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Chapter 7

Effectiveness of a cultural competence training on the dropout rates and no-show mean in non-western migrants with affective disorders: a randomized controlled trial

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Submitted

ABSTRACT

Objective: In this study we explore the effects of a cultural competence training for therapists on the dropout and no-show rates among Turkish and Moroccan migrants with depressive and anxiety disorders.

Methods/Design: A randomized clinical trial was performed. Participants were 220 Moroccan and Turkish adult patients who were referred to an outpatient clinic for depressive and anxiety disorders. They were randomly assigned to mental health workers who were trained in a cultural module and to those who were not. The primary and secondary outcome measures were dropout and no-show rates over a 6-month period after the intake session. Several possible determinants of outcome were explored.

Results: There were no significant differences in dropout rates (21% versus 12%) and no-show mean between the intervention and control group. Language problems predicted a significantly lower dropout rate in both conditions.

Conclusions: Training in cultural competence did not reduce the dropout and no-show rates. Possibly there was no difference between the conditions because the therapists in the usual care condition were also competent in motivating and treating migrant patients. Implications for future research are to analyze possible determinants of dropout and obtain more insight in the reasons of dropout.

BACKGROUND

Ethnic minorities in western countries run a higher risk for developing anxiety and depressive disorders than indigenous persons (Breslau et al., 2011; de Wit et al., 2008; Missinne et al., 2012; Weich et al., 2004). Their mental health needs are a major priority but there is evidence of less favourable outcomes of treatment in these patient groups (Chen et al., 2010; Lagomasino et al., 2011; Schraufnagel et al., 2006). There are several reasons why there may be more barriers in the pathways to specialized treatment for ethnic minorities (Bhui et al., 2003; Mills, 2012). In the Netherlands two of the largest non-western ethnic minority populations are people with a Turkish and Moroccan ethnic background, who mostly live in urban areas. Several studies have been conducted to explore the mental health needs and health care use of these groups: It has been found that anxiety and depression are more prevalent compared to ethnic Dutch people (de Graaf et al., 2011; de Wit et al., 2008; van der Wurff et al., 2004). Help-seeking pathways and behaviour (for example preference for help from family, general practitioner or traditional healer) among Mediterranean migrants seemed to be relatively similar to those of the ethnic-Dutch (Knipscheer et al., 2005). The migrant groups were also well presented in general practice and the quality of care in primary care seemed comparable to that of the ethnic Dutch population (Fassaert et al., 2009a; Fassaert et al., 2010). Nevertheless, especially when the patient's proficiency in Dutch was poor and acculturation low, quality of care and satisfaction with the general practice was found to be at stake (Harmsen et al., 2008). When focussing on specialized mental health care, several studies did not find ethnic differences (Fassaert et al., 2009a; Schrier et al., 2005) while others did in terms of use, treatment intensity and dropout rates (Fassaert et al., 2009b; Fassaert et al., 2006). High dropout rates may lead to higher risks of chronicity of symptoms and prolonged disabilities. Several factors may be related to treatment dropout and adherence to mental health treatment (Pinto-Meza et al., 2011). It has been found that low income, young age, type of disorder (mood disorders and substance dependence), low treatment motivation, logistic barriers and delay between initial contact and scheduled appointment were associated with treatment dropout (Aderka et al., 2011; Eiraldi et al., 2006; Gallucci et al., 2005; Pinto-Meza et al., 2011; Taylor et al., 2012). Patients report as reasons for drop out: feeling better, the desire to handle symptoms on one's own and medication side effects. Male gender, receiving pharmacotherapy and the presence of insurance coverage were predictors of adherence to treatment (Pinto-Meza et al., 2011; Wang et al., 2000). Few dropout studies did focus on the role of ethnicity.

Organista et al. (1994) found in a USA study that ethnic minority status and young age was associated with higher dropout. Arnow et al. (2007) found in a comparative USA study that ethnicity, younger age, low income and depression with co morbid anxiety were predictors of dropout. In a qualitative Dutch study reasons for dropout rates among migrants were associated with language problems, different interpretations of symptoms and different expectations of treatment (Hilderink et al., 2009).

A general idea is that adequate treatment can only be given when a firm and steady working-relationship can be established. In case of cultural and/or language differences, it may be more difficult to create this working-alliance. It is thought that training therapists in cultural competences might bridge the gap between migrant patients and their therapists (Beach et al., 2005; Bhui et al., 2007; Dein, 1997; Lie et al., 2010; van Loon et al., 2013). Training in intercultural competence focuses on awareness of culturally determined notions of health and illness, specific intercultural skills (use of a cultural interview or interpreter) and the cultural background of specific ethnic groups. Up to now there is little evidence that training in cultural competence reduces dropout of treatment or improves treatment outcome (Bhui et al., 2007; Cardemil et al., 2005; Griner et al., 2006; Hinton et al., 2011; Hinton et al., 2005; Pan et al., 2011).

The aim of this study was to test whether a cultural competence training can reduce the treatment dropout in Moroccan and Turkish patients with depressive and anxiety disorders in specialized mental health care. In order to test the effectiveness of this training we designed a randomized controlled trial (RCT). Our research questions were:

1. Does the intercultural competences training of therapists reduce treatment dropout rates among Moroccan and Turkish patients with depressive and anxiety disorders in outpatient specialized mental health care?
2. Does the intercultural competence training of therapists reduce no-show rates?
3. What other patient or treatment related variables are associated with dropout and no-show?

METHOD

Study design

This study is a multi-centre randomized controlled study among Moroccan and Turkish immigrant outpatients with depressive and anxiety disorders. Patients were randomly assigned to the intervention group in which (intake-, pharmaco- and psycho-) therapists, were trained in cultural competences or to the control group with therapists who provided regular care. All intervention- and control group data were extracted anonymously from electronic medical records. The study was approved by the Medical Ethics Committee of the VU University Medical Center.

Participants and assignment

Within two outpatient mood disorder clinics for depression and anxiety treatment in Amsterdam, all new Moroccan and Turkish registries, mostly referred by their general practitioner, were screened for participation in the study between January 2010 and January 2012.

Patients (ages 18 to 65) were eligible to participate if:

1. their main problem was a depressive and/or an anxiety disorder.
2. they were first or second generation Moroccan or Turkish immigrants. The definition for a first generation immigrant is that the patient him- or herself was born in Morocco or Turkey. The definition for the second generation migrant is that at least one of the patient's parents was born in Morocco or Turkey (Dutch Central Statistics Office, 2000).

Patients were excluded from the study if their main problem was one of the following disorders: a psychotic disorder, bipolar disorder, organic brain syndrome, substance dependence, or a severe borderline-, schizotypal-, or antisocial personality disorder. A total of 220 patients were eligible. These patients were randomly assigned to an intake therapist from the intervention condition (trained in cultural competence) or control condition (usual care). After the intake the mental health problem of the patient was discussed in a treatment indication team with a subsequent recommendation for a treatment plan. After that the patient was put on a waiting list. As soon as a therapist, from

the intervention or control condition, was available an invitation for the first treatment session was given to the patient by a posted letter.

Intervention versus control-group therapists

In both clinics six therapists (1 psychiatrist, 1 psychiatric resident and 4 psychotherapists) were randomly selected for the intervention group and six for the control group of this study. In both groups the years of treatment experience and the professional background were evenly distributed. Yet, there was a difference in cultural background: the only two migrant therapists (a Moroccan psychiatrist and a Turkish resident) were both assigned to the intervention condition ($\chi^2=4.47$, $df=1$, $p=.03$). Doctors provided the pharmacotherapy and psychologists the psychotherapies.

Intervention and control condition

Therapists of the intervention condition were trained in cultural competencies. The training program was based on existing modules that are widely used in the Netherlands and are based on international and national literature (Hinton et al., 2004; Kleinman, 1988; Kleinman, 2005; Kortman, 2006; Kramer, 2007; Schraufnagel et al., 2006). The aim of the module was to train the intervention therapists' knowledge, awareness and skills in diagnosing and treating Moroccan and Turkish patients with depression and anxiety disorders. The therapists were also trained in a short version of the Cultural Interview (Groen, 2009; Lewis-Fernandez et al., 1995; Rohlf et al., 2009). Subjects to be discussed in the cultural interview are:

- cultural identity (language, ethnicity, position in host country and homeland),
- cultural explanation of the illness (idea of origins and reasons of symptoms and help seeking behaviour),
- psycho-social functioning from a cultural perspective (social support or pressure in host and homeland),
- cultural aspects of the relation between therapist and patient (preference of language, cultural background of therapist or interpreter).

After the training the therapists joined a monthly peer group to keep the knowledge, awareness and intercultural skills vivid. More details of the training were described in the study design (van Loon et al., 2011).

Outcome

Patient and treatment characteristics

Demographic factors as ethnicity, age, gender, marital status, having children and labour status or social security were collected. With regard to treatment characteristics, waiting-time, type of treatment offered, referrals, number of treatment contacts and treatment outcome were extracted from the medical files.

Primary and secondary outcome measures

The primary outcome measure was dropout of pharmacotherapy and/or psychotherapy treatment after intake. Treatment dropout was defined as: the patient is in need of more therapy in the therapist's opinion but ignores at least two invitations of the therapist and does not continue the sessions. Secondary outcome measures focused on no-show. No-show was defined as: the patient had an appointment, did not show and did not contact in advance to cancel the appointment. A new appointment is made afterward. As possible determinants of dropout and no-show we studied treatment condition, cultural background, age, gender of the patient and the therapist, and waiting time as these were found to be determinants of dropout in the literature.

Treatment integrity

Therapists were asked to record on a specific form, what aspects of the cultural interview they had discussed during the intake. These forms were analyzed afterwards. During the monthly peer group sessions, individual cases were discussed, and the therapists from the intervention group gave each other advice in how to apply specific strategies to bridge the cultural gap. In total on each location 25 sessions took place with a mean of 75% attendance of the therapists.

Analysis

We estimated a 30% reduction of dropout in the intervention group compared with the control group. In order to acquire sufficient power for this analysis, we needed at least 75 patients for each condition (beta 0.01 and alpha 0.05) (Bausel et al., 2002). Basic characteristics were compared between treatment conditions. Dropout was analysed by logistic regression models and no-show counts with a (non) parametric Poisson model using bi and multivariate statistics. Possible determinants were modelled along and

grouped by patient and treatment characteristics. Dropout was measured at six months follow-up after the intake.

RESULTS

Recruitment and assignment

Figure 7.1 shows the patients' flowchart. Due to several logistic problems, patients were not always treated by therapists from the allocated condition (protocol violation). Although 65-78% patients were treated by therapists from the right condition, the availability of psychotherapists who were trained in cultural competencies was limited. Therefore only 35% of the patients in the intervention group received psychotherapy from a therapist who was trained in cultural competencies.

Patients and treatment characteristics

Table 7.1 shows the characteristics of the enrolled patients. There were no significant differences between the intervention and control group. Socio-economic aspects were

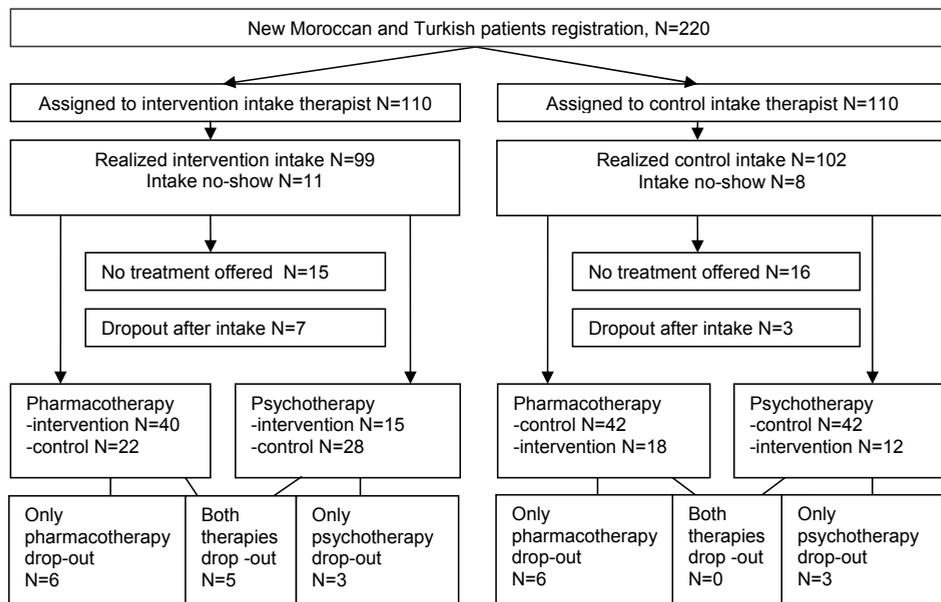


Figure 7.1 Assignment of patients to intervention or control conditions.

Table 7.1 Characteristics of enrolled patients by condition

	Intervention N=99		Control N=102		t/ χ^2	df	p
	N	%	N	%			
Mean age (SD)	39.57 (9.05)		39.83 (9.67)		0.20	199	0.44
Ethnic background							
Moroccan	75	75.76	75	73.53	0.13	1	0.72
Turkish	24	24.24	27	26.47	0.13	1	0.72
Female gender	61	61.61	62	60.78	0.02	1	0.90
Social Security use	44	44.44	49	48.04	0.28	1	0.60
Married or living together	67	67.68	65	63.73	0.53	1	0.47
Having children	77	77.78	85	83.33	0.08	1	0.38
Language problem	34	34.34	39	38.26	0.39	1	0.53
Diagnosis							
Depressive disorder	54	54.54	41	40.20	3.94	1	0.05
Anxiety disorder	21	21.21	28	27.45	1.15	1	0.28
Depression and anxiety	13	13.13	21	20.59	2.08	1	0.15
Other	11	11.11	12	11.76	0.08	1	0.78
Mean GAF (SD)	56.81 (6.90)		57.88 (8.56)		2.24	180	0.77

not always mentioned in the medical files, but based on available data, social security use was 47% for both groups (n=93). There were no significant differences in patient characteristics between Moroccan and Turkish patients except for language problems. These were significantly more often found in the Turkish group ($\chi^2=5.24$, $df=1$, $p=.02$). After the intake, Turkish patients were more often referred to other clinics (15.68% versus 10% for the Moroccan group).

Table 7.2 shows that treatment characteristics were comparable in both conditions, except for the waiting time for pharmacotherapy which was significantly longer in the control condition. In the pharmacotherapy group, we recorded whether patients had received adequate treatment with antidepressants (for more than one month in an adequate dose), and how many steps of the antidepressant treatment algorithm were followed adequately. We found a mean number of steps of one (in three to four months). The rates of at least one adequate treatment with an antidepressant were comparable, 64.06% (n=41) for the intervention group and 71.66% (n=43) for the control group. Offered psychotherapy was also for both groups comparable (n=43 for the intervention and n=54 for the control group) offered and was described as IPT, PST, CGT, Panic management or not specified psychotherapy. A small group of patients completed

treatment within half a year: 5 (5.56%) patients of the intervention group and 6 (5.88%) of the control group ended the treatment in consultation and mutual agreement with the therapist and with positive treatment effect.

The implementation of the cultural competence skills was analysed using data from the medical files. We checked whether the Cultural Interview was applied during the intake and whether the form was filled out. We found that cultural topics were significantly more often discussed during the intake in the intervention group than in the control group: cultural identity (60.60% versus 0.98%, $\chi^2=5.47$, $df=1$, $p=.02$), cultural psychosocial functioning (22.22% versus 7.84%, $\chi^2=7.86$, $df=1$, $p=.01$), cultural aspects of the relation between therapist and patient (13.13% versus 2.94%, $\chi^2=7.01$, $df=1$, $p=.01$). Only

Table 7.2 Overall treatment characteristics of enrolled patients

	Intervention N=99		Control N=102		t/ χ^2	df	p
	N	%	N	%			
Treatment offered							
Only Pharmacotherapy	34	34.34	26	25.49	1.88	1	0.17
Only Psychotherapy	15	15.15	20	19.61	0.69	1	0.41
Combination treatment	28	28.28	34	33.33	0.60	1	0.44
Only group or supportive treatment	7	7.07	6	5.88	0.11	1	0.73
No treatment indication (remission, referred)	15	15.15	16	15.68	0.89	1	0.76
Waiting time after intake, in weeks, M (SD)							
Pharmacotherapy	8.85 (8.58)		12.38 (9.60)		2.12	120	0.03*
Psychotherapy	13.58 (10.07)		14.25 (10.28)		0.32	95	0.75
Dropout							
Total dropout	21	21.21	12	12.12	3.27	1	0.07
First treatment appointment	7	7.07	3	2.94	1.81	1	0.18
Pharmacotherapy follow up appointment	11 ^a	11.11	6	5.88	1.77	1	0.18
Psychotherapy follow up appointment	8 ^a	8.08	3	2.94	2.56	1	0.11
No-show, M (SD)							
Pharmacotherapy	1.11 (1.37)		1.29 (1.93)		0.55	120	0.58
Psychotherapy	1.21 (1.51)		1.09 (2.00)		-0.32	95	0.75
Contacts, M (SD)							
Pharmacotherapy	4.61 (3.51)		4.90 (3.18)		0.45	120	0.65
Psychotherapy	4.37 (4.49)		3.62 (3.96)		-0.85	95	0.39

^a 5 dropout patients received psychotherapy and pharmacotherapy

* $p < .05$

Table 7.3 Determinants of dropout (n=33 of total n=170) using logistic regression

	Bivariate model		Multivariate model Socio-Demographics		Multivariate model Treatment variables		Multivariate model Full model	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Socio-demographic variables patient								
Age > 40 years	0.96	(0.45-2.08)	1.22	(0.53-2.79)			1.40	(0.59-3.32)
Female	1.69	(0.73-3.93)	1.83	(0.75-4.46)			2.02	(0.80-5.11)
Moroccan ethnicity	1.08	(0.42-2.72)	0.95	(0.36-2.48)			0.84	(0.31-2.26)
Language problem	0.39*	(0.15-0.99)	0.37*	(0.14-0.98)			0.33*	(0.12-0.89)
Treatment variables								
Intervention intake	1.93	(0.87-4.25)			2.07	(0.91-4.68)	2.17	(0.93-5.07)
Moroccan/Turkish intake therapist	0.98	(0.34-2.81)			0.76	(0.25-2.28)	0.83	(0.27-2.61)
Waiting time > 11 weeks	1.29	(0.59-2.81)			1.30	(0.59-2.88)	1.42	(0.62-3.23)
R ² (Nagelkerke)			0.06	N=200	0.04	N=164	0.10	N=163

* p<.05

Table 7.4 Determinants of number of no-shows using a Poisson regression model (n=170) with incidence ratios (IRR)

	Bivariate model		Multivariate model Socio-Demographics		Multivariate model Treatment variables		Multivariate model Full model	
	IRR	95% CI	IRR	95% CI	IRR	95% CI	IRR	95% CI
Socio-demographic variables patient								
Age > 40 years	0.78	(0.25-2.49)	1.13	(0.41-3.10)			1.17	(0.45-3.04)
Female	2.58	(0.73-9.07)	2.72	(0.88-8.44)			2.63	(0.89-7.95)
Moroccan ethnicity	2.31	(0.44-11.98)	2.12	(0.44-10.12)			2.14	(0.47-9.74)
Language problem	0.51	(0.15-1.71)	0.53	(0.16-1.72)			0.58	(0.18-1.89)
Treatment variables								
Intervention intake	0.51	(0.15-1.75)			0.53	(0.33-2.21)	0.56	(0.16-1.79)
Moroccan/Turkish intake therapist	0.58	(0.09-3.45)			0.73	(0.13-4.26)	0.45	(0.15-1.37)
Waiting time > 11 weeks	0.47	(0.14-1.60)			0.45	(0.13-1.56)	0.72	(0.12-4.53)

* p<.05

the cultural explanation of the illness was discussed similarly in both intake conditions (15.15% versus 11.76%, $\chi^2=0.49$, $df=1$, $p=.48$).

Dropout and no-show

A total of 21 patients from the intervention condition and 12 from the control condition dropped out after the intake (see Table 7.2). After the intake 7 intervention patients and 3 control patients never started the offered treatment. In the follow up appointments 14 intervention patients and 9 control patients did not continue the treatments. The mean no-show percentages for both conditions were comparable. Table 7.3 shows the analysis of possible determinants of dropout. Treatment condition was not associated with dropout. Language problems, were associated with lower dropout percentages (OR 0.33; $p=.03$), no other determinants were significantly associated with dropout.

Table 7.4 illustrates that none of the determinants we analysed was associated with no-show.

DISCUSSION

In this study training therapists in cultural competence did not reduce dropout and no-show rates in non-western migrants with affective disorders in secondary care. During the six months after the intake 21% of the Moroccan and Turkish patients in the intervention and 12% in the control condition dropped out of treatment. The mean no-show rate was comparable in both groups. The dropout rates we found are comparable to those found in general in mental health care other studies. The Dutch Mental Health Organization (GGZ Nederland) found 20% dropout rate for adults in mental health treatment in the Netherlands (diagnose, duration of treatment and ethnicity not differentiated) (GGZ Nederland, 2010). A first interpretation of the lack of effect of our intervention may therefore be that the treatment teams we selected to take part in the study had already achieved the skills necessary to be able to reach dropout and no-show rates, which are similar to those among native Dutch patients. This leaves little room for improvement by the training. We selected the teams we did because they work in areas with large ethnic minority populations. The disadvantage of this may be that these teams are experienced in working with minority patients and that a cultural competence training has little added value.

In international studies on this subject in mental health care with a comparable treatment period (about 6 months) a comparable dropout percentage was found. One study of Tarricone et al. found 17% dropout among migrants in Italy (Tarricone et al., 2010). In the USA Arnow et al. (2007) studied dropout in a 12 week-acute treatment study of chronically depressed outpatients. In this study three treatment options were compared (medication, CBASP, and a combination). They found significantly higher mean dropout among ethnic-minority patients (34%) than among Caucasian patients 22% ($\chi^2=5.05$, $df=1$, $p=.025$). The higher rates among ethnic minority patients in Arnow's study compared to our findings can be partly explained by one treatment condition in which no therapist contact and only medication was offered. The psychotherapy contact seemed of great importance regarding the treatment adherence for ethnic minority patients (Arnow et al., 2007).

In this study we focused on a group of patients who are mostly underrepresented in clinical trials because language problems are an exclusion criterion and because migrant patients are less motivated to participate in randomized controlled trials. In the intervention condition the intake session was carried out by a therapist trained in general cultural competence and in the Cultural Interview. Although topics from the Cultural Interview were significantly more discussed in the intervention group, implementation of the Cultural Interview was not optimal. This may have diluted a possible effect of the intervention. Also the fact that patients were not always treated by therapists from the right conditions has resulted in a dilution of the intervention. On the other hand, general cultural competencies might have been at a relatively high level in therapists from both conditions, reflected in the overall dropout rate that is comparable to the overall dropout rates in mental health care in the Netherlands. The fact that the therapists all have chosen to work in a clinic with an overrepresentation of Moroccan and Turkish patients, and all have ample experience in working with this group of patients may explain a lack of a significant difference between the groups. It was found that the desire to work with migrant patients is of great importance in delivering cultural competent care (Campinha-Bacote, 1999; Campinha-Bacote, 2002).

The only determinant of dropout we found in our study were language problems. Language problems were negatively correlated with dropout, also after correction for other patient and treatment characteristics. This is in contrast with the literature (Korrelboom et al., 2007). We can not explain this correlation but again a possible explanation may be the motivation of the therapist to bridge the language gap. Also professional interpreters were available at expense of the government till January 2012.

In former studies it was found that professional interpreters have a positive effect on the patient experience of treatment in case of language problems (Flores, 2005).

Conclusions

We could not demonstrate a positive effect of training in cultural competence of therapists who are already working in a clinic with predominantly patients from ethnic minorities. The lack of effect of our intervention may be due to the effect that the therapists involved in the study were already optimally proficient and very motivated in engaging non-western migrant patients. An alternative conclusion may be that contamination and less than optimal training of the intervention is responsible for this negative trial result. Also the dropout percentages in both groups were comparable to other studies also with only western patients included. Nevertheless a substantial part of the treatment population dropped out. Implications for future practice is to select motivated therapists to bridge the cultural gaps in treating ethnic minority patients. Implications for future research are to get more insight in the reasons of dropout in treatment of affective disorders.

REFERENCES

- GGZ Nederland Sector rapport 2010. GGZ Nederland. 2010.
- Aderka, I.M., Anholt, G.E., Van Balkom, A.J.L.M., Smit, J.H., Hermesh, H., Hofmann, S.G., Van Oppen, P., 2011. Differences between early and late drop-outs from treatment for obsessive-compulsive disorder. *J. Anxiety. Disord.* 25(7), 918-923.
- Arnow, B.A., Blasey, C., Manber, R., Constantino, M.J., Markowitz, J.C., Klein, D.N., Thase, M.E., Kocsis, J.H., Rush, A.J., 2007. Dropouts versus completers among chronically depressed outpatients. *J. Affect. Disord.* 97(1-3), 197-202.
- Bausel, R.B., Li, Y.I., 2002. *Power Analysis For Experimental Research*. Cambridge University Press.
- Beach, M.C., Price, E.G., Gary, T.L., Robinson, K.A., Gozu, A., Palacio, A., Smarth, C., Jenckes, M.W., Feuerstein, C., Bass, E.B., Powe, N.R., Cooper, L.A., 2005. Cultural competence: a systematic review of health care provider educational interventions. *Med. Care* 43(4), 356-373.
- Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., Feder, G., 2003. Ethnic variations in pathways to and use of specialist mental health services in the UK. Systematic review. *Br. J. Psychiatry* 182, 105-116.
- Bhui, K., Warfa, N., Edonya, P., McKenzie, K., Bhugra, D., 2007. Cultural competence in mental health care: a review of model evaluations. *BMC Health Serv. Res* 7, 15.

- Breslau, J., Borges, G., Tancredi, D., Saito, N., Kravitz, R., Hinton, L., Vega, W., Medina-Mora, M.E., Guilar-Gaxiola, S., 2011. Migration from Mexico to the United States and subsequent risk for depressive and anxiety disorders: a cross-national study. *Arch. Gen. Psychiatry* 68(4), 428-433.
- Campinha-Bacote, J., 1999. A model and instrument for addressing cultural competence in health care. *J. Nurs. Educ.* 38(5), 203-207.
- Campinha-Bacote, J., 2002. The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. *J. Transcult. Nurs.* 13(3), 181-184.
- Cardemil, E.V., Kim, S., Pinedo, T.M., Miller, I.W., 2005. Developing a culturally appropriate depression prevention program: the family coping skills program. *Cultur. Divers. Ethnic. Minor. Psychol.* 11(2), 99-112.
- Chen, J., Rizzo, J., 2010. Racial and ethnic disparities in use of psychotherapy: evidence from U.S. national survey data. *Psychiatr. Serv.* 61(4), 364-372.
- De Graaf, R., Ten Have, M., Van Dorsselaer, S. De psychische gezondheid van de Nederlandse bevolking; Nemesis-2: Opzet en eerste resultaten. 2011. Utrecht, Trimbosinstituut.
- De Wit, M.A.S., Tuinebreijer, W.C., Dekker, J., Beekman, A.J., Gorissen, W.H.M., Schrier, A.C., Penninx, B.W.J.H., Komproe, I.H., Verhoeff, A.P., 2008. Depressive and anxiety disorders in different ethnic groups: a population based study among native Dutch, and Turkish, Moroccan and Surinamese migrants in Amsterdam. *Soc. Psychiatry Psychiatr. Epidemiol.* 43(11), 905-912.
- Dein, S., 1997. ABC of mental health. Mental health in a multiethnic society. *BMJ* 315(7106), 473-476.
- Dutch Central Statistics Office. Standaard definitie allochtonen. INDEX 10. 2000.
- Eiraldi, R.B., Mazzuca, L.B., Clarke, A.T., Power, T.J., 2006. Service Utilization among ethnic minority children with ADHD: a model of help-seeking behavior. *Adm Policy Ment. Health* 33(5), 607-622.
- Fassaert, T., De Wit, M.A.S., Verhoeff, A.P., Tuinebreijer, W.C., Gorissen, W.H.M., Beekman, A.T.F., Dekker, J., 2009a. Uptake of health services for common mental disorders by first-generation Turkish and Moroccan migrants in the Netherlands. *BMC. Public Health* 9, 307.
- Fassaert, T., Hesselink, A.E., Verhoeff, A.P., 2009b. Acculturation and use of health care services by Turkish and Moroccan migrants: a cross-sectional population-based study. *BMC. Public Health* 9, 332.
- Fassaert, T., Nielen, M., Verheij, R., Verhoeff, A., Dekker, J., Beekman, A., De Wit, M., 2010. Quality of care for anxiety and depression in different ethnic groups by family practitioners in urban areas in the Netherlands. *Gen. Hosp. Psychiatry* 32(4), 368-376.
- Flores, G., 2005. The impact of medical interpreter services on the quality of health care: a systematic review. *Med. Care Res. Rev.* 62(3), 255-299.
- Gallucci, G., Swartz, W., Hackerman, F., 2005. Impact of the wait for an initial appointment on the rate of kept appointments at a mental health center. *Psychiatr. Serv.* 56(3), 344-346.
- Griner, D., Smith, T.B., 2006. Culturally adapted mental health interventions: a meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training* 43(4), 531-548.
- Groen, S., 2009. Recognizing cultural identity in mental health care: Rethinking the cultural formulation of a somali patient. *Transcult. Psychiatry* 46(3), 451-462.
- Harmsen, J.A.M., Bernsen, R.M.D., Bruijnzeels, M.A., Meeuwesen, L., 2008. Patients' evaluation of quality of care in general practice: what are the cultural and linguistic barriers? *Patient. Educ. Couns.* 72(1), 155-162.

- Hilderink, I., Van 't Land, H., Smits, C. Drop-out onder allochtone GGZ-clienten. Zicht op onderliggende factoren en aanbevelingen om drop-out te verminderen. 2009. Utrecht, Trimbos-instituut.
- Hinton, D.E., Chhean, D., Pich, V., Safren, S.A., Hofmann, S.G., Pollack, M.H., 2005. A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: a cross-over design. *J. Trauma Stress*. 18(6), 617-629.
- Hinton, D.E., Hofmann, S.G., Rivera, E., Otto, M.W., Pollack, M.H., 2011. Culturally adapted CBT (CA-CBT) for Latino women with treatment-resistant PTSD: a pilot study comparing CA-CBT to applied muscle relaxation. *Behav. Res. Ther.* 49(4), 275-280.
- Hinton, D.E., Pham, T., Tran, M., Safren, S.A., Otto, M.W., Pollack, M.H., 2004. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. *J Trauma Stress*. 17(5), 429-433.
- Kleinman, A., 1988. *Illness narratives. Suffering, healing, and the human condition*. Basic Books, New York.
- Kleinman, A., 2005. *Culture and psychiatric diagnosis and treatment: What are the necessary skills?* Trimbos-instituut, Utrecht.
- Knipscheer, J.W., Kleber, R.J., 2005. Migranten in de ggz: empirische bevindingen rond gezondheid, hulpzoekgedrag, hulpbehoeften en waardering van zorg. *Tijdschrift voor Psychiatrie* 47, 753-759.
- Korrelboom, C.W., Huijbrechts, I.P., Zitar, D., Hoffman, T.O., 2007. [Who are the 'no-shows' and why don't they turn up?]. *Tijdschr. Psychiatr.* 49(9), 623-628.
- Kortman, F., 2006. *Transculturele psychiatrie. Van praktijk naar theorie*. Van Gorcum, Assen.
- Kramer, S. *Nieuwsgierig blijven. Implementatie van de interculturele competenties in de GGZ*. 2007. Mikado.
- Lagomasino, I.T., Stockdale, S.E., Miranda, J., 2011. Racial-ethnic composition of provider practices and disparities in treatment of depression and anxiety, 2003-2007. *Psychiatr. Serv.* 62(9), 1019-1025.
- Lewis-Fernandez, R., Kleinman, A., 1995. Cultural psychiatry. Theoretical, clinical, and research issues. *Psychiatr. Clin. North Am.* 18(3), 433-448.
- Lie, D., Lee-Rey, E., Gomez, A., Bereksnyei, S., Braddock, Ch. 3, 2010. Does Cultural Competency Training of Health Professionals Improve Patient Outcomes? A Systematic Review and Proposed Algorithm for Future Research. *J. Gen. Intern. Med.*
- Mills, M.L., 2012. Unconventional mental health treatment: reexamining the racial-ethnic disparity in treatment-seeking behavior. *Psychiatr. Serv.* 63(2), 142-146.
- Missinne, S., Bracke, P., 2012. Depressive symptoms among immigrants and ethnic minorities: a population based study in 23 European countries. *Soc. Psychiatry Psychiatr. Epidemiol.* 47(1), 97-109.
- Organista, K.C., Munoz, R.F., Gonzalez, J.S., 1994. Cognitive-behavioral therapy for depression in low-income and minority medical outpatients: description of a program and exploratory analyses. *Cognitive Therapy Res.* 95(6), 241-259.
- Pan, D., Huey, S.J.J., Hernandez, D., 2011. Culturally adapted versus standard exposure treatment for phobic Asian Americans: Treatment efficacy, moderators, and predictors. *Cultur. Divers. Ethnic. Minor. Psychol.* 17(1), 11-22.
- Pinto-Meza, A., Fernandez, A., Bruffaerts, R., Alonso, J., Kovess, V., De Graaf, R., De Girolamo, G., Matschinger, H., Haro, J.M., 2011. Dropping out of mental health treatment among patients with depression and anxiety by type of provider: results of the European Study of the Epidemiology of Mental Disorders. *Soc. Psychiatry Psychiatr. Epidemiol.* 46(4), 273-280.

- Rohlof, H., Knipscheer, J.W., Kleber, R.J., 2009. Use of the cultural formulation with refugees. *Transcult. Psychiatry* 46(3), 487-505.
- Schraufnagel, T.J., Wagner, A.W., Miranda, J., Roy-Byrne, P.P., 2006. Treating minority patients with depression and anxiety: what does the evidence tell us? *Gen Hosp. Psychiatry* 28(1), 27-36.
- Schrier, A.C., Theunissen, J.T., Kempe, P.T., Beekman, A.T.F., 2005. Migranten in de ambulante GGZ maken een inhaalslag. *Tijdschrift voor psychiatrie* 47(11), 771-777.
- Tarricone, I., Atti, A., Braca, M., Pompei, G., Morri, M., Poggi, F., Melega, S., Stivanello, E., Tonti, L., Nolet, M., Berardi, D., 2010. Migrants referring to the Bologna Transcultural Psychiatric Team: Reasons for drop-out. *Int. J. Soc. Psychiatry*.
- Taylor, S., Abramowitz, J.S., McKay, D., 2012. Non-adherence and non-response in the treatment of anxiety disorders. *J. Anxiety. Disord.* 26(5), 583-589.
- Uiters, E., Deville, W.L.J.M., Foets, M., Groenewegen, P.P., 2006. Use of health care services by ethnic minorities in The Netherlands: do patterns differ? *Eur. J. Public Health* 16(4), 388-393.
- Van der Wurff, F.B., Beekman, A.T.F., Dijkshoorn, H., Spijker, J.A., Smits, C.H.M., Stek, M.L., Verhoeff, A., 2004. Prevalence and risk-factors for depression in elderly Turkish and Moroccan migrants in the Netherlands. *J. Affect. Disord.* 83(1), 33-41.
- Van Loon, A., Van Schaik, A., Dekker, J., Beekman, A., 2013. Bridging the gap for ethnic minority adult outpatients with depression and anxiety disorders by culturally adapted treatments. *J. Affect. Disord.*
- Van Loon, A., Van Schaik, D.J.F., Dekker, J.J., Beekman, A.T.F., 2011. Effectiveness of an intercultural module added to the treatment guidelines for Moroccan and Turkish patients with depressive and anxiety disorders. *BMC. Psychiatry* 11, 13.
- Wang, P.S., Gilman, S.E., Guardino, M., Christiana, J.M., Morselli, P.L., Mickelson, K., Kessler, R.C., 2000. Initiation of and adherence to treatment for mental disorders: examination of patient advocate group members in 11 countries. *Med. Care* 38(9), 926-936.
- Weich, S., Nazroo, J., Sproston, K., McManus, S., Blanchard, M., Erens, B., Karlsen, S., King, M., Lloyd, K., Stansfeld, S., Tyrer, P., 2004. Common mental disorders and ethnicity in England: the EMPIRIC study. *Psychol. Med.* 34(8), 1543-1551.

