized governmental organisation which executes several public health tasks on the municipal level. For example, youth health care, infectious disease control, community mental health, (sexual) health education and so on. There are 25 regions, whereas Southern Gelderland contains, among others, the municipality of Nijmegen.

Refugees: 'unwanted' guests?

Apart from capacity problems and societal resistance, the influx has led to extensive attention and effort from numerous governmental institutions, aid agencies and volunteers. Generally, there is a great deal of goodwill and momentum regarding the refugee challenge, partly in response to tragedies depicted in the media, such as the photo of Aylan, a drowned child on a Turkish beach near Bodrum (Van Houtum & Lucassen, 2016). By contrast, a restrictive European immigration policy – manifestly illustrated by heavily fortified external European borders – discourages refugees from entering 'Fortress Europe' (Van Houtum & Lucassen, 2016). Professing an intention to prevent refugees from risking their lives during the flight and to discourage durable settlement, paradoxically the fortified European borders result in refugees using alternative, illegal and more dangerous routes that are often facilitated through human trafficking. Consequently, the European border is becoming deadlier and refugees are more likely to settle (semi-)permanently when finally entering the European Union (EU), due to the difficulty and danger of re-entering.

In line with the EU policy, the Dutch asylum policy is based on a deterrent approach as well. It is characterized by massive segregated emergency sheltering and asylum accommodation (Bakker, Cheung, & Philimore, 2016; Van Houtum & Lucassen, 2016). Bakker et al. (2016) established that this has a specific negative effect on mental health, due to a lack of rest, privacy and occupational activity. Paradoxically, this exclusionary asylum policy stands in contrast with the inclusive objectives of the integration process. Indeed, the Dutch government prioritizes the integration of statusholders with equal access to work, health, and education and the development of a wide range of social networks, as well as local language proficiency (Bakker, Cheung, & Philimore, 2016). This is called the Asylum-Integration Paradox. In short, there seems to be an inconsistency between the actual policy, intentions and what is being expressed to the outside world. Moreover, according to Van Houtum and Lucassen (2016), the current refugee influx is being approached as a unique and dangerous crisis, neglecting the history and context of refugees as well as the fact that migration is a apart of human society. Thus, it requires a new and sustainable vision on refugee accommodation and integration, in which the refugee influx is facilitated and a quick integration into society is ensured (Leerkes & Scholten, 2016; Van Houtum & Lucassen, 2016).

Mental wellbeing and integration: two interconnected concepts

Notwithstanding the above, although the approach towards refugees seems to discourage their arrival, the Dutch inclusive integration policy and momentum for goodwill seem promising. Because of the hazards most refugees have encountered, mental health is one of the themes of attention. According to the report Resilience and Confidence (Drogendijk et al., 2016) the mental wellbeing of refugees is affected by experiences during conflict or a suppressive regime, experiences during their flight or experiences in the host country (e.g. restrictions in asylum phase, culture differences, etc.). Moreover, this theme is important as it is assumed that (mental) health improvement is a prerequisite for participation and integration of refugees in their new host country and vice versa (Gezondheidsraad, 2016; Rijksoverheid & VNG, 2016). Therefore, it is assumed that an integral approach is necessary in order to deal with mental health problems of statusholders (Pharos & GGD GHOR Nederland, 2016). Consequently, this study argues that mental wellbeing is not an isolated sector, but one of the interconnected sectors within the broader process of integration. This is especially noticeable when zooming in on the prevention of mental health problems, which for example include professional activities such as informing, counselling and psycho-education, but also processes related to societal integration such as housing, education, job opportunities, societal acceptance and certainty about the residence permit (Drogendijk et al., 2016; Haker et al., 2016). Since mental wellbeing plays such an

important role in integration, and is an example of the integral nature of the process of integration, this study analyses Dutch integration policy by focusing on the aspect of mental wellbeing.

The challenge to safeguard 'healthy' integration

During the research phase, it became clear that all actors involved have a common goal: to assist the statusholder to integrate and participate in society as quickly as possible, while promoting their mental wellbeing and carefully prevent and treat psychosocial and mental health problems from developing. This underlines the inclusive character of the Dutch integration policy. It is therefore disturbing that, despite all the right intentions, the network concerned with this aspect of integration is largely underdeveloped. Although a lot has been organised on the municipal/regional level since the increased refugee influx, there are many regional differences regarding the type and number of the activities (Drogendijk et al., 2016). In addition, during interviews for the internship report, most interviewees answered that the actors within the network are working at cross purposes, do not know how to refer to a specialist or do not work in a culturally sensitive manner. This indicates that the actors involved with the mental wellbeing of statusholders are looking for a way to organise the network and their activities in response to the refugee influx. In fact, this seems to work in cycles. During the internship, it became clear that these problems existed in the 80's and 90's as well, when immigrants and refugees from countries such as Turkey, Afghanistan and Bosnia demanded a more culturally sensitive approach. In this regard, it appears the actors involved are trying to reinvent the wheel. It is also remarkable that the network for asylum seekers seems to be more developed than that for statusholders, while by contrast the asylum policy is more exclusive and integration policy more inclusive. For example, according to Drogendijk et al. (2016), the range of preventive psychosocial care (PSH) programs is primarily dispersed and especially aimed at Dutch Asylum Centres (AZC's) rather than refugees in emergency shelters and statusholders settled in the municipality. Moreover, the actors involved with asylum seekers have come to an agreement on cooperation in the mental health sector (Menzis COA Administratie, 2015), while for statusholders the majority of the actors are uninformed of each other's activities and are still exploring ways to organise the network.

1.2 Research aim and question

As shown in the introduction, it seems paradoxical that the network regarding the mental wellbeing of statusholders is underdeveloped, while the Dutch integration policy is characterized by inclusion and goodwill among the actors involved, and aimed at facilitating participation into Dutch society. Although most refugees are resilient and not many develop a posttraumatic stress disorder (PTSD), refugees are extra vulnerable to develop trauma, depression and/or psychological disorders (Drogendijk et al., 2016; Haker et al., 2016). Therefore, it is a cause for concern that during the phase when refugees face the most challenges in the host country and are at risk of developing mental health problems societal and governmental support networks are not functioning adequately. This raises questions: why is the preventive mental health network for statusholders underdeveloped? Which obstacles hinder the functioning of the process from signalling to treatment? To what extent do these obstacles apply to the integration policy? Does the Asylum-Integration Paradox restrain an adequate development of the network? And if not, are the restraints of a more practical or organisational nature? To investigate the above research problem, the following research objective and question were formulated:

Research objective and question

Objective: To map the various obstacles to the development and functioning of the Dutch organisational network concerned with the mental wellbeing of statusholders, in order to investigate whether the Dutch integration policy is truly inclusive and able to support the goodwill amongst the actors involved.

Research question: Which factors hinder the development and functioning of the Dutch organisational network concerned with the mental wellbeing of statusholders, as part of the all-encompassing integration?

To examine this research question, the following four sub-questions need to be answered:

1) What are the challenges related to improving refugees' mental wellbeing during the trajectory from becoming a statusholder to naturalisation?
2) How is the Dutch organisational network concerned with improving the mental wellbeing of statusholders organised, from early signalling and prevention to mental health care?
3) Which challenges affect the development and functioning of this organisational network concerned with improving the mental wellbeing of statusholders?
4) To what extent do the challenges to the network concerned with improving the mental wellbeing of statusholders affect the Dutch integration policy as a whole?

This research is demarcated as follows. First, this research primarily uses the term *mental wellbeing* to address the psychological state of the statusholder, which is broader than mental health disorders such as stress or depression alone but includes the effects of indirect factors such as labour, language proficiency and sports as well. The main reason for this is to analyse mental wellbeing during all stages from early signalling to mental health treatment and to prevent ambiguity. The term *psychosocial health* is usually related to the Dutch disaster- and crisis management sector and actors in the social domain, whereas the term *mental health* will most likely be used in the curative health care sector Within this research these terms are both a subcategory of the comprehensive term mental wellbeing. This is coherent with the Dutch national vision that promotes an integral local approach to improving the statusholder's health, which combines multiple domains such as health care, labour, social environment and education (Ondersteuningsteam Azielzoekers en Vergunninghouders, 2017; Pharos & GGD GHOR Nederland, 2016).

Second, this research focuses on the supply-side of the organisational network concerned with improving the mental wellbeing of statusholders, which includes a wide range of actors from early signalling in the social domain to specialized treatment in a mental health organisation. In this research, the organisation and functioning of this network, including the provision of care, is being regarded as the supply-side of the network. Since the organisational network is rather underdeveloped, it was first needed to map the supply-side before it could be analysed and compared to the demand-side (i.e. the needs and perceptions of the statusholders themselves). This is being conducted in a background study, which led to the development of a stepped-care pyramid structure (see paragraph 4.3). However, since it would be too ambitious for the scope of this master thesis, the demand-side of the network is largely unaddressed. In fact, this can be structured in another pyramid as well, according to an interpretation of Maslow's hierarchy of needs.

Third, although this research acknowledges that the mental wellbeing of both juvenile and adult statusholders are interconnected, in the Netherlands the (mental health) care networks differentiated according to age. Since a major decentralization process in 2015, youth care – including youth mental health care – has become the legal responsibility of municipalities, while the care providers (e.g. GP or psychiatrist from a mental health organisation) and health insurance companies are responsible for adult curative health care. Due to practical reasons, this research will take notice of the interconnectedness of the mental wellbeing of both groups, but will focus exclusively on the network concerning adult statusholders.

1.3 Societal and theoretical relevance

This research is socially relevant, since it flows from an internship at the 'GGD Gelderland-Zuid', where I was tasked to map the mental health care network for statusholders with a special focus on prevention and signalling and on direction by the municipalities. This internship report strongly corresponds with the knowledge-sharing-program 'Health and Vitality Refugees' (Pharos & GGD GHOR Nederland, 2016), which among others aims to develop a practical guide for municipalities to guarantee integral prevention of psychological problems and to maintain mental resilience. This shows awareness, especially at the national level, that knowledge is needed about the organisation and functioning of the care network. Moreover, by attending several meetings during my internship and from the study Resilience and Confidence (Drogendijk et al., 2016), it can be concluded that there is much progress to be made in the field of communication and information within the network. Still, this network for statusholders is a component of broader processes of refugee accommodation and integration. This leads to two important notes about the mental health care for refugees: 1) there is a distinction between mental health care for asylum seekers and statusholders and 2) mental health care is one part of an integral approach to integration (Ondersteuningsteam Azielzoekers en Vergunninghouders, 2017; Pharos & GGD GHOR Nederland, 2016). Moreover, the focus on signalling and prevention already links to this integral approach, as it can be broadly interpreted. For example, a Dutch language course may stimulate participation in society, which may increase the statusholder's feelings of well-being as his social need is satisfied. In addition, the language teacher may detect mental health problems as well, due to frequent interaction with the statusholder. By contrast, a focus on curative care lacks this scope, as it focuses more on problems as PTSD and other (serious) mental health disorders. In sum, it is relevant to focus on the processes in the lower levels of the mental health care system (i.e. signalling and prevention), which support an integral approach, and to go beyond mapping the network for statusholders by analysing the obstacles. This can stimulate the development of the care network for statusholders and integration policy in the future.

The scientific relevance is as follows. Firs, this research adds to several academic debates, within the broader, multidisciplinary field of refugee studies. For example, it adds to the debate on human geography and immigration, where most studies address the role of othering, processes of exclusion as well as discouragement and focus on borders in an inter-state manner (Hyndman & Mountz, 2007; Newman & Paasi, 1998; Van Houtum & Van Naerssen, 2002; Van Houtum & Lucassen, 2016). This thesis goes further and zooms in on the relatively invisible borders within a country: the hidden boundaries that a refugee needs to cross in order to become a Dutch citizen, after he receives his temporary residence permit. It also adds to theory on the role of culture in relation to integration of refugees (Ghorashi, 2005; Hoffer, 2012) and cultural sensitivity within the health care sector (Bala & Kramer, 2010; Dutta, 2017; Farnsworth & O'Brien, 2015; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999). One of the least addressed themes within the refugee studies is mental health. This research adds to the role of post-migration experiences to the mental wellbeing of refugees (Bakker, 2016).

Second, this research aims to be innovative through applying the debate on organisational barriers to the field of refugee studies. Due to the integral approach to the mental wellbeing of statusholders, there is a wide range of actors involved. This can be linked to the New Public Governance (NPG) paradigm of Osborne (2006), which incorporates concepts such as inter-organisational cooperation and coproduction. This research questions whether organisational barriers may interact with barriers related to debates within the refugee studies in order to put the more ideological barriers in perspective.

Third, this research is also innovative by combining interrelated theoretical themes from human geography, social science, health studies and public administration, and by encouraging crossover between theories. Lastly, where most studies focus on asylum policy, this research primarily focusses on barriers affecting the mental wellbeing during integration. In this regard, it builds on the Asylum-Integration Paradox by Bakker, Cheung & Philimore (2016): while the Dutch government promotes integration (i.e. inclusion), the Dutch asylum policy is characterized by exclusion. Bakker et al. (2016) concluded that the asylum and integration policies are connected when it comes to the integration outcomes and that more research is needed on the impact of integration policy.

1.4 Theoretical preview

This study uses a theoretical framework based on different scientific debates and topics. First, literature on the mental wellbeing of refugees was used to identify barriers during the Asylum accommodation and integration phases, since it is assumed that, beside the pre-flight and flight experiences, post-migration factors may play an important role as well. Next, theory on bordering, othering and orientalism is used in regard to asylum seekers and statusholders. This identifies barriers related to hidden practices of discrimination and western dominance. As an extreme to othering, theory of cultural sensitivity is used to question whether it may present an alternative and solution to western-centred approaches. Lastly, public administrative literature on cooperation, management and the role of professionals in an inter-organisational network is used to identify more practical organisational barriers to put the previous barriers into perspective. These different theoretical lenses resulted in a matrix of four types of barriers to the integration and mental wellbeing of the statusholder, divided in long or short term and ideological or practical barriers: 1) supply-oriented barriers, 2) practices of bordering and othering, 3) cultural approach barriers, and 4) organisational barriers.

1.5 Methodological preview

This master thesis is a qualitative study that consist of two parts: a descriptive background study on the structure of the organisational network concerned with the statusholder's mental wellbeing and an analytical study of challenges to its functioning, to mental wellbeing and how this relates to the all-encompassing integration. The central aim is to investigate whether the network is truly conducive to the integration and mental wellbeing of refugees or reveals deeper practices of bordering, othering and a western-centred approach. Therefore, this research consists of two parts: a descriptive background study on the structure of the organisational network concerned with the statusholder's mental wellbeing and an analytical study of challenges to its functioning, to mental wellbeing and how this relates to the all-encompassing integration. As part of the internship at the GGD Gelderland-Zuid, a (descriptive) background study about the structure and organisation of the network was conducted, which resulted in a practical report. This was the groundwork for this thesis. The research design is a case study of the organisational network concerned with improving the mental wellbeing of statusholders in

the municipality of Nijmegen. The data was collected through a document analysis, 15 in-depth interviews with actors inside the network, as well as in-depth interviews with one current statusholder and one ex-statusholder in order to reflect on the results. Working meetings at the GGD Gelderland-Zuid and two regional working conferences provided a further source of data.

1.6 Outline of the following chapters

This master thesis is structured as follows. In Chapter 2 the theoretical framework is elaborated and a framework of possible barriers to the integration and mental wellbeing of statusholders is developed. It is structured according four different theoretical clusters: supply-oriented barriers, practices of bordering and othering, cultural approach barriers and organisational barriers. Chapter 3 describes the research design, data collection and methodological choices and limitations. Chapter 4 provides the results of the background study and a pyramid structure which was developed during the internship. Chapter 5 presents the results of the case study of Nijmegen. In Chapter 6 the results of the case study will be discussed according to the theoretical framework as well as the two in-depth expert interviews with refugees. Finally, Chapter 7 provides a final conclusion, reflections and recommendations for further research.

2. Theoretical framework

This chapter provides the theoretical framework of this master thesis. It is structured as follows. First of all, in paragraph 2.1 the concept of mental wellbeing and the relation to post-migration factors during the asylum and integration stages are being addressed. Therefore, this paragraph explores the more practical barriers affecting the statusholder's mental wellbeing. In paragraph 2.2 the concepts of bordering and othering are used to explore whether the approach to refugees and their mental wellbeing may be biased according to a Western-centred perspective. Next, paragraph 2.3 considers the concept of cultural sensitivity to be an alternative – or rather extreme – to bordering and othering. Lastly, public administrative theory on network management and professionalism is considered as an intervening factor, in order to explore whether organisational barriers are a hindrance in adequately attending to the mental wellbeing of statusholders as well. Since this study uses different theoretical concepts in order to analyse the barriers to the mental wellbeing and integration of statusholders, a selection on theories and critics/alternatives was made.

2.1 Mental wellbeing of statusholders

This thesis incorporates a holistic view of mental wellbeing that has multiple dimensions (Liddle & Carter, 2015), such as both mental health, physical health and psychosocial health. that integrates both mental health and psychosocial health. As Khawaja, Ibrahim and Schweitzer (2017) note:

> "[Mental wellbeing] is seen as a combination of a subjective state of relaxation, presence of a positive mood and an absence of negative mood, satisfaction with life, and psychological state of personal growth, autonomy and personal relatedness with high quality relations and social interactions (Australian Institute of Health and Wellbeing, 2011; Ryff & Keyes, 1995; Wyn, Cuervo, & Landstedt, 2015)" (p. 6).

Most refugees arrive from conflict zones and have experienced a hazardous odyssey to reach Europe (Drogendijk, et al., 2016). This does not imply that every refugee develops mental health problems. Vulnerability to develop mental health problems – due to traumatic events – differs per person and depends on the type (Heptinstall, Sethna, & Taylor, 2004) and frequency of the events (Bronstein & Montgomery, 2011). In addition, most people who experience traumatic events, including refugees, are resilient and able to recover quite well (Drogendijk et al., 2016; Haker et al., 2016; Van der Velden, Van Loon, IJzermans, & Kleber, 2006). Only a small part of the refugees in the Netherlands (one to three on a scale of 10) develop a posttraumatic stress disorder (Gezondheidsraad, 2016; Haker, et al., 2016). Most of them are relatively young and strong compared to the non-migrants in their country of origin. This is called the "healthy immigrant-effect" (Rechel, Mladovsky, Ingleby, Mackenbach, & McKee, as cited in Haker et al., 2016). Still, according to Haker et al. (2016), trauma, depression and mental health problems generally do occur more often among immigrants than among the native Dutch population.

Although mental health problems that do occur can be largely explained by risk factors such as traumatic pre-flight and flight experiences (Grove & Zwi, 2006), in some cases post-migration factors also contribute to mental health problems (Bakker, 2016; Esses, Hamilton, & Gaucher, 2017; Montgomery, 2009). For example, state-provided asylum accommodation is negatively associated with the refugees' mental wellbeing, due to, among other factors, a lack of privacy, lack of autonomy and time spent in detention, increased anxiety and uncertainty regarding legal

status, and frequent changes in accommodation (Asgary & Segar, 2011; Bakker, 2016; Bakker, Cheung, & Philimore, 2016; Esses, Hamilton, & Gaucher, 2017; Gezondheidsraad, 2016; Grove & Zwi, 2006). Asylum-seeking children are especially affected by frequent changes in accommodation and influenced by parental mental health problems (Goosen, 2014). Post-migration risk factors, in relation to domains of integration such as work, education and social network, will be further elaborated below.

2.1.1 Barriers during integration

According to the Gezondheidsraad (2016) the mental wellbeing of statusholders is linked to their societal integration and participation. On the one hand, healthy people are better able to participate in society and build their own life. While, on the other hand, a better societal integration and participation will contribute to mental wellbeing. However, there are several barriers to societal integration and participation, which affect the mental wellbeing of refugees. These include language barriers, economic opportunities, experiences of discrimination, cultural assimilation and the difficulty of navigating the health care and social systems (Esses, Hamilton, & Gaucher, 2017; Sundquist & Johansson, as cited in Asgary & Segar, 2011).

During the integration, labour is an especially important factor affecting the mental wellbeing of refugees (Haker, et al., 2016).

> "The right to work is particularly important as it can enhance their sense of dignity, self-respect and self-worth, and brings with it independence and financial self-sufficiency. Employment is also, more broadly, a crucial facet of integration and can help them recover from often traumatic experiences" (Council of Europe: Parliamentary Assembly, 2014, p. 1).

The labour process is often hindered by discrimination, language deficiencies and slow or limited recognition of foreign diplomas (Bakker, 2016; De Lange, 2016). Therefore, a (proactive) integration policy – one that focusses on education, Dutch language proficiency and finding a job - is regarded as important in addressing the refugee influx in the long run (Bakker, 2016; Van Houtum & Lucassen, 2016). For instance, "Dutch integration courses significantly enhance the health outcomes of statusholders while the ability to speak Dutch aids social network development" (Bakker, Cheung, & Philimore, 2016, p. 129). Furthermore, according to Bakker (2016), the temporary residential status is negatively related to labour market participation as well, since statusholders do not know if their efforts to learning the language and build a network will pay off. By contrast, having the Dutch nationality is associated with an improving labour market participation.

There are barriers to health care services as well. In a study by Shannon, Vinson, Cook and Lennon (2016), unsuccessful referrals – i.e. when a refugee did not attend a mental health appointment – by health care practitioners were associated with barriers resulting from a lack of coordinated care, transportation, insurance and culturally competent care, along with mistrust, language interpretation and unwillingness of mental health practitioners to see refugees. Another observation was that cultural barriers not only included the discordant health beliefs of refugees, but also the failure of providers to educate refugees about mental health, or to culturally adapt western mental health services to accommodate refugees. Asgary and Segar (2011) distinguish between internal and external barriers. Internal barriers aim to explain why refugees fail to seek heath care, for instance because of a failure to identify symptoms of mental illness, fear of deportation or loss of legal status, unfamiliarity with the health care system, as well as a tendency to find support within their own community. External barriers aim to identify factors that explain why refugees, even if they do seek health care, are unsuccessfully treated.

These include affordability, linguistic barriers, cultural competency, prioritizing resettlement and limited availability of services.

2.2 The refugee crisis: processes of bordering and othering

To understand the position of the statusholder and analyse the obstacles and biases in the integration process, it is useful to consider processes of bordering and othering. Bordering is a process of securing and governing the 'own' economic welfare and identity of the indigenous population of a (host) country (Van Houtum & Van Naerssen, 2002, p. 1). This is related to the concept of othering: acting in accordance with a binary differentiation between 'us' and 'them'. As made famous in his book *Orientalism*, Said (1978) argued that the Occident (the West or more specifically Europe) has a dominant and rather paternalistic approach to the Orient (the East). This is characterized by a Western conception of the Orient: a way of thinking and acting towards the 'other' in order to determine – and strengthen – one's own identity. This implies a self-centred view of (Western) superiority. Moreover, the perception of us and them can be related to spatial dimensions as well, which Said calls 'imaginative geography'. These are social constructs determining the own identity through defining the 'familiar space' which is 'ours' and an 'unfamiliar space' beyond 'ours', which is 'theirs' (Said, 1978, p. 56). This, in turn, affects and legitimizes actions and discourses regarding the Other. Thus, "imaginary geographies are profoundly ideological and representations of space entangled with relations of power" (Gregory, 1995, p. 474).

In conclusion, processes of bordering and othering – as discussed within the concept of orientalism – may support a Western bias towards refugees in two ways: 1) from a power perspective they feel obliged to help the less developed or marginalized and 2) from an identity perspective they may see the refugees as a threat, therefore insisting on 'their' adjustment to 'our' norms and values. In fact, this implies a process of non-physical or cultural bordering, largely based on stereotypical thinking. These processes will be elaborated below according to different levels of borders. The first section focusses on the physical and discursive borders in relation to the European refugee crisis. The next section will zoom in on the 'paper border', as manifested in Dutch asylum policy. The last section discusses processes of bordering and othering inherent in the integration and naturalisation trajectory the statusholder is required to follow.

2.2.1 Fortress Europe and the European refugee crisis

Orientalism – or othering in general – can be linked to the current 'European refugee crisis'. Van Houtum and Lucassen (2016) argue that since the implementation of the Schengen agreement[2] in 1995, the Europe has become a fortress with a common external frontier. In a short time, this has become one of the deadliest borders in the World. Meanwhile, 'Fortress Europe' is obstructing and dehumanizing migrants and refugees (Van Houtum & Lucassen, 2016). As a result of the 'European refugee crisis' the European Union (EU) decided to fortify the external border in order to discourage attempts at finding refuge in a EU country. In practice, this leads to two paradoxes. First, while they are desperately trying to find safety and a better life, refugees are increasingly seen as a security threat themselves. Second, while the EU professes the aim to protect refugees from risking their lives during their flight, fortifying the external borders results in refugees taking extra risky routes and being contained in dehumanizing refugee camps at the border or in Turkey.

[2] The "Schengen Agreement" is a European agreement in which the internal border checks were dissolved in order to have common borders and a common visa policy. Within the Schengen Area EU citizens are allowed to move freely between EU countries.

The use of metaphors in public and political discourse further contribute to bordering and othering through imaginative geographies. Arriving migrants and refugees are often framed through threatening war-related language or water-related terms (Johnson et al., 2004; Van Houtum & Lucassen, 2016). For example, the frequently used term 'border surveillance' suggests the need to defend the homeland from insecurity and foreign threats. This anxiety is strengthened by discourse on terrorists, criminals and sexual offenders joining the refugees. As an example of water language, the terms refugee influx, waves or flows suggest a dehumanizing comparison between refugees and impersonal natural disasters. In addition, it suggests an incursion of refugees as well. This discourse is reinforced by the media. According to Eerdmans (2016), the Dutch newspapers 'De Volkskrant' and 'De Telegraaf' use an orientalist discourse in the representation of refugees, stereotyping them as the 'other' or a threat in both the case of Aylan and the 2016 New Year's Eve sexual assaults in Cologne.

2.2.2 The Asylum seeker: still facing borders

Much attention regarding othering is directed at asylum policy. According to Sales (2002), asylum seekers are demarcated as "other" and undeserving, since they are excluded from welfare provision, are housed in designated centres and have employment restrictions. They are often portrayed as 'uninvited', imposing and making demands on 'us' (Grove & Zwi, 2006, p. 1934). Such discursive construction serves as a justification for holding refugees at the borderlands of society in unoccupied buildings or tents, symbolizing the gathering of the powerless, the marginalized and politically contested (Van Houtum & Van Naerssen, 2002, p. 131). Indeed, refugee-receiving states tend to create stateless spaces in extra-territorial locales, where they hold migrants in legal ambiguity as a mechanism of control (Hyndman & Mountz, 2007). In these 'noncommunities of the excluded' (Hyndman, 2000), othering is expressed in terms of those who wait and those who participate, demarcated by the borders between 'their zone and ours' (Van Houtum & Van Naerssen, 2002, p. 131). Thus, asylum seekers are still facing a symbolic spatial border before they can enter the receiving society. Van Houtum and Lucassen (2016) add that the asylum policy is somewhat paradoxical, since the intention is to offer legal protection, while simultaneously it is meant to be unattractive. All the above illustrates that the intention and vision of a government may incorporate a hidden agenda when it comes to accepting refugees as asylum seekers.

2.2.3 Bordering citizenship

As shown, othering can be related to the refugee crisis from a geopolitical and asylum policy perspective, however to what extent is the integration policy exclusive as well? According to Powell & Menendian (2016), the only viable solution to the problem of othering is one involving inclusion and belongingness, since a sustainable and effective resolution must not only improve intergroup relations, but also reduce intergroup inequities and group-based marginality. An easy solution such as segregation keeps the problem intact, while the benevolent solution of cultural assimilation – the attempt to erase the differences that define group boundaries and create a "melting pot" – is still hierarchical, since it demands the marginalized group to adopt the identity of the dominant group, leaving the latter's identity intact. As an alternative, "belongingness entails an unwavering commitment to not simply tolerating and respecting difference, but to ensure that all people are welcome and feel that they belong in the society (Powell & Menendian, 2016)". To do so, it is important that the 'other' is being humanized and that negative representations or stereotypes are challenged and rejected. It is important to create inclusive structures, which recognize and accommodate difference, providing societal access and integration. Subsequently, this should be complemented by a vision or narrative of inclusion. First, the use of "voice" and "dialogue" can give expression to

group-based needs and issues (Gülerce, as cited in, Powell & Menendian, 2016). Second, through generating stories of inclusion that reframe our individual and group identities, we also go through a remaking of ourselves. Thus, inclusion implies the courage to look beyond (cultural) differences, approach the 'other' as an equal human and foster new identities.

While inclusion and integration seem to be the solution to the dominant view of the 'other', practices of othering are noticeable within the integration phase as well. Bakker et al. (2016) argue that both asylum- and integration policies may contribute to exclusion rather than inclusion, as they found in the UK and the Netherlands. They call this the Asylum-Integration Paradox. The institutionally exclusionist asylum policy is likely to have a negative impact on integration outcomes, since it affects the refugee's networks and mental health. However, the integration policy – while aiming to be inclusive – is rather restrictive as well, which is likely to have a negative impact on integration outcomes. For example, Dutch statusholders are expected to pay for their own integration classes. This implicates two things: 1) there is a connection between the asylum support systems and refugee integration and they should always be addressed simultaneously, and 2) that the integration policy may also contribute to exclusion rather than being merely inclusive.

The exclusive nature of the integration policy is reinforced by practices of othering such as rituals of integration to become like 'us' (e.g. the civic integration exam), a public perception of an 'overload' to public services in relation to refugee numbers, as well as a lack of understanding in regard to the personal stories and circumstances of the refugees (Grove & Zwi, 2006). In relation to interactions between health care practitioners and immigrants in particular, Johnson et al. (2004) discovered three ways in which othering practices are manifested in the health care sector: 1) Essentialism is related to stigmatizing and making overgeneralisations, 2) culturalism involves emphasizing cultural differences and 3) racialisation is related to differences in psychical characteristics or appearances. These stereotypical and discriminating perceptions of the 'other' contribute to alienation and marginalisation.

Practices of othering are also present at a structural level. According to Ghorashi (2005), the Dutch welfare state transformed refugees into passive dependants of the state, by creating an exclusive discourse towards refugees of them being helpless and victimized people who are not able to act independently. By contrast, the early yours of their exile are important since they can be used to distance themselves from the past and put energy into building a new life. In conclusion, practices of bordering and othering are not only clearly related to geopolitical and asylum policies, they are applicable to integration policies as well. In fact, while inclusion may be a solution to othering, these very same practices of othering – i.e. bordering the citizenship and indigenous identity – actually seem to hinder the inclusive nature of the integration.

2.3 Cultural sensitivity: the solution?

The latter section indicates that an alternative to processes of bordering and othering – which rely heavily on the protection and superiority of the own identity – is a culturally sensitive approach. Cultural sensitivity – in regard to public health – can be defined as "the extent to which ethnical/cultural characteristics, experiences, norms, values, behavioural patterns and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs" (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999). This definition can be conceptualized by two primary dimensions: 1) surface structure, which involves matching interventions to observable, superficial characteristics of the target group, and 2) deep structure, which involves a deeper understanding of cultural, social, historical, environmental and

psychological forces that influence the health behaviour. According to Kieft, Jordans, De Jong and Kamperman (2008), cultural sensitivity is an obvious pre-requisite when working with western-oriented therapeutic assumptions in a non-western setting or with non-western clients. Furthermore, it is essential for obtaining the trust and engagement of clients from a refugee background (Farnsworth & O'Brien, 2015), but also to mitigate barriers to care and support. This suggest the importance of a culturally sensitive approach within the network.

2.3.1 Cultural sensitivity or cultural knowledge?

However, the belief that greater "cultural sensitivity" is required in health care is insufficient, as it wrongly assumes that one can "know" another culture – i.e. culture is not static but dynamic (Johnson, et al., 2004). While the debate whether culture is static or dynamic lies outside the scope of this thesis, its relevance is reflected in the theoretical distinction regarding cultural sensitivity. According to Dutta (2017) there is a distinction between a culture-centred and culture-sensitive approach in regard to health communication (i.e. prevention). The latter is directed toward the goal of producing health interventions that incorporate the cultural characteristics, values, beliefs, experiences, and norms of the target population in the design, delivery, and evaluation phases of the intervention (Resnicow et al., as cited in, Dutta, 2017). On the other hand, a culture-centred approach, which is based on a more dynamic interpretation of culture, aims to change social structures surrounding health services through dialogue between cultural members in order to create space for marginalized cultural voices. This indicates that cultural sensitivity in fact still maintains power by 'othering' cultural participants based on the expertise of external actors (Dutta, 2017, p. 331). Although both approaches serve different agendas and outcomes, they contradict each other and the culture-centred approach comes closer to a solution to 'othering' by Powell and Menendian (2016).

2.3.2 Exploring the intercultural approach

The distinction between a culture-sensitive and culture-centred approach indicates that the initial concept of cultural sensitivity in fact incorporates the very same practices of othering that it tries to solve. Therefore, as the culture-centred approach implies, the concept of cultural sensitivity should be reinterpreted by focussing on dialogue, instead of having a static perception of culture. According to Hoffer (2012) it is necessary to have an open attitude towards culture and recognize its dynamic and diverse nature. Hence, a care provider should study the client as an individual, during his contemporary cultural development, instead of learning about all possible subgroups and cultures. In addition, the care provider should communicate and ask questions, rather than use acquired cultural knowledge. Therefore, the term *intercultural sensitivity* is a better alternative, since it is based on a conversation between two individuals with different cultural perspectives (Hoffer, 2017). According to Bala & Kramer (2010), this is important, since engaging in an open, nonintrusive, non-judgmental manner, respectful, with a genuine interest in their problems, facilitates the establishment of a therapeutic relationship based on trust. Moreover, in such a patient-centred approach to cultural sensitivity, clients can communicate their health care desires and offer feedback about how well their desires are being met (Herman et al., 2007). In sum, as Moncada Linares (2016, p. 140) argues, "instead of perpetuating *othering* narratives that lead to misconceptions and prejudices, the aim should be to promote feelings of "oneness" that cultivate mutual recognition, appreciation, respect, collaboration, and intercultural exchanges among people."

2.4 The challenges of an inter-organisational network

Beside the more structural and hidden obstacles, there can be organisational barriers as well. Since the provision of care and support to statusholders in the Netherlands aims to have an integral approach (Haker et al., 2016; Pharos & GGD GHOR Nederland, 2016; Van Berkum et

al., 2016), it is organised within a network. Therefore, it can be linked to the paradigm of New Public Governance (NPG) (Osborne S. , 2006), which argues that the delivery of public services is nowadays characterized by pluralism and inter-organisational implementation, opposed to the business-like managerial, top-down thinking within New Public Management (NPM) since the 1980's. A key feature in such a service-dominant approach of public services is coproduction (Osborne, Radnor, & Nasi, 2012). "Co-production is a process through which inputs from individuals who are not in the same organisation are transformed into goods and services" (Ostrom, 1996, p. 1073). This is not limited to the service (e.g. care) providers, the user is a coproducer as well (Osborne, Radnor, & Nasi, 2012, p. 139). Thus, since integration, prevention and health care are organised as an inter-organisational network, the statusholder should be an important stakeholder and play an active role regarding his needs.

It is worth briefly elaborating on network theory and the challenges it faces in the research at hand. A crucial component is the mutually dependency of actors in order to reach their goals (De Bruijn, 2008; Klijn & Koppenjan, 2006). The mutual dependence of the actors creates sustainable relations between them and establishes the need for rules to regulate interactions (Klijn & Koppenjan, 2006). In the end, policy is a result of complex interactions between the actors involved, which can be called games:

> "In these games, each of the various actors has its own perceptions of the nature of the problem, the desired solutions, and of the other actors in the network. On the basis of these perceptions, actors select strategies…. These strategies are however influenced by the perceptions of the actors, the power and resource divisions in the network and the rules of the network" (Klijn & Koppenjan, 2006, p. 5).

An inter-organisational network faces several challenges. Klijn & Koppenjan (2010) describe that, among others, the actors need to be aware of their mutual dependencies and existence, need to have a common interest instead of conflicting objectives, the actors in the game need to be in the same network and actors can be excluded from the interaction. Since the network concerning the statusholder's wellbeing is not only a policy network, but service delivery as well, it is important that the experiences and knowledge from the service user are heard as well (Osborne, Radnor, & Nasi, 2012). To ensure cooperation (between both actors and the users), network management (i.e. steering) is an important feature of networks (De Bruijn, 2008; Klijn & Koppenjan, 2006; Klijn, Steijn, & Edelenbos, 2010). In this regard, governmental actors have a special position, due to their unique resources and goals (Klijn & Koppenjan, 2006, pp. 14-15). Although they cannot unilaterally impose their will upon the other actors, they can manage the network in two ways: process management or network constitution (Klijn & Koppenjan, 2006; Klijn, Steijn, & Edelenbos, 2010). Whereas process management aims to facilitate the interactions, network constitution aims to alter the institutional design (e.g. actor positions, rules, etc.). Klijn, Steijn and Edelenbos (2010) argue that 'connection' (i.e. to identify the crucial actors and activate and connect them in the network) is the most promising strategy in realizing outcomes.

The inter-organisational context has an effect on the professional, since knowledge is dispersed and, as the different (professional) communities interact, the objectives and standards of individual professionals become contested within complex and dynamic arenas (Brandsen & Honingh, 2013). Therefore, they need to cooperate with the network partners as communication and trust are important in establishing their legitimacy. On the other hand, professionals were used to derive their legitimacy from their substantive knowledge and expertise, resulting in rather closed communities. This implies two things: 1) due to the shift to governance, professional autonomy is contested within the collaborative network and 2) if professionals are

not acknowledging this shift, it may result in conflicts. This results in tensions between the bureaucrat or manager and the professional, between the bigger picture and knowledge (De Bruijn & Noordegraaf, 2010; Honingh & Hooge, 2009; Noordegraaf & Van der Meulen, 2008). According to De Bruijn and Noordegraaf (2010), managers are in fact needed to support and protect the professional, but to offer opposition as well. For example, in a context of cooperation, it is important that a manager stimulates collaboration when professionals are inclined to neglect it. Therefore, they argue for a new style of professionalism, characterized by a problem-oriented, open and cooperative approach instead of further specialization, isolation and exclusion. Although analysed within professional organisations, this tension may be applicable to the whole network as well, since it is separated into two parts: the public health and societal support and professional health care.

In short, this paragraph explored the inter-organisational context of the network regarding the mental wellbeing of statusholders and the implications for its functioning. Since integration is affected by the mental wellbeing of a statusholder and vice versa, safeguarding the mental wellbeing – and integration outcome on the long run - involves efforts from a wide range of actors, including volunteers, teachers, social workers, public health or policy officials, the GP, and mental health professionals. These actors, from a professional, bureaucratic or voluntary background, need to cooperate, as well as attend to the statusholder's needs. It is interesting to question whether these more practical barriers outweigh the importance of the ideological barriers regarding othering and culture.

2.5 Conclusion

This chapter has presented a theoretical framework with four clusters of barriers to analyse the prevention and treatment regarding the statusholders' mental wellbeing. Although most refugees are relatively resilient, they have several risk factors affecting their mental wellbeing. Post-migration factors present an important cluster. The mental wellbeing of refugees is especially affected by their stay in an AZC, but there are several factors during their integration which affect the mental wellbeing as well. These are the *supply-oriented barriers*, since they are related to the provision of public services regarding the integration, participation, prevention or treatment of statusholders. The second barrier discussed was the *practice of bordering and othering* in regard to the refugee crisis. It shows that a refugee has to cross multiple, both formal and invisible, borders in order to become a 'healthy' Dutch citizen. During the integration phase, which aims at inclusion, these structural, long term and ideological barriers may actually facilitate exclusion and hostility towards refugees.

Two solutions to othering were discussed: 1) inclusion and belongingness and 2) (inter)cultural-sensitivity. The latter presented the third barrier: *cultural approach barriers*. Cultural sensitivity is often seen as the solution in health care, but, in fact, by seeing culture as something that can be learned in order to treat refugees, othering is preserved. Therefore, an alternative solution is an interculturally sensitive approach, which is characterized by an open attitude, voice and mutual respect. Lastly, *organisational barriers* may put practices of othering or cultural sensitivity in perspective. The theory shows that an integral and inter-organisational network for policy and service delivery induces several challenges. Therefore, it is important that statusholder's needs are heard, that actors have common goals and cooperate, that the municipality facilitates the network and that professionals are open to cooperate with both the actors and the statusholders. If this is lacking, it might suggest that the network faces short term practical barriers that may downplay the more ideological barriers and hinder the goodwill among actors involved.

In sum, the theoretical framework can be illustrated by the matrix model below (figure 1), in which the four different clusters of barriers are being distinguished by their endurance as well as the nature of their approach in relation to the statusholder's mental wellbeing and integration (i.e. ideological or practical). This framework helps analysing the barriers related to improving the mental wellbeing of statusholders as well as identifying which cluster is most salient.

Table 1: Conceptual framework presenting the theoretical clusters

	Short term	**Long term**
Ideological	*Cultural approach barriers*	*Hidden barriers of bordering and othering*
Practical	*Supply-oriented barriers*	*Organisational barriers*

3. Methodology

This chapter elaborates and justifies the research strategies and methods used to conduct the research. Paragraph 3.1 describes the research design and research method, including the relation to the internship. Paragraph 3.2 describes the process of data collection and data analysis. Finally, in paragraph 3.3, the limitations of the research design are discussed.

3.1 Research design and method

This thesis is a qualitative research project with a descriptive and analytical character. In qualitative research, empirical observations are characterized by an interpretative and naturalist approach (Boeije, 2005; Vennix, 2010). It is especially useful when a researcher wants to study the meaning of interactions, processes, behaviour, emotions and experiences (Boeije, 2005, p. 36). To examine the factors that hinder the development and functioning of the Dutch organisational network concerned with the mental wellbeing of statusholders, it is necessary to observe the perceptions and experiences of the research subjects in their own environment as they shape the functioning of this network, affect the statusholder's mental wellbeing and may even be a factor of hindrance. A quantitative approach, using a survey as research method, could have used more participants and even include a research population of statusholders themselves. However, such a research design would not be able to answer questions regarding organisational behaviour and interactions between care practitioners and statusholders, as well as to understand practices of bordering and othering. Finally, this qualitative research consists of two parts: a descriptive background study on the structure of the organisational network concerned with the statusholder's mental wellbeing and an analytical study of challenges to its functioning, to mental wellbeing and how this relates to the all-encompassing integration. These two parts will be discussed below.

3.1.1 Descriptive background study and relation to the internship

Since the organisational network concerned with improving the mental wellbeing of statusholder is largely underdeveloped, as described in Chapter 1, this research is limited to examining the supply-side of the network. However, during the internship, it became clear that the network lacks a comprehensive organisational structure as well as a map of the wide range of actors involved. Consequently, it was necessary to conduct a descriptive background study before barriers to the integration process could be examined. As discussed earlier, first the process from asylum to permanent residence was mapped, and the Dutch policy regarding mental wellbeing of statusholders examined. Subsequently, a conceptual framework of the organisational structure was developed. This was based on the national vision of resilience, stepped care as well as the importance of prevention and early signalling. This structure is visualised as a pyramid (as will be discussed in chapter 4). Lastly, the functioning of the processes from early signalling and prevention to mental health care were described and a preliminary organisational map of the region Gelderland-Zuid was established.

The internship project

This background study was conducted during the internship project at the GGD Gelderland-Zuid, which resulted in a practical Dutch report. During the internship, I was part of the research population, since I contributed to network development by developing an abstract layout for an organisational map showing the actors involved. In collaboration with a working group from the national policy programme 'kennisdelingsprogramma Gezondheid Statushouders', I developed a chart showing the process from early signalling to actual mental health treatment as well. This policy programme is aimed at supporting municipalities with developing an

integral approach to the statusholder's health. Both developed models were conceived well. It made actors reflect on their behaviour/activities and they were a useful subject for discussion.

3.1.2 The case study: the analytical part

The background study gave useful insights in the structure and functioning of the organisational network involved with the mental wellbeing of statusholders. The next step was to analyse the different barriers or obstacles to a 'healthy' integration. This was done through a case study. Whereas the focus of the internship report was on the region Gelderland-Zuid, the case study focussed exclusively on the municipality of Nijmegen. Municipalities are responsible for statusholders, therefore in every municipality the network is somewhat different. The municipality of Nijmegen was chosen as case study, since it is the biggest municipality in the region, hosting the most statusholders and having the most experience with statusholders. In addition, Nijmegen was home to a controversial asylum emergency shelter, called Heumensoord. Lastly, the municipality of Nijmegen is clear about its intention to be a social and hospitable municipality for refugees (Gemeente Nijmegen, 2016). It would therefore be interesting to see how processes of integration fare in a sympathetic environment. However, as will be argued in the limitations, Nijmegen is not representative for the whole region, which also consists of some smaller, rural municipalities. Moreover, to address the municipal direction (which was a task of the internship project) it is useful to compare different municipalities. Therefore, during the background study, the municipalities of 'Berg en Dal', 'Tiel' and 'Zaltbommel' were also interviewed. Since, the participant from the municipality of Tiel, could not answer the questions, although being the right policy officer, this interview was stopped. The insights of these interviews outside the case study are included in the master thesis as well.

3.2 Data collection and data analysis

During qualitative research, there is a constant interchange between theory, observation and analysis (Vennix, 2010, p. 99). Before the research started, a special advisory group ('klankbordgroep') with local and national stakeholders and experts was established to give substantive feedback and answer questions during the research process. This group came together several times during the internship and was very useful to guarantee adequate linkage with the field of practice and to use as an informal focus group to obtain expert knowledge. The research started with a preliminary analysis of policy documents and reports, which, among others, resulted in a description of the national vision as well as the asylum and integration procedures. In addition, it resulted in a first exploration of theoretical themes based on concepts of mental wellbeing, prevention, positive psychology and othering. The next step was to develop a structure of the network, by analysing reports and discussing this with members of the advisory group. This marked the ending of the groundwork for the master research project and the internship report.

The fieldwork consisted of a first round of 15 interviews with participants from every level of the identified network, structured from early signalling to mental health treatment. These included interviewees such as a volunteer and two team leaders from the Dutch council for Refugees, social workers, municipal policy officers (from different municipalities), public health experts, General Practitioners and mental health specialists. They were asked about their own organisation and activities, cooperation with other actors, as well as perceived barriers and opportunities. By analysing the interviews, examining documents and websites of these organisations, the organisation and functioning of the network could be described.

After the descriptive part regarding the structure and organisation of the network was finished, a first round of analysis identified a number of paters to different obstacles. In collaboration

with an expert from the advisory group, this resulted in four clusters: demand-oriented barriers, supply-oriented barriers, policy-oriented barriers and organisational barriers. Since the interviews showed the importance of cooperation and lack of cultural sensitivity, theory on these themes were explored as well. This necessitated in a further elaboration of the theoretical framework. Next, the interviews were coded and analysed by the following themes: post-migration factors during integration, barriers to provide health care and prevention, practices of othering and exclusion, cultural sensitivity, cooperation or organisational barriers, professional-bureaucrat dilemma and a sustainable (policy) approach. This analysis resulted in extra questions on cultural sensitivity and a Western-centred approach. Furthermore, since these interviews exclusively focussed on the supply-side of the network and several questions remained, it was important to interview a refugee or expert as well. This resulted in a second round of interviews, in which two refugees were interviewed to reflect on the other interviews. These two interviews represent different periods. For example, one is an afghan ex-refugee, who arrived in the Netherlands during the 1990's and is now the director of Bureau Wijland[3], one of the organisations within the network. The other is a current Syrian statusholder from Nijmegen, who works for Pharos as a junior project leader and as an 'sleutelpersoon'[4], a refugee who provides information about the Dutch health care system to his own subgroup.

Both rounds of interviews were held in Dutch and were semi-structured according to an interview guide, which is included in appendix 2. Most interviews were conducted by phone. These were transcribed on a A3-sheet version of the interview guide during the interview. Each interviewee received a summary of the interview by mail for their approval and to provide the opportunity to for feedback. There were six face-to-face interviews. However, due to circumstances only one of them was recorded. In some cases, new or remaining questions were asked, but unfortunately only few replied. Finally, quotes used from the interviews are translated in English.

Lastly, during the internship, I attended several working meetings and conferences, which provided useful insights as well. These can be regarded as unofficial observations. There were particularly two large working conferences within the region (in Wijchen and Geldermalsen), in which I collaborated myself and promoted the pyramid structure and abstract layout of the network that I have developed. During one conference with the stakeholders from Nijmegen in Wijchen on May 11th, 2017, I presented my findings of the internship report. The conferences were structured into two parts: a plenary part and an interactive part. During the conference in Geldermalsen on May 16th, 2017, the participants were divided in rooms which each represented a municipality and had to come up with an integral plan themselves. This offered me insight in the visions, intentions and perceptions of the participants, who are part of the network themselves.

3.3 Methodological reflections

This paragraph discusses the limitations, validity and reliability of this research. Because the thesis is related to an internship within the network concerning the statusholder's mental wellbeing, I was part of the natural setting being researched. Thus, I needed to be aware of two possible biases: the participant bias and observer bias (Diesing, 1972). The first one implies that people who are being studied may alter their behaviour if they are aware that they are being studied. One of the first things you do when starting the internship is introducing yourself and your research to your colleagues and network partners. This may create certain expectations

[3] Bureau Wijland is an advisory and expertise bureau for diversity and sustainability, located in Nijmegen.
[4] Literally translated to 'key person' or 'unifying refugee'

towards the research and alter their behaviour. Moreover, before an interview is being conducted, it is appropriate to introduce the research and specific interview objective. Interviewees may then deliberately alter their answers, especially when there are organisational interests at stake. The second bias implies that the researcher may become less critical when his or her involvement in the environment being studied increases. This is especially relevant to this research, as the internship report – which is a part of the master thesis – is written for the GGD, and indirectly for the VNG and the actors within the advisory group. This implies that organisational goals may steer the research question and focus. Although there is no direct influence on the master thesis, since they were separately written, the internship report is largely based on the background study which is part of this study as well. This underlines an ethical dilemma: the question whether to blend into the research population, specifically the internship organisation, or remain impartial. During the internship, this was frequently challenging, as the goals of the internship organisation and University were often conflicting, especially during the formulation of the research proposal.

It is important to reflect on the validity and reliability of this research. Validity means that one measures what one intends to measure (Boeije, 2005, p. 145). There are two types: internal validity and external validity. Internal validity is concerned with the extent to which the research design explains what the objective intends (Vennix, 2010, p. 78). External validity is concerned with the generalisability of the research, or to what extent the findings are applicable to other cases (Boeije, 2005, p. 155). Using an in-depth analysis within a case study and conducting semi-structured in-depth interviews improves the internal validity. However, due to the timespan of the research it was only feasible to do a limited number of interviews, while a larger number of interviews would have improved the internal validity. Two particular points can be made in this regard. First, because of the many organisations involved, it was only possible to interview one or two members of each organisation. Taking the views of one member to say something about the organisation as a whole may limit the validity. Second, it would have been interesting to interview actual statusholders with mental health or integration problems to compare their needs with the provision of care. However, due to time constraints and language barriers, this would have been very challenging. By doing two expert interviews with a current and ex-refugee, this problem was somehow countered.

Since this research focuses exclusively on the municipality of Nijmegen as a single case, the external validity is limited. Indeed, there are many differences between municipalities, making a comparison highly interesting. Besides, due to municipal policy differences generalising the findings from this case study to other municipalities is limited. Moreover, the whole process of integration and participation, prevention as well as mental health care is rather complicated and complex within one municipality alone. Also, it is currently underdeveloped. Also, the process of guiding towards integration and providing adequate (preventive) mental health care is very much in development. For these reasons, an in-depth single case study was deemed the most suitable. This makes this thesis a starting point for further research.

Lastly, reliability is concerned with the repeatability of the research. To enhance reliability, this research uses multiple methods (i.e. triangulation): in-depth interviews, a document analysis and unofficial observations. Moreover, this research carefully uses an interview guide for semi-structural interviews. The interviews where coded by using crayons to underline codes within the summarized interviews.

4. Results I: the background study

This chapter presents the background study of this thesis. Paragraph 4.1 elaborates the developed pyramid structure and its different interconnected 'steps'. In paragraph 4.2, the role of the municipality in directing and managing this structure is discussed. The second results chapter addresses the case study and elaborates on the functioning and organisation of the network in Nijmegen, as well as the different barriers that have been identified that might hinder a smooth integration process.

4.1 Structuring the network from signalling to mental health treatment

This research has mapped the organisational network concerning the mental wellbeing of statusholders in the province Gelderland of the Netherlands. This was the main task of the practical internship report and will be summarized in this paragraph. The network is called 'psychische gezondheid statushouders'[5] and is structured from the initial process of early signalling up to the point where the mental health care treatment takes place.

4.1.1 A conceptual framework structuring the network

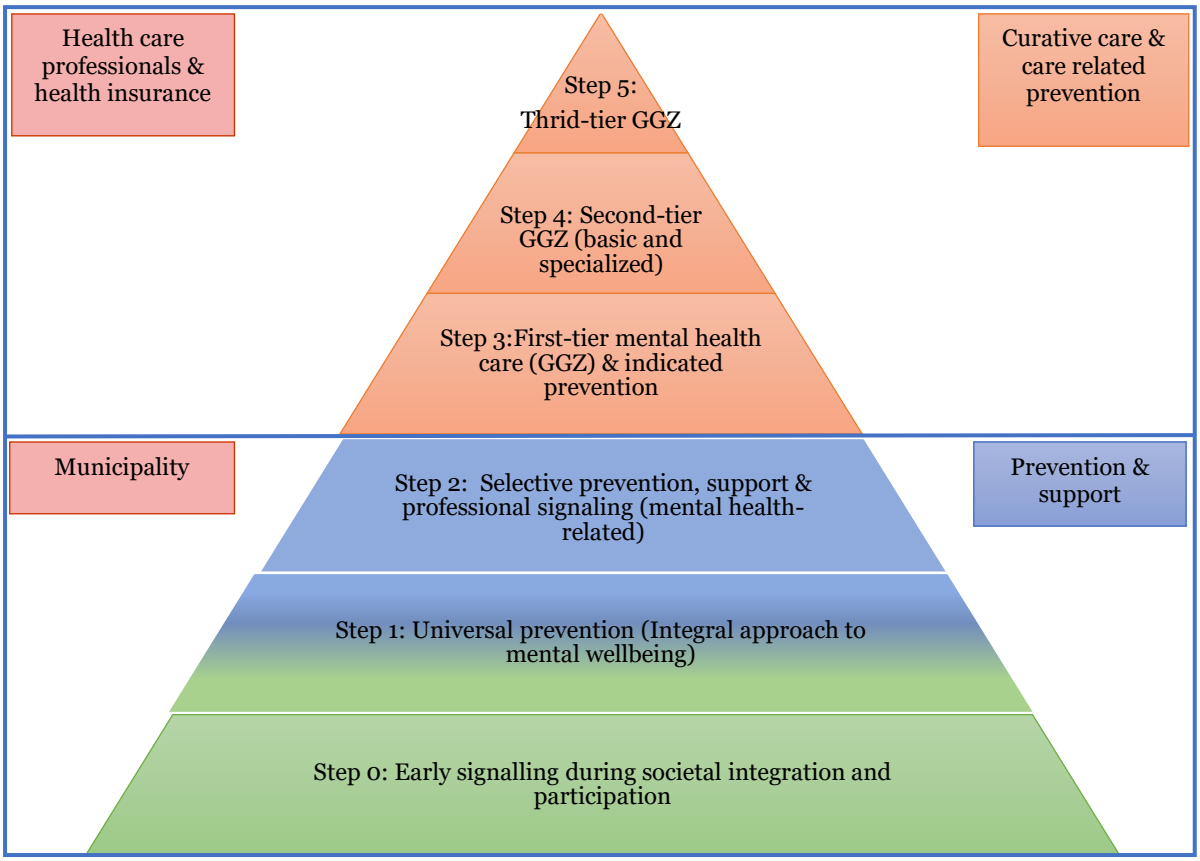
The practical report aimed to develop a conceptual framework that might also serve as a schematic map of the different local actors. Since there was no documentation on this, the framework first needed a structure. The structure was inspired by two findings of the knowledge synthesis report by Pharos (Haker, et al., 2016): namely that 1) Only a small number of the refugees develop severe mental health problems such as PTSD and 2) Most refugees benefit from preventive activities, especially in the social domain. This implies that statusholders will more often interact with the actors in the social domain and municipal care sector and only a few meet a psychologist or psychiatrist from a mental health organisation. This finding corresponds with the stepped care model, which is common in the health care sector. This model states that care should only be scaled up when necessary, since not all patients need the same intensity of care (Haaga, 2000). Therefore, the model implies an intention to first employ lower tiered care and promote self-reliance. This can be illustrated by using a pyramid (figure 2). A pyramid illustrates that most statusholders use the lower steps and only a few statusholder with significant mental health problems see the actors at the top. The structure will be elaborated below.

The structure is based on two distinctions. First, there is a distinction between the lower and upper parts of the pyramid, based on legal and financial responsibility: 1) Municipal preventive sector, consisting of the societal and public health sectors, and 2) Curative care or mental health sector. The three lower steps are directed and subsidized by the municipality, whereas the mental health sector is financed by the health insurance companies, limiting the public coordination. Another distinction is based on different types of prevention, which are translated to statusholders. Van der Stel (2004) distinguishes four types of prevention:

- *Universal prevention*: collective prevention to a whole population, without health risks.
- *Selective prevention*: prevention to individuals or specific high-risk groups.
- *Indicated prevention*: individual prevention aimed at preventing the development of problems, when symptoms or problems are visible.
- *Care related prevention:* prevention during cure treatment, aimed at preventing further escalation and promoting self-reliance in the long run.

[5] This can be literally translated to 'network mental wellbeing statusholders'.

Figure 1: Stepped care (supply) pyramid mental wellbeing statusholder



4.1.2 The different interrelated processes from signalling to treatment

The five steps of the pyramid are briefly summarized below. The pyramid starts at the bottom with the *early signalling during the societal integration and participation.* This is 'step zero', since every statusholder follows this path, irrespective of their mental wellbeing. In addition, this step denotes an integral approach to the statusholder, since it incorporates processes as housing, work and education. It is of major importance within the network for two reasons. First, since the actors in the integration and participation process may have a rather frequent and intimate relationship with the statusholders, they are well positioned to detect mental health problems in an early stage. Second, broadly understood, mental wellbeing can be influenced by for instance participation in the labour market, quality of housing, feelings of acceptation into society, guarantees regarding the permanent residence permit, opportunities for self-actualization and by developing a social network (Drogendijk et al., 2016; Haker et al., 2016). This implies that actors within the societal integration and participation process can play an important role in the second step: *universal prevention*. The activities the actors offer range from societal support and providing generic information to teaching the Dutch language. All these activities can empower the statusholder. The third step, *selective prevention*, is only for statusholders whose developing mental health problems have been signalled, or when there is a high risk of mental health problems. Professional/care organisations then organise specific information meetings, trainings, psycho-education or other health-oriented activities. The

tentative problems or early signals are further assessed in order to establish whether a statusholder needs curative care. It is therefore a process of professional signalling as well.

The top three steps are part of the Dutch mental health system. This is divided into three tiers. *First-tier mental health care (GGZ)* primarily consists of the General Practitioner (GP) and the Mental Health Nurse Practitioner (POH-GGZ). The POH-GGZ is a mental health expert within the GP's office who can assess the patient's mental state or and offer initial treatment. They both provide for easy accessible care or treatment, room for storytelling and diagnosis. Moreover, the GP has a pivotal role since he or she is the only one who can legally refer patients to mental health organisations in the next tiers, or to the POH-GGZ or psychologists in the first tier. The *second-tier GGZ* consists of the regional mental health organisations, whereas the *third-tier GGZ* are national centres specialized in the diagnosis and treatment of people with complex (war-related) psychotrauma or specifically for refugees. The second-tier can be further specified into basic and specialized mental health care. The latter may refer to organisations specialized in addiction or intercultural psychiatry.

Two final points are worth mentioning. In spite of what the model suggests, the steps are not necessarily linear. In some cases, certain steps can be skipped. For example, a statusholder can undergo universal prevention, wherein he is informed of the role of the GP, and then decide to go directly to the GP, skipping the selective prevention step. Thus, the model is abstract and are implemented more dynamically in practice. Second, the pyramid only shows the supply side of the network. It shows the organisational interconnectedness between different levels of prevention and care and the vast array of actors involved, not only limited to the health professionals. However, a demand-oriented pyramid including the needs of the statusholders can be envisioned as well. This pyramid could for instance be structured according to an interpretation of the Maslow pyramid. In order to make a comparison and test whether supply and demand are in balance with each other, a pyramid based on the needs or demands of the statusholders needs to be developed in further research.

4.2 Managing the complex structure

As the pyramid structure shows, the network 'psychische gezondheid statushouders' is rather extensive and complicated. The mental wellbeing of statusholders can be affected by, amongst others, volunteers, welfare workers, municipal officials, care professionals and psychiatrists. To ensure an effective cooperation and adequate access to mental health care, a network manager who can direct the network and has oversight over all activities is essential. Practically speaking, in the Netherlands the municipality is the network manager, since they are legally responsible for public health (i.e. prevention) (Drogendijk et al., 2016; Tolhuis, 2016). This is embedded in several laws. For example, article 2 of the Public Health Act dictates that municipalities are responsible for improving coherence within the public health sector and coordination with the curative care sector. Moreover, according the Societal Assistance Act municipalities are responsible for societal assistance to all municipal inhabitants, including statusholders. Lastly, although statusholders are responsible for their own integration (e.g. which language teacher they choose), municipalities are responsible for the participation declaration trajectory as was shown in paragraph 2.1. The fundamental assumption of this legal basis is that statusholders are part of the municipal inhabitants and should not be treated as a separate group. Since the Dutch society is individualistic, this implies the assumption of self-responsibility as well

5. Results II: the case study

This chapter presents the case study of this research. The structure developed in the background study was used to examine the organisation and functioning of the network in the municipality of Nijmegen. Paragraph 5.1 describes the functioning of the network in the municipality of Nijmegen from early signalling to prevention or mental health treatment. It also shows the importance of the relation between integration and mental wellbeing. Paragraph 5.2 addresses the role of the municipality as a network manager, and the challenges it faces. Lastly, Paragraph 5.3 discusses the different barriers to safeguarding the statusholder's mental wellbeing.

5.1 Dealing with the mental wellbeing of statusholders in Nijmegen

The functioning of the network in the municipality of Nijmegen is described below. The information stems from the internship report and is largely based on interviews with several actors from every step of the pyramid. This paragraph is structured according those steps: from early signalling to mental health treatment.

5.1.1 Early signalling of mental wellbeing

Early signalling usually comes from actors who have developed a deep, lengthy and/or trusting relationship with the statusholder during the societal integration and participation process. Early signalling can be divided into four clusters of actors (constructed in cooperation with a national working group with four regional coordinators): 1) Naturalisation & participation declaration trajectory, 2) Societal support, 3) Municipal services and 4) Everyday life & other. They will be elaborated below.

Naturalisation & participation declaration trajectory cluster

The first cluster comprises of actors who are involved with teaching the Dutch language, habits and societal principles. Since statusholders are obliged to arrange their own language- and integration courses (Vereniging van Nederlandse Gemeenten, 2016), a language- and integration teacher may potentially detect mental health or psychosocial problems. However, in a classic teaching setting, such as conducted in Nijmegen at the organisation STEP, the relationship between teacher and statusholder remains rather superficial compared to other early signalling actors. By contrast, a language coach- or buddy may develop a more interactive relationship. This is a volunteer who meets the statusholder for one or two hours each week to practice Dutch in different situations (Vluchtelingenwerk Nederland, n.d.-b). Such a volunteer is facilitated by several organisations, mostly by the VWON. The language buddy model offers the opportunity to develop a trusting relationship. Such a context stimulates storytelling, which is important factor in early signalling. According to two interviews at VWON, the volunteer always reports warning signals to a team coordinator, who assists and trains him and has connections with external actors such as the GP, municipality or welfare and social support organisations.

Lastly, all professionals and volunteers who implement the Participation Declaration Trajectory (PVT) on behalf of the municipality may also detect mental wellbeing problems. The PVT is the trajectory that accompanies the participation declaration. This is a municipal-level guidance program, which has been offered since January 1st, 2016 (Vereniging van Nederlandse Gemeenten, 2016). The PVT consists of several workshops and meetings to learn about Dutch society. Since it is compulsory, all statusholders are seen during the early phase of settling in a municipality. This contributes to early signalling. Municipalities may give their own interpretation to the PVT and are free to choose which organizational actors they contract to

implement the activities. The municipality of Nijmegen contracted a standard programme by ProDemos (an organisation that informs on the Dutch system of democracy and rule of law) and VWON, which consists of three interactive sessions about Dutch fundamental values (Vereniging van Nederlandse Gemeenten, 2017a). According to an interviewee from VWON, the first session intentionally leaves room for questions and storytelling. Other actors involved are STEP (four workshops and excursions), NABEL foundation (three trainings specifically for the Arabic population), the GGD, the library, sporting clubs, ex-refugees and several volunteers from VWON.

Societal support cluster

The societal support cluster comprises of actors who have developed a trusting and open relation with statusholders and are there to stimulate the integration process. First, according to most interviews, a buddy – not to confuse with a language coach or buddy – can have an important impact on early signalling. A buddy is assigned to a statusholder for several months in order to assist him with practical tasks regarding societal integration and participation. Where the language buddy solely concentrates on teaching Dutch in order to pass the civic integration exam, a buddy develops a personal and supportive relationship. According to the interviews, a buddy is usually the first person a statusholder trusts in the new environment. In Nijmegen buddies are assigned to Eritrean statusholders in Lent within the LiNK project of VWON by the end of 2015, since they needed extra support in activation and participation. The buddies assist them at finding suitable volunteer work, courses or a sports club (LiNK, n.d.). For other statusholders STEP offers the 'Neighbourhood Buddies' project, in which statusholders are linked to local residents in order to familiarise in their neighbourhood.

Second, VWON offers a Settlement coach, a volunteer who supports the statusholder during the first eight to twelve months after settling in the municipality, aimed at stimulating self-reliance. He assists, among others, with applying for welfare and familiarising in the Dutch society as well. Moreover, VWON provides for a 'VIP 18' trajectory as well. This is a trajectory that will also focus on societal participation and will take eighteen months instead of twelve. According to interviews at the VWON, coaches may detect (mental) problems such as concentration issues, forgetfulness, addiction and debts. Third, the municipality of Nijmegen ordered Bureau Wijland[6], Inter-lokaal[7] and VWON to implement the pilot 'trajectory supervision for statusholders'. Six trajectory supervisors are appointed, directed by a team with representatives from all three executive organisations, to optimise and monitor the integration process of assigned statusholders from an overview perspective. Since they do not provide daily support, but try to improve coherence between involved organisations, they may identify obstacles to integration that stem from both mental health and organisational problems. Lastly, welfare workers can have a signalling role as well, since they are the eyes and ears of the local community. They are involved with various activities such as sports, youth- and community work, debt counselling and parenting support. Notable welfare organisations in Nijmegen are Inter-lokaal, Tandem Welzijn, Forte Welzijn and SWON (the welfare foundation for elderly in Nijmegen).

Municipal services cluster

Municipal services are less qualified to detect early warning signals. During his integration process, statusholders interact with several municipal officials. For instance, officials who assist

[6] Bureau Wijland is an advisory and expertise bureau for diversity and sustainability, located in Nijmegen.

[7] Inter-lokaal is a welfare and social service organisation in Nijmegen, specialized in diversity. It was established as a 'gastarbeiderswinkel' in 1976, an organisation for social and judicial support and advice for migrant workers, by students in the early seventies. Therefore, it has a long history with a cultural sensitive work ethic.

the statusholder in regard to housing, well-being, income/social assistance or societal participation. In the Netherlands people who are on welfare, are obliged to actively apply for a job. Since every statusholder is on welfare, an account manager Work and Income will automatically meet all statusholders in a municipality (De Haan, 2017). However, municipal employees are not equipped to recognize or deal with the mental health problems of their clients. Lastly, the municipality of Nijmegen has organised an information and advice centre in each district, the so called 'Stip'. This is a readily accessible place where residents of a district can go with questions, for advice or to meet other people. A Stip is manned by volunteers, who are supported by professionals. Inter-lokaal coordinates the operational implementation by several welfare organisations. Since Stips are closely related to social district teams ('sociaal wijkteams'), which include several care- and welfare professionals for custom-made care and societal support, they are in some ways their front office, and have an important signalling function.

Everyday life & other cluster

The last cluster is characterized by the social network and family, religious workers or leaders and teachers or professionals within the education sector. There are two groups of religious actors. First, Dutch churches organise several activities exclusively for statusholders, such as information meetings, sports, meals, city tours and language courses (Drogendijk, et al., 2016). Second, a statusholder may also seek support at their own religious community. A religious/communal leader can detect problems and act as a spokesman towards external actors. Next, teachers and professionals within the educational sector have a rather unique position, since they have the opportunity to see both parents and children. As with Dutch civilians, education is compulsory for statusholders, and education requirements are the same. Therefore, a teacher will see most statusholders on a regular basis and has a potential to detect mental health problems as well. According to several interviews, the education sector demonstrates overlap between detecting mental wellbeing related problems of adult and juvenile statusholders. For instance, an interviewed care coordinator of an International Transitional Class (ISK)[8] in Nijmegen, points out that several of their students have (war)traumas or behavioural problems, detected by their mentor. When internal behavioural analyses or interventions are insufficient and the behavioural problems are related to family-oriented or parenting problems, there is a signalling possibility for adult statusholders as well.

5.1.2 Health improvement through empowerment, support or treatment?

The case study discovered that there are generally three ways to improve the statusholder's mental wellbeing after problems are detected during the early signalling stage. First, the statusholder can be empowered through preventive activities, avoiding the need for further professional support or treatment. By contrast, when mental health problems seem more serious, the interviews suggest that the statusholder can be helped in two ways, depending on the nature of this or her problems. On the one hand, when the statusholder's problems are psychosocial or family-related, he or she is generally directed to the social district team for individual or family-oriented support. On the other hand, when the statusholder's problems are clearly mental health-related, he or she is usually directed to the GP right away. The GP then examines the problems and may refer the statusholder to the POH-GGZ or a professional mental health organisation for further individual treatment. These three routes to improving mental wellbeing are elaborated below.

[8] An 'Internationale schakelklas' is a transitional school for migrant children in the age of secondary education, which will last for a maximum of two years. The first year is characterized by the intake, accompanied with basic attention for language, figures and Dutch habits. During the second year, the children are evaluated in order to decide to which regular level of secondary education they can advance.

Empowerment implies that the statusholder becomes self-sufficient by having access to the right tools to facilitate integration, which indirectly improves mental wellbeing. This can be achieved by both universal and selective prevention, depending on the need for practical or (mental) health related information. In regard to *universal prevention*, the interviews suggest that the statusholders can be empowered by, amongst others, informing them on the health care system, familiarising them in Dutch society, encouraging participation, teaching the Dutch language and promoting self-reliance by assisting in various practical matters such as arranging welfare. As shown in the results, volunteers can play a vital role in such activities, due to their informal and trusting relationship, which encourages storytelling (i.e. the possibility to share personal information and experiences). For example, a (language)- buddy can vastly improve the practical orientation in the housing environment, language proficiency and societal knowledge in an accessible and informal manner. This not only empowers the statusholders, but lowers barriers to care as well, since are more likely to express their feelings and feel more confident in seeking support. In fact, most interviewees argued that trust and storytelling are indeed very important. However, a volunteer is no health professional. Due to the lack of expertise in detecting problems associated with mental wellbeing, they are prone to miss important signals or detect them too late. Thus, as several interviews mention, it is important that their understanding of diversity and mental wellbeing is improved through trainings and information meetings, in which specialized mental health organisations can play a role.

As a way of involving the statusholder within the network, the organisational actors may use a 'sleutelpersoon'[9] or a 'ervaringsdeskundige'[10]. A 'sleutelpersoon' is a statusholder who has received training and has specific knowledge about, for instance, the Dutch health care system. They are involved with signalling, advising, informing as well as developing informational material and are employed to conduct workshops at the participation declaration trajectory (PVT) (Vereniging van Nederlandse Gemeenten, 2017b). In addition, they are trusted, represent a broad social network and speak both Dutch and the language of the participants. A 'ervaringsdeskundige' is a statusholder or ex-statusholder who has lived in the Netherlands for quite a while and who has either integrated successfully, or has some experience with treatment in mental health care. Statusholders are introduced to 'ervaringsdeskundigen' at workshops or information meetings to encourage trust.

The statusholder is empowered through *selective prevention* when he or she already shows signs of problems related to his or her mental wellbeing, but which can be sufficiently improved by providing information, training or psycho-education. According to the interviews, there are two type of actors who provide these activities: the GGD and the prevention department of mental health organisations. The GGD offers health care-related information in most municipalities within their region, including Nijmegen. This can be organised as both universal prevention in relation to the participation declaration trajectory or requested for a specific case (GGD Gelderland-Zuid, n.d.). The information events of the GGD may address matters such as coping with stress and mental problems, hygiene and infectious diseases and sexual health (Smal, Torensma, & Tichelman, 2017), as well as nutrition and parenting (GGD Gelderland-Zuid, n.d.). In Nijmegen, both Indigo and IrisZorg are mental health organisations with a prevention department. They can be requested to provide information, trainings or psycho education to a group of statusholders. For instance, Indigo is involved in prevention activities among statusholders in Lent and has informed them about mental health problems and how to cope with them during several sessions.

[9] Literally translated to 'key person' or 'unifying refugee'
[10] Literally translated to 'experience expert' or 'experienced immigrant'

When offering information is insufficient and a statusholder has psychosocial, social-economic, parenting or relationship-related problems, the actors in the early signalling stage generally direct him or her to the *social district team.* Although a social district team is active within the selective prevention stage, they do not provide group-oriented information but custom-made support. A social district team consists of representatives from various welfare and care organisations, giving it a multidisciplinary and integral character. For example, the social district team in Nijmegen includes social support organisations such as NIM Maatschappelijk werk and Mee Gelderse Poort[11], welfare organisations such as Tandem Welzijn or Forte Welzijn, the POH-GGZ, as well as youth care or youth workers. These representatives first discuss the situation in a 'keukentafelgesprek', an informal consultation at home. Next, they decide upon a suitable approach for further support. The social district team can direct the statusholder to one of their representing organisations. For example, when a statusholder experiences social isolation – e.g. when he lives in a rather small and closed (rural) community – he can be assisted by a social support or welfare worker. However, sometimes social problems are causing mental health problems as well. In that case, a social district team may choose to refer to the GP, who in turn may refer to formal mental health care. By contrast, some interviews mentioned that a GP can refer back to a social district team as well, if the diagnosis revealed socio-economic causes.

A statusholder may visit the *GP* by himself, but the interviews suggest that he or she is generally directed by actors in the early signalling or prevention. The GP then assesses mental health problems as PTSD, depression or anxiety, and psychosomatic disorders[12] like psychological induced head ache or sleeping problems. Two GPs and a POH-GGZ from Nijmegen were interviewed regarding their role and experiences. One interviewed GP is responsible for the health of approximately fifty Eritrean statusholders in the district of Lent. After assessing most of them during consultations, he has only referred three statusholders to mental health care and one to the POH-GGZ. The other GP from southern Nijmegen has only little experience with statusholders and confirmed that only few are being referred to mental health care as well. In addition, the interviews suggest that the use of the POH-GGZ is limited. Meanwhile, the interviews emphasize the easily accessible nature and expertise of the POH-GGZ as well. According to the interviews, there are two reasons for the POH-GGZ being overlooked. First, statusholders are often unable to recognize and talk about their mental health problems, which challenges treatment or referral. Second, since GPs are legally responsible for the health of their patients and can formally refer to mental health care, they feel the duty to build a trusting relationship in order to assess the mental health problems themselves. Besides, the GP tends to refer the statusholder directly to specialized second-tier mental health care, due to the severity of their mental health problems as well as language and culture-related issues. In Nijmegen, there are two specialized mental health organisations for refugees: i-psy and Evergreen GGZ. They both offer intercultural psychiatric treatment in the refugees' own language and through professionals with a similar cultural background. These organisations were established in the past decade, as the provision of cultural sensitive care was lacking. Some statusholders are referred directly to a national specialized treatment centre such as Phoenix, the transcultural clinic within Pro Persona[13], specialized in psychotrauma of asylum seekers and refugees, since

[11] An organisation for information, advice and support to any disabled person, both physical and mental.
[12] A disorder or disease which involves both body and mind and where physical problems are often caused underlying mental health problems as anxiety or stress.
[13] Pro Persona is a specialized second-tier mental health organisation in the Province of Gelderland, near Nijmegen. They offer the third-tier GGZ clinic Phoenix for asylum seekers and refugees as well, when regional treatment was insufficient.

it is located near Nijmegen. However, according a psychiatrist from i-psy, from Phoenix statusholders are often redirected to i-psy due to language and communication problems.

5.2 The municipality directing the network

The findings regarding municipal direction are based on interviews with different municipalities and the experiences of other actors within the network of Nijmegen. It is important to mention that there is a difference between large/urban and small/rural municipalities. The interviews indicate that smaller municipalities may have less experience with refugees, but may benefit from short lines of communication. On the other hand, in a large and urban municipality of Nijmegen, there is more attention to refugee issues as well as experience with diversity and cultural sensitive care. According to a participant form the Dutch Council for Refugees, most smaller municipalities are unaware of the wide range of actors involved and often face challenges to their organisational capacity. Yet, the role of the municipality remains the same.

The results identify three different roles regarding municipal direction: 1) the network manager role, 2) the financing role and 3) the initiator role. First, as a *network manager* the municipality is tasked with the organisational coherence and coordination of the network. Municipalities can facilitate the network by organizing network meetings and conferences, enforcing network agreements and by maintaining relations with and among network partners. In essence, this role is all about bringing actors together, having an overview and promoting mental health as a subject of concern.

Second, as a *financer*, municipalities can direct the network by either subsidizing or contracting actors for preventive interventions. A municipality can subsidize an actor in order to organise preventive activities such as information meetings, for example in regard to the participation declaration trajectory. A municipality can purchase these activities as well on a project basis, when preventive activities are needed for a specific group. Next, in contracts with prevention and care suppliers, municipalities can enforce conditions such as for instance a cultural sensitive work ethic. However, since curative care is financed by the health insurance companies, and not by municipalities, direction on coordination and quality of the mental health sector is rather limited. A municipality can only lobby for public interests, try to involve mental health specialists in the signalling and prevention phase (e.g. for training of volunteers or network agreements) and invite them to network meetings. This implies that the financing role may conflict with the overall network manager role: municipalities are responsible for the wellbeing of their inhabitants, including the statusholders, but lack the power of strict and formal direction in the upper layer of the network.

Third, the municipality can *initiate* and organise preventive activities on their own as well. Municipalities can to this at both the universal and selective level of prevention. First, at the universal level they organise the participation declaration trajectory and organise general information meetings. Second, at the selective level they can actively plan an approach to a high-risk group. An example of the initiator role is the municipal approach to a group of young adult Eritrean males, who live in an old student complex in Lent. They show signs of addiction, sleeping- and mental problems (“Integratie Eritrese statushouders Lent behoeft extra aandacht”, 2017). During information meetings, they announced the need for support. As a result, the municipality initiated extra commitment and supply of care, which consisted of a specific

program from the East-Netherlands department of the Dutch Council for Refugees (VWON)[14]. Also taking part in the initiative were students who lived in the same building, youth- and community workers, social workers and a large number of volunteers (ibid.). In addition, actors as the GGD, IrisZorg (a mental health expert in addiction), Indigo (a general mental health organisation), the GP and POH-GGZ where involved as health professionals. The Prevention Department of Indigo organised several information meetings and trainings. This is a good example of a very active initiator role by the municipality of Nijmegen.

Despite this success story, the interviews point out that municipalities are still exploring their directive role regarding the statusholder's mental wellbeing. This results in a lack of oversight and coordination. Therefore, various interviewees argued that it would be beneficial for municipalities to arrange their own social map (i.e. a practical map of the network and their specific organisations) on the basis of the conceptual framework from my internship report. Smaller municipalities – who host only a small proportion of the statusholders – may choose to develop an intermunicipal social map. Interviews also indicate that their directive role is rather strategic, since they lack expertise. At the operational level, direction is transferred to the GGD or social district teams. The GGD, an expert in public health, has a key role in coordinating local public health networks. The social district teams are part of the municipality and bring actors together to provide social support to individuals or families.

5.3 Obstacles to stimulating the mental wellbeing of statusholders

In the interviews, it became clear that there are roughly two obstacles or barriers: personal or demand oriented barriers and societal or supply oriented barriers. The first type of barrier consists of the psychological baggage of the statusholder (e.g. traumatic experiences, loss, homesickness, etc.) and difficulties regarding language and culture. The second type of barrier consists of organisational, policy or practical and structural difficulties in ensuring the integration and participation of statusholders. The barriers will be discussed below according the different clusters that were identified by analysing the interviews. They are based on the perceptions and experiences of the fifteen interviewees within the organisational network. The results of the expert interviews are used in the discussion to comment on these barriers.

5.3.1 Demand-oriented barriers

The demand-oriented barriers that are related here, are those that were identified by actors in the network, and stem from their and experiences while providing support and treatment to the statusholders. Thus, although they are related to the statusholder, these barriers are not an actual indication of his or her 'real' needs and experiences. Yet, the perceptions of the organisational actors may impact the needs and experiences of the statusholder, as will be addressed in the discussion.

One interviewed public health professional gave an interesting metaphor in regard to the statusholder's lack of knowledge of the Dutch society. As it happens, integration and participation into Dutch society can be compared with visiting a hospital. When entering a hospital for the first time, one usually has a hard time finding one's destination. Although there are often signs with routes available in each hallway, finding the way may be stressful and

[14] The Dutch Council for Refugees ('Vluchtelingenwerk Nederland') is an independent, non-governmental organisation which defends the rights of refugees (e.g. fair asylum-procedure and access to work, housing, education and health care) and offers practical support during the asylum-procedure and integration into Dutch society. They primarily use volunteers. There are eight regional offices with the 'East- Netherlands' department being active in the municipality of Nijmegen.

challenging. For example, a statusholder may get lost and miss his appointment. Moreover, the pressure to be on time may lead to stress and difficulty in thinking straight. To address this, a hospital usually has a host at the entrance. When the statusholder enters Dutch society, he faces similar challenges. He or she is unfamiliar with the new environment and the destination – i.e. to integrate within five years – implies the same pressure. When he or she fails to reach his destination or to find he way in Dutch society, this may lead to unnecessary stress as well as difficulties in detecting, preventing and treating problems regarding his or her mental wellbeing. To prevent this, Dutch society has made routes available as well, for example brochures, information meetings, the participation declaration trajectory and so on. However, most information is often in Dutch. Therefore, several interviews suggest that the statusholder needs active support in order to familiarise him with Dutch society. The interviews suggest that a volunteer such as a buddy or settlement coach may fulfil the function of the host at the hospital entrance.

The interviewees encountered barriers regarding interaction with statusholders as well. The interviewed GPs experience a language barrier during their consultation. Statusholders have difficulties describing their problems and even interpreters may be of hindrance rather than help. One GP said that some amateur interpreters ended up in a conversation with the statusholder rather than doing their job. Besides language problems and a lack of knowledge regarding Dutch society and the health care system, most interviewees mention that statusholders bring cultural barriers to the signalling, prevention and treatment as well. Since mental health problems are often a taboo, statusholders are reluctant to find help, do not acknowledge mental health problems or do not show up at a mental health treatment. According to a GP, group pressure often plays a significant role and may lead to statusholders being ostracised by their social environment when they notice him visiting a psychiatrist. Moreover, statusholders may have different expectations of the health care system or interpret mental health problems as physical problems. For example, the Dutch are used to openly talk with a GP, while GPs in Eritrea may collaborate with the regime and are not trusted. In the Netherlands, a visit to the GP comes first, but Syrians are used to immediately visit the hospital. Problems mentioned are mistrust, difficulties talking about traumatic experiences and uncertainty about their future.

5.3.2 Supply-oriented barriers

The supply-oriented barriers are related to the provision of universal and selective prevention as well as mental health treatment. These barriers reflect the perception and awareness of the organisational actors about the extent to which supply and demand are in balance. Thus, to what extent their provision of care meets the statusholder's needs.

The most important mentioned barrier is the lack of cultural sensitivity within the whole organisational network. This is largely related to lack of know-how in coping the problems discussed in the previous paragraph. However, few interviewees actually explained this barrier in detail. Cultural sensitivity was often mentioned as a solution. However, several interviewees noticed that it is difficult to implement. For example, an interviewed GP remarks that he first-tier health care (where the GP works) presents an extra challenge, since GPs are generalists instead of specialists. Therefore, they need to have feeling with a topic such as diversity in order have a culturally sensitive work ethic. In regard to the organisations within the social domain, several interviews argued that cultural sensitivity can be improved by hiring employees with different cultural backgrounds. Furthermore, some interviews mentioned a Western-centred perspective within the network. For example, an interview GP mentioned that statusholders are often approached through a Western view on PTSD and trauma. Another interviewee

mentioned that most information and public services are in Dutch. In fact, the director of Evergreen GGZ, an intercultural mental health organisation, said that it is impossible to discharge this perspective because every psychologist or psychiatrist, despite their ethnic background, is educated by Dutch standards. Consequently, organisational actors may prescribe preventive activities, while statusholders have more practical needs. Several interviewees referred to the fact that mental health problems tend to become noticeable at a later stage during the integration. When the statusholder's survival instinct subsides and practical issues such as housing, education and work are addressed, changes increase that the statusholder will develop a trauma-related mental health problem. Just when he or she needs to integrate and familiarise into society as well as pass the civic integration exam. Thus, another barrier may be faulty timing of preventive activities. In fact, most interviewees think there is a lack of knowledge and information on mental health problems in the early stages of integration.

Some interviewees also mentioned a failure to detect and treat problems on time. For example, the social district team and some smaller mental health organisations have a waiting list and cannot cope with the number of registrations. The interviewee from Inter-lokaal adds that the waiting time at the social district team may even be three to four months, which may result in a deterioration of mental wellbeing. In addition, the non-professional and informal nature of relying on volunteers to provide early signalling may result in detecting mental health problems too late. Several health care professionals, including the GPs, also mentioned that statusholder generally need a longer consult in order to build trust and cope with communication difficulties. However, this is hindered by the fact that a GP consult covered by basic health insurance normally lasts only ten minutes.

5.3.3 Policy-oriented barriers

The policy-oriented barriers can be divided into barriers related to the national and local policy. First of all, as one interviewee noted, the current organisational network is strained by an extensive decentralisation of the social domain in 2015, in which the municipalities received more responsibilities, particularly regarding societal support and youth care (Wmo 2015: wat is er veranderd?, 2015). According to the interviewee, this extra workload may explain why mental wellbeing of statusholders received little attention in 2015.

One of the most mentioned barriers was the lack of compensation for an interpreter. During the asylum procedure, organisational actors are compensated when using an interpreter, whereas it disappears during the integration phase (Drogendijk, et al., 2016). The interviewees point out that it is essential in order to optimally support the statusholder's integration and that its lack hinders access to curative care. Thus, statusholders can only be effectively treated by special intercultural mental health organisations. According to a GP, the municipality of Nijmegen has provided a fund for GPs that can be used to reclaim costs for the 'tolkentelefoon', the facility to use an interpreter by phone. However, he argues that this leads to uncertainty about finances, since the costs can only be reclaimed on an annual basis. As a result, a GP might not be willing to treat a statusholder. While writing this thesis, the government declared that GPs are free to use the interpreter service by the Dutch Interpreter and Translation Centre for free from May 1st, 2017 until May 1st, 2019 (Landelijke Huisartsen Vereniging, 2017). Yet, beside only temporary availability, the compensation is still restricted. First, it is only available for statusholders who received their temporary residence permit after July 1st, 2016. Second, it is not available to statusholders who are registered at a GP's office longer than six months and the compensation is only available for a duration of six months after registration.

At the municipal level, two interviewees argued that the policy is rather project-based and lacks a sustainable vision. An interviewed social worker argued that the larger organisations should get more expertise on refugees and cultural sensitivity. Currently, this expertise is primarily offered by smaller organisations within the care sector that are characterized by competition. Since the larger organisations do not know how to cope with diversity, they usually refer to these experts. By contrast, according to two interviewed mental health care experts, the network can become more culturally sensitive if the organisational actors collaborate and communicate with these smaller expert organisations more often, leaving the discrepancy intact. Moreover, since most organisations rely on subsidies or contracts from the municipality, they sometimes need to wait till January (i.e. when they receive funding again) before they can continue their activities. Another mentioned policy barrier is the lack of attention to mental wellbeing. According to an interviewed team leader of VWON, the municipality of Nijmegen primarily pays attention to universal prevention and societal support during early signalling. The mental wellbeing of statusholder – which basically correlates with societal participation – is largely neglected. A psychiatrist from i-psy adds that this policy may lead to disagreement when a statusholder wants exemption from integration due to his mental health problems. Lastly, it may be coincidental, but as it happens two interviewed municipal policy officers were relatively new at their function. They were inadequately prepared for their job and could not always answer the questions. As a result, one interview was even stopped. During the internship, I noticed that it was hard to arrange interviews with a municipal policy officer, since the mental wellbeing of statusholders is apparently a relatively new policy topic. Moreover, due to the wide range of activities and actors, the topic is often covered in portfolios of different policy officers. Although it needs more research to confirm, it might suggest that municipal employment policy is a barrier as well.

5.3.4 Organisational barriers

Organisational barriers can be divided into barriers related to the municipal direction and regarding the network as a whole. Every interview included a question about perceptions on the municipal direction. Most answers noticed that the municipality lacks oversight regarding the wide range of actors involved, as well as their activities. In addition, the municipality has not made a municipal organisational map of the network to assist its functioning. The interviewed municipal policy officers themselves reply that the municipality is still exploring its role. Thus, the municipality is currently not pursuing network arrangements, coordination and collaboration. Also, the interviewed municipal policy officers indicate that differences between municipalities may lead to different organisational barriers. For instance, large municipalities have more difficulties providing oversight, whereas small municipalities face capacity problems and lack experience. Moreover, during the internship I noticed that municipalities sometimes have different names for the same type of organisation or have slightly different types of organisations in their network. For example, municipalities may have different names for the social district team. These differences between municipalities also show that there is an organisational conflict between the municipal responsibility and regional actors such as the GGD and mental health organisations. The municipality directs the network, but the GGD promotes public health within all municipalities. Lastly, several interviewees noticed that the municipal direction on the curative care is limited. One even spoke of the existence of “two worlds”. This hinders the overall network manager role.

As a result of the lack of oversight – and due to the wide range of actors involved with the statusholder’s mental wellbeing – organisations sometimes work at cross purposes. Some organisations are unaware of each other’s existence or of their role in the early signalling. The director of Evergreen GGZ even recounted that, although he promoted his intercultural

provision of care earlier on, they just recently received Syrian statusholders since the regional coordinator from the GGD promoted their offer within the network. In addition, during a working group session at the conference in Geldermalsen, participants noted that they have difficulties finding each other and that red tape is not only challenging for statusholders, but for organisations as well. They also acknowledged that they are too self-involved and often neglect the true needs of the statusholders. Thus, lack of cooperation is an important barrier. This is especially noticeable between the actors within the early signalling and prevention phase and the actors within curative care. Some interviewees recalled the existence of 'two worlds': prevention and cure. On the one hand, the GPs would like to have more information about the patient from the actors in the early stages. On the other hand, the actors in the early stages miss involvement from mental health professionals, in the form of training in cultural sensitivity and mental health issues. Conflicts between the 'two worlds' are mainly attributed to the different nature of both sectors: bureaucratic versus professional. For example, an interviewed municipal policy officer said that the municipality has difficulties in cooperating with the GP, since GPs feel too important, receive too many invitations for working meetings, and prefer to be visited instead. Lastly, other mentioned organisational barriers are the lack of monitoring mental health treatment and not using the POH-GGZ, who is an easy accessible mental health expert that can readily treat the statusholder or give advice to the GP.

6. Discussion

In this chapter, the results are discussed by analysing them in accordance with the theoretical framework. Two additional expert interviews with an ex-refugee and current statusholder are used to reflect on the results. This chapter is structured according to the different clusters of barriers that were identified in the results chapter: the demand-oriented barriers (6.1), supply-oriented barriers (6.2), policy-oriented barriers (6.3) and organisational barriers (6.4). During the data analysis, it became evident that the theoretical framework, with its matrix of clusters, was insufficient in structuring the discussion. This was due to overlap between the theoretical clusters within the matrix. Paragraph 6.5 will elaborate the overlap and present a newly developed framework that better accommodates the outcome of the research project.

6.1 Demand-oriented barriers

Demand-oriented barriers reflect the perception and experience of the organisational actors in regard to obstacles faced by the statusholder. Thus, which barriers they think hinder the integration and interaction with statusholders. In line with the distinction between internal and external barriers discussed in the theory, the barriers identified by the organisational actors primarily consist of two types: knowledge-related barriers and interaction-related barriers. The knowledge-related barriers are primarily related to the statusholder's lack of familiarity with Dutch society, which hinders the integration and may affect the statusholder's mental wellbeing. The interaction-related barriers are concerned with the obstacles perceived by the organisational actors during their interaction with statusholders. The results show that these are particularly attributed to culture. Language tends to overlap between both types of barriers. In the first type of barriers, language is regarded as the lack of speaking Dutch, which hinders integration. In the second type of barriers, language differences are seen as an obstacle to communication between statusholder and care provider.

6.1.1 Familiarizing the 'other'

The results demonstrated that most interviewees perceive the lack of knowledge about Dutch society and language as major obstacles, which may affect the statusholder's mental wellbeing as well as the early signalling, prevention and mental health treatment. For example, statusholders may have difficulties communicating their problems or may not know how to find their way in the health care system. Therefore, the organisational actors strongly believe that providing language training as well as information on Dutch society – and in particular mental health care – contribute to the statusholder's mental wellbeing, since this improves integration and participation in Dutch society. The expert interviews agree that integration has a positive effect on the statusholder's mental wellbeing, since it overcomes knowledge-related barriers. For example, the interviewed Syrian statusholder explains that for Syrians building a new life and learning about the new society prevents stress or traumas. The ex-refugee mentioned that "when a statusholder exercises, works and speaks Dutch, he feels much better." Thus, it seems as though the knowledge-related barriers can be positively addressed through actively encourage integration.

The theory on post-migration factors acknowledges that the difficulty of navigating the health care and social systems as well as language barriers impact the mental wellbeing of refugees. However, the perception of the knowledge-related barriers reveals practices of bordering and othering as well. As demonstrated with the metaphor of a hospital, the organisational actors present the image that the statusholder is entering an 'unfamiliar' environment. This is form of essentialism, since statusholders are stereotypically portrayed as newcomers with a lack of

knowledge, neglecting educational or social backgrounds. The process by which statusholders are required to become like 'us', in order to successfully participate in 'our' society can also be recognised. This is reinforced by 'rituals of integration' such as the participation declaration and civic integration exam. This also illustrates the power aspect within the concept of orientalism. For instance, when the statusholder fails or refuses to become like 'us', he is punished through fines or by being denied the permanent residence permit. Moreover, these rituals actually are symbolic borders to Dutch society, as they represent hidden practices of othering. They are not as visible as the physical border or clearly exclusionist as the asylum policy, they are much more paradoxical: supporting integration and at the same time protecting Dutch identity. Thus, as stated by Newman (2006, p. 172), "many of the borders which order our lives are invisible to the human eye but they nevertheless impact strongly on our daily life practices." For example, these rituals may cause stress, due to uncertainty of receiving the permanent residential permit, and more so when an application for exemption due to mental health problems is rejected.

In sum, the perception of the knowledge-related barriers that statusholders face uncovers an interesting paradox: while rituals and practices of integration (e.g. language lessons or societal support) seem to positively affect the mental wellbeing of statusholders by familiarizing him in Dutch society, it is an act of 'othering' as well, since the statusholder needs to adjust to 'our' language, societal values and health care system. Thus, this implies that practices of bordering and othering may not inherently be negative, exclusive or discriminative. They may be related to practices that involve 'inclusion' as well. However, the theory lacks an explanation for this, since it, emphasizes the negative aspect of othering.

6.1.2 The culture of the 'other'

According to the results, cultural differences and communication problems are the most important interaction-related barriers. The obstacles the organisational actors experience relate to help-seeking behaviour, expectations regarding the health care system, differences in perceptions of mental health problems, difficulties explaining mental health problems, mistrust, taboos and group pressure. Since the interaction-related barriers primarily originate from a lack of understanding each other's culture, they can be interpreted as cultural barriers. These cultural barriers, although they do occur, are rather superficial and abstract. Almost every interviewee mentioned the exact same barriers, as if they read them in a report or heard them at a training. Although this might suggest that they all experience the exact same cultural barriers, the ex-refugee reflects that the organisational actors lack a dynamic interpretation of culture. For example, most mental health organisations providing intercultural psychiatry are regarded as being specialized in refugees. However, these organisations were primarily established to provide intercultural treatment to the Turkish population who came to the Netherlands as immigrant workers during the 1960's and 70's. Therefore, today most professionals and health care practitioners in these expert organisations have a Turkish background. Although a Turkish psychologist speaks Arabic and seems to have a similar cultural background, his or her culture may differ significantly from that of a Syrian refugee, quoting the ex-refugee:

> "Someone with a refugee background does not immediately associate with a Turkish care provider, who has a village-oriented native culture. A woman from Kabul is used to a whole different culture. [In fact,] culture is much more complex. For example, within a National culture, there are [differences between] village and city cultures. Moreover, there are two identities: vertical identities related to, among others, the family and horizontal identities related to one's personal development."

An abstract perception of culture is reinforced by the available information. For example, Pharos has produced two factsheets describing background information on dealing with the two largest statusholder populations in the Netherlands: Syrians (2016a) and Eritreans (2016b). An example of the type of information the factsheets contain is for instance that Syrian refugees are usually better educated and used to a higher standard of public services. Although these factsheets provide useful information and indicate that there are actually cultural differences within the whole statusholder population, they still encourage the organisational actors to approach every Syrian or Eritrean statusholder according the provided background information. This suggests that the statusholder is not treated as fellow human being with his own personal identity. Instead he is treated as part of a larger culture that can be 'known', which incorporates a foreign language that can be translated, as well as behaviour that can be predicted. Without jumping to conclusions on the use of a cultural-sensitive approach, this clearly indicates that the organisational actors lack an open attitude to culture.

Keeping in mind the earlier theoretical discussion on the cultural approach, the lack of a dynamic perception of culture may correspond with practices of othering. The mentioned cultural barriers in the results, indicate that the organisational actors emphasize cultural differences in their interaction with statusholders. As a form of othering, culturalism can be applied to indicate that organisational actors blame the 'other' culture as a hindrance to safeguarding the mental wellbeing of statusholders, while at the same time implying that the Dutch culture is tolerant and open by contrast. For example, ascribing a taboo as a cultural barrier implies that in the Netherlands mental health care is, by contrast, very much open to discussion. However, it is questionable to what extent this is actually the case within, for instance, closed religious or rural Dutch communities. In addition, by arguing that statusholders may define their mental problems as physical problems, the organisational actors assume that their own understanding of mental health problems is superior. This neglects the fact that health care practitioners can make a wrong diagnosis as well. These examples illustrate how stereotypical thinking actually defines the 'own' Dutch identity, while this very same culture is rather complex as well. When related to the orientalist discourse, it becomes clear that perceptions of interaction-related cultural barriers lead to emphasizing the western perspective as superior and more developed. For example, some interviewees proposed that 'we' have the obligation to normalise mental health care for statusholders, and to break down 'their' taboos.

Thus, by analysing the abstract perception of culture as an interaction-related barrier, the theoretical discussion on processes of othering may explain the goodwill of the organisational actors, irrespective of making overgeneralisations. Although othering aims to explain exclusion, it also explains why the organisational actors feel the obligation to take care of the statusholder, since they – perhaps unintentionally – perceive the Dutch perspective on mental wellbeing as superior.

6.2 Supply-oriented barriers

Supply-oriented barriers are related to the approach within the early signalling phase as well as the provision of preventive activities and mental health care. In relation to the theoretical framework, three barriers stand out. The functioning of the network is hindered by a lack of cultural sensitivity. As a result, there seems to be a mismatch between the provision of care and the statusholder's needs and experiences. Therefore, the lack of cultural sensitivity corresponds with an additional supply-oriented barriers: the reluctance to hire refugees as employees
.

6.2.1 Cultural sensitivity within the network

The results indicate that there is a lack of cultural sensitivity within the inter-organisational network. The organisational actors lack the know-how to cope with the problems demand-oriented barriers. By being aware of the statusholder's cultural habits and health believes, the organisational actors assume that cultural sensitivity is the solution to these interaction-related problems. As shown in the previous paragraph, this corresponds with the lack of a dynamic approach to culture. As discussed in the theoretical debate on cultural sensitivity, this implies that the there is a lack of a culture-centred approach instead of a culture-sensitive approach. Most actors actually approach the statusholder from their 'Western', 'Dutch' or even 'White' perspective, neglecting the "voice" and agency of the statusholder. In fact, as described in the results, during their education in the Netherlands, even the 'culturally sensitive' professionals are trained in Western perspectives on mental health care. The Western-centred approach also corresponds with the fact that the Dutch welfare state approaches the refugee as a helpless and victimized person (Ghorashi, 2005), which is an act of othering. As shown in the previous paragraph, this may lead to practices of 'othering', since the actors do what they think is best for the statusholder, which reinforces a binary differentiation between 'us' and 'them'.

The expert interviews explain that the lack of cultural sensitivity indeed corresponds with a Western perspective on mental wellbeing. As will further elaborated in section 6.2.3, the Syrian statusholder notes that the mental wellbeing of Syrians is not related to traumatic experiences and PTSS, but to building a new life. In addition, the ex-refugee explains the refugee is not understood by the organisational actors, since they are blind a process of mourning, which returns with each new traumatic event in their homeland, as it endangers their family and friends. He uses the metaphor of a tree which is being uprooted:

> "In his homeland, the refugee has developed himself as a full-grown tree with deep roots, depending on the social network, family, personal development and career. When one uprooted, on is alienated. When the statusholder resettles in a host country, he brings along his [personal] baggage containing images of war, experiences during flight, barbed wires, violence, and so on. [At that moment], the refugee is in a state of survival. When he arrives the rooting process begins, in which the sprout is being put into the water again in order to grow. However, [instead of immediately growing into a new tree], most refugees mourn about the tree they left behind.… [Meanwhile], at the roots of the sprout new branches start to grow, due to experiences in the Netherlands."

The metaphor of the sprout also points out that refugees are marginalised. As the ex-refugee argues, "native plants have no difficulty growing in their environment, whereas foreign plants need to adjust to the different temperature and need to have the right space." Thus, compared to the results, this implies that it is indeed important to facilitate trust and storytelling, in order to be aware of the mourning process of the individual statusholder. When in turn related to the theory, this leads to an interesting paradox: most interviewees (who are paid employees in the network) argue that volunteers lack expertise on cultural sensitivity and mental health care and should therefore be trained by professionals from intercultural mental health organisations, while in fact volunteers are the ones who are truly *interculturally sensitive*. For instance, a language buddy approaches a statusholder as an individual human being and while practicing Dutch they communicate despite cultural differences. Thus, volunteers can contribute to feelings of recognition, respect, and perhaps even "oneness".

The above can be somewhat put into perspective. The Syrian statusholder argues that "you cannot speak of a clash between a Western perspective and that of the statusholder. The (cultural) vision of the statusholder changes as well during the integration process, as quoted:

"Syrian refugees are not closed, they are open to learn about the Dutch culture as well." Moreover, since the concept of 'inter- or transcultural psychiatry' is a Western concept in itself, it is questionable whether 'cultural sensitivity' offers a solution at all. Thus, this section implies that there is not a lack of cultural sensitivity, but a lack of approaching every statusholder as an individual with his own dynamic mourning process and voice. Consequently, such an approach will diminish practices of 'othering'.

6.2.2 Reluctance to safeguard societal participation

The results show that the organisational actors are aware that cultural sensitivity can be improved through employment policy. Several interviewees emphasized that it is important to hire employees with different cultural backgrounds. By having a cultural diverse organisation, they believe that is easier to overcome language and cultural barriers. This is especially important during the early signalling phase, as warning signals are easier to detect. Currently, most employees and volunteers lack expertise and experience in either diversity or mental health issues. Besides, as argued earlier on, most current hired 'culturally sensitive' employees lack a refugee background. This may limit the network's functioning and indirectly affect the statusholder's mental wellbeing and integration.

As the expert interviews demonstrate, the current employment policy conflicts with the vision that the statusholder can be empowered through societal participation (i.e. a form of universal prevention). According to the Syrian statusholder, hiring statusholders would have a positive impact on their integration and mental wellbeing, quoting:

> "Syrians want to rebuild their lives and are willing to learn. Finding a job is their biggest problem; there are only few [Syrian statusholders] with mental problems, and most of these emerge as they lack [daily] occupation. In Syria, they had a good job, but here [in the Netherlands] they have difficulties finding one. … In Germany, my dentist qualification would have been converted to a temporary working permit, but in the Netherlands, it is too complicated. … The other half of the Syrian population used to be an entrepreneur, which is difficult as they now need to work under a manager and have to adapt to a cooperative working environment. … Thus, support regarding a job would work very preventive regarding their mental wellbeing".

In fact, by using a document analysis of Dutch reports, it becomes clear that only one third (36%) of the statusholder population in the Netherlands has a job, which is significantly less than the native population (64%) (Haker et al., 2016). In addition, when compared to applicants with a Dutch name and even a conviction for a violent offence, applicants from ethnic minorities with a clean record still are significantly less likely to receive a positive reaction to a job application (Van den Berg, Blommaert, Bijleveld, & Ruiter, 2017). As an explanation for the challenges statusholders face in regard to labour, the ex-refugee argues that the organisational actors are reluctant to hire statusholders. This would in fact not only improve their integration, but cultural sensitivity as well. In fact, in order to be culturally sensitive, he argues that organisations should equally reflect the societal population:

> "When a [care] organisation is blind to her environment and 95% of its employees are 'white', while 50% of the population has societal problems and is coloured, they cannot understand each other. [As a solution], you can give some subsidy to Inter-lokaal[15], but this results in blocking the interculturalisation process of the [general] care providers and solves nothing."

[15] Inter-lokaal is a welfare and social service organisation in Nijmegen, specialized in diversity. It was established as a 'gastarbeiderswinkel' in 1976, an organisation for social and judicial support and advice for

In short, by hiring a statusholder in organisations that are involved in the network would seem to be a win-win situation, since it positively affects both the mental wellbeing and integration of statusholders as well as the cultural sensitivity within the whole inter-organisational network.

The theoretical discussion on both post-migration and othering agrees that hiring refugees would be beneficial for their integration. Labour is seen as an especially important integrative factor affecting the mental wellbeing of refugees. However, according to the literature, temporal residence permit is negatively related to labour. In addition, statusholders have poor employment prospects due to language barriers, discrimination and the limited recognition of foreign diplomas. These practices, which involve stereotypical thinking and exclusion, may be related to othering. As an alternative to othering, hiring statusholders would foster inclusion and belongingness to Dutch society. Thus, this implies that one of the most important inclusive factors is missing and that the current employment policy in regard to hiring statusholders is exclusive instead. In addition, when the importance of integration is to be promoted by organisations within the network, one would expect them to take a leading role, so that their hiring policy would reflect the diversity of the people they service. However, the theoretical discussion on cultural sensitivity does not clearly considers hiring refugees to promote cultural sensitivity. Instead, it argues for an open, nonintrusive and empathic approach to the statusholder, which could actually be used by any professional within the network. Thus, it cannot be concluded that hiring refugees would improve cultural sensitivity, although it is beneficial for their mental wellbeing and integration.

6.3 Policy-oriented barriers

Policy-oriented barriers are related to the national and municipal policy towards safeguarding the mental wellbeing of statusholders. The results demonstrate two prominent policy-oriented barriers: restrictive policies and the lack of durability.

6.3.1 Restricting integration?

According to the results, the policies involving that hinder the functioning of the organisational network. An example is the lack of compensation for using an interpreter during the integration phase. The interviews show that the lack of interpreter compensation was identified as a major stumbling block by care providers. This is odd, since the theory on inclusiveness and belonging shows that it is important to facilitate communication during integration. Besides, intercultural sensitivity implies a conversation between two individuals despite their culture. During the period of this research the Dutch government indeed changed this policy and now provides free interpreter services by the Dutch Interpreter and Translation Centre. However, as shown in the results, this is very limited. In fact, these policy changes to cope with the refugee influx are naïve, as they are rather temporal and reactive compared to a proactive sustainable policy for all arriving refugees in the future. By contrast, just as with the municipal subsidy policy, money obviously plays a role as well. Yet, the example implies that the national vision may contribute to a restrictive integration rather than inclusion.

According to a document analysis of Dutch reports and policy documents, the national vision on mental wellbeing is based on concepts such as an integral approach, resilience and own responsibility to integrate. In fact, it is built around the premise that few refugees develop severe mental health problems such as PTSD, and that attention should therefore be given to prevention, especially in the social domain. The ex-refugee agrees on these concepts but reflects

migrant workers, by students in the early seventies. Therefore, it has a long history with a cultural sensitive work ethic

on them as well, by noting that Dutch society is rather individualist and challenging. For example, although the Dutch government has built "pillars and a bridge between both banks, the actors do not walk on the bridge to help the statusholder cross when he is afraid." Although Dutch society is rather individualistic, reflected by demands on the own responsibility of the statusholder, the organisational actors involved are keen on helping and stimulating integration. Thus, they have a certain goodwill and try to balance their active support with self-responsibility of the statusholder. However, their activities and vision may be largely based on assumptions. In this regard, it is striking that the knowledge synthesis by Pharos (Haker et al., 2016), which is in fact one of the backbones of the national policy framework (e.g. the knowledge sharing programme), literally states that "indications for the use of care, support and prevention are rather hypothetical, since it lacks solid data, registrations and monitoring".

In relation to the literature, "hypothetical indications" would suggest the presence of a rather Western-centred approach, in which the organisational actors believe that 'their' vision is the right one. Take for example the finding that only few refugees (one to three on a scale of 10) develop PTSD and that they are resilient. This finding, which actually forms the groundwork of the national vision and local activities, stems from a meta-analysis conducted by Dutch researchers as part of an advisory report of the Dutch 'Gezondheidsraad' (2016). This study interviewed Dutch experts and analysed meta-analyses and reviews (both systemic and scoping), generally written in English. This implies three disturbing things: 1) the finding is just an estimate, based on several studies from before the refugee crisis instead of current data on mental health problems in the Netherlands, 2) the analysed meta-analyses and reviews are not written by researchers from the (current) refugee population 3) and the study has not interviewed refugees in the Netherlands, but Dutch experts. Due to demand-oriented barriers that have been described earlier, there may be a much larger group of refugees with mental health problems than we know. Furthermore, although interviews suggest that only a small number of statusholders are referred to mental health care, the finding may be premature. As an interviewed intercultural psychiatrist stated, most statusholders will develop mental health problems at a later stage during integration and when their survival state ends.

In sum, this section illustrates that the approach of the organisational actors, although meant in the best interests for statusholders, in fact incorporates practices of bordering and othering. However, the theory cannot explain whether the vision is restrictive due to an 'not in my backyard' argument or orientalist argument related to power. On the one hand, it might suggest that the vision is characterized by an exclusive discourse of statusholders being an 'overload' to public services. For example, this may explain why the Dutch government is reluctant to compensate interpreters. On the other hand, the Western-centred approach may be labelled as being orientalist as well. For example, the imaginative geography of the statusholder fleeing conflict or oppression at the borderlands of Europe emphasizes the 'developed' and 'stable' nature of Dutch society and justifies the Dutch vision on mental wellbeing.

6.3.2 A sustainable network?

The results show that the refugee crisis is primarily addressed as a temporal phenomenon, requiring a short term/project-based solution. As discussed above, the policy change to provide free interpreter services to GPs is a temporal and reactive solution, since it is only available until 2019 and is restricted to statusholder who received their residence permit after July 1st, 2016. This demonstrates the lack of sustainability on the structural policy level.

As a result, the organisational network operates rather project-based. An example of a project-based approach is the active municipal approach to a group of Eritrean statusholders in Lent.

Requested by the statusholders themselves, the municipality of Nijmegen brought several organisational actors together to address problems related to their mental wellbeing, such as, among others, the GGD, the GP and POH-GGZ, the Dutch Council for Refugees as well as Indigo to provide preventive activities. Although this is beneficial for inter-organisational cooperation, these 'best practice'-projects obstruct the sustainability of the network. Moreover, the fact that the statusholders had to request extra attention, implies that the organisational actors either failed to understand or detect their needs or that the municipal policy vision is based on own-responsibility. Since the municipality of Nijmegen aims to have an active approach towards statusholders, it seems as though this 'best-practice' underlines a lack of (inter)cultural sensitivity in the first place.

Another example of the lack of sustainability is competition. By dispersing knowledge on diversity, cultural sensitivity and mental health care, only some organisations are specialized in these topics. These organisations – such as Inter-lokaal, Evergreen GGZ and i-psy – emerged as they saw the need of addressing diversity and culture within the (health) care sector. However, rather that emanating from benevolent intentions, according to the ex-refugee this sub-industry is characterized by competition, opportunism and isolated expertise rather than durable embedment within the network. From an organisational network perspective, competition is disadvantageous for cooperation, since it challenges common interests. Therefore, as network managers, municipalities try to influence the profit-seeking market process by subsidizing and contracting these actors. Quoting the ex-refugee:

> "These experts, who pretend to understand the refugee population, are acknowlegded by municipalities [and they] earn lots of money. … when the government decides to spend 100 million Euros on psychosocial care to the Roma population, tomorrow, everyone will establish specialist centres for them."

Thus, by steering the network, municipalities keep competition intact. Moreover, according to the ex-refugee, the lack of sustainability is also partly related to the Dutch political system, since national and local governments change every four years. Consequently, the organisational actors are currently trying to re-invent the wheel, while refugees from years ago still struggle with different mental wellbeing related problems. Thus, the problem of integration is a structural problem. Part of this may be the consequence of past policies that supported multi-culturalism rather than integration. The ex-refugee:

> "At their arrival, a small group of refugees is curious and tries to integrate, another group is being marginalised (e.g. treated for mental health problems), and a relative large group joins their subculture and remains under the radar [, while suffering mental health problems]. We have allowed this to happen, because we promoted integration while allowing to retain one's own culture. As a result, the ship of the Dutch society has towed all little boats containing Moluccan, Turkish and many more immigrants, without understanding that they will stay for a longer period of time. This leads to a structural problem. For example, there is a structural lack of culturally different people in high offices.… For example, only one Dutch mayor has a different cultural background…. [Moreover, the Dutch government] acknowlegded religious leaders to speak for their subgroup, resulting in a monopoly as well as contributing to polarisation and radicalisation."

In short, this section demonstrated that the short-term or project-based nature of the relevant policy is a structural barrier to the goodwill amongst the organisational actors as well as the statusholders themselves. Furthermore, it showed the relation between policy and organisational barriers and the organisational limitations for sustainability. Since it primarily involves reactive thinking, in contrast to deliberately implement restrictive policies, the

discussion on othering is difficult to apply. Although, imagining statusholders as a temporary or short-term problem may result in approaching them as 'undesired'. Lastly, as demonstrated by the Dutch multicultural society of the previous years, the assumption and myth of a temporal stay must be interrupted in order to develop a sustainable and just structural policy (Leerkes & Scholten, 2016; Van Houtum & Lucassen, 2016).

6.4 Organisational barriers

The results show that there are two major organisational barriers: the inter-organisational cooperation and collaboration among professionals in particular. In fact, at first glance, the research problem seems an organisational one, as the inter-organisational network 'psychische gezondheid statushouders' is rather underdeveloped and still seeking an optimal configuration.

6.4.1 A wide range of actors: challenges to cooperation and network management

Both results chapters demonstrated that a wide range of actors is involved in improving the statusholder's mental wellbeing on different interconnected levels such as the early signalling, prevention and mental health care. To ensure that problems are detected in time and statusholders are adequately supported as well as referred to a mental health care organisation, it is important that all these actors work together. By using theory on inter-organisational networks, it can be demonstrated that the lack of cooperation and coordination is a significant barrier. This downplays the more ideological barriers, as there can be no policy without implementation.

One of the preconditions to an inter-organisational network is that the actors are aware of their mutual dependencies and existence. As shown in the results, this is not always the case. Some organisations are self-involved and others just simply are not aware of their role within the network, especially in the early signalling phase. During the observations, it was interesting to see that representatives of different organisations were meeting each other for the first time and sometimes had not been aware of each other's existence. Also, most interviewees in the early stages of the network expressed the need to know which organisations they can refer to, for example regarding the intercultural offer of mental health care. Another challenge to an inter-organisational network is the need to have common interests. In general, this study observed that the actors show goodwill and have a common goal in supporting the statusholder's mental wellbeing. In fact, this improves cooperation. For example, the participation declaration trajectory, trajectory supervision pilot and case of the Lent, show that multiple actors are involved in these projects, largely because of their common goal. This common goal is reinforced by stories and presentations during the working conferences, showing the successes and importance of the national vision. However, during the interviews it also became clear that there are narrow organisational objectives. Organisations as Evergreen GGZ and i-psy are both offering intercultural psychiatry. Since the existence of their organisations depend on treating statusholders, they are rivals. Many organisations have their own interests and limited scope. For example, VWON is interested in practical issues related to the integration, Inter-lokaal is promoting diversity and an ISK only focusses on their student's wellbeing. Thus, these actors are involved in a 'game' where they try to promote their own interests and expertise.

To facilitate cooperation, a network requires a manager. On legal grounds, this is supposed to be the municipality. However, as the results demonstrate, the municipality is still exploring their network manager role. This is hindered by a recent major decentralisation process, employee changes within the municipality and the fact that the mental wellbeing of statusholders is a relatively new theme. In addition, the study shows that there may be a conflict regarding the responsibilities and scope of regional organisations such as the GGD and the

municipality. For example, the task of the GGD is also to manage public health networks. Thus, currently the network lacks a clear and solid network manager, who actively pushes for clear agreements, brings actors together and provides oversight through an organisational map. This explains some of the current challenges to cooperation.

Since the provision of (mental health) care can be defined as a public service, the statusholder is expected to be involved as a coproducer. However, while not going deeper into the debate whether an 'interaction' always involves a dual input, the statusholder's voice is not always heard. In fact, the statusholder is largely approached in a hierarchical way. According to the ex-refugee, the organisational actors all speak for the refugee, but seldom communicate with the statusholder himself. The results put this into perspective. On the one hand, the statusholder is taught about Dutch habits, the health care system and so on during general information meetings and integration courses, during which communication indeed tends to be one-way. Another example is the inherently hierarchical nature of treatment. As was shown earlier, this is provided from a Western perspective on PTSD and trauma. Thus, in general the statusholder is approached from what 'we' think is important, often based on reports and policy documents.
On the other hand, the actors aim to involve statusholders as coproducer, as promoted by the national knowledge-sharing programme (Pharos & GGD GHOR Nederland, 2016). The results discussed that statusholders may be used during information meetings, workshops and other preventive activities as a 'sleutelpersoon'[16] or 'ervaringsdeskundige'[17]. Since these statusholders give feedback about the care provision as well, they are beneficial to the functioning of the network. However, according to the ex-refugee, although they contribute to a trusting relationship, such employed statusholders are a way of "treating symptoms", to actually use statusholders as coproducers, they need to be hired at the organisations within the network. Thus, while in general interactions between care providers and statusholders tend to be rather hierarchal, the goodwill among the actors does result in some useful initiatives of coproduction.

6.4.2 The autonomy of the professional

Another interesting finding is, that most professionals within the network are generally trying to derive their legitimacy from their substantive knowledge and expertise, rather than from communication and trust. For example, an interviewed municipal policy officer said that the municipality has difficulties in cooperating with the GP, since GPs feel too important, receive too many invitations for working meetings, and prefer to be visited instead. Thus, it seems as though GPs take their professional autonomy for granted. This is reinforced by the fact that their role is primarily framed as being the gatekeeper to the mental health care, because they are the only ones who are legally able to refer a patient to a specialized mental health organisation. In some ways, they are the narrow part of an hourglass, which statusholders have to pass to be eligible for treatment in the other part of the care pyramid. As a result, as one interviewed GP argues, although they need to be more culturally sensitive, "GPs are 'generalists' and need to have 'feeling' with refugees to do so. Specialization in treating refugees cannot be compulsory for GPs, as they need to be accessible for every Dutch citizen."
On the other hand, the results show that GPs rarely use the accessible specialist POH-GGZ in order to give mental health advice or treat the statusholder instead. While this expert can easily provide advice or assist the GP during consult.

Another frequently mentioned issue is the lack of involvement by mental health organisations in improving cultural sensitivity throughout the network. Although Indigo and IrisZorg both

[16] A 'unifying refugee' is trained to provide information on the Dutch health care system.
[17] An 'experience immigrant' may provide information through his personal experiences as a refugee.

have prevention departments offering interventions and advice, mental health organisations generally fail to provide adequate training in cultural sensitivity and the detection of mental health problems to organisational actors in the early signalling and prevention. Meanwhile, these actors – especially volunteers – say that they would be enormously helped by such an exchange of knowledge. Besides, in order to improve cultural sensitivity in the overall network, the interviews show that it is important to have sufficient training and information in this regard.

In short, the interview findings suggest that the conflict between bureaucrat – in this regard actors from the public and social domain – and (mental health) professionals is a salient factor that hinders the functioning of the network. Some interviewees actually viewed the network as consisting of two different worlds: the public health and mental health part. Whereas the first is characterized by prevention and improving the mental wellbeing, i.e. reaching out to the statusholder, the second part, or (mental) health care aims to cure. In addition, the public network is aimed at the overall process of societal integration and participation, while (mental) health care is primarily focused on mental health disorders. As a result, these worlds collide. Furthermore, when zoomed in on the individual health care, the findings suggest that they are intent on the legitimizing their autonomy by knowledge, while instead the inter-organisational context asks for an, open, cooperative and societal-oriented approach. This corresponds with the intercultural-sensitive approach towards the statusholder.

6.5 Towards a new comprehensive theoretical framework

This chapter discussed the results by using the theoretical framework and two expert interviews (an ex-refugee and current statusholder). Instead of using the theoretical framework, this chapter was structured according to the clusters from the results. As it happens, both frameworks do not correspond. This is illustrated in figure below:

Table 2: Comparison between the clusters from theory and results

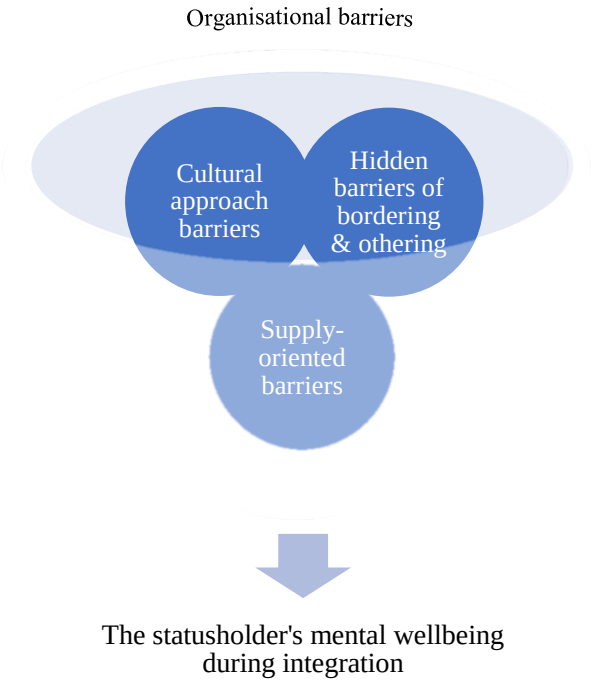
Theory	Short term	Long term
Ideological	*Cultural approach barriers*	*Hidden barriers of bordering and othering*
Practical	*Supply-oriented barriers*	*Organizational barriers*

Results	Short term	Long term
Ideological	*Demand-oriented barriers*	*Policy-oriented barriers*
Practical	*Supply-oriented barriers*	*Organizational barriers*

At first sight, it seems as though two types of clusters from the theoretical framework correspond with two from the results: supply-oriented barriers and organisational barriers. However, ‘hidden barriers of bordering and othering’ and ‘cultural approach barriers’ do not correspond with the demand-oriented barriers and the policy barriers. In fact, as the discussion shows, the theoretical clusters overlap. For example, take the perception of the demand-oriented barriers from the results. These demonstrate that challenges during interactions with statusholders and their integration are attributed to statusholders having a different culture and language and lack knowledge about Dutch society. This actually corresponds with three clusters in the theoretical framework: the static perception of culture corresponds with the cultural approach barriers, language and knowledge barriers are post-migration factors that correspond with supply-oriented barriers and the perception of statusholders being ‘others’ in an

‘unfamiliar’ environment reveals hidden practices of othering. Thus, the discussion shows that the theoretical framework is insufficient in grasping the complexity, since the clusters are interrelated. Consequently, a new framework needs to be developed. The new framework is portrayed as a funnel:

Figure 2: Funnel framework of interrelated barriers



The cultural approach barriers, hidden barriers of bordering and othering, and the supply-oriented barriers overlap when applied to the results. However, the organisational barriers are the odd man out. Although the role of the professional demonstrated some overlap with the intercultural-sensitive approach, organisational barriers do not directly relate to the other clusters, as they primarily address the inter-organisational context. However, the discussion demonstrates that the organisational barriers significantly affect the functioning of the network, which in turn affects mental wellbeing and integration outcomes. Thus, organisational barriers put the other more ideological barriers in perspective and may even indirectly affect them as well. For example, when organisations fail to cooperate or meet the statusholder’s needs, chances are higher that the statusholders will experience post-migration stress factors or that they will experience a lack of cultural sensitivity. In sum, in order to examine the mental wellbeing of statusholders in a society and how this relates to their integration outcomes, it is necessary to analyse the three interrelated clusters in relation to the contextual organisational barriers. This can be illustrated through picturing the organisational barriers as a funnel in which the three interrelated clusters are subsumed.

7. Conclusion and recommendations

This chapter presents the final conclusion of this master thesis. Paragraph 7.1 provides the final conclusion by answering the research question and summarizing the findings. Paragraph 7.2, discusses the shortcomings of this research and presents recommendations for further research.

7.1 Final conclusion

This study focuses on the barriers to the mental wellbeing of statusholders during their integration in the Netherlands, as well as the challenge to organise prevention and mental health care during the increased refugee influx since 2015. This thesis aimed to answer the following research question:

"Which factors hinder the development and functioning of the Dutch organisational network concerned with the mental wellbeing of statusholders, as part of the all-encompassing integration?"

To answer the research question, I formulated five sub-questions. These will be briefly answered below.

The *first sub-question* deals with the challenges related to improve the refugee's mental wellbeing during the trajectory from becoming a statusholder to naturalisation. This study identifies two types of barriers that hinder improving the statusholder's mental wellbeing. Demand-oriented barriers reflect the perceptions of the organisational actors about the challenges the statusholders face. These include a lack of knowledge about Dutch society as well as difficulties between organisational actors and statusholders due to language and cultural differences. As was shown, these barriers involve practices of othering, since preconceived assumptions about the statusholder's culture and 'unfamiliarity' with Dutch society lead to overgeneralization of the 'other'. The other type of barriers, supply-oriented barriers, are related to the provision of care and preventive activities. The research identified a lack of cultural sensitivity, which is related to a Western-centred approach, and the reluctance to hire refugees. This stands in contrast to the possibility that an inclusive employment policy may benefit both cultural sensitivity and integration.

The *second sub-question* was about the structure of the Dutch organisational network concerned with improving the mental wellbeing of statusholders. This was largely addressed during the preliminary or background study for this research. This study developed a pyramid model presenting the interrelated processes from early signalling and prevention to treatment within mental health care. This revealed that the network is divided into two parts: public health and mental health care. statusholder's mental wellbeing can be improved in three ways: through empowerment, psychosocial support or mental health treatment. It can be concluded that improving the mental wellbeing of statusholders involves a wide range of organisational actors, who are often linked to the integration process as well. Thus, the structure of the organisational network supports the view that integration and mental wellbeing are interrelated

The *third sub-question* was about the challenges that affect the development and functioning of this organisational network. This study identified two types of barriers that affect the development and function of the organisational network. The policy-oriented barriers are related to the national and municipal policy on mental wellbeing. These barriers are related to a restrictive nature of some policies and a lack of a sustainability. The national vision on mental

wellbeing is largely based on Western-oriented assumption and the refugee influx is primarily approached as a temporary problem that needs project-based solutions. The organisational barriers are related to cooperation within the network, the extent to which statusholders are coproducers and the relation between bureaucrats and professionals. These barriers demonstrated that cooperation and network management are important factors to the functioning of the organisational network.

The *fourth sub-question* examined whether the challenges to improving the mental wellbeing of statusholders during their integration affect the integration policy as well. This study focused primarily on the mental wellbeing of statusholders. However, this is strongly related to the integration phase (and vice versa), since most activities involving the empowering of the statusholder are related to societal integration and participation. For example, by familiarizing the statusholder in Dutch society and teaching the Dutch language, it is assumed that mental health problems can be prevented. In fact, the practices of 'othering' and lack of cultural sensitivity that are related to improving the mental wellbeing of statusholders are very much applicable to the integration policy as a whole. These include a Western-centred approach, abstract perception of culture and practices of 'nursing' or 'familiarizing'. Therefore, since mental wellbeing and integration are related, this study supports the finding that the integration policy the integration policy, while aiming to be inclusive, in some ways works to exclude, marginalise and restrict.

The findings of this research suggest that the provision of care and mental health treatment to statusholders in the municipality of Nijmegen contain practices of bordering and othering that hinder the goodwill of organisational actors and their intention to support inclusion. These practices are unintentional, and not inherently negative or discriminatory. In fact, goodwill and practices of othering both emanate from an underlying Western-oriented approach to care for refugees and statusholders. This manifests as a lack of cultural sensitivity, or the abstract interpretation of culture. In regard to cultural approach, this study noticed an interesting paradox: while volunteers are believed to lack expertise on diversity and mental health issues, they may actually promote (inter)cultural sensitivity due to their trusting, open and non-judgemental relationship with the statusholder.

Another paradox that was identified – by comparing mental wellbeing to integration – shows that othering may not be inherently negative: while rituals and practices of integration (e.g. language lessons or societal support) seem to positively affect the mental wellbeing of statusholders by familiarizing them in Dutch society, it is an act of 'othering' as well, since in this process the statusholder needs to adjust to 'our' language, societal values and health care system.

Lastly, this research attempted to add public administrative theory to the field of refugee studies. By comparing clusters of barriers from the theoretical framework and results, this research demonstrated that organisational barriers play an important intervening role to the other three interrelated clusters of barriers. This resulted in a funnel framework which concludes that theory on inter-organisational networks and professionals is useful to analyse quality of support for the mental wellbeing of refugees.

7.2 Recommendations

This paragraph elaborates the recommendations for further research and policy.

Recommendations for further research
This research attempted to combine several theoretical debates to the analysis of safeguarding the mental wellbeing of refugees during integration. The discussion showed that these theoretical perspectives tend to overlap, indirectly influenced by organisational challenges. It would be interesting test whether the presented funnel framework can be applied to other case studies. It would also be interesting to explore other theoretical debates that interrelate to the debates presented in this study.

As this research particularly focused on the organisational network concerned with prevention and the provision of (mental health) care, it is recommended to examine other interrelated dimensions of societal integration and participation in more depth as well. It would be particularly interesting to compare the organisation and function of these dimensions and examine overlap, cooperation and possibilities for an integral approach. For example, this study showed that integrational dimensions as labour can have an impact on a refugee's mental wellbeing.

This research could not map the needs and perceptions of the statusholders as well as to compare them to the organisational and policy dimensions of the network concerned with improving the refugee's mental wellbeing during integration. Although, an attempt was made to include the needs of the statusholders by interviewing a current and ex-statusholder, their opinions are by no means a sufficient representation of the population as a whole. They are both involved in the organisational dimension and are not exclusively part of the receiving end. Therefore, further research is needed to examine the demand-side of the network and develop a demand-oriented (pyramid) model as well. Next, it would be interesting to compare both models.

Policy recommendations
This study has shown that volunteers have an important role within the organisational network, since they may develop a trusting and personal relationship with the statusholder. Therefore, although it is commonly believed that volunteers lack expertise on cultural sensitivity, they may in fact contribute to intercultural-sensitivity, by promoting an open, non-judgemental and empathic approach.

The conclusions of this study suggest that improving the mental wellbeing of refugees during their integration corresponds with practices of 'othering'. These practices involve a binary differentiation between 'us' and 'them' as well as the superiority of a Western-centred approach. The organisational actors within the network should be aware of these practices. In addition, cultural sensitivity is not 'the' solution. Instead of trying to 'know' the 'other' culture, a care provider should be aware of the statusholder's mourning process and have a dynamic approach to his or her culture. By doing so, the care provider can improve his or her understanding of the statusholder and promote belonging or inclusion into Dutch society.

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Appendices

Appendix I: List of interviewees

Organisation	Name	Function/role
Bureau Wijland	Qader Shafiq	Director
Evergreen GGZ	Durka Mahendram	Director
Municipality of Berg & Dal	Anneke Kolmans	Policy officer Societal Support Statusholders
Municipality of Nijmegen	Anke van Diepenbeek	Policy officer Care and Welfare
Municipality of Zaltbommel	Jessica Aarnink	Policy officer Environment, Society and Development
GP's office Het Meijhuis	Liesbeth van Besouw	GP
GP's office Oosterhout	John Stevens	GP
GP's office Oosterhout	Miep Baltussen	POH GGZ
Indigo	Irm Staarink	Coordinator Prevention Nijmegen
i-psy	Erdem Yaktemur	Psychiatrist
ISK	Gisella Emkow	Care coordinator
Pharos	Omar Najem	'Sleutelpersoon'[18] and project coordinator
Stip/ Inter-lokaal	Faysal Zouay	Coordinator Stip and project manager Diversity
Social district team/ Nim Maatschappelijk werk	Mustapha Elkarouni	Case manager/ social worker
East-Netherlands department of the Dutch Council for Refugees	Maaike Stolte	Coach settlement and project leader Parenting Support
East-Netherlands department of the Dutch Council for Refugees	Christa Hijkoop	Team leader for the municipality of Nijmegen
East-Netherlands department of the Dutch Council for Refugees	Germa Bongers	Team leader for the municipality of Neder-Betuwe and Buren

[18] Literally translated to 'key person' or 'unifying refugee'

Appendix II: Interview guide

This research used basically two interview guides: a guide for the initial in-depth interviews with the organizational actors and a guide for the expert interviews. The interviews were semi-structured. As described in the methodological chapter, most initial interviews where transcribed on a A3-print during the interview by phone. An example of the interview guide fort the interview health care practitioners is attached at the end of this appendix. The Document is in Dutch, but gives an impression of (the style of) the interview guide.

First round: organisational interviews
This research used three (slightly) different interview guides for the initial 15 in-depth interviews, according to the type of respondents: professionals, health practitioners or municipal policy officers. Every interview started with a personal question about the interviewee's function. The main questions where structures according the following topics: organisational network, municipal direction, barriers, and opportunities. The questions, which are translated to English, are presented below:

Type ***Topics***	**Professionals**	**Health care practitioners**	**Municipal policy officers**
Organisational network	Which role does (*fill in the organization*) play within the network?	What are the roles of the GP/POH-GGZ	How is the municipal direction organised?
	Which organisational actors do you cooperate with?	By what route do early signals reach the GP?	Which other roles has the municipality within the network?
		To what extent are statusholders referred to mental health care?	
Municipal direction	What are your experiences with the municipal direction?	What are your experiences with the municipal direction?	-
Barriers	Which obstacles challenge the functioning of your organisation?	Which barriers hinder the functioning of the whole network?	Which obstacles hinder prevention and mental health care to statusholders?
		Which barriers hinder the interaction with statusholders during consult?	
Opportunities	How can the network be improved to mitigate these obstacles?	How can the network be improved to mitigate these obstacles?	How can municipal direction be improved?
	How can a trusting relationship with the statusholder be facilitated?	How can a trusting relationship with the statusholder be facilitated?	-
	Which possibilities are related to empowerment or the lowering of barriers?	Which possibilities are related to empowerment or the lowering of barriers?	Which possibilities are related to empowerment or the lowering of barriers?

Second round: expert interviews
The two in-depth expert interviews had a different interview guide. The interview with the ex-refugee evolved in an unstructured and open conversation on the following topics: the organizational network during the 1990's and now, the refugee's perspective/needs in regard to mental wellbeing, the national vision, the Dutch multicultural society and cultural sensitivity.
The interview guide used during the interview with the current Syrian statusholder contained the following questions:

1) What are your own experiences as a statusholder?
2) You are involved in the initiative 'Syriers Gezond'[19], why was this established?
3) Which challenges face statusholders in regard to their mental wellbeing?
4) What are the needs of the statusholders in order to improve their mental wellbeing?
5) To what extent is the current provision of care sufficient?
6) What do statusholders think of the national vision based on assumptions regarding PTSS, resilience and own responsibility?
7) To what extent is the statusholder's integration hindered by the Dutch system?

[19] Literally translated to 'Syrians being healthy'.

GGD Gelderland Zuid

Topiclijst interviews met huisarts/POH binnen het netwerk psychische gezondheid statushouder

Datum gesprek:
Naam:
Organisatie:
Telefoonnummer:
E-mail:

Vanuit de GGD Gelderland-Zuid i.s.m. een klankbordgroep van Pharos, Vluchtelingenwerk Oost-Nederland, Pro Persona en de gemeente Nijmegen willen Karlijn Hoondert en ik graag het netwerk omtrent de psychische gezondheid van de statushouder in kaart brengen. Hierbij richten wij ons inhoudelijk met name op de preventie, signalering & doorverwijzing en de gemeentelijke regie met als doel het netwerk en de regie te versterken ten bate van de preventie en zorg aan statushouders.

Dit interview duurt ongeveer 30 minuten.

	Opening
	Kunt u kort iets vertellen over uw ervaring met statushouders?
	Positie netwerk
a	Welke rol/rollen kan een huisarts/POH spelen binnen het netwerk psychische gezondheid voor statushouders?
b	Hoe komen signalen bij u (via welke organisaties) en verloopt het doorverwijzen binnen de GGZ?
c	In hoeverre bent u het eens met een stepped care model ? Wat mist er nog (organisaties, stappen, etc.)?
d	Wat is uw kijk op de gemeentelijke regie op het netwerk? In hoeverre kan de gemeente regie hebben op de GGZ?
	Knelpunten
a	Wat zijn knelpunten waar u tegen aan loopt in het functioneren van het netwerk? (kloven, etc.)
b	en bij uw eigen werkzaamheden? (houding statushouder, handvatten/tools, cultuursensitief, etc.)

	Mogelijkheden
a	Welke mogelijkheden ziet u in het netwerk rondom statushouders? (voor preventie, signalering en doorverwijzing) Wat zou anders kunnen?
b	Vertrouwen speelt een belangrijke rol om een statushouder van onder naar boven in de zorgpiramide te krijgen (zelfde gezicht, storytelling, etc.). Hoe zou dit bevorderd kunnen worden in het netwerk en welke rol speelt de huisarts/POH hier in?
c	En hoe kan dat wat betreft empowerment van de statushouder of het verlagen van drempels?
	Overig
	Zijn er nog andere dingen die uw zelf kwijt wil?
	Heeft u nog vragen aan mij?

Ik zal een kort verslag maken van dit gesprek. Dit zal ik u mailen, zodat u eventuele aanvullingen of correcties kunt doorgeven.

Hartelijk bedankt voor dit gesprek!

Appendix III: Members of the advisory group

Organisation	Name	Function/role
Municipality of Nijmegen	Mariken van Woerkem	Project Manager Social Domain
Pharos	Evert Bloemen	Doctor, trainer and advisor
Pro Persona	Mario Braakman	Psychiatrist and anthropologist
VNG	Karlijn Hoondert	Regional coordinator 'Health Statusholders Gelderland-Zuid'
East-Netherlands department of the Dutch Council for Refugees	Maaike Stolte	Coach settlement and project leader for parenting support
GGD Gelderland-Zuid	Elone Quartel	'Gezondheidsmakelaar'[20] & project coordinator for the 'Rivierenland' region

[20] Literally translated to 'health broker', an official who coordinates health networks in on the district level.