PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Mental health problems of undocumented migrants (UM) in the Netherlands: a qualitative exploration of help-seeking behaviour and experiences with primary care
AUTHORS	Teunissen, Erik; Sherally, Jamilah; van den Muijsenbergh, Maria; Dowrick, CF; van Weel-Baumgarten, Evelyn; van Weel, Chris

VERSION 1 - REVIEW

REVIEWER	David Ingleby University of Amsterdam The Netherlands
REVIEW RETURNED	17-Jun-2014

GENERAL COMMENTS	The topic of this article is an extremely important but neglected one, and for this reason I think it deserves every chance of publication. However, precisely because the topic is so important I feel the authors should strive to meet the highest standard possible. I hope the following notes will help to this end. **Access to health care by undocumented migrants in the Netherlands.** A more precise description of the legal situation is desirable. The Netherlands is remarkable for having very generous health care provision for UMs who cannot pay their bills. However, the legislation is so complex and so ineffectively implemented that the benefits of this are limited. It's worth getting the message across that good laws that are badly implemented do not lead to much improvement. The article only mentions the 1998 Linking Act, but there have been two major revisions of the law since then: one in 2006, when the whole system of health care coverage was reformed, and one in 2009, when a new regime came into force for undocumented migrants. 'Medically necessary care' is now equated with 'basic health care coverage', as defined by the 2006 Health Insurance Act. (The precise extent of 'basic coverage' is revised annually.) The decision as to how to treat the patient is left to the health professionals – but the radical change in the 2009 law is that *the*

	same standards and guidelines are assumed to be followed for UMs as for any other patient. The only exception permitted is when the UM is not expected to stay in the country long enough to receive treatment. Critics have pointed out, however, that deportation is never certain until it is actually carried out, and such exceptions are hardly (if ever) made. See http://files.nowhereland.info/667.pdf for a good summary of the current legislation. Except for certain treatments (e.g. dental care) that are not covered in the basic package, a UM now enjoys – in theory – certainty as to the treatment that can be received. However, the uncertainty has simply been relocated from the consulting room to the billing department. Full payment is compulsory unless the patient can prove inability to pay, in which case 80% of the cost is reimbursed by the health insurance companies. 'Proof of inability to pay' is nowhere defined, which results in great variations between service providers. Therefore, a UM can be sure of treatment - but not of exemption from payment. In addition, UMs can use any service provider for 'directly accessible care', such as a GP practice, but for care that can only be obtained with a referral (such as non-emergency hospital care), only specified providers can be reimbursed. This creates problems of accessibility. It is true that UMs in the Netherlands seldom know their rights – but even more importantly, the same seems to be true of service providers. Even the NGO *Dokters van de Wereld* claims to this day on its website that it is up to the individual doctor whether or not care will be given – without mentioning that the same is true for all patients. More important is the question of whether a treatment is included in the standard package of 'basic health care coverage'. Several aspects of the new law are mentioned in the article under review, but some points remain unclear. A short but precise summary of the law is essential in order to explain the background to this research. The article by Grit et al. (2012) is hardly relevant, because the research it reports was carried out in 2007 and 2008 – before the new law was introduced. This law is only mentioned in a footnote, which suggests the text was also written before 2009. **Prevalence of mental health problems** A second way in which the article could be made more incisive and

	informative would be by examining critically what is meant by 'mental health problems', and how common they are among UMs. We are told that these migrants 'often suffer from mental health problems', but there is no indication of what 'often' means. Citing Woodward et al. (2013), the authors state: "Among studies reporting health status of UM in the European Union, psychological issues appear most widespread". Yet this was an investigation of *research studies* on UMs, not of UMs. Many factors could affect the number of reports focusing on psychological issues, apart from the prevalence of such problems. Moreover, Woodward et al themselves note that most of the studies "lacked methodological rigour and consistency". Indeed, establishing the prevalence of mental health problems among UMs is fraught with difficulties, because we do not know what the denominator is (the size of the background population). Moreover, health services only see the select group who gain access to help and know nothing about those who do not. Two issues in particular could be given more attention in the article: *The heterogeneity of the UM population.* There are many pathways into irregularity. Many UMs in the Netherlands are rejected asylum seekers, but we do not know what the proportion is in relation to 'overstayers', illegal entrants, trafficked persons and other categories. All of these types of UM are likely to have different health profiles as a result of their varying age, sex, socioeconomic position, past experiences, etc. Social exclusion and forced migration will predispose to more problems, while on the other hand some UMs will be relatively young and by virtue of the 'healthy migrant effect', healthier. The article tends to generalise about UMs, but more attention should be paid to the heterogeneity of this category. *The ambiguity of the concept of 'mental health problems'.* There is little discussion of the different meanings that can be attached to the term 'mental health problems', in particular the extent to which the experience and behaviour of UMs can be seen as 'normal reactions to an abnormal situation'. (The same applies, of course, to much of the literature on asylum seekers.) Common problems among both UMs and asylum seekers are symptoms of distress, depression and anxiety. Yet the situation they are in may be *objectively* distressing, hopeless and worrying, to such an extent that one would be more inclined to question the mental health of a person who remained unaffected than one who was. There is thus is a serious risk of unnecessarily 'medicalising' and 'pathologising' problems if one applies the same norms that would be relevant to, say, the average Dutch patient. This is not to say that help is not being asked for or should not be given: the issue is whether it should be seen as specifically *medical* help – whether the person should be regarded as suffering from an 'illness' and what the most helpful responses

	are. The article seems wary of tackling such issues, but this is a limitation. We are told that all respondents but one "reported some form of mental health problems spontaneously", but there is no indication of how they did this. Was this label used by the researchers to label certain kinds of remarks, and if so, which remarks? Did respondents use the term "mental health"? There seems an apparent contradiction between the statement "all respondents but one reported some form of mental health problems spontaneously", and "only 2 out of the 15 interviewees mentioned mental health problems immediately when asked for the reasons they visited the GP". Indeed, the main presenting problems were physical ones and 'mental health' problems were only discussed subsequently. In short, there is a lack of clarity about what is being talked about under the label 'mental health problems'. The following observation is interesting in this connection: "When possible solutions to existing mental health problems were discussed, all UM unanimously agreed that receiving a residence permit was the most important factor." This suggests that they themselves regarded their condition as "a normal response to an abnormal situation". The same is suggested here: "Medication was suggested by a few UM as a possible means of treatment. However, nearly all 15 UM emphasized that medication alone could not solve anything. Many were even reluctant to take psychotropics." Why is the word "even" used in the last sentence? Surely the use of medication to alter states of mind which may be unpleasant, but are in themselves normal, is always debateable? We now know that antidepressants do not work significantly better that placebo's for mild depression; and that GPs have been largely responsible for over-prescription of this type of medication. Especially given the undesirable side-effects of such medication, a critical discussion of these issues would seem appropriate. **Other points**

	The experiences of the UMs interviewed did not seem to differ much from those reported in studies of other migrants – aside, of course, from the issues surrounding entitlement to care and the perpetual worries that accompany “illegal” status. Suggestions about providing better information and more explanation of the Dutch medical system are valuable, but relevant to all migrants. The care given by GPs was on the whole rated positively, but one should bear in mind the possibility of a biased selection of respondents. We are not told how many were recruited via GPs. The type of migrant who has a bad experience with a GP and never goes back is not likely to be recruited in this way. More discussion of the role of the GP in providing psycho-social support to UMs would be illuminating. To what extent could more accessible, more relevant and more effective support be provided in other ways for this group? Another point concerns ethical approval. the authors state: “This project was submitted for ethical approval and was waved [waived?] by the Ethical committee of the Radboudumc on the grounds that analysis of health care professionals into the quality of their care – in this case of UM – was an integral part of their professionalism.” This is a curious reaction. Providing a justification for doing the research does not provide any assurances that it was carried out in a way that safeguarded the rights, interests and confidentiality of the respondents. More should be said about the measures that were taken to ensure (for example) that raising potentially distressing issues without follow-up did not exacerbate respondents’ problems. Finally, the Methods section should state during which period the research was carried out.

REVIEWER	Dr. Ulrike Kluge Research Group Transcultural Psychiatry Clinic for Psychiatry and Psychotherapy Charité University Medicine Berlin
REVIEW RETURNED	26-Jun-2014

GENERAL COMMENTS	First of all, there are several blanks missing in the manuscript. Content related:

	The authors state, that there are taboos on mental health problems. It would be helpful if this could be differentiated regarding different groups, because this isn´t the same everywhere "outside Europe", this is in line with the part on the collectivistic cultures. Zaumseil (2006) wrote a long paper on the difficulties of collectivism/individualism and that inner group differences sometimes higher than intergroup differences. The authors stated that UM keep mental health problems to themselfes: explanations seem to be attributed to certain countries of origan. I would doubt that the extent of the fact that people do not want to talk is to be explained by the country of origin. The "Language" limitation seems to me really like a limitation due to the fact that language is still one of the main obstacles to receive care- rather on an institutional level, nd especially for mental health services and care. There is one misleading interpretation of one part of the interview, "UM did not perceive their treatment as different from...." the original interview paragraph supposed something different in my opinion. This leads to one of the limitations, it would be really useful to have some contrasting interview parts for the arguments. The instruction for the interview seems to be a bit too inductive, furthermore the authors state that the interview instruction/questions does not include question to the personal mental health status- does it not? There is some misspelling: "let's day" instead of "let's say". There is some literature that should be integrated, because there are some studies that worked on something similar, that are not referred to by the authors: - Strassmayr C, Matanov A, Priebe S, Barros H, Canavan R, Díaz-Olalla J M, Gabor E, Gaddini A, Greacen T, Holcnerová P, Kluge U, Welbel M, Nicaise P, Schene A H, Soares J J F, Katschnig H. (2012) Mental health care for irregular migrants in Europe: Barriers and how they are overcome. BMC public health. 05; 12(1):367. - and Dr. Susann Huschke, now in Belfast published on one of the "hidden" groups. But I am not totally sure, if she published in english as well.

VERSION 1 – AUTHOR RESPONSE

Addressing the COMMENTS of Professor David Ingleby.

Thank you very much for your constructive question and comments. These were very helpful in refining the paper. The first six comments were about legislation. As the focus of our research were the experiences of UMs, we have kept the information about legislation concise and have adapted this information where necessary.

Comment 1: Access to health care by undocumented migrants in the Netherlands.
A more precise description of the legal situation is desirable. The Netherlands is remarkable for having very generous health care provision for UMs who cannot pay their bills. However, the legislation is so complex and so ineffectively implemented that the benefits of this are limited. It's worth getting the message across that good laws that are badly implemented do not lead to much improvement.

Our response:

We have added a more precise description of the legislation concerning access to health care on page 3 and 4. We have added the following sentences:
From 1998 to 2009 the care was regulated by the Linking Act and financed by a special fund called "Koppelingsfonds". In this period 'medically necessary care' and care to protect public health could be reimbursed, but it became apparent that service providers used different interpretations of these concepts. Therefore efforts were made to formulate a uniform system for reimbursement, and in 2009 a new law came into force with the following legislation:

• The definition of 'Medically necessary care' is equated with 'basic health coverage' as defined by the 2006 Health Insurance Act.
• UMs should be treated according the same standards and guidelines as other patients, unless they are expected to leave the country soon.
• Costs can be reimbursed by a special fund from the National Health Care Institute to healthcare providers if they have failed in their efforts to let the undocumented migrant pay his own bill.
• With the exception of care for pregnant women and childbirth (for which 100% reimbursement is possible), only 80% of the costs of directly accessible care (General practice and emergency department) can be reimbursed.
• 'For non directly accessible' plannable care (e.g. other hospital departments, pharmacies, nursing homes, dispensaries) 100% reimbursement is possible, but only for a selected group of healthcare providers appointed in each region by the National Health Care Institute. For this care, UMs need a referral or prescription.

We have changed two sentences on page 4:
UMs therefore are entitled to receive primary care delivered by GPs which they have to pay for themselves. However, if UMs are unable to pay for these services, GPs can get a reimbursement from the above mentioned fund. After referral by the GP, UMs have access to all secondary care services but will be referred mostly to those hospitals, mental health care institutions and pharmacies that are appointed by the National Health Care Institute.

To get the message across that the Netherlands have good health care provision for UMs but that legislation is complex and ineffectively implemented we have added the following sentence on page 4:
The Netherlands are known to have legislation to guarantee generous health care provision for UMs who cannot afford to pay the bills. In practice, however, the provision of this care is limited as legislation is complex and ineffectively implemented. Service providers are often not aware of their obligations to provide care for UMs.

Comment 2: The article only mentions the 1998 Linking Act, but there have been two major revisions of the law since then: one in 2006, when the whole system of health care coverage was reformed, and one in 2009, when a new regime came into force for undocumented migrants. 'Medically necessary care' is now equated with 'basic health care coverage', as defined by the 2006 Health Insurance Act. (The precise extent of 'basic coverage' is revised annually.) The decision as to how to treat the patient is left to the health professionals – but the radical change in the 2009 law is that the same standards and guidelines are assumed to be followed for UMs as for any other patient. The only exception permitted is when the UM is not expected to stay in the country long enough to receive treatment. Critics have pointed out, however, that deportation is never certain until it is actually carried out, and such exceptions are hardly (if ever) made.

See http://files.nowhereland.info/667.pdf for a good summary of the current legislation.

Our response:
Concerning your remark describing the revisions we refer back to the answers and text changes

under comment 1.
We have added http://Files.nowhereland.info/667.pdf as a reference in the article.

Comment 3: Except for certain treatments (e.g. dental care) that are not covered in the basic package, a UM now enjoys – in theory – certainty as to the treatment that can be received. However, the uncertainty has simply been relocated from the consulting room to the billing department. Full payment is compulsory unless the patient can prove inability to pay, in which case 80% of the cost is reimbursed by the health insurance companies. 'Proof of inability to pay' is nowhere defined, which results in great variations between service providers. Therefore, a UM can be sure of treatment - but not of exemption from payment.

Our response:
Concerning this remark we have added the following sentence in the article on page 4: Because 'proof of inability to pay' is nowhere defined, there are great variations in billing UMs for services.

Comment 4:
In addition, UMs can use any service provider for 'directly accessible care', such as a GP practice, but for care that can only be obtained with a referral (such as non-emergency hospital care), only specified providers can be reimbursed. This creates problems of accessibility.

Our response:
Referring this comment we have added the following sentence on page 4:
The limited – and often variable – group of service providers in secondary care who are entitled reimbursement of costs of care of UMs also creates problems of accessibility.

Comment 5:
It is true that UMs in the Netherlands seldom know their rights – but even more importantly, the same seems to be true of service providers. Even the NGO Dokters van de Wereld claims to this day on its website that it is up to the individual doctor whether or not care will be given – without mentioning that the same is true for all patients. More important is the question of whether a treatment is included in the standard package of 'basic health care coverage'

Our response:
We agree with your comment that service providers are often not aware of UM's rights and their own obligations and possibilities to deliver care to UMs and we think this also accounts for the differences in fulfilling their obligations, as some service providers deny to treat UMs.
We have added the following sentence on page 4: Service providers are often not aware of their obligations to provide care for UMs.

Comment 6:
Several aspects of the new law are mentioned in the article under review, but some points remain unclear. A short but precise summary of the law is essential in order to explain the background to this research. The article by Grit et al. (2012) is hardly relevant, because the research it reports was carried out in 2007 and 2008 – before the new law was introduced. This law is only mentioned in a footnote, which suggests the text was also written before 2009.

Our response:
For your remark to give a short but precise description of the new law we refer back to the answers and text changes under comment 1.
You question the relevance of the article by Grit et al (2012).
We think this reference is useful for the description of how health care was organised before the new law was introduced (page 3), but have removed this reference for the description of the health care

organisation of UM after 2009 (page 4).

Comment 7:
A second way in which the article could be made more incisive and informative would be by examining critically what is meant by 'mental health problems', and how common they are among UMs. We are told that these migrants 'often suffer from mental health problems', but there is no indication of what 'often' means. Citing Woodward et al. (2013), the authors state: "Among studies reporting health status of UM in the European Union, psychological issues appear most widespread". Yet this was an investigation of research studies on UMs, not of UMs. Many factors could affect the number of reports focusing on psychological issues, apart from the prevalence of such problems. Moreover, Woodward et al themselves note that most of the studies "lacked methodological rigour and consistency".

Our response:
As the reviewer points out, estimating the prevalence of mental health problems is fraught with difficulties and biases. Therefore we were not able to provide 'hard data' and have decided not to change the original text. We have added the results of two research studies to give an illustration what 'often' means and how common mental health problems are amongst UMs in the Netherlands (page 3): .
In a study of 100 female UMs in the Netherlands, psychological problems like anxiety, sleeplessness and agitation were mentioned by more than 70 per cent of the women. In a European survey amongst UMs, more than one-third of 177 UMs in the Netherlands perceived their mental health as bad or very bad.

We have also added the following sentence about the mental health studies that were discussed in the article of Woodward et al on page 5:
Most of these mental health studies indicate that mental health problems are highly prevalent amongst UMs but detailed conclusions are hard to provide: studies used different criteria for mental health problems, research populations were highly heterogeneous and some studies lacked a rigorous design.

Comment 8:
Indeed, establishing the prevalence of mental health problems among UMs is fraught with difficulties, because we do not know what the denominator is (the size of the background population). Moreover, health services only see the select group who gain access to help and know nothing about those who do not. Two issues in particular could be given more attention in the article:

The heterogeneity of the UM population. There are many pathways into irregularity. Many UMs in the Netherlands are rejected asylum seekers, but we do not know what the proportion is in relation to 'overstayers', illegal entrants, trafficked persons and other categories. All of these types of UM are likely to have different health profiles as a result of their varying age, sex, socioeconomic position, past experiences, etc. Social exclusion and forced migration will predispose to more problems, while on the other hand some UMs will be relatively young and by virtue of the 'healthy migrant effect', healthier. The article tends to generalise about UMs, but more attention should be paid to the heterogeneity of this category.

Our response:
We have added the following sentences on page 5:
Just as in other EU countries, the UM population in the Netherlands is highly heterogenous and there is a large variety in mental health profiles between and within groups. It is likely that UMs who suffer severely from social exclusion and forced migration will have a different mental health profile from UMs who have come voluntarily to the Netherlands and who mostly are relatively young and healthy

("healthy migrant effect").

Comment 9:
The ambiguity of the concept of 'mental health problems'. There is little discussion of the different meanings that can be attached to the term 'mental health problems', in particular the extent to which the experience and behaviour of UMs can be seen as 'normal reactions to an abnormal situation'. (The same applies, of course, to much of the literature on asylum seekers.) Common problems among both UMs and asylum seekers are symptoms of distress, depression and anxiety. Yet the situation they are in may be objectively distressing, hopeless and worrying, to such an extent that one would be more inclined to question the mental health of a person who remained unaffected than one who was. There is thus is a serious risk of unnecessarily 'medicalising' and 'pathologising' problems if one applies the same norms that would be relevant to, say, the average Dutch patient. This is not to say that help is not being asked for or should not be given: the issue is whether it should be seen as specifically medical help – whether the person should be regarded as suffering from an 'illness' and what the most helpful responses are.

Our response:
We agree that most mental health problems UMs experience can be seen as 'a normal reaction to an abnormal situation.' This is also stated by the UMs themselves in the interviews as described in the discussion on page 17: The majority of the respondents were under the impression that their mental health problems and those of their peers were directly related to their status as UM.
We have added an extra sentence after this sentence to emphasize this: The majority of the respondents were under the impression that their mental health problems and those of their peers were directly related to their status as UM. This is a finding that has not emerged clearly in earlier research and indicates that UMs regard their mental health problems as 'a normal response to an abnormal situation.'

On page 17 we have also added a sentence about how to avoid 'medicalising': This knowledge might help the GP to find the underlying reasons for their mental health problems and might prevent unnecessarily 'medicalising' and 'pathologising' of UMs psychological responses to their difficult life circumstances.

Comment 10:
The article seems wary of tackling such issues, but this is a limitation. We are told that all respondents but one "reported some form of mental health problems spontaneously", but there is no indication of how they did this. Was this label used by the researchers to label certain kinds of remarks, and if so, which remarks? Did respondents use the term "mental health"?

Our response:

First of all, we have explained the UMs in a letter what we meant with mental health problems; we also explained the concept 'mental health problems' again in the interview. As you can read on page 6, we defined mental health problems in the broadest sense of the word, from minor mental health complaints to severe psychopathology.

To clarify how we informed UMs about the concept mental health problems we have added the following sentence on page 6: This definition was written down in plain language in the letter to the UMs and explained in the interview.

To give an indication how we started to talk about mental health problems we have described the questionnaire more detailed and have changed the sentence on page 6 : The interview guide did not

contain explicit questions about the participants' personal mental health problems, but did contain questions about UMs experiences with peers having mental health problems, vignettes with mental health issues, and some implicit questions about personal mental health problems in general. They were asked if they have ever visited a GP for mental health problems and how they experienced the care of the health care providers.

In the results section we have described how they reported mental health problems to the interviewer by changing the following sentences on page 8:

After the interviewer explained what was meant by mental health problems, the question whether they knew peers with mental health problems, and the presentation of vignettes with mental health problems, all but one respondent spontaneously reported some form of mental health problems.

During the interviews some respondents used remarks as "hearing voices", "sleeping problems [caused] by stress", "I always cry", "to have nightmares" and "stress and problems with husband", but didn't mention them as mental health problems. All these remarks were labeled by the researchers as mental health problems as well.

Comment 11:

There seems an apparent contradiction between the statement "all respondents but one reported some form of mental health problems spontaneously", and "only 2 out of the 15 interviewees mentioned mental health problems immediately when asked for the reasons they visited the GP". Indeed, the main presenting problems were physical ones and 'mental health' problems were only discussed subsequently. In short, there is a lack of clarity about what is being talked about under the label 'mental health problems'.

Our response:
As we see it, this is no contradiction: most mental health problems were present, but only presented or disclosed after a further exploration by the GP. As you can read in the text, UMs were often unaware that the GP could treat mental illnesses, lacked trust to discuss mental health problems, or didn't trust the GP as a doctor who could treat mental illnesses. Also, taboo on mental health issues hindered UM to discuss their mental health problems with a GP. In our view the difference between the presence and presentation of mental health problems had been addressed in the text, but we have added an extra sentence on page 19 to emphasize this:
These factors might explain why UMs often did not mention mental health problems as a reason for encounter to visit a GP.

To make clear what physical and mental health problems UMs mentioned as reason for encounter to visit a GP we have added the following sentences on page 8:
Most commonly mentioned were general and unspecified symptoms (e.g. fatigue, chickenpox), skin problems (e.g. wounds, acne), and respiratory problems (e.g. cough and lung problems). One of them mentioned psychological problems as reason for encounter, and another mentioned the need for psychotropic prescriptions.

Comment 12:
The following observation is interesting in this connection: "When possible solutions to existing mental health problems were discussed, all UM unanimously agreed that receiving a residence permit was the most important factor." This suggests that they themselves regarded their condition as "a normal response to an abnormal situation".

The same is suggested here: "Medication was suggested by a few UM as a possible means of

treatment. However, nearly all 15 UM emphasized that medication alone could not solve anything. Many were even reluctant to take psychotropics."

Why is the word "even" used in the last sentence? Surely the use of medication to alter states of mind which may be unpleasant, but are in themselves normal, is always debateable? We now know that antidepressants do not work significantly better that placebo's for mild depression; and that GPs have been largely responsible for over-prescription of this type of medication. Especially given the undesirable side-effects of such medication, a critical discussion of these issues would seem appropriate.

Our response
We agree with your opinion that the first observation suggests that UMs regard their mental health problems as "a normal response to an abnormal situation" and refer back to the comment 9.
We have removed the word "even" in the sentence "many were even reluctant to take psychotropic" on page 17, as we agree that this can be interpreted wrongly by the reader.
We agree that the topic of 'psychopharmacology' is important. However, the focus of this article is not about the optimal treatment options for mental health problems; therefore we have decided not to discuss this issue in this paper.

Comment 13
The experiences of the UMs interviewed did not seem to differ much from those reported in studies of other migrants – aside, of course, from the issues surrounding entitlement to care and the perpetual worries that accompany "illegal" status. Suggestions about providing better information and more explanation of the Dutch medical system are valuable, but relevant to all migrants.

Our response:
Your statement that suggestions about providing better information of the Dutch system is relevant to all migrants is absolutely right, but because UMs were the focus of our study, we have decided not to include suggestions for documented migrants as well.

Comment 14
The care given by GPs was on the whole rated positively, but one should bear in mind the possibility of a biased selection of respondents. We are not told how many were recruited via GPs. The type of migrant who has a bad experience with a GP and never goes back is not likely to be recruited in this way.

Our response
We agree that there is a possibility of a biased selection of respondents but via our recruitment strategy we have tried to minimise this bias: only a minority of UMs (4 out of 15) were recruited via a GP. To make clear how many UMs were recruited via GPs we have added the following sentence on page 8: Four patients were recruited via GPs, and 11 were recruited via trusted representatives of churches, migrant organisations and voluntary organisations.

We have already written in our article on page 19 : Perhaps satisfaction bias was introduced through the inclusion of UMs who were referred to or registered at practices in which GPs had affinity with this group. We think this makes the reader clear that there is a possibility of a biased selection.
Although we didn't recruit migrants who visited a GP only once and never returned because of negative experienced we have recruited several UMs who have had a bad experience with a GP. Their negative experiences were described on page 10, 11 and 12. In our view, we already dealt with this matter adequately. Therefore we have not changed the original text.

Comment 15:

More discussion of the role of the GP in providing psycho-social support to UMs would be illuminating. To what extent could more accessible, more relevant and more effective support be provided in other ways for this group?

Our response:
We agree that this is very interesting, however our focus of the study was on the experiences of UMs and therefore we have decided not to elaborate on this.

Comment 16: Another point concerns ethical approval. the authors state: “This project was submitted for ethical approval and was waved [waived?] by the Ethical committee of the Radboudumc on the grounds that analysis of health care professionals into the quality of their care – in this case of UM – was an integral part of their professionalism.”

This is a curious reaction. Providing a justification for doing the research does not provide any assurances that it was carried out in a way that safeguarded the rights, interests and confidentiality of the respondents. More should be said about the measures that were taken to ensure (for example) that raising potentially distressing issues without follow-up did not exacerbate respondents’ problems.

Our response:

Thank you for pointing this out, we accidentally copied the wrong sentence about the ethical committee and are happy we have the opportunity to correct this in the following manner:

We have changed a sentence on page 7:
This project was part of the EU-Restore project. Restore as a project was submitted for ethical approval and was waived by the Ethical committee of the Radboud umc. For this specific study we contacted the committee again and their decision remained as it was, on condition that the questions for the migrants were not confrontational or stressful.

In as far as the reviewer would have a question of how the confidentiality of the respondents was safeguarded during the study we have added this in the following sentences on page 7:

They were explicitly informed that the interview was for research purposes only and that their information would not be shared with their GP or with anyone else.

The interviewer was instructed not to ask explicit questions about the UMs personal health status. Only if UMs disclosed these problems spontaneously, and after careful consideration that the questions or conversation were not confrontational or stressful, was the interviewer allowed to ask more personal questions.

We also changed a sentence on page 7:
The interviewer kept all the information of UMs in a secure database and interviews were recorded and transcribed anonymously ad verbatim in the same language as the interview.

Comment 17: Finally, the Methods section should state during which period the research was carried out.

Our response:
We have added the following sentence on page 7: The research was carried out between April and June 2013.

Addressing the comments of Dr. Ulrike Kluge

Thank you for your thoughtful comments. They were very helpful to us in refining the paper.

Comment 18: The authors state, that there are taboos on mental health problems. It would be helpful if this could be differentiated regarding different groups, because this isn´t the same everywhere "outside Europe", this is in line with the part on the collectivistic cultures. Zaumseil (2006) wrote a long paper on the difficulties of collectivism/individualism and that inner group differences sometimes higher than intergroup differences. The authors stated that UM keep mental health problems to themselfes: explanations seem to be attributed to certain countries of origan. I would doubt that the extent of the fact that people do not want to talk is to be explained by the country of origin.

Our response:
You ask us to differentiate between the different groups and mention that the inner group differences in collectivistic/indvidualistic cultures are sometimes higher than inter group differences. We have added the following sentence on page 19:
These factors might explain why UMs often did not mention mental health problems as a reason for encounter to visit a GP. The taboo on discussing mental health problems was a striking finding of this study. Most of the respondents who mentioned this came from African communities, known to have strong collectivistic oriented cultures. At the same time, some African UMs said that they did not experience mental health problems as a taboo at all, indicating that there is a large variety of opinion about this within the same communities.

Comment 19:
The "Language" limitation seems to me really like a limitation due to the fact that language is still one of the main obstacles to receive care- rather on an institutional level, nd especially for mental health services and care.

Our response:
Language barriers are known to be a main limitation to receive good quality care, both on institutional level and on individual the level, and counts for mental health services and primary care. We have written this finding on page 5 in the Introduction: Language barriers and cultural differences add to the risk of inequity in health care access and quality.
But contrary to our expectations, it was a main finding that none of our respondents mentioned language as a main barrier to receive care, although we explicitely asked all respondents for this. To stress this contradiction we have added the following sentence in the discussion on page 18: Our findings contradict other studies with UM that showed that language was a main obstacle to access primary health care, and often a main barrier to discuss mental health problems with a GP.
As we have written in our article in the Discussion on page 19, this could be explained by selection bias, as the majority of the respondents were able to speak Dutch or English.

Comment 20:
There is one misleading interpretation of one part of the interview, "UM did not perceive their treatment as different from...." the original interview paragraph supposed something different in my opinion. This leads to one of the limitations, it would be really useful to have some contrasting interview parts for the arguments.

Our response:
Thank you for this comment. We do not agree that this is a misleading interpretation but rather is an acknowledgement of what the participating UM exactly told us. We regret the word ‘misleading’ in this respect.
To avoid misunderstandings we have changed the sentence on page 14:
Having said this however, most UMs did state that in their experiences GPs didn’t treated them differently because of their undocumented status.

We have also added some contrasting interview parts of an UM on page 12:
“R:The reason why he asked me those questions, maybe its like he thought like for example I’m an immigrant or maybe I don’t have a paper. That’s it. I'm educated, I know those questions” (R7, male, Sierra Leone)

Comment 21:
The instruction for the interview seems to be a bit too inductive, furthermore the authors state that the interview instruction/questions does not include question to the personal mental health status- does it not? There is some misspelling: "let's day" instead of "let's say".

Our response:
We didn’t completely understand why you think the instructions were too inductive. In our opinion we have followed the rules for semi-structured interviews adequately. We have asked them open questions and gave them opportunities to add topics of their own.
We agree that the interview guide does include some general questions about their mental health status, but we like to emphasize that these questions only were used when an UM spontaneously talked about their personal health problems. For this topic, we refer back to the answers and text changes under comment 16.
We have corrected the misspelling and have made some other corrections as well: thank you for this.

Question 22
There is some literature that should be integrated, because there are some studies that worked on something similar, that are not referred to by the authors:
- Strassmayr C, Matanov A, Priebe S, Barros H, Canavan R, Díaz-Olalla J M, Gabor E, Gaddini A, Greacen T, Holcnerová P, Kluge U, Welbel M, Nicaise P, Schene A H, Soares J J F, Katschnig H. (2012) Mental health care for irregular migrants in Europe: Barriers and how they are overcome. BMC public health. 05; 12(1):367.
- and Dr. Susann Huschke, now in Belfast published on one of the "hidden" groups. But I am not totally sure, if she published in english as well.

Our response:
We have added the article of Strassmayr et al as a reference in our study on page 20.
We have looked for english papers of dr. Susann Huscke, but couldn’t find any, so we didn’t include references of her.

VERSION 2 – REVIEW

REVIEWER	David Ingleby University of Amsterdam Netherlands
REVIEW RETURNED	07-Sep-2014

GENERAL COMMENTS	My comments at this time concern only the revisions carried out in response to the first review. The authors have attended meticulously to my earlier comments and I am fully satisfied with the modifications they have made. I have only two additional minor comments concerning language: Firstly, the verb "to waive" is used twice in connection with ethics committee approval, but I think the authors meant that the study was approved/passed/accepted. In this case, the relevant sentence should read "was submitted for ethical approval and was passed by

	the Ethical committee....." If the committee decided that it did not need to assess the project, one would say that it "waived" the approval procedure. I assume this was not the case. Secondly, under the heading "Accessibility problems", the authors state: "At the same time however - in accordance with various universal covenants- they are entitled to free 'medically necessary' care". This should read "they were entitled", as we are talking about a time in the past.

REVIEWER	Dr. Ulrike Kluge AG Transkulturelle Psychiatrie Klinik für Psychiatrie und Psychotherapie, Charité Universitätsmedizin Berlin, CCM
REVIEW RETURNED	20-Aug-2014

- The reviewer completed the checklist but made no further comments.