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Master's Thesis

Enhancing Access to Mental Health Care for Refugees and Asylum seekers through the Intercultural Competence of Volunteers

Erasmus School of Health Policy & Management
MSc. Health Economics, Policy and Law

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Abstract

Introduction. This thesis grants first insights into the role of volunteers in overcoming the barriers to mental health care access experienced by refugees in the Netherlands. The aim is to shed light on the missing pieces and discover how the incorporation of intercultural competence into the training programmes of volunteers could contribute to the enhancement of the integration and inclusion of refugees.

Theoretical framework. The conceptual model on 'Access to health care' served as a conceptual guide throughout this research by identifying the specific areas of access to health care that need improvement. In addition, the framework assisted in clarifying the role of volunteers in every step towards accessing health care. Furthermore, the importance of intercultural competence training programmes was demonstrated, as these can facilitate the performance of volunteers and help overcome the unmet needs of refugees.

Research methods. The research was conducted by means of a qualitative study design. The main method of research was conducting interviews with refugees, volunteers, and trainers of volunteers. Data were collected via in-depth, semi-structured interviews with a total of 10 respondents.

Results. The findings show that barriers to accessing mental health care occur due to: refugees' inability to perceive, seek, reach, pay, or engage and to the lacking within the system in providing approachability, acceptability, availability, affordability and appropriateness of health care. Volunteers play a prominent role in the enhancement of access to mental health care for refugees as they are often perceived as mediators between refugees and health care professionals and as a gateway to integration and inclusion.

Discussion and conclusion. A policy implication of this study entails amplified support of initiatives that provide cultural sensitivity training programmes to all volunteers that work with refugees. In order to identify and learn from best practices, it would be interesting to see how resettlement organizations across the European Union incorporate intercultural competence in their training programmes. Mental health and well-being are crucial to refugees' integration into Dutch society and should therefore not be neglected.

Preface

This thesis is a final work as partial fulfilment for the degree of Master of Science in Health Economics, Policy and Law (HEPL) at the Erasmus University Rotterdam. The Master's Thesis is titled 'Enhancing Access to Mental Health Care for Refugees and Asylum seekers through the Intercultural Competence of Volunteers' and was conducted from February 2021 until June 2021.

The motive for this research originated from my passion for developing evidence-based strategies to improve access to healthcare for all, particularly for marginalized populations. Today, more people than ever before live in a country other than the one in which they were born and raised. Some people move in search of work or economic opportunities. Others move to escape conflict, war, or human rights violations. How do we support access to healthcare for refugees and asylum seekers?

I found it very interesting to gain insights in the world of volunteers, refugees and trainers and to explore the way they perceive access to mental healthcare for refugees in the Netherlands. Respondents were very open and enthusiastic about my research topic.

I want to thank all participants whom I have interviewed for their time, energy, honesty, and dedication. I would also like to thank my parents and friends, who supported me with love, encouragement and belief. Furthermore, I would like to express my sincere gratitude to my supervisor, Prof. Dr. Buijsen, for his constant guidance throughout this research project. I look back on a very pleasant and informative research process. Thank you for your unwavering support.

I hope you enjoy your reading,

Julia Olufemi Dewez

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1. Introduction

Since the late 2000s there has been an increasing influx of refugees and asylum seekers in the WHO European Region. According to the United Nations High Commissioner for Refugees (UNHCR), the number of forcibly displaced individuals by mid-2020 surpassed 80 million worldwide. These included 26.3 million refugees and 4.2 million asylum seekers (UNHCR, 2020). Forcibly displaced populations have often been exposed to stressful events, such as: wars and other forms of armed conflict; natural disasters; and persecution or discrimination before departure from their host countries (WHO Regional Office for Europe, 2018). In addition, numerous refugees and asylum seekers undergo both physical and psychological stress during transition to and upon arrival in their host country, which could lead to an elevated risk of developing mental health problems (Li et al., 2016). Depression and posttraumatic stress disorder (PTSD) are highly associated with refugees as it is found that they experience uncertainty over legal status, residency and the social perspective in the recipient country (Mangrio & Sjögren Forss, 2017).

Even though refugees and asylum seekers have a higher need for mental health care in comparison to others, they show lower mental health care utilization. Western European host countries have specialized mental health services available, yet refugees and asylum seekers face substantial barriers when it comes to mental health care access (Mangrio & Sjögren Forss, 2017). In a study by Kiselev et al. (2020), Syrian refugees identified key barriers that explain this behaviour, including multiple structural and socio-cultural aspects, with a larger emphasis on socio-cultural barriers to accessing mental health care. Socio-cultural barriers are man-made constructs that originate form social norms and cultural values. They often include institutional barriers and barriers associated to social stigma and cultural taboo. The presence of socio-cultural barriers mainly has an adverse impact on information seeking by restricting access to information sources and inducing negative emotions (Savolainen, 2016). Moreover, health care providers and refugee coordinators recognize language; lack of resources and awareness; fear of stigma; and mismatch between local health systems and perceived needs of refugees as key barriers to accessing health care (Kiselev et al., 2020).

According to McAllum (2019), refugee resettlement organizations aim to act as intercultural mediators between refugees and host nationals through volunteers, who steer multiple cultural

perspectives and translate them for others. Nevertheless, intercultural mediation can be challenging, as divergent cultural foundations can create discomfort and misunderstanding. Additionally, it has been found that refugees' mental health interventions are most effective when they are embedded in a culturally- and linguistically-sensitive context, tailored for refugee groups (Im & Swan, 2020). Yet, even the better equipped refugee's resettlement agencies struggle to adequately recognize and respond to the mental health needs of refugees. Therefore, it is necessary to invest in training volunteers on cultural models to consequently deal with the unmet mental health needs (Satinsky et al., 2019).

Societal relevance

Refugees and asylum seekers represent a sizeable proportion of the European Region community, therefore the health of this group is of high relevance for public health and should be promoted in order to achieve the goal of universal health coverage and optimal population health outcomes (WHO, 2018). There is insufficient recognition of the health needs of refugees and asylum seekers as a structural part of society. Too little attention is being given to how arriving refugees are coping with traumatic events that led to their flight, and with the aftermath of their stressful journey (Fotaki, 2019). Volunteers are an important link between civil society organizations and the community, as they can represent both (Haski-Leventhal et al., 2010). They play a vital role as cultural mediators in the integration of refugees into their host country. In addition, they provide fundamental services such as health care, legal aid and the seeking of accommodation. Consequently, it is important that volunteers dealing with refugees and asylum seekers have the appropriate competences to fulfil their activities effectively. Across the European Union, civil society organizations play a large role in filling the gaps where the states fail to provide adequate reception for asylum seekers (Archer, 2015).

Scientific relevance

Up till now, there has been a considerable amount of research about volunteering in general and the roles and motivations of volunteers in various settings. Several scientific studies highlight the importance of timely and adequate support for refugees with the integration into their host country (Im & Swan, 2020; Kiselev et al., 2020). Research also shows that in the Dutch case, refugees usually suffer from a restriction of opportunities and isolation from host societies (Smets & ten Kate, 2008). Further, it has been recognized that refugees face several socio-cultural and structural

barriers to accessing mental health care in their host country. Nevertheless, scientific research should tackle the neglected issue of how volunteers should be adequately trained to deal with refugees, focussing on intercultural competences to overcome the socio-cultural barriers. While the international research community has produced manifold and valuable insight into volunteerism and civic engagement in general, the field of volunteering for refugees has been widely overlooked up to this point. The increasing influx of refugees and asylum seekers; the growing public discourse on the reception conditions of this population group; and the significance of volunteers have recently led to an increase of scientific interest in the field. Results, however, still remain limited. For that purpose, this research aims to shed light on the missing pieces and discover how the incorporation of intercultural competence into the training programmes of volunteers could improve the integration and inclusion of refugees.

Objective and research questions

The main objective of this research is to identify the main socio-cultural barriers to mental health care access experienced by refugees and asylum seekers. Moreover, this study aims to investigate how intercultural competence is currently incorporated in the volunteers' training programmes and how this could be improved in the future. Lastly, the present study seeks to reveal how the improvement of the intercultural competence of volunteers can contribute to uncovering the unmet mental health care needs of refugees and asylum seekers. Therefore, the research question reads as follows:

How could the intercultural competence of volunteers be improved, thereby overcoming the socio-cultural barriers to mental health care access of refugees and asylum seekers in the Netherlands?

After analysing the existing literature mentioned above, the main research question was formulated. For a comprehensive approach to the research problem, this question will be supported by the following three theoretically informed sub-questions:

1. To what extent do Dutch resettlement organizations facilitate the engagement between volunteers and refugees?
2. What are the main socio-cultural barriers to mental health care access experienced by refugees?
3. How is intercultural competence incorporated in the training programmes of volunteers dealing with refugees?

Outline

In the following chapter, the various concepts will be explained and previous publications about volunteerism, refugees, and intercultural competence will be explored. Then, in Chapter 3, the methods that were used to acquire data and perform the empirical analysis are set out and justified. In the chapter hereafter, the results from the interviews will be presented. Finally, in Chapter 5, the conclusions will be drawn and discussed.

2. Theoretical framework

This chapter discusses relevant theoretical considerations. First of all, Chapter 2.1 provides a definition of volunteering and introduces the concept of volunteering for refugees and asylum seekers. In Chapter 2.2, the definition of refugees and asylum seekers is examined. Further, the existing literature on intercultural competence is presented in Chapter 2.3. Finally, in Chapter 2.4, 'Access to health care' is discussed as a model that relates to the barriers in access to mental health care experienced by refugees and asylum seekers.

2.1. Defining the concept of 'volunteering'

Although the notion of volunteering is referred to in numerous studies, no cohesive theory of volunteering has emerged yet (Hustinx et al., 2010). First and foremost, volunteering is a complex phenomenon that spans a wide variety of activities, organizations and sectors. Empirical research on volunteering typically takes an approach directed toward standardization and refers to 'volunteering' as an all-encompassing concept that has intrigued scholars across a broad spectrum of disciplines and backgrounds. Large amounts of research explore variations in volunteering in terms of separate sub dimensions, including: attachment to volunteering; the length of volunteer service; volunteer retention; motivation to volunteer; intensity of volunteering; volunteer performance; and so on. The majority of empirical studies of volunteering are preoccupied with either assessing general volunteering levels or explaining sub dimensions of volunteering (Hustinx, 2005).

Volunteering continues to be a social construct with multiple definitions. Different disciplines have dissimilar ideas about the meaning and function of volunteering (Hustinx et al., 2010). For instance, in economic terms, volunteering is understood as unpaid non-compulsory work; meaning that individuals give time, without being paid, to activities performed either through an organization or directly for others outside their own household (Salamon et al., 2011). In sociology, volunteering is regarded as a measure of social order, solidarity, trust, inclusion and social cohesion (Hustinx et al., 2010).

According to the International Federation of Red Cross and Red Crescent Societies (2019), a volunteer is a person who carries out volunteering activities for a national society, on a regular or

occasional basis. Volunteering is carried out by individuals motivated by free will, not by the desire for material or financial gain, nor by external social, political or economic pressure. “Volunteers work for a more humane and peaceful world” (International Federation of Red Cross and Red Crescent Societies, 2019).

Accordingly, for the purpose of this research, a combination of the sociological and economic perspectives will be adopted, resembling the definition of the IFRC. Volunteering for refugees and asylum seekers will be defined as: ‘all activities that are performed voluntarily by individuals without desire for financial gain and for the benefit of refugees and asylum seekers.’ These performed activities aim at improving the access to mental health care services of refugees and asylum seekers in material, medical and psychological or social regards, even if these activities do not imply direct contact between refugees and volunteers.

2.2. Defining the concepts ‘refugee’ and ‘asylum seekers’

The concept ‘refugee’ is usually adopted for an individual who has fled their own country because of well-founded fear of persecution, conflict, violence, or other serious public circumstances. The reasons could lie in their race, religion, nationality, or membership of a particular social/political party. This vulnerable population group requires international protection (United Nations High Commissioner for Refugees, 2021).

The concept ‘asylum seeker’ is usually reserved for an individual who enters a country other than their own, seeking safety from prosecution or serious harm and awaiting a decision on the application for refugee status. In case of a negative decision, the individual must leave the country, unless permission to stay is provided on humanitarian grounds (Aspinall & Watters, 2010).

While the experience of refugees and asylum seekers may differ considerably, the term ‘refugees’ will be used hereafter to represent both refugees and asylum seekers.

2.3. Defining the concept ‘intercultural competence’

According to Deardorff (2008), intercultural competence (ICC) is the knowledge of other cultures, values, beliefs, and behaviours. Volunteers with ICC have skills to interpret and relate; and skills to discover and/or to interact with persons of diverse backgrounds. Although scholars believed that

simply interacting with a new culture would enhance intercultural understanding and competence, ongoing research shows that cultural contact will increase ICC only under the right circumstances. The outcomes of intercultural competence depend on the individual capacity of the volunteer; the institutional capacity of the programmes facilitating the practice; and the nature of the service activity. Recent studies on international service specify a range of institutional factors that influence the intercultural experience for volunteers. These factors include overall programme management, the size and complexity of the organization, supervision, and group status. Scholars claim that more research is needed in this area to improve the understanding of the impact of institutional models on the enhancement of ICC of volunteers (Lough, 2011).

With the aim to guide a programme that promotes intercultural competence, this competence needs to be sub-divided into five key components, including: attitude, knowledge, skills, internal outcomes, and external outcomes (Deardorff, 2011). Each component can be broken down further. First, the three *attitudes* – respect, openness, and curiosity – are fundamental for the development of knowledge and skills necessary for intercultural competence. Second, *knowledge* – consisting of cultural self-awareness, culture-specific knowledge, deep culture knowledge, and sociolinguistic awareness – contributes to understanding the world from others' perspectives. Third, the *skills* – such as listening, observing, evaluating, analysing, interpreting, and relating – are crucial in order to understand and process information. Fourth, *the internal outcome* – which consists of adaptability, flexibility, and empathy – are abilities that allow individuals to see from different perspectives and respond to others' desires and needs. Finally, *the external outcomes* are the internal outcomes experienced by others; they are seen as appropriate behaviour and communication in an intercultural situation (Deardorff, 2011).

2.4. Conceptual model – Access to health care

This research paper aims to identify how volunteers could assist in reducing socio-cultural barriers for refugees to facilitate their access to mental health care. Accordingly, it is important to define 'access to mental health care', in order to identify the specific areas of access that need improvement.

The five A's of 'Access to health care' all contribute to the achievement of access to equitable mental health prevention and care for all, including refugees (World Health Organization, 2018).

In this context, 'Access to health care' is defined as: 'the opportunity to identify health care needs, to seek health care services, to reach, to obtain or use health care services, and to actually have a need for services fulfilled' (Levesque et al., 2013). Refugees might face challenges in all five dimensions of access to health care, including: approachability, acceptability, availability, affordability and appropriateness. Various issues identified by refugees include: the lack of disease prevention; delayed diagnosis and care; sub-standard quality and interrupted treatment; lack of targeted information and health education; and lack of adequate surveillance and case management (World Health Organization, 2018). Furthermore, the five dimensions of health care access interact with five corresponding abilities of individuals, which, when combined, generate access. The dimensions of abilities include: ability to perceive, ability to seek, ability to reach, ability to pay, and ability to engage (Levesque et al., 2013). In line with the research question, which aims to identify how to connect refugees with mental care services through volunteers, it is crucial to foster the five abilities of refugees as well, in order to overcome the barriers from the demand-side.

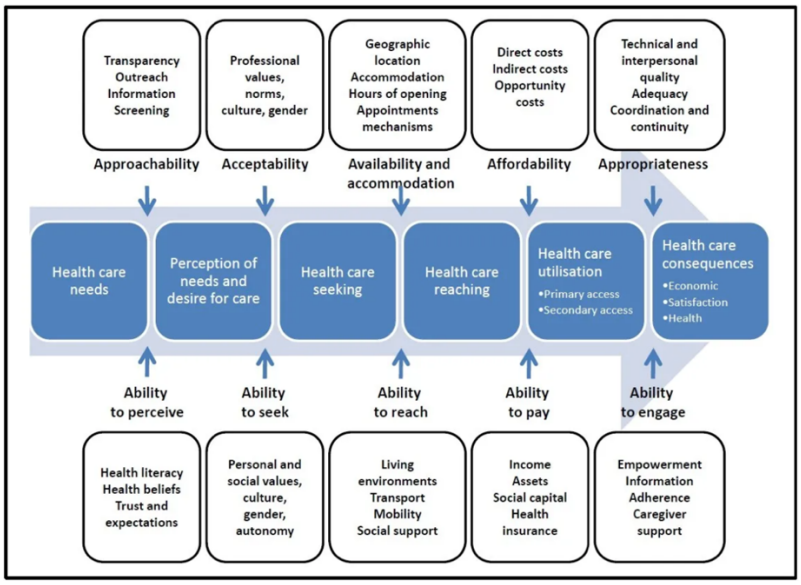

Figure 1: A conceptual framework of access to health care (Levesque et al., 2013)

The model will serve as a conceptual guide throughout this research, by identifying the specific areas of access to health care that need improvement. Interviews are held with refugees to improve understanding of the socio-cultural barriers that occur within each dimension. In addition, the framework assists in clarifying the role of volunteers in every step towards 'accessing health care'. Finally, the importance of intercultural competence training programmes will be demonstrated as these can facilitate the performance of volunteers and help overcome the unmet needs of refugees.

3. Research methods

In the following chapter, the research methods will be further elaborated upon. Firstly, the chosen study design will be clarified. Then, a description of the process of data collection will be given, followed by the sampling strategy. Thirdly, the process of data analysis will be justified. Lastly, the validity, reliability and ethical considerations will be discussed.

3.1. Study design

The research was conducted by means of a qualitative study design. This was chosen as the most appropriate means to explore the experiences, perceptions, and opinions of participants regarding the main socio-cultural barriers, the intercultural competence of volunteers and how this competence could contribute to the enhancement of access to mental health care for refugees (Yin, 2002). According to Yin (2002), a qualitative study is particularly useful when the boundaries between phenomenon and context are not clearly marked. When examining the socio-cultural barriers experienced by refugees, it should be kept in mind that their understandings are shaped by the broader social context. The goal of qualitative research is to gather rich data in a natural setting, rather than experimental (Green, 2013). Thus, this research is about understanding, describing, and developing a theory instead of testing a hypothesis by calculations (Morse, 1994). An advantage of this design is the flexibility of adapting to changes in the research context, without too many restrictions beforehand. Moreover, the researcher plays a key role in this type of research, as their insights and values have an influence on the research field (Mortelmans, 2013). Most importantly, the study design suits the research questions, which aims to discover the views and experiences of refugees and volunteers. Therefore, a strategy was needed which is sensitive to the interpretations of social phenomena by respondents (Bryman, 2008).

3.2. Data collection and sampling strategies

Throughout this master's thesis, the main method of research was conducting interviews with refugees, volunteers, and trainers of volunteers. Data were collected via in-depth, semi-structured interviews, which served the aim of answering the three sub-questions and addressing all topics related to the research questions. Subsequently, interviews were held based on a pre-established topic list which gave the researcher guidance throughout the interview. Simultaneously, the open character of the interview method allowed unexpected insights to come to the fore (Mortelmans, 2013). Interviews allowed respondents to share their opinions and stories with the interviewer.

This interaction created meaning between them and assisted the interviewer to better understand how respondents view the social context in which they live (Tracy, 2013). Furthermore, the interviews were conducted in English or Dutch. Audio-recordings were complemented by notes to allow the researcher to capture and maintain the complete data (Sutton & Austin, 2015). These notes were maintained and secured, as well as the audio tapes and transcripts, as they contain sensitive information and are relevant to this research. In addition to the interviews, various databases, including PubMed, Google Scholar and official documents were consulted to analyse secondary sources on existing data.

3.2.1. Sampling and participants

A non-probability sampling method was used, so that only participants who met practical criteria were included in this research. The stakeholder sample consists of people that volunteer at and in the environment of the designated accommodation centres; people who train volunteers that work with refugees; and people who help volunteers become active within the labour market. Additionally, refugees located in the Netherlands were included in the sample to explore and describe their personal experiences. Based on guidelines for qualitative research, a sample of 10 participants was recruited (Braun & Clarke, 2016). The final number of participants was dependent on data saturation, defined as the point at which no new themes emerged.

3.3. Data analysis

The process of data analysis consisted of several steps, namely: the interpretation of data; transcribing and checking; and coding. The theoretical standpoints of the research were considered to interpret the information from the participants' viewpoint. An abductive theoretical perspective was used during the process of data analysis, moving between data and theory (Timmermans & Tavory, 2012). This means that the analysis was a mix of deductive and inductive perspectives. The deductive theory allowed the analysis of social phenomena using theoretical concepts which were discussed in Chapter 2. Further, an inductive perspective permitted the researcher to deduce theory from empirical observations (Bryman, 2008). In this way, the conceptual model was used to structure and gather the data, while simultaneously keeping a broad and open theoretical view for new structures that stood out (Nicolini, 2009). Furthermore, all interviews were audio recorded and subsequently transcribed verbatim. The interviews that were held in Dutch were translated after they had been coded to prevent inadequate translations and to ensure implied connotations were not neglected (Suh et al., 2009). During the process of data analysis, a qualitative method of

coding was used to analyse the collected data. The interviews were coded by hand, using 5 codes and 14 sub-codes. All the codes were entered into a table to make the coherence transparent and present the findings in a meaningful manner (Sutton & Austin, 2015).

3.4. Validity and reliability

Internal validity in qualitative research means that the methods need to be accurate and that results are precise and correct (Mortelmans, 2013). However, due to the subjectivity of qualitative research and the influence of the interviewer on the research context, complete objectivity was impossible to obtain. Nevertheless, measures were taken to reduce biases or at least to account for them (Tracy, 2013). Furthermore, the external validity of the results is not assumed, since an important characteristic of qualitative research is that there is no attempt to generalize the findings to a wider population. Qualitative research is used to gain insights into participants' feelings and thoughts, which can provide the foundation for a future stand-alone qualitative study or guide researchers to map out survey instruments for quantitative studies (Sutton & Austin, 2015). As the respondents of the interview were located in the Netherlands, it would not make sense to assume that the findings would apply to other countries as the local context might be completely different (Mortelmans, 2013). Moreover, reliability measures the consistency of the methods and research over time to ensure that results can be replicated. For the purpose of internal reliability, the interviews were recorded and transcribed. After transcription, the interviews were heard once again, during which the completeness of the transcript was checked and mistakes were corrected. In addition, the interviews were semi-structured and executed by the same interviewer, which therefore increases the reliability (Yin, 2013).

3.5. Ethical considerations

As for the ethical considerations, all participants were made aware of the general terms and conditions for participating in this research before the interview. Informed consent was given in a written form. Additionally, only after the participants had given the permission, was the audio recording of the interview started. Prior to the interview, respondents were asked for permission for transcribing the interview and the purpose and course of the interview were explained. Important aspects regarding privacy were that all personal data were anonymised. In addition, the recordings were destroyed after the second revision of the transcripts.

4. Results

This chapter aims to answer the three sub-research questions ('To what extent do Dutch resettlement organizations facilitate the engagement between volunteers and refugees?', 'What are the main socio-cultural barriers to mental health care access experienced by refugees?', and 'How is intercultural competence incorporated in the training programmes of volunteers dealing with refugees?'). To this aim, the main findings from the analysis of interview data are presented.

In order to present the findings coherently, the chapter is organised as follows. First, Chapter 4.1 deals with the extent to which Dutch resettlement organizations facilitate the engagement between volunteers and refugees. Second, Chapter 4.2 illustrates the psychological challenges and the barriers to accessing mental health care experienced by refugees, in accordance with the conceptual model 'Access to health care'. Chapter 4.3 sheds light on the current training programmes of volunteers and the question of how intercultural competence is incorporated in these training programmes. Lastly, Chapter 4.4. demonstrates the role of volunteers as mediators between refugees and mental health care.

Within the scope of this study, 10 individuals were interviewed. Four respondents are Syrian refugees, another three respondents are volunteers, two are trainers of volunteers, and the remaining respondent founded an organization that helps refugees grow and fund their own business.

4.1. To what extent do Dutch resettlement organizations facilitate the engagement between volunteers and refugees?

For the purpose of learning more about the engagement between volunteers and refugees, respondents were asked to report about whether the resettlement organizations facilitate this contact. Overall, interview data show that it is 'kind of a double-edged sword'. On the one hand, resettlement organizations such as 'Central Agency for the Reception of Asylum Seekers' (COA) and 'VluchtelingenWerk Nederland' are the connector between volunteers and refugees. The resettlement organizations engage and attract a lot of volunteers, as they are central to this network. Volunteers aiming to work with refugees are aware of these organisations and can easily access them. In addition, these organizations coordinate and guide voluntary work.

On the other hand, respondents mentioned that having resettlement organizations as the connector makes refugees dependent on them. This implies that the engagement between volunteers and refugees is determined by the rules of the organizations. Further, almost all refugees stressed how bureaucratically the COA deals with procedures, without making any exceptions on protocols. Similarly, volunteers mentioned that the communication between individual volunteers and staff at the centre is not always efficient. Interviewees reported a lack of structured communication and agreement between volunteers and the staff at COA, which leads to complicated voluntary engagement and volunteers deciding to leave the organization.

Furthermore, respondents were asked at what stage of the asylum process the engagement between volunteers and refugees started and which roles and tasks the volunteers performed during this period. Interview data illustrate that volunteers at the asylum centres and within the voluntary organizations perform a variety of tasks that aim at improving the reception conditions of refugees. Refugees encounter various organizations during their asylum procedure. For instance, during the stage of registration, the Immigration and Naturalisation Service (IND) processes the applications. Further, the Dutch Council for Refugees, 'VluchtelingenWerk Nederland', deploys volunteers at the central reception centre where they give direct social guidance by informing refugees about where they have ended up, what lies ahead, what the procedure looks like, and how they can be supported. Then, assuming that asylum seekers get a residence status, they are transferred to the municipalities where volunteers can support them in various areas, such as safe housing, language practice, guidance in preparation for a future in the Netherlands, leisure activities, and general tips and advice. In addition, volunteers support refugees with administrative formalities, in dealing with the public authorities and with translations.

Concerning the stage at which the engagement started, most respondents referred to the phase where refugees get transferred to the municipalities. Refugees indicated that during their stay in the Asylum Seekers' Centres (AZC), there was a shortage of guidance and support from volunteers. Many asylum seekers awaiting their residence permit moved from camp to camp for at least one and a half years. During this period, volunteers only dealt with some courses on how to work with bills or how to save as much money as possible. Yet, no mental health support or psychological help was offered, even though almost all refugees mentioned the urge they felt to talk to someone and to deal with their traumas.

4.2. What are the main socio-cultural barriers to mental health care access experienced by refugees?

In order to investigate the socio-cultural barriers to mental health care access, the respondents were asked to first report on the psychological challenges refugees face. These insights were then used to identify the (unmet) needs for mental health care. Secondly, respondents were asked about whether refugees experience barriers to accessing mental health care and, if so, which barriers can be identified. The conceptual model in Chapter 2, 'Access to health care', will be used to identify the dimensions in which refugees experience most barriers and how volunteers can help overcome these.

4.2.1. Psychological challenges

Data show a large variety of challenges, yet several responses were mentioned recurrently. First of all, it is important to distinguish between pre-migration stressors, migration stressors, and post-migration stressors. These different types of stressors affect the psychological well-being of refugees and are often carried from one phase to another.

Pre-migration stressors

Pre-migration stressors are experienced in the period before the displacement in the country of origin of refugees. These stressors include war, violence, torture, chaos, and loss of possessions. Most refugees have gone through a lot of trauma, often resulting in PTSD, depression, or anxiety disorders. Yet sometimes they do not even know that they are dealing with a trauma and are unknowingly carrying this weight on their shoulders. Therefore, it is essential to evaluate the pre-migration stressors as well, even though they have not arisen in the Netherlands. One of the volunteers reported:

> *"Like a tree, they have been ripped out of their ground. Completely uprooted, they are then put in a new country and told; okay, now you need to fix it."*
>
> (Interviewee 10)

Respondents frequently highlighted the emotional and psychological trauma that refugees go through and the impact this has on mental health issues. Two respondents indicated the difficulty trauma survivors have to regulate their emotions, such as anger, fear, sadness, and shame.

Migration stressors

Migration stressors take place during the intermediate stage when refugees are in a country of transit. This stage can sometimes take a long time and can be stressful and difficult as there are no definite prospects. Especially with an already existing trauma, refugees are in need of help and someone they can talk to and trust. However, during this period, refugees are often not able to do anything and actually experience a kind of emptiness of existence. The following quote by one refugee highlights how stressful and hopeless they were during this period:

> *"Nothing. We knew nothing. When will we get a permit, what will happen the next day, when will we start moving from camp to camp again? It was terrible for us, for our daughter. I have a daughter, who is six now. When she came here, she was four."* (Interviewee 2)

Post-migration stressors

Post-migration stressors are the challenges experienced by refugees after their arrival in the Netherlands. The post-migration period includes the stay at the AZC and their integration into society after being transferred to a municipality. Many respondents mentioned that the psychological challenge starts with being labelled as 'refugee' and the connotation it carries that includes fear, crime, and insecurity. According to multiple interviewees, people should use the term 'newcomer' instead of refugee as this has a more positive undertone. People often perceive refugees as a single population group, yet there are many different kinds of refugees and each case should be dealt with individually. As reported by one interviewee, refugees should be put into categories upon arrival; refugees who have an educational background and can easily integrate into society and others who possibly need more guidance. Further, all refugees stated that when they arrived in the Netherlands, they were excited to start their lives, contribute to the labour market and communicate with society. However, after waiting one and a half years for the asylum procedure, all refugees felt exhausted and hopeless. The following quote denotes the experience of a refugee during their stay in the AZCs:

> *"You don't have any rights, you cannot even go to the gym, you don't have any address. So I stayed in this procedure for a year and a half and that was really tough. Because what I noticed for myself when I arrived here, I had a lot of energy, I wanted to do a lot of things, I had*

dreams, ambitions... But after this year and a half, just going around these AZCs, around seven or eight, it was really, really exhausting in the end. I needed a whole year to recover from this year and a half, not only from the war."
(Interviewee 4)

Remarkably, many respondents reported on the long asylum procedure and on awaiting the decision on the residence permit. Refugees mentioned that, during this period, they were relocated three to eight times to different ACZs. A volunteer explained that this happens because of the perspective that a refugee is probably not going to stay in the host country. They therefore do not want people to get attached to their environment and to the people around them. This also causes psychological challenges for refugees. Instead of building a sense of belonging and community, the transfers in fact induce loneliness and anxiety. Another psychological stressor is caused by the large number of people that share a small room in the AZC. Refugees have almost no private space and are constantly surrounded by confusion and negativity from others.

Besides the challenges experienced during the asylum procedure, refugees are also confronted with challenges when they are placed in a municipality. These challenges often include fear of debts and worries about family, the political situation in their country of origin and family reunification. Furthermore, refugees highlighted another major challenge, namely not being valued in the labour market. Especially highly educated refugees with university degrees, a lot of experience and knowledge, felt like they were not being considered as competent. They explained that a lot of refugees had had their own businesses back home and were very successful. Yet, all of a sudden they lost everything when coming to the Netherlands with no status and not being able to work. The following quote is from a refugee on their psychological challenge of not being valued in the labour market:

"It felt like, after years of putting in hard work, of getting experience, of working really hard on yourself, your self-esteem is being destroyed. You are not being valued in the labour market, even though you have the exact same kind of experience, it's very painful."
(Interviewee 7)

According to them, the system fails to provide work that corresponds to their experience and knowledge. In order to terminate the financial support from the state, the government offers refugees any kind of job, whether this job suits them or not. Moreover, another interviewee reported that refugees encounter mistrust and a lack of support and understanding, which affects their psychological well-being. Some refugees get guidance in the housing procedure and labour market, yet others are left in the dark.

4.2.2. Barriers to mental health care

Interview data show that ten out of ten respondents mentioned factors that complicate or even constitute barriers to accessing mental health care for refugees. In order to facilitate a better understanding of these barriers, they will be presented according to the dimensions of the conceptual model 'Access to health care'. Within each dimension: health care needs; perception of needs and desires for care; health care seeking; health care reaching; health care utilisation; and health care consequences, the coexisting barriers will shortly be discussed. It is, however, essential to acknowledge that these barriers occur due to refugees' inability to perceive, seek, reach, pay, or engage. In addition, the system can also fail in providing: approachability, acceptability, availability, affordability and appropriateness of health care.

Health care needs

Nearly all respondents reported barriers to health care needs. There are two reasons for this: on the one hand, refugees do not always seem to have to the ability to perceive health care. Multiple interviewees stated that refugees often keep quiet about their mental health problems and do not ask for help, due to a lack of trust in the system. On the other hand, many interviewees encounter problems in transparency, outreach, information and screening within the system. According to the interviewees, municipalities initiate a lot for refugees to integrate, yet fail to incorporate the psychological element. Some refugees indicated the need for mental health care, but experienced a lack of information on the possibilities and did not know these kind or services exist.

Perception of needs and desires for care

As for the barriers to the perception of needs and desires for care, the focus lies on the cultural norms and values. These barriers can be explained by the fact that, for many people, especially from the middle east, mental health is not a concept. They do not have the terms or vocabulary to

talk about anxiety, PTSD, or other mental health issues. Consequently, when they arrive in the Netherlands, they are not used to talking about their mental health. There is a lot of shame, stigma, and fear associated with desires for mental health care and people are scared of being called crazy. Nevertheless, the acceptability of professionals also plays a key role. For instance, the ability of a professional to approach people from a different culture and understand what they need or desire.

Health care seeking

The most prominent barrier to health care seeking is the difficulty refugees have to reach out for health care. This can be due to unawareness, negative feelings towards the system or the lack of social support. Most refugees reported that they did not feel understood by the workers at the AZC and that many people did not seem to understand what they had been through. In addition, one interviewee mentioned that when a refugee does not have a residence permit, they cannot seek proper health care, solely the care provided at the AZC. Further, language was mentioned several times as being a barrier, especially for non-English speaking refugees. One interviewee explained that language forms a barrier to health care seeking when refugees cannot express what they feel or need.

Health care reaching

Health care reaching can further be complicated by transportation obstacles. Interviewees have reported that it is not always easy to reach the location for health care. One refugee described that without a BSN number, it is not possible to open a bank account. Consequently, it was impossible to get transportation tickets, as many stations do not have coin machines. Another interviewee emphasised that, even when refugees do reach out and want to improve their mental health, the resources in the Netherlands are quite limited. This relates to the availability of health care; there are often long waiting lists to see a psychiatrist or therapist which discourages refugees to proceed.

Health care utilization and Health care consequences

Finally, health care utilization and health care consequences are the last steps towards gaining access to health care. Interview data do not focus on barriers within these steps, as health care utilization and consequences are dependent on the previous steps and can not be influenced by volunteers. Therefore, it is crucial to concentrate on diminishing the barriers to health care needs;

perception of needs and desires for care; health care seeking; and health care reaching, in order to optimise health care utilization and health consequences.

4.3. How is intercultural competence incorporated in the training programmes of volunteers dealing with refugees?

There is no straightforward answer to this question, as not all volunteers get the same training opportunities. For instance, volunteers at VluchtelingenWerk Nederland are able to attend several internal training sessions. Yet, there are plenty of volunteers who are not part of this organization, thus can not follow these training programmes. It is therefore crucial to look at each case separately and to learn from best practices. As seen in the theoretical framework in Chapter 2, intercultural competence is 'the knowledge of other cultures, values, beliefs, and behaviours. Volunteers with ICC have skills to interpret and relate, and skills to discover and/or to interact with persons of diverse backgrounds'.

First of all, a senior trainer from VluchtelingenWerk Nederland explains that most volunteers who join this organization generally already have some kind of knowledge of other cultures, values, beliefs, and behaviours. In addition, VluchtelingenWerk offers an extensive training and education programme, in which volunteers can participate to improve their skills. It all starts with a basic class which is compulsory for everyone. This class consists of two components: intercultural communication and counselling. There is then a follow-up programme in which volunteers learn how to deal with psychological and social problems. This programme focuses on how to recognize psychological, somatic, psychiatric, and social complaints, in order to take further action with a professional. Moreover, there is another training course on cultural sensitivity work. In that training course, volunteers deal with the questions of what culture really is; What do you think culture is? How do we look at it? What can influence it? Several models and theories, such as Hofstede, are touched upon during this training course. The senior trainer then confirmed that their training programmes are assessed at least twice a year, and based on the feedback of people and signals from society, new improvements are made.

Another interviewee mentioned that, indeed, not all volunteers receive equal training opportunities. Most training programmes are targeted towards people who volunteer in municipalities and not so much within the AZCs. Yet, it is noticeable that people who volunteer

are interested in other cultures, which is already an important condition. They have usually developed intercultural competencies through travel, professional work, or other voluntary work. The interviewee, however, admits that training programmes are certainly the right method to develop sensitivity to other cultures.

Indeed, interview data show that volunteers within the AZCs do often not receive training. There is no screening, checklist of skills, or even an initial interview. Occasionally, they might receive some tips on how to communicate with refugees or what to say, but this is not done in a systematic way. A volunteer stated that they use their own intuition and experience and try to be empathetic and understanding towards refugees. However, there is a significant difference between the abilities of volunteers in this context. Quite a few interviewees stated that volunteers with, for instance, an Arabic or Mediterranean background, could more easily relate to refugees and understand their way of communicating better. Further, a refugee highlighted the need to have volunteers from the same culture, as they understand the verbal and non-verbal language better. Fortunately, interview data reveal that some organizations allowed a Syrian refugee to give cultural sensitivity training to all volunteers, as it is important to allow people themselves to talk.

4.4. What is the role of volunteers as mediators?

The following section will evaluate the role of volunteers as mediators between refugees and mental healthcare. Respondents were asked how volunteers could contribute to the improvement of access to mental health care for refugees.

Many interviewees answered that it is mostly about support and connection. Refugees perceive volunteers as the gateway to establishing a connection with Dutch society; volunteers often help refugees understand Dutch norms, values, and culture. Hence, refugees are taken out of isolation or seclusion within their co-ethnic circles by volunteers. As a result, feeling integrated and included within Dutch society could help reduce mental health issues. When refugees arrive in the Netherlands, they have often been through a lot. What they need is a mediator who encourages them to talk to someone completely different from their own culture, because otherwise they often tend to stay in their comfort zone. It is about needing someone who speaks from the heart and who means well.

"We really just need a friend. That's all we need."
(Interviewee 3)

Furthermore, several refugees mentioned that volunteers have a completely different approach than a professional or an official party. According to them, there are always restrictions or borders between refugees and a professional, because they are being paid to do their job. Volunteers, on the other hand, go the extra mile to understand the needs of refugees and to make them feel included. The following quote is from a refugee who highlights the benefit of interacting with a volunteer:

"But when it comes to a volunteer, you feel it's genuine. They are doing it, because they believe in it or they really want to help. It comes across as more supportive, I would say. And you feel like they are putting in a lot of effort."
(Interviewee 7)

Another respondent emphasized that volunteers could also help lowering the barrier to reach health care by accompanying refugees to a health professional for the first time. The presence of a volunteer, who feels like a friend, could reduce the hesitation, fear or embarrassment and allow refugees to come into contact with a care provider. Additionally, a volunteer could advise refugees on the different possibilities and discuss the options.

5. Discussion and conclusion

In the current assessment, light is shed on the role of volunteers in enhancing access to mental health care for refugees in the Netherlands. For this purpose, the following research question was asked:

"*How could the intercultural competence of volunteers be improved, thereby overcoming the socio-cultural barriers to mental health care access of refugees and asylum seekers in the Netherlands?*

In order to answer this question, three sub questions were included. In what follows, the interview data will be compared and contrasted to existing literature. In addition, the contributions of this research to the existing scientific knowledge will be discussed. The research questions and objective will be addressed, while linking them to the conceptual model 'Access to health care'. Afterwards, the limitations of the study will be presented. Lastly, conclusions will be drawn and recommendations for future research will be given.

5.1. Findings and implications

The study has been guided by existing concepts of volunteering, intercultural competence and a conceptual model on access to health care. The model claims that the determinants of access to health care integrate demand and supply-side-factors. More explicitly, access may be conceived as the interface between users and health care resources and consequently can be influenced by characteristics of those who supply as well as those who utilise the services (Levesque et al., 2013). This belief is in line with the results presented in Chapter 4, as barriers have been identified on both the demand and supply-side of access to health care.

The first sub question states: "To what extent do Dutch resettlement organizations facilitate the engagement between volunteers and refugees?" The findings of the study show that resettlement organizations play an essential role in ensuring the engagement between volunteers and refugees, as they are central in this network. According to Archer (2015), these organizations play a large role in filling the gaps where the state fails to provide an adequate reception for asylum seekers. Yet, interview data also show that having the resettlement organization as a moderator is not always perceived as a positive matter, as it makes the engagement between volunteers and refugees dependent on the rules of the organization. Moreover, refugees facing health needs during their

stay in the Asylum Seekers' Centres were rarely aware of existing health services. Various elements, such as information regarding available services and outreach activities were not approachable. This can be recognized as a supply-side barrier within the first dimension of access to health care induced by the resettlement organizations.

Nevertheless, municipalities are increasingly dependent on the support of resettlement organizations in receiving and integrating refugees. Volunteers are an important link between resettlement organizations and the community and play a vital role as cultural mediators in the integration of refugees into their host country (Haski-Leventhal et al., 2010). Therefore, an increased involvement of municipalities in activating, coordinating, and supporting local volunteers in their engagement with refugees is recommended. This could be done through the establishment of local networks and material and financial support.

The second sub question states: "What are the main socio-cultural barriers to mental health care access experienced by refugees?" As shown in earlier studies, refugees have an elevated risk of developing mental health issues due to pre-migration, migration and post-migration stressors (Li et al., 2016). This is in line with the interview data which show that refugees experience psychological challenges during the different stages of migration. However, due to the substantial barriers experienced by refugees when it comes to access to health care, they show lower mental health care utilization in comparison to host-country nationals (Mangrio & Sjögren Forss, 2017). The five dimensions of accessibility of services and the five abilities of users have an impact on the process of utilising health care and relate to causes and consequences of interacting with health professionals and utilising health services (Levesque et al., 2013).

According to previous research by Kiselev et al. (2020), the main barriers to accessing mental health care are language; lack of resources and awareness; fear of stigma; and mismatch between local health systems and perceived needs of refugees. This is consistent with the findings of the current research. Respondents identified barriers within the four dimensions of access to health care, including health care needs, perception of needs and desires for care, health care seeking, and health care reaching. In order to overcome these barriers to health care, significant advancements have to be made at both ends. The supply-side, including the government, municipalities and resettlement organizations, should foster approachability, acceptability, availability, affordability

and appropriateness of health care. Simultaneously, the demand-side should enhance their ability to perceive, seek, reach, pay and engage. Volunteers play a key role in the process of connecting refugees with mental health care services. They provide fundamental services such as accompanying refugees to a health professional for the first time, translating conversations, and providing legal aid (Archer, 2015). In addition, interview data show that volunteers are the gateway to establishing a connection with Dutch society. Hereby, volunteers have an active contribution to the enhancement of access to health care for refugees. Previous studies found that even the better-equipped resettlement agencies struggle to adequately recognize and respond to refugees' mental health needs. Since volunteers have an important role to play, it is crucial that they have the appropriate competencies to fulfil their tasks (Archer, 2015; Satinsky et al., 2019).

The third sub question states: "How is intercultural competence incorporated in the training programmes of volunteers dealing with refugees?" The findings of this study show that not all volunteers get the same training opportunities at the various organizations. Fortunately, trainers of volunteers recognize that most people who volunteer for refugees already have some intercultural competences. Within the better-equipped resettlement organizations, training and education programmes focus on improving these skills and competences. Nevertheless, volunteers within the Asylum Seekers' Centres do often not receive any kind of training.

According to the concept of 'Intercultural Competence' presented in Chapter 2, intercultural contact can increase ICC only under the right circumstance and not merely by interacting with a new culture. The outcomes of intercultural competence are influenced by the individual capacity of the volunteer; the institutional capacity of the programmes facilitating the practice; and the nature of the service activity (Lough, 2011). In agreement with this notion, interview data show that some volunteers in these settings could indeed improve their abilities to understand and communicate with people from a different culture. A policy implication of this study would therefore entail amplified support of initiatives that provide cultural sensitivity training programmes to all volunteers who work with refugees. Additionally, this research emphasizes the importance of involving refugees in the training programmes for volunteers. Volunteering among refugees can not only be an instrument for integration, but also an indicator of societal inclusion.

5.2. Limitations

Despite the interesting findings that were retrieved from the data, there are some limitations that should be considered. Although the criteria of validity and reliability are not completely applicable to qualitative research, it is important to fulfil them as much as possible. Qualitative research is often criticized for lacking scientific thoroughness, as the findings are a collection of personal opinions subject to researcher bias. Values that reflect the personal beliefs or emotions of the researcher could pose a bias on the results. However, the bias can be reduced by engaging with other researchers and having the study cross-checked independently (Tracy, 2013). In addition, it is important to recognize pre-existing values and suppress them while conducting research. Even though it is not feasible to completely keep these values in check, by trying to restrict the influence of them on the research as much as possible, a more nuanced view is created. Further, a qualitative study with a rather small sample size (10 respondents) has been conducted. This method was suitable to explore the experiences and opinions of refugees and volunteers on the research topic. Yet, it remains unclear to what extent findings are generalizable and applicable to other countries or settings. Nonetheless, by keeping a variety of respondents, the findings from this study are relevant for further research from a theoretical point of view as they confirm that the existing theory of access to health care can help identify which areas of access need to be enhanced. In order to be able to judge how significant the results are in other settings, further quantitative research, involving a greater population, will be required.

5.3. Conclusions and recommendations for future research

This is an exploratory study that grants initial insights into the role of volunteers in overcoming the socio-cultural barriers to health care access experienced by refugees in the Netherlands. The interview data shed light on the current training programmes of volunteers and the importance of intercultural competences. Currently, there is a lot of scientific interest in the field of volunteering for refugees, as the significance of volunteers in the reception and integration of this population group has been widely recognized. An interesting aspect of this study is that the experiences and opinions of refugees, volunteers, and trainers have been included in the results. This research can be used as a tool to reflect on the ways in which volunteers could contribute to the enhancement of access to mental health care, within the first four dimensions of the model ‘Access to health care.’

However, in order to ensure complete access to mental health care for refugees, it is essential to look further into the dimensions of health care utilization and health care consequences. Future research could focus more on the role of medical professionals, such as psychologists and psychiatrists and their influence on the appropriateness of care. Additionally, to be able to draw better conclusions about the way in which resettlement organizations influence volunteering for refugees, more interviews, including a wider variety of actors, among which representatives of local organizations, would be required. Lastly, to identify and learn from best practices, it would be interesting to see how resettlement organizations across the European Union incorporate intercultural competence in their training programmes for volunteers.

From the findings of this research, it can be seen that volunteers play a prominent role in the enhancement of access to mental health care for refugees in the Netherlands. They are often perceived as mediators between refugees and health care professionals and as a gateway to integration and inclusion. The objective of this study was to discover how the improvement of the intercultural competence of volunteers could contribute to uncovering the unmet mental health needs of refugees. Interview data revealed that volunteers with the key competences can relate to refugees and understand their way of communicating better. Consequently, it is crucial to invest in the availability of these cultural sensitivity programmes for all volunteers working with refugees. Mental health and well-being are crucial to refugees' integration into Dutch society and should therefore not be neglected.

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