A Review of the Linkage Act 1998: how accessible are health services for undocumented migrants in Amsterdam?

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Abstract

The goal of this thesis is to understand the contemporary access of undocumented migrants to healthcare. This knowledge is important as The Linkage Act 1998 restricted undocumented migrants’ access to healthcare by only allowing for ‘necessary’ treatment. Chapter two tries to contextualise the contemporary access to healthcare; explaining how the last found study was completed in 2005, before the Dutch state’s treatment of undocumented migrants became heavily criticised by the European Union. The context has had developments by social movements such as the We Are Here group and the Bed Bath and Bread protest, which have had been receiving recognition throughout their protests for a more humane treatment by the Dutch state.

Chapter three supports the access to healthcare argument by explaining how undocumented migrants are highly susceptible to Post Traumatic Stress Disorder and other mental health illnesses. This is due to turmoil in their country of origin and stressors endured in their asylum seeking pursuit. Ill mental health can often coincide with ill physical health, described as ‘co-morbidity’. This thesis outlines the importance of the ease of access to healthcare from a gender equality viewpoint.

Chapter four, the research design, focuses on how the communication of available services is transferred within undocumented migrant’s social networks in Amsterdam. Who avails of what services, and who is proving the healthcare? The use of the term ‘necessary’ is consistently drawn upon in my research when investigating how the phrase is interpreted and put into practise. The completed research is sub-divided into two parts – interviews and observational research for both physical and mental health.

Social problems can have a detrimental impact to one’s psychological state, this thesis explores this issue by interviewing psychologists and social workers in Amsterdam to see if they can aid the understanding of who can solve this issue? This thesis concludes with an analysis of the influential actors in the deliverance of care.
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Preface

Governing bodies in the Netherlands and Europe have in recent years increased their restrictive stance through administrative procedures concerning the acceptance of asylum seekers into Europe. In the Netherlands the right wing party PVV, headed by anti-immigrant anti-Islamic leader Geert Wilders, has seen an increase in votes. In 2010 the PVV won 31 of 150 seats in parliament. The PVV quoted "It looks like, for the first time in history, the PVV will be the biggest party in the Netherlands" (NRC.nl, 2010). A decline of European asylum acceptance and social services has coincided with the introduction of Frontex, the EU border control unit. Since Frontex’s introduction there has been a sharp increase in the death toll of asylum seekers while attempting to migrate to Europe by sea; April 2015’s death toll was ten times higher than that in April 2014 (The Economist, 2015).

The European Commission in 2015 ruled that the Dutch government was breaching European rules by not providing shelter, food and clothing for undocumented residents (Savela 2015). The administrative exclusion of humanitarian and public services to failed asylum seekers led me to choose to investigate the accessibility of health care. How accessible are psychological services to undocumented migrants in Amsterdam. How are their basic health needs met?

Keywords: Undocumented, Netherlands, Amsterdam, Public Services, Access to Health Care, Mental Health, Physical Health
Chapter 1: Introduction

1. Problem Formulation

This thesis will begin with a brief explanation of the immigration history in the Netherlands; this will aid the understanding of the contemporary context. Large-scale migration into the Netherlands began in the early 50s due to the decolonization of Indonesia, following closely by Suriname. This wave of immigration was followed in the 1960s by Southern European and North African ‘guest workers’, which were recruited by the Government after World War Two to aid the reconstruction of society. The third wave of immigration into the Netherlands was driven by family reunification in the 1980s and finally by refugee acceptance in the 1990s. The contemporary non EEA immigration acceptance consists mostly of high-skilled migrants with a decrease in acceptance of all other forms of migration by the Dutch government (Siegel, 2011). The contemporary high skilled migrant acceptance is justified through the explanation that it is mandatory in order to maintain the economy. The Dutch government, alongside many other European countries has an increased support of right wing parties. This can be illustrated through policy implementation: The first explicit immigration policy in 1970 was the Memorandum on Foreign Employees, which outlined that the Netherlands was not a migrant receiving country. This was followed by the economic downturn in the 1980s which highlighted the importance of providing migrants with access to social services such as housing, medical care and education. Education in migrant’s mother tongue was implemented in order to assist migrant’s return (Siegel, 2011). This did not aid the migrant’s return to their country of origin as hoped by the Dutch government, as immigration continued to increase. In 1995 the level of asylum seekers reaching the Netherlands stood at 53,000. The Dutch government began to limit the services available for migrants through administration; one way in which this was enabled was in the Linkage Act 1998.

This section, using the available information, will aid the reader in understanding how a migrant can become undocumented in the Netherlands, and the different procedures and experiences that they can undergo while doing so. It is difficult to efficiently understand the contemporary living situation and demographics of undocumented migrants in the
Netherlands due to the nature of undocumentation. The demographics available concerning asylum seekers will be explained, as it is the only reliable and contemporary information that can aid understanding. Vluchtelingenwerk Nederland, the national Dutch refugee organisation, state that in the year 2014 a total of 23,970 asylum seekers were granted protection in the Netherlands; thus comprising of the number of asylum seekers who gained a legal refugee status. The majority of which are young single males from Syria and Eritrea. Many asylum seekers however are not granted status but cannot return to their country. One reason for the inability of failed asylum seekers to return to the country of origin is not having the possession of valid travel documents. Another reason is a lack of cooperation for the return by the migrant, such as the fear of prosecution upon return. Those who remain in the host country without status for various reasons can be referred to as undocumented, or illegal migrants. In 2009 Schoevers et al estimated that 75,000 to 150,000 failed asylum seekers reside in the Netherlands. It is important to note that this estimate is likely to have risen due to reported increase in asylum seeking.

The Linkage Act 1998 (‘Koppelingswet’) applies to those living in the Netherlands without Dutch nationality. This act introduced that when applying for public services, listed in this act as housing, education, driving licences, social assistance and health care, those without Dutch nationality will be asked for proof of legal residency. Those who do not have legal residency are excluded from all access to public services due to the Linkage Act 1998. If an illegal resident applies for a social service, and are rejected on these grounds, the Ministry of Justice outlines that the service providers are not obliged, but have the ability to report this illegality to the police. There are a few exceptions to the inaccessibility to public services. One is that illegal residents who are under eighteen can access education and their course can be finished as long as they were a minor at first point of entry. A second exception is that illegal residents have access to legal aid. The last exception is that illegal residents have access to “necessary medical assistance, including preventative medical assistance such as vaccination, pregnancy care etc”. A further explanation is given:

If you are residing in the Netherlands illegally and require medical care, for instance because you have an injury as the result of an accident, you will naturally receive help. Even when you need vaccination to prevent you from contracting a serious disease this will not be any problem. In case of pregnancy, you will of course be given the care you require (Ministry of Justice, 2004)
The description from the Ministry of Justice portrays a situation with an ease of access, yet the word in the former explanation ‘necessary’ may transpire as subjective.

Dutch governmental treatment of asylum seekers for those with both ongoing and failed applications, has been under heavy criticism; one such criticism is the inaccessibility of medical care. When an asylum seeker receives a rejection of refugee status, the Dutch state does not recognize the failed asylum seeker to have formally entered the country. Some are detained within designated detention centres, these centres are seen as a temporary place to secure illegals until a return to the country of origin is organised. Officers control the centres to ensure unauthorised departure does not occur. Amnesty International (2013) states that health care within detention centres should be equal to what can be availed within society. There are nurses, psychologists and general physicians available. A medical intake is carried out on each asylum seeker within the first twenty four hours of arrival. In 2013 the detention centres health services were under critique as Aleksandr Dolmatov, a detained asylum seeker, took his own life while in detention. His suicidal tendencies were known within the detention centre yet no doctors were provided after his first suicide attempt (Amnesty International, 2013). A similar case in 2014 occurred when a detainee took his own life after no psychological support was given, even though it was medically understood that this service was needed (DutchNews.nl, 2014). Both asylum seekers awaiting their decision and detained failed asylum seekers are stated within policy to have full access to health care; yet there have been two suicides within the last two years. Dorine Manson, the head of Vluchtelingenwerk Nederland outlined “detention is the reality for many [asylum seekers], including vulnerable groups like children or people with serious physical or mental problems” (DutchNews.nl, 2014). In addition, the Central Agency for the Reception of Asylum Seekers has published that:

2,741 (violent) incidents were recorded in Dutch asylum centres in the first 6 months of last year. These include 13 suicides, 80 suicide attempts, 124 intimidations and threats, 47 assaults, 58 missing people, 23 hunger strikes, 4 self-immolations and 10 suspicions of human trafficking. In the first half of 2014 there were about 12 thousand asylum seekers in Dutch centres, that number has doubled in the meantime. (Van Jaarsveldt, 2015)

Asylum seekers are likely to have undergone trauma alongside a decrease in their physical health due to precarious travel arrangements throughout the migration process. This is elevated by limited healthcare in their country of origin, many of which may have undiagnosed personality disorders. Failed asylum seekers cannot reside legally within Dutch
society but cannot return to their country of origin. Undocumented migrants are currently mobilizing within the Netherlands in a ‘Bed, Bath and Bread’ protest in order to demand access to permanent shelter and food (DutchNews.nl, 2015). The We Are Here group (‘Wij Zijn Hier’) is another movement in Amsterdam; this group comprises of undocumented migrants who are demanding legal recognition from the Dutch government. ‘We Are Here’ squat in empty buildings in Amsterdam and organise protests and awareness campaigns. The We Are Here organisation outlines:

What is our Problem? Since we got rejected as refugees, we do not get any housing but are also not allowed to work. Therefore we are out on the street. We didn’t expect to find ourselves in this situation when we came here as refugees. In fact, we lack all basic human rights (WijZijnHier.org, 2015).

I aim to investigate this limited legality further; what is the contemporary accessibility for these migrants in relation to psychological support? Are their medical needs acknowledged, as the aforementioned Linkage Act 1998 and concluding Ministry of Justice statement seems to contradict the Amnesty International reports and We Are Here statements?

2. Objective

Through my literature review I only came across two published works of literature in an ethnographic style, which focuses on undocumented migrants within the Netherlands and their access to health care. One study conducted in 2009 interviewed 80 women in order to ascertain the condition of the contemporary healthcare access and which health problems are prevalent for undocumented women. This study referenced a second research however this could not be found, this would lead me to judge however that it was completed over eight years ago if it was to be referenced in 2009. Thus there is no completed works in the last ten years which incorporates a male perspective. The perspective of males is imperative to ensure that an equal understanding is achieved and efficient services are delivered. The gender paradigm understood within society does not operate in isolation, male masculinity is constructed by the identity traits that oppose femininity and vice versa. Edwards (2015) outlines that “in the West, it is assumed that the reproductive function of males and females is a sufficient basis for prescribing psychological and behavioural characteristics onto members of society.”
Gender profiles and stereotypes dictate how males should act, this differs globally and thus migrants from different countries follow different norms. This is why I have considered it imperative to focus on males throughout my research, as I found it to be absent from contemporary literature. Undocumented males living in Amsterdam may, or may not, adapt to the contemporary male norms that are active within Dutch society, gender norms are not fixed and can transform and be obtained. Undocumented males, if not already embodied, can acquire a male identity consisting of strength and able-bodiedness, potentially leading them to be perceived as not requiring care. This stereotype can be an additional hindrance to the pursuance of health care, since the perilous journey to the Netherlands from their sending countries can already be traumatizing and damaging to one’s health. As treatment is only given to those who are perceived of needing necessary aid, undocumented migrants must be explicit in their symptoms. It has also been frequently reported that males avail of health care services when required less than women (Bertakis et al 2000, Connell 2012).

My research question is an explanatory and descriptive one: A Contemporary Review of the Linkage Act 1998: How Accessible are Health Services for Undocumented Migrants in Amsterdam? Through this I aim to ascertain:

1. How the use of the term necessary is implemented in daily healthcare practice?

2. Since access to healthcare has become restrictive through the implementation of the Linkage Act, how is the knowledge of available services communicated and to whom; what is the average profile of an undocumented health care user (age, ethnicity, class and gender)?

3. How does discretion of care differ throughout different health sectors?
Chapter 2: Contextualizing Dutch Healthcare Access for Undocumented Migrants

A Foundation for Comparison

Many states within contemporary Western Europe have shifted their ideals to a neo-liberal individualistic stance, which increases the importance placed on citizenship. States have increasingly restricted the attainment of asylum status, and have adapted limitations concerning state protection and rights, this incorporates the ‘race to the bottom’ technique in which states create the receiving environment to be less appealing hoping that those who seek asylum will opt for other nation states (Fassin 2005). Within the neo-liberal stance, an emphasis is placed on migrants not to be a burden on the welfare system and to ensure self-sufficiency, resulting in migrants having to earn their state protection and services.

This section will draw upon the contemporary exclusion/inclusion of undocumented migrants to state health services in Spain, Italy, France and the United States in order to assist in understanding what the situation in the Dutch society may be. Has the discourse of undocumented thus undeserving become engrained into the Dutch society, much like in the United States? Chavez (2013) discusses the discourses surrounding undocumented immigrants in the United States; that the reason that they have been excluded from Obamacare is that they are seen to be taking ‘too much’ from the health and welfare systems already and that ‘they don’t pay enough taxes’ to avail of such social services. The actual situation is that undocumented migrants are using costly health services such as emergency wards the least, and constitute the category who are least likely to leave hospital bills unpaid (Chavez 2013). These untrue justifications for exclusion may reflect those within the Dutch parliament. Chavez (2013) describes one consequence of excluding undocumented migrants from Obamacare within the United States: undocumented migrants assist in creating the backbone of the economy as they complete large demands of unskilled labour positions such as manual labour and domestic services. If these migrants cannot work due to illness and subsequently cannot get access to healthcare, the needs of the labour market are not adequately reflected within state services. Only high skilled migrants are listed explicitly by the Dutch government as desired immigrants to work. Understanding that the Dutch informal labour market may not demographically mirror the United States context as just described, I
feel that the United States may reflect the future Dutch labour market. Is the public
perception in the Netherlands similar to that in the United States, that undocumented migrants
don’t contribute enough to society to avail of healthcare?

Fassin (2005) describes this increased difficulty for migrants to obtain state support and
integrate within France; Fassin states how a social worker considers all irregular migrants to
be ‘sans-papiers’ as asylum claims are predominantly refused. This creates and embeds an
illegal stigma towards migrants and thus results in social workers withholding state support
during their asylum process, such as healthcare, as it is presumed that they will not be able to
obtain legality. These examples illustrate the contemporary argument that the acceptance of
too many immigrants or refugees will burden the welfare system is often presented as the
justification for the implementation of draconian policies. Does the staff in the detention
centres in the Netherlands exclude undocumented migrants from healthcare due to their
preconceived illegal and undeserving identity?

The difference concerning social welfare utilization based on ethnicity was outlined by
Devillanova (2008). This study focused on undocumented migrants and their access to social
welfare services in Italy. The situation in Italy is similar to the Netherlands., only pre and
post-natal care is provided and what is considered ‘essential treatments’ – illnesses that are
not immediately dangerous but can worsen in the future are treated. He found that the
utilization of available social welfare was highly dependent on one's social networks. This
study highlighted the importance of networks in shaping social behaviour such as utilizing
health care when necessary. Are the social networks as important in the Netherlands for
transferring information as they are in Italy, since the geographical context may play a critical
role in Italy? This group cohesion is something that I hope to further explore within this
thesis. This strong nationality grouping may play a role within the studied group norms of We
Are Here. Social networks aid the supply of information relating to social welfare services
such as location, cost, opening hours etc. and can also mobilize and create pressure both for
the individual and the service (Devillanova, 2008).

Devillanova (2007) outlines that many contemporary network studies within welfare access
may be highly problematic as empirical research studies a geographical area by ethnicity and
has the underlying presumption that those who share language and nationality are within
one’s social network. This will not be done within my thesis and thus aims to provide further
clarity to this gap of knowledge. Devillanova’s (2007) findings show that if one has a strong social network tie, the waiting time for attending a medical centre when needed is reduced by 30%. Strong ties are important, as they aid in economic security and the provision of information about healthcare services.

Throughout Europe, irregular migration has continued to be within the political spotlight. The parallel issues of ethical and multicultural health service deliverance versus undocumented residents within society have created conflicting views. Spain introduced in response to this legislation which granted free healthcare to all residents. Torres-Cantero et al. (2007) conducted a study which tried to ascertain whether ill undocumented migrants accessed health care to the same extent when required as legal residents. As Ecuadorians were the largest migrant group in Madrid, one of Spain’s largest cities, the study focused on this migrant group solely in Madrid. The study found that once illegality was removed, other factors became prevalent such as job stability and former educational attainment. It was stated that other issues that may arise are administrative discrimination or denial of service however within this study this was not apparent. These may play a role within an Amsterdam context and thus hopes to be explored. Torres-Cantero et al. (2007) asked as to whether the 380 undocumented migrants had visited an NGO; the findings were that only 53% had visited one. The study concluded that the awareness of such services and resources were transmitted predominantly through social networks. Eliminating legal barriers to healthcare does not transform into equal utilization and access as other barriers begin to transpire such as the awareness of services and discrimination of acceptance. The results of this study demonstrate that legality is no longer the determining factor for unequal utilization of healthcare in Spain, it is now education.

Why did Spain remove this barrier to health care, was it due to the political climate at the time caused by the mobilization of NGOs and political activists within society? Can this be legality be replicated within the Netherlands? (Torres-Cantero et al, 2007)
This section will discuss what knowledge is available to date by a study completed which focuses on the comparative health differences, both physical and mental, between asylum seekers and refugees in the Netherlands in 2005. The demographics and findings of the study by Gerritsen et al (2006) can be found below.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total (N=410)</th>
<th>Refugees(N=178)</th>
<th>Asylum Seekers (N=232)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of Origin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somalia</td>
<td>87 (21.2)</td>
<td>25 (14.0)</td>
<td>62 (26.7)</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>206 (50.2)</td>
<td>90 (50.6)</td>
<td>116 (50.0)</td>
</tr>
<tr>
<td>Iran</td>
<td>117 (28.5)</td>
<td>63 (35.4)</td>
<td>54 (23.3)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>241 (58.8)</td>
<td>99 (55.6)</td>
<td>142 (61.2)</td>
</tr>
<tr>
<td>Female</td>
<td>169 (41.2)</td>
<td>79 (44.4)</td>
<td>90 (38.8)</td>
</tr>
<tr>
<td>Mean Age (SD) [years]</td>
<td>37.0 (12.4)</td>
<td>40.3 (13.3)</td>
<td>34.4 (11.1)</td>
</tr>
<tr>
<td>Mean Time in the Netherlands (SD) [years]</td>
<td>5.6 (4.0)</td>
<td>8.8 (4.1)</td>
<td>3.4 (1.6)</td>
</tr>
<tr>
<td>Mean Number of Traumatic Events (SD) (0-17)</td>
<td>6.1 (3.7)</td>
<td>5.3 (3.6)</td>
<td>6.8 (3.7)</td>
</tr>
<tr>
<td></td>
<td>(N=384)</td>
<td>(n=172)</td>
<td>(n=212)</td>
</tr>
<tr>
<td>Mean Score for Post Migration</td>
<td>2.0 (0.6)</td>
<td>1.6 (0.4)</td>
<td>2.3 (0.5)</td>
</tr>
<tr>
<td>Stressors (SD) (1-4)</td>
<td>(N=381)</td>
<td>(n=162)</td>
<td>(n=119)</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Mean Sum Score for Social Support (SD) (0-6)</td>
<td>4.1 (1.9)</td>
<td>4.8 (1.5)</td>
<td>3.6 (2.0)</td>
</tr>
<tr>
<td></td>
<td>(N=404)</td>
<td>(n=177)</td>
<td>(n=227)</td>
</tr>
<tr>
<td>Feeling at Home in the Netherlands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Much/Reasonably</td>
<td>249 (60.9)</td>
<td>130 (73.0)</td>
<td>119 (51.5)</td>
</tr>
<tr>
<td>A little/Not at All</td>
<td>160 (39.1)</td>
<td>48 (27.0)</td>
<td>112 (48.5)</td>
</tr>
<tr>
<td></td>
<td>(N=409)</td>
<td>(n=231)</td>
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It was found that those without a legal status considered their mental health to be in a worse state. “More asylum seekers than refugees reported a poor general health status, and even 75.9% of the Iranian asylum seekers considered their health to be poor” (Gerritsen et al 2006). Both the asylum seekers and refugees listed themselves as having experienced trauma however the Somali asylum seekers had experienced more traumatic events and post-migration stress. The most frequent traumatic events listed are forced family separation (66%) and unnatural deaths of friends and family (62%). The most listed post-traumatic stressor for asylum seekers was ‘dissatisfaction with the delays in the application for a residence permit’ and ‘uncertainty about getting a residence permit’. Further to this, asylum seekers felt they received less social support than refugees and felt less at home in the Netherlands. They more frequently listed anxiety (41.2%) and depression (61.5%) as a mental health problem, while refugees listed these both in the 20% range. “The associations between legal status and poor general health and between legal status and depression/anxiety symptoms remained” (Gerritsen et al 2006). Dental problems and severe migraines/headaches were listed as the most common physical health problem for both groups. One of the most frequently cited reasons for their lower mental health condition was the structural violence imposed upon these migrants by the Dutch state, such as inadequate processes like the delays in applications for a residence permits and the lack of opportunity structures.
The experience of traumatic events resulted in both lower physical and mental health. There was a high correlation between traumatic events experienced and post migration stress (Gerritsen et al 2006). It should be noted however that this quantitative study did not cite as to if, and if not - why not, these migrants had attended any forms of health clinics and what their experience was with the medical sector.

Health practitioners within the Netherlands have used their professional judgment and morals to exercise leniency on strict guidelines of access given by the state (Van der Leun 2006). The last research found on the daily application of the Linkage Act by policy practitioners was completed over a decade ago by Van der Leun in 2006. For these reasons in this thesis it is difficult to complete a comparative study as an in depth analysis is difficult to compare, the true situation is not fully understood. Societies are developing and are not in a fixed state. Previous studies have found contradicting correlations concerning gender and migrant’s mental health.

I aim to further explore the contrasting gender discourses within societies proposed by Bucher et al (2010) of male migrants being a risk and migrant women being at risk, throughout this thesis also. This discourse surrounding gender can be commonly seen through the sensationalization of images of vulnerable women and children by the media in an attempt to create awareness of issues such as asylum seekers in need of our aid (Schrover & Schinkel 2013). The reproduced image of vulnerable female asylum seekers supports the discourse that men are stronger, more able-bodied and thus are less in need of relief. The idea of male migrants being a risk can also be found within Dutch politics: the former reasoning of failed integration due to a migrant’s lack of Dutch cultural knowledge and language skills has shifted to putting the blame on specific cultural ‘problems’ that are perceived as needed to be eradicated. The perceived integration or assimilation problem lies within cultures that are understood by politicians to privilege men, dominate women and legitimise domestic violence (Roggeband & Verloo 2007). At a street level this can be illustrated by the limited night shelters in Amsterdam, an area with the highest concentration of undocumented migrants within the Netherlands; some are specifically for women and children only, I argue that this may result in explicit exclusion of males accessing shelter (ASKV 2012). Separating shelters exclusively for women can reinforce the idea that males are violent and must be removed for women’s safety as they can damage their well-being.
What may be more troublesome is not having male only shelters, or having shelters which adhere to needs that males have, as women are the minority demographically yet they receive gender specific shelters. This may aid in reinforcing the concept of ‘putting equality into practise’ yet only adhering to women’s needs.

The boundaries of those who are recognised by the state as deserving of state protection may have shifted. Previously migrants who were recognised by the state were those who were healthy, as workers who could contribute to state sovereignty were the ideal migrant e.g. guest workers within the Netherlands (Fassin 2005). States now are primarily accepting asylum claims on the grounds of impaired physical health, as it is easier for states to declare asylum claims unfounded rather than to go against medical reports outlining physical illnesses. This has led to asylum seekers being asked if they could ‘invoke’ illnesses in order to obtain a residency permit. To illustrate within a French context, Fassin (2005) outlines how mental illnesses, such as depression, are not recognised comparably as grounds for permission to remain even though they may be just as life threatening (ibid).

Depression was not a very good case, however, because state medical experts often refused to consider it as a valid reason and, in fact, often suggested that, back in the country of origin, the patient would benefit from returning to a traditional environment and forms of treatment. (Fassin 2005)

The acceptance of asylum seekers on medical grounds has raised, this can allude to the perception that the state are denoting more humanitarian help. As medical grounds are not listed within the Geneva Convention however they are being declared as ‘unfounded’ by right-wing politicians. This process is rarely carried out thoroughly as it is highly bureaucratic and few health workers offer the help that is needed. Amnesty International sometimes aids the documentation collection process for permission to remain on medical grounds; a result of which the success rate of residence permits is up to 80% compared to 10% otherwise (Verbruggen 2001). This illustrates that the state actors don’t consider the process worthwhile, as the stigma attached to these undocumented migrants may result in the perception of them not being worthy of state support.
In order to reduce health inequalities it is important to fully understand the complex situation at hand. This thesis aims to bring clarity to how much of a role the permission to remain on medical grounds plays in the lives of undocumented migrants; how frequently is this status obtained, how is illness perceived by the IND (Immigratie- en Naturalisatiedienst/Immigration and Naturalization Service), and is this status deemed to be more easily attainable - through such measures as exaggerating illnesses? The gender dynamics are to be further explored as discourses, which surround gender aid in shaping our perception of society - if there is an untrue discourse that creates discrimination and/or impedes needed aid it is imperative that it is uncovered and exposed. The well-being, but also the perspective of how any illnesses were treated by the Dutch healthcare are hoped to be further explored as this viewpoint was missing from Gerritsen et al’s (2006) study.

3. The Linkage Act

This section of this thesis will further explain the Linkage Act 1998 (Koppelingswet 1998) and the impacts it has had to date. This further explanation is to aid the reader to understand the impact of the Linkage Act and the importance of developing knowledge on the situation of undocumented migrants and their access to health care.

After the guest workers continued to reside in the Netherlands and the fear for state sovereignty spread (due to the economic downturn in the 1980s) the Linkage Act was created, developed and finally implemented in 1998. The restrictive immigration stance became further fuelled by a political party shift in 2002. The act was based upon the idea that if state services were more difficult to access as a migrant, then immigration would decline. This act made it impossible for migrants to access many social services as their permission to remain was automatically revoked if a claim was made. Initially all undocumented migrants were forbidden to access state services. Objections by policy practitioners within the field were made, stating that the act was unnecessary, inhumane and unworkable. This led to certain restrictions being lifted: education was made accessible for undocumented migrants until the age of 18 rather than 16, health services were available to those in need of ‘urgent medical treatment’ (Medisch noodzakelijke zorg) and midwifery and legal advice became accessible to all. Policy practitioners no longer had to report undocumented migrants to the police or the IND (Immigratie- en Naturalisatiedienst/Immigration and Naturalization Service) (Bruquetas–Callejo et al 2007). Although the more restrictive draconian policies
were not fully implemented, there is a clear illustration of the preference in which the Dutch state had intended.

Due to strong resistance, the minister responsible has changed the definition of ‘urgent medical care’, and stated on many occasions that every doctor has an obligation to help anybody regardless of his or her position in society, race, and belief, etc. Instead of the word ‘urgent’, the term ‘necessary’ is now used. The official description outlining when medical care can be obtained is the following, as translated by Verbruggen (2001):

1. In case – or for prevention - of life threatening situations, or in case – or for prevention - of situations of permanent loss of essential functions.

2. In case there is a danger for a third party, e.g. certain contagious diseases (in particular TB) and for psychological disturbances and consequent aggressive behaviour.


4. Access for children without a status to preventive Health Care and to a vaccination programme similar to the national vaccination programme.

Two funds were set aside to ensure that health centres will not suffer financially as a result of the Linkage Act. The finances lost through undocumented migrants being unable to pay for their hospital bills would be claimed and cleared through a limited subsidy called the ‘Dubieuze Debiteuren’. The second provision is called the ‘Linkage Fund’ (‘Koppelingsfonds’) (Verbruggen 2001). Five million euros are set aside every year for the Linkage Fund, it is essentially the money which would have been paid for child support and other welfares. This limited subsidy was set aside by the Government to clear front line workers unpaid bills if they are to treat those who do not have insurance and cannot afford the cost of treatment. Frontline workers are understood to be doctors, pharmacies and midwives etc. The Linkage Fund was initially declared too difficult to access, by NGO organizations such as the Johannes Wier Stichting, as there was a high level of bureaucratic work to complete. The health care provider should prove that the person is undocumented, that the costs for the health care cannot be claimed in any other way, that the provided care was urgent, and that the financial burden on the provider was ‘excessive’. It must be noted that although services like Rainbow Group and Kruispost exist, which exist explicitly for uninsured patients to access (almost) free health care, another larger organization ‘De Witte Jas Health Centre’ closed their doors in 2001. They exclaimed that it was time for private
GPs to also begin to take responsibility to treat uninsured and undocumented residents. Verbruggen (2001) stated that GPs in Amsterdam who consult within a predominantly immigrant neighbourhood such as the Dapperbuurt, have more uninsured patients than other, which results in an uneven distribution of uninsured patients and extra bureaucratic filing for the clinic. This results in migrants becoming heavily reliant on their local services. Although there is no judicial reason in which a doctor cannot consult an undocumented migrant, it can be very difficult for this ability in Amsterdam to be obtained. Verbruggen (Ibid) further outlines his findings in relation to hospital appointments; it is stated that in practice it can also be difficult to gain access to hospital treatment. Verbruggen (Ibid) states that one way in which this can be sought is that a financial advisor can meet with the undocumented migrant to draw a financial plan. If an agreement cannot be reached, Verbruggen (Ibid) states that they may be turned away; it was concluded that 20% of all referrals at the time of the study were unsuccessful. I aim to study this in a contemporary context in Amsterdam.

Dutch policy making has shifted up towards international bodies such as the European Union, outwards towards think tanks and also, what this thesis proposes to focus on, downwards to local authorities and services. Van der Leun (2006) discusses how state policies are very rarely implemented as intended; that policy practitioners such as doctors and teachers find loopholes and ways in which the services can still be availed of. This is outlined as the choice between their ethics and morals combined with their professional opinion versus the state's restrictive policies. Van der Leun’s research in 2006 found that doctors enjoyed the highest level of policy implementation discretion in the Netherlands; organizations such as Medisch Opvangproject Ongedocumenteerden/Medical Care Project Undocumented, also known as MOO and Stichting Kruispost, which are solely created for those unable to access insurance, illustrates this high level of decree (Van der Leun 2006).

The advancing restrictive stance by the Dutch state is said to be manifesting fear within the migrant communities, resulting in avoidance in seeking health care. Van der Leun (2006) while studying the discretion used by healthcare practitioners found a divergence in responses to leniency: these inconsistencies concerning the term urgent (now necessary) treatment was stated to have fuelled tensions throughout the field. Van der Leun foresaw further policy changes and stricter sanctions in health care as the stringent access to state services for undocumented migrants had remained to be seen in practise. For policy to be studied it should be focused more on the implementation by practitioners and those effected at the street level. This is what this thesis will explore; has the health care accessibility in the
Netherlands had any changes in the last two decades. A psychiatrist in Rotterdam claims: ‘There is not a single doctor who can determine what imperative medical care encompass’, how have health care workers in the last two decades decided how much care to provide to undocumented migrants; how much has been determined ‘enough’ (Van der Leun 2006).
Chapter 3: Theoretical Framework

1. Migrants and their Health Conditions

There is a consensus among scholars that people are highly susceptible of enduring mental illnesses while undergoing migration, especially if this migration is involuntary. This section of my thesis will outline the importance of undocumented migrants having readily available access to healthcare illustrated by existing literature. The study Migration and Mental Health completed by Bhugra (2004) has been widely recognised and accepted within the field. They outline that the nature, scale and reasons for migration, sometimes referred to as push and pull factors, are critical variables in influencing a migrant’s mental wellbeing. After the migration process, when a migrant is residing in the host society, Bhugra (2004) outlines that the migrant’s self-image, social relationships, and the maintenance of their cultural ties have an impact on their mental well-being and thus influence the relationship with their host society. Asylum seeking migrants who have Post Traumatic Stress Disorder (PTSD) are particularly vulnerable to the stresses that the asylum procedure poses, such as long waiting times and the lack of clarity concerning their future (Silove et al 1997).

Both voluntary and involuntary migration can pose challenges although not all migrants endure the same phenomenon and have the same experiences. A migrant's legality within their host society is decided by various categories such as gender, age, educational attainment and nationality. Many irregular migrants are refused a legal status and left in a highly precarious situation. Undocumented migrants suffer from a lack of capital in their host society; pressure is often simultaneously emitted from their home society in the form of remittances, or in the obligation to assist in the migration process of community members. The reality of the undocumented migrant’s situation which entails low financial resources and various imposed stigmas are rarely coherently communicated home, thus adequate support from this network is scarce in a high pressured situation. Different support structures to ensure mental well-being are crucial for migrants (Bhugra 2004).
2. Institutionalized Stigma

This section of my thesis will aim to explain the creation of restrictive policies towards undocumented migrants and any existing mistreatment of asylum seekers and undocumented migrants by the concept of institutionalized stigma. This grounded theory will be used in order to explore and investigate the contemporary health accessibility situation and give reason for the Linkage Act’s exclusion before my research, data set and analysis is presented.

The concept and implications of a stigma has been thoroughly researched and conceptualized by Erving Goffman. He outlines three types of stigmatization - body, character and tribal. This section of my thesis will focus on the stigmatization of character (unemployment, weak will, imprisonment within detention and mental instabilities) as well as on the tribal aspect which is embedded within one’s nationality. Goffman states that within society the process of categorization by personal attributes are in a constant state of production, such as those entailing residence permit criteria - income, health, origin etc. Those attributes that are undesirable, and thus leading to the refusal of one’s legal residency, can be understood to conclude that the person is bad, weak or indeed dangerous (Goffman 1963). A stigma arises when there is a contrast in one’s actual identity and their opposing ‘virtual identity’ which is ascribed by their surrounding society. This virtual identity, in relation to my topic, can arise when Amsterdam residents have negative preconceived and unfounded ideas relating to a migrant which results in societal exclusion. Goffman (1963) further states that to be a person with a stigma, one must endure discrimination, which exists through reducing one’s life chances. This may be illustrated within this topic through the IND (Immigratie- en Naturalisatiedienst/Immigration and Naturalization Service) having unfounded scepticism in relation to a migrant’s asylum claim or by an undocumented migrant not receiving medical assistance due to not having the ability to acquire health insurance.

Elias’ study in 1994 compliments this thesis as it concerns hostility which arises between ‘established’ residents and the threat to their way of life felt upon the arrival of the newcomers/‘outsiders’. It was considered that the newcomers were less well bred; this was based solely on the length of time in which they have resided within the community. The newcomers, (in my study juxtaposing to undocumented migrants) began to feel inferior and weakened due to the mistreatment by the established group. The underlying reason for this feeling of weakness and inferiority was a lack of group cohesion; they themselves were strangers to each other. This can be illustrated in the findings of asylum seekers and refugees
by Gerritson et al (2010) in Amsterdam. Resources are difficult to gather as the exclusionist policies based upon stigmas such as nationality have resulted in the inability to work and utilize many social resources. The context results in the internalizing process of the stigma and the decline of one’s self-image. I intend to investigate to what extent a decline in self-image has occurred, or how much solidarity exists within the undocumented migrants in Amsterdam.

Our societal system is based upon stratification that requires various statutes constituting different power amounts. In order to distinguish who can obtain more or less power, ethnic discrimination is created and justified. I will draw upon Elias’ Established and Outsider Relations (1994) to reflect the Dutch society and the position of undocumented migrants. Within this research the outsiders are perceived as a threat to the livelihood of those established residents. The stigmatization within Elias' research is presented by the established residents as objective; “it is not we who have placed this stigmatization, but the powers that made the world” (Elias 1994). This indifference of stigmatization can also be demonstrated in policy creation; the exclusion of outsiders to state services creates and reinforces stigma. The effects of this on to the ‘outsider’ group, can transpire into paralyzing apathy by those within the dominant group due to it become normalized (Elias 1994).

Maintaining greater group cohesion ensures that the power dynamics will be preserved; this can be illustrated within the Dutch policy practitioners and legislative creators – hiring those within your group will ensure that the legislation will reinforce the levels of deservingness of different groups (Elias 1994). Having the right identity ensures that one is the authorized initiator in situations (Eidheim 1966) A group ideal, in this case the state of the Netherlands, can lead to the destruction of other groups which may be perceived in impairing the attainment of the ideal, such as the arrival of asylum seekers which are perceived as draining state sovereignty.
3. Contemporary Health within Dutch Society

3.1 Gender Roles in Health Care Practise

Gender theory is a highly complex term, one which must be understood in order to usefully incorporate gender and health. A lot of the studies of gender have been conducted in the global North, however as my thesis deals with immigrants to the Netherlands, many of whom originate from the global South, I must take this into consideration. The simplicity of using the western understood terms ‘men’ and ‘women’ in multicultural medical practise records underlies this misunderstanding: “Categorical thinking in its commonest form takes a dichotomous classification of bodies as a complete definition of gender” (Connell, 2012). The issues surrounding the gender order within health care can be highlighted by a paper written by Harrison in 1978 which outlines that living a ‘male’ lifestyle is damaging to one’s health - such as drinking, smoking, engaging in dangerous behaviour and a poor diet. This combined with evidence showing men having a lower rate of GP visits when required may indicate an issue surrounding gender and health relations. This is not to undermine categorical thinking completely within healthcare, such as ‘older black women in lower socio-economic areas’ or ‘undocumented males in Amsterdam’, these categories can share many health issues and may lead to efficiency however the implications of category creation in health care must be understood. Connell (2005) further illustrates that it is a taken for granted norm that men are the forerunners of gender, and thus when gender equality is discussed in health care only women are discussed, aside from males being perpetrators of violence. Gender identities rely on discourses which are created and reinforced through research, media and daily discussions but these can also be continuously transformed. The health care workforce is itself highly gendered, such as the somewhat outdated norm of doctors as males and women as nurses. Emphasising gender equality within health care starts with emphasising gender relations and the discourses that surround these (Connell 2005).

The social construction of the male identity can be critical, as recognised within criminology, as most of the crimes committed are by males. This thesis hopes to further investigate how the male discourse and embodiment of masculinity impacts health accessibility within undocumented males in Amsterdam; both for those working within the health sector and for the male undocumented migrants. The exploration of queer and transgender complex
relations within this context would be pertinent, as concerning issues that may reside within the country of origin may be influential to their identity creation.

3.2 The Internet as a Health Care Tool

To reflect upon Torres-Cantero et al (2007) NGOs may not be as imperative of an information source for migrants as thought. Social networks are a very important key player for information and communication flows, however the internet is also a valuable and crucial information source. Undocumented migrants can access the internet through computer services available in such places like ASKV and of course they have access through their smart phones. The internet is a powerful information tool and has the majority of the information concerning locations of health care practises for uninsured migrants, costs of medicines and treatment procedures.

A large impact that the internet can have for undocumented migrants and their relationship with health care in Amsterdam which may hold importance, is using the internet as a tool for online diagnosis. This can be done before contacting a doctor, especially if resources such as accessibility and finances are an obstacle. This can be done after a doctor’s consultation for a ‘second opinion’. Another reason, apart from convenience - such as 24 hour availability and (relative) free cost, is that the health information can be sought anonymously. This may be very appealing for those who are embarrassed or ashamed concerning their mental or physical illnesses, or the stigma of illegality and attending such designated clinics. Online health sites can be more preferable for those who are seeking care for sensitive issues. Online web searches also entail their own privacy issues such as consulting with a web doctor and having personal records stored online - this may be a discouraging factor. Another hindrance may be the potential credibility of online medical information and the validity of the websites (Miller and West, 2009). Miller and West (2009) state that in an American context, with the rising cost of health care the current trends suggest that the rise in the internet as a source for medical care for select groups will increase. This comparative was reflected upon previously with the contrast of undocumented migrants to the Linkage Act and those to Obamacare.
4. Conclusion

Elias (1994) outlines: “Give a group a bad name and they are likely to live up to it”. If a state deprives a created category of Bed, Bath and Bread and they will become unwashed, poverty stricken, and may engage in illegal activities in order to obtain an income. The created and maintained power hierarchy often results in a self-fulfilling prophecy. This thesis proposes to analyse the current situation at play due to the Dutch state excluding undocumented migrants to health services. The exclusion based on stigmas are manifested in the Linkage Act 1998; I will focus on the impact of this legislation to health services, how are they being utilized by undocumented migrants. I have illustrated the vulnerability that undocumented migrants in Dutch society face, thus illustrating why health care, such as psychological services, are important. The first reason is due to the precarious migration conditions to Amsterdam and their living arrangements after their rejection by the IND (Immigratie- en Naturalisatiedienst/Immigration and Naturalization Service) which often comprises of little human rights such as basic food and shelter. A second need of access for health care and utilization is due to undocumented migrant’s marginalization in society. There can frequently be a lack of group cohesion, which is required to enable social support and acts as a network for vital information flows such as jobs, and more importantly in this context, health care. Social cohesion is the basis of power attainment and maintenance. Lastly ensuring efficiently trained staff within healthcare is important as complications during access may arise; various concepts of gender and in defining potential reasons for ill mental health. It is important that the Dutch healthcare system understand if their services are fit for purpose and are being delivered efficiently, in an ethnically appropriate way.
Chapter 5: Research Design

1. Conceptual Framework

Throughout my time researching this subject, understanding the sensitivities involved was something that I had to remember to keep in mind. Confidentiality was critical to enforce throughout the data collection - for both my observation of doctor’s consultations and my undocumented respondents identity. This confidentiality was in order to gain trust with my respondents as both the issues of illegality and health, particularly mental health, can be very personal topics and they must be treated with empathy and understanding.

Qualitative methods were selected as they offer a “thick description” of the respondent's social world (Hughes 1993). Qualitative methods do offer limited applicability through findings however to gain an in-depth understanding of the treatment received by undocumented migrants I knew that this was the right method approach to take. Qualitative methods offer the necessary flexibility to look at the wide range of factors involved in the production of disproportionality. I wanted to understand the situation and the viewpoints from the actors involved rather than to generalize. I completed both interviews and observations in order to complete triangulation, to ensure I understood it from more than one standpoint. My respondents had the ability to speak freely about the health service in interviews yet I was also able to see it in deliverance through my observational research. This was in an effort to overcome the weaknesses, such as a limited perspective, that can coincide with using a singular method. Kruispost, a free health clinic in Amsterdam, was important to choose as one of my locations of study as the opening hours were both during the day and at night - which does not limit the possibilities for those constrained by working hours.

I studied this issue from a macro-policy level perspective, through to a meso-institutional level perspective, to a micro-individual one; I studied the English translation of the legislation and NGO publications to ensure that I didn’t misinterpret any statements. It is understood that qualitative researchers inserts themselves into the research due to observational participation and through interpretation of situations; it is undeniable that my influence of this research is marked upon the findings. Due to my limited time scope I understand that my
sample was not representative of all cases of undocumented migrants and their access to health care. I also conducted purposive sampling to ensure relevance due to my limited time.

In the following analysis, historical, theoretical, and ethnographic lenses will be used to examine the links between the The Linkage Act as a policy, the policy practitioners and their understanding and implementation of this policy and also how implementation impacts undocumented migrants in both mental health and physical health. Through my research I began to understand the strong correlation between physical and mental health. Self-harm, substance abuse and an overall unhealthy lifestyle are common among those with ill mental health; this has been described as ‘co-morbidity’. It is imperative that the situation is better understood due to the rapidly developing context of reception in Europe, it therefore needs to be studied further in order for the situation to be adequately dealt with and services to be sufficiently delivered. An integrated delivery of both physical and mental health services has been prioritised within the United Kingdom’s Department of Health in recognition of their mutual influence. I hope that my thesis will attribute to this awareness within the Netherlands (Department of Health, 2011).

Table of Respondents

<table>
<thead>
<tr>
<th>Name</th>
<th>Participant’s Role</th>
<th>Type of Data Collection Used</th>
<th>Location of Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vincent</td>
<td>All Included NGO Owner</td>
<td>Face to Face Interview</td>
<td>Vincent’s Home</td>
</tr>
<tr>
<td>Sarah</td>
<td>Social Worker at Kruispost</td>
<td>Phone Interview</td>
<td>Me: Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sarah: Kruispost</td>
</tr>
<tr>
<td>Saeed</td>
<td>Undocumented Migrant</td>
<td>Informal Interview x3</td>
<td>Vluchtgarage (His Home) x2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kruispost</td>
</tr>
<tr>
<td>Bakker</td>
<td>Undocumented Migrant</td>
<td>Informal Interview</td>
<td>Vluchtgarage to Equator Foundation</td>
</tr>
</tbody>
</table>
## 2. Interviews

My interviews were both semi-structured and unstructured. My first interview with Vincent, the owner of the NGO that I volunteer for, took place in his kitchen while he was looking after his two young boys. As Vincent knew the topic of my thesis I didn’t arrive with an interview guide and I let him discuss the topic freely, adding what his interpretation of the situation was and what he thought I should know and focus on. Another interview that I completed was with a social worker in Kruispost; this was conducted over the phone when I wasn’t expecting the phone call so this was not recorded and it was unstructured; I allowed her lead the majority of the interview. The other interviews were conducted in the respondent's office; this was in order to gain more information where possible - such as

<table>
<thead>
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<th>Name</th>
<th>Position</th>
<th>Method</th>
<th>Location</th>
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<tbody>
<tr>
<td>Dr Co Van Melle</td>
<td>Doctor at Rainbow Group</td>
<td>Informal Interview</td>
<td>Consultation Room in Rainbow Group</td>
</tr>
<tr>
<td>Harrie Herrfs</td>
<td>BBB’s manager of care and policy advisor for the NGO HVO-Querido</td>
<td>Face to Face Interview</td>
<td>Night Shelter</td>
</tr>
<tr>
<td>Karin</td>
<td>Social Worker at Rainbow Group</td>
<td>Face to Face Interview</td>
<td>Consultation Room in Rainbow Group</td>
</tr>
<tr>
<td>Mussa</td>
<td>Undocumented Migrant</td>
<td>Service User at NGO All Included</td>
<td>All Included</td>
</tr>
<tr>
<td>Karel</td>
<td>Legal Advisor at ASKV NGO</td>
<td>Face to Face Interview</td>
<td>ASKV</td>
</tr>
<tr>
<td>Oukje</td>
<td>Psychologist at Equator Foundation</td>
<td>Phone Interview</td>
<td>We were both at home</td>
</tr>
</tbody>
</table>
information booklets. This was also to ensure that they were comfortable and to lend for more time, as no commuting would be necessary.

I accessed my respondents initially through the refugee NGO ‘All Included’ for which I have volunteered throughout my studies. I considered myself very lucky to have been introduced as a colleague to many of my participants through Vincent. I felt that this improved how I was perceived in the eyes of the undocumented migrants; I hoped to avoid coming across as ‘another wealthy, white and privileged student studying them’. In order to complete the research to its fullest potentiality I needed to gain trust and respect from my respondents. I tried to conduct a mutual performance in which we both conversed and held a social meeting and not solely me asking questions and probing for answers. A lot of my encounters snowballed through this connection; however I did ensure that I contacted NGOs outside of this network to try to expand my scope, thus not limiting my selection of respondents. The time limitation impeded my scope; I could not follow through and complete a full analysis of my respondent’s treatment and therefore cannot give a fair judgment of the delivery and quality of the health services. There was purposive sampling as I was put into contact with undocumented migrants who were in the process of attending health services.

I also had the experience of talking to social and psychological service providers about their understanding and experiences of the situation. It was evident from the policy analysis that the situation in terms of regulations and procedures was developing; therefore I felt that quantitative research would not offer me the in-depth analysis that was required to understand the true interrelationship within the services. This was evident in service providers also as they too were trying new treatments and had to explain the reasons for these changes to me in depth; I feel that quantitative data collection methods could not offer me this possibility.

3. Participant Observation

I completed participant observation while carrying out my data collection. I attempted and succeeded in ensuring that behaviours were relatively natural throughout this participant observation. This is imperative in ensuring validity. I found my observation to be very beneficial as it was less intrusive than conducting an interview with undocumented migrants; spending a few hours with Saeed led me to see the true hidden activities such as substance
abuse - which may not be disclosed in a formal interview with a representative member of the We Are Here group. A greater breadth of coverage was obtained; whilst I spent time in his living quarters within the Vluchtgarage and Vluchttoren, I meet his friends and those who he spends time with whom are also within the We Are Here group. Throughout this observation Saeed shared with me many life events that aided my understanding of his present circumstances. I also learnt the daily activities with which he fills his time on a daily basis. I studied Saeed over a few months and learnt about his experiences within the Netherlands over the last seven years. I learnt about his expectations and hopes concerning his upcoming surgery, how he experiences and perceives both physical and mental health services in Amsterdam. I escorted him and another member of the We Are Here group to medical appointments. Through this I also liaised with two of his advocates and received his files from doctors and psychologists, as I began to take over the role of his ‘backer’.

Drawing from the observational research based upon the Chicago School tradition which allows and acknowledges that “social life is not fixed, but it is dynamic and changing”; therefore if one is to truly understand someone’s life they must get involved, participate, record what affects them and how they make interpretations of events (May 1993).

4. Limitations

One limitation which I endured frequently was the linguistic barrier; state policies, service provider’s annual reports and encounters with migrants within the services to name a few could not be understood as they were predominantly in Dutch. As an Irish immigrant I have no Dutch, I had to hold all communication, if it was possible, through English. Throughout my data collection, none of the participants I encountered had English as their first language; this is a hindrance of self-expression and clarity, within both doctor's consultations and in interviews.

Another limitation that may have hindered my data collection was researcher bias and personal influence. I myself am an uninsured resident in the Netherlands, and as I am currently working, this too is deemed illegal. While residing in Ireland this did not seem to shock me, since many families cannot afford health insurance. There is a system of ‘Medical/GP Cards’ which lower and waiver some costs for very low-income families.
Going to visit a doctor was normalized as something that was only done in severe cases due to high costs; most GPs in Ireland are private practitioners. In an Irish Government study it was found that 26.3% of fee paying respondents had medical problems in the previous year but had not consulted a doctor due to the cost (O'Reilly et al, 2007). I therefore moved to the Netherlands with the presumption that the perspective of healthcare access would be similar to mine.

During my time as a student in UvA I attended the student doctor, I was deterred due to the high costs as it was an emergency however, I attended and the payment was postponed. This occurred again but I was already in debt to the student doctor. I attended Kruispost as my study observations left me familiar with opening hours and the small costs endured. As an uninsured Kruispost patient, it left me with a shared experience to hold a basis of understanding. I understand that my respondent’s situations and mine are completely incomparable; however I feel that my immersion in the field may lead to bias. I took the role of ‘the other’ in attending this clinic and I may be able to further understand the meanings which are attributed such as the concept of the ‘not me identity, in which I felt also that ‘I did not truly belong there’ as much as others did. It produced a deeper emotional understanding for me and may have reduced the researcher distance.

5. Data Analysis

To analyse my data I completed theoretical thematic analysis; throughout the review and conclusion of my findings I ensured to use my completed literature review and selected grounded theory to back up my data. I was continuously looking for the answers and themes embedded within my data set through my analysis; I ensured not to simply use the questions that I put towards my respondents as themes. It was a recursive process, the constant state of moving back and forward between my entire data collection, my data set and the piece of analysis that was in production (Braun & Clark, 2006). The policy texts were studied and I sent emails to the publishers and institutions involved to clarify any potential misunderstandings. I discovered the important aspects and influences from an emic perspective; I tried to have no presumptions before entering the field. I labelled interesting, surprising and influential features with specific codes and allowed the themes and concepts embedded throughout my collected data to emerge. Progressive Focusing was completed, as
both during and after collection, I would find new relationships and ideas that are to be explored. It was difficult to decide when I had collected sufficient data to conclude and answer my research questions adequately.

Upon my thematic data analysis I shared my data explicitly and referred to my supervisor and fellow students in order to receive feedback and different perspectives within my data set. I continued to look at the web of interrelations throughout my data set; such as the influence that ASKV had (a migrant NGO in Amsterdam) while referring undocumented migrants to the Equator Foundation (a psychological trauma clinic), who then refer these migrants back to Medisch Opvangproject Ongedocumenteerden/Medical Care Project Undocumented or ‘MOO’ which is a subsection of ASKV; in what is known within the Amsterdam NGOs as the ‘aliens chain’. In my analysis I aimed at interpreting the transcribed texts in assisting to explain roles and importance of each player within the web of actors in these services; how each played within the role of influencing and constructing the present situation. Who influences the discretion levels used in providing the services, what actors push the boundaries in admittance to psychosocial services? What are the causal explanations for the previously outlined increase in exclusive policies? How does the information of available psychosocial supports flow amongst the networks and are there any hindrances blocking the knowledge of services?
Chapter 6: Analysis

1. Arriving in Amsterdam

This section will discuss an undocumented migrant’s first encounter with medical care through such avenues as the IND and their perception of urgent medical treatment and the permission to remain on medical grounds. This section will further discuss how an undocumented migrant can first obtain medical care. Upon arrival in Amsterdam, many irregular migrants apply for asylum, as it is increasingly difficult to live in the Netherlands without papers as ‘black work’ is becoming scarcer due to strict legislations being passed. During an interview I conducted, Vincent – mentioned NGO owner, explained that when a migrant applies for permission to remain, the asylum process takes an average of eight days and that during this time they are entitled to full medical care. If they are granted permission to remain, they then receive full access to social service. If they are refused asylum they are left to the streets. If the asylum application is a medical application on such grounds as a sight-threatening eye infection or severe PTSD (Post Traumatic Stress Disorder), the Dutch immigration services determine whether it is financially wise to treat the infection or to deport the migrant. Vincent continued to explain that a second factor taken into consideration is whether the medical care required is available in their home country. It has been stated in my literature findings that if a migrant is deported due to the IND’s (Immigratie-en Naturalisatiedienst/Immigration and Naturalization Service) determination that the medical care is available in their country of origin, there may be large societal barriers that block the migrant from receiving that treatment. Karel, ASKV’s employee, added to this by explaining:

I remember one case, a woman from Burundi, who clearly had well documented psychiatric difficulties but the IND and subsequent courts ruled that she could be sent back as in Burundi there was exactly one psychiatrist active in the country who might be able to help her. That is a country of several million (ten million) where half the population or god knows how many are heavily traumatised by the genocide that took place. Availability is a rather relative term. If a court can rule based on one psychiatrist being active in the country then how available is medical care.
As illustrated, it is a relative term as many of the services that are available and are considered basic treatment in the Netherlands are difficult to access or almost non-existent in their sending country, such as dentists or specialised midwives/gynaecologists. Therefore it can be too difficult to measure accessibility: this also makes it difficult to argue the hypothetical situation in a court ruling as to how a migrant would be unable to access these services if deported.

Migrants can obtain legal status on temporary medical grounds, as Karel during my interview, looked through his files and concluded that ⅓ of all cases that were closed in ASKV’s psychological department ‘MOO’ (Medisch Opvangproject Ongedocumenteerden/Medical Care Project Undocumented) received a legal status. Karel did state that what is considered imperative enough to require permission to remain is random. When asked as to whether migrants over accentuate their illnesses in attempt to be granted permission to remain, he concluded “of course! There’s no doubt about that!” this could fuel any potential scepticism in the medical or immigration sector. If a migrant is refused a legal status, many of my interviewees concluded that Kruispost is usually a migrant’s usual first point of call when in need of medical care. Kruispost is a free walk in clinic specifically for uninsured patients, it is well known in the Amsterdam area. Once they arrive at this clinic there is a high level of referrals to more specialised health practitioners.

Upon my visit to Kruispost, the majority of patients were killing the incredibly long waiting time for a consultation (one hour at least) surfing the internet on their smartphones or tablets, Saeed included. This led me to conclude that information concerning these (almost) free clinics are likely to be obtained for many online. The use of smartphones was also frequently seen in the Vluchtgarage.

2. Physical Health Access

2.1 Saeed Nasser Qadi

I was arranged to meet Saeed through the NGO, All Included, which I volunteer for. My manager was aware of my thesis topic concerning health access and Saeed had used the NGO’s services before. I was to escort Saeed to Kruispost. Saeed, at that point, had a pain in his lower stomach for about two months and had found it difficult to eat and digest food. He
had visited a doctor previously concerning this yet had no GP which he attended who knew his ill health situation. Saeed was to have a surgery in the Amsterdam Medical Centre (AMC) for his stomach pain, in which a surgical camera would be inserted to further understand the root cause of the pain. I was to bring him to Kruispost to see if the doctor could liaise with the Amsterdam Medical Centre (AMC) in relation to the cost as Saeed was being told by the medical staff that he was to cover the medical bills. We were also hoping to get a prescription for medication to aid the pain and other health issues until his surgery date. The number that Saeed left for me in All Included to contact him for our meeting was incorrect. When I did receive the correct number, the date and time was set for our meeting. He did not show for the appointment; I left voicemails and text messages but I didn’t have any communication. I waited for half an hour outside Kruispost and then left.

I called Saeed and he invited me to the Vluchtgarage for a party before the police eviction took place. I met Saeed for the first time at the train station. He was in his late twenties, dressed in urban, hip-hop affiliated clothes. He was quite short and very friendly, thanking me for visiting his place and offering my help to him in relation to his medical circumstances. Upon visiting Saeed’s place of residence within the Vluchtgarage, he stated something upon walking me in to the entrance that played over in my mind “there are mad people and great people here, a total mix” however he continued to emphasize this in a negative and apologetic manner while walking around the premises. We entered via a broken window on the ground floor, where Saeed slept. He did not belong to any of the rooms upstairs which were divided by nationality. At the beginning of our encounter, he showed me his identity card from We Are Here, the self-organised undocumented migrant group. Which had his age listed as 27, name, and nationality which was declared to be Somali. This Somalian nationality concurs with Vincent’s NGO records. Saeed expressed later however that the IND refused his application status as they did not believe his claimed nationality; the IND based this on suspicion and followed this by a voice test to define his accent. Saeed later that day, after explaining his disgust at the IND for conducting these tests and refusing his asylum application, outlined that he considered his identity to be Saudi Arabian. He grew up in Saudi Arabia and some of his family still live there.

Saeed showed me around the Vluchtgarage, room by room, introducing me to the residents who continuously offered me tea and coffee and to sit down and chat. Saeed pointed out the dangers in the buildings and explained how the walls were moulded due to dampness, which I
could see on the ground also. The cooking conditions, Saeed declared, were incredibly dangerous due to the use of camping-style gas cookers which are described as being frequently left on. I was told about, and could also see, the incredibly poor sanitation. The food, he stated, was unhealthy and rotten and he declared it to be inedible. Saeed stated the underlying reason for his ill health was firstly the lack of sanitation and secondly the daily encounters with stress which he faces. He stated the stress originates from the fights he has with other residents and that they have amongst themselves which creates an overall negative living atmosphere. Other stress origins arose from his asylum procedure and the frequent contact with the police. Saeed explained how the police stopped him for various reasons due to ethnic discrimination, and that once finding out he had no papers - would bring him to the police station and detain him in a cell.

Saeed states that throughout his entire residency in the Netherlands that he has never paid for any medical expenses during his visits to doctors and hospitals. This was mirrored in Vincent’s refusal to contribute financially towards Saeed’s surgery as he stated that the hospital would inevitably pay for the costs, that just first “They always put pressure on the person to organise the money”.

2.2 General Practitioner Access in Amsterdam

My three experiences in Kruispost and the Rainbow Group consultation hours led me to understand that accessing a GP (General Practitioner) without cost was relatively attainable in designated centres for those without insurance. Dentists and other specialised medical staff practise within Kruispost on a regular basis also. A small donation in Kruispost was advised but I have experienced on every occasion that it is not necessary. A 5 euro charge for medicine may be required in certain pharmacies, but a patient could travel to a designated one that Dr. Co Van Melle, a voluntary doctor a Rainbow Group, advises of. Within Kruispost there are price lists on the walls - which stated that a consultation was 5 euro and charges varied for different treatments. Upon me and Saeed’s departure after the consultation he stated that he didn’t have the amount and left. A consultation for an EU citizen was EUR 25 as employees in the practise stated that all EU citizens should have insurance and thus they need to pay more, yet on my visit I too didn’t pay for my consultation. The Rainbow Group did not charge patients for visits to Dr. Co Van Melle.
Both morning and night consultations in Kruispost were held, which allowed for those with
different schedules to avail of medical care at ease. Vincent explained that approaching state
run health centres as the GGD (Geneeskundige en Gezondheidsdienst/Health Service) for
their limited treatments such as Tuberculosis vaccinations or AIDS testing was something
that would not deter an undocumented migrant. The Linkage Act states that a policy
practitioner (such as a health worker) can, but is not obliged, to report undocumented
migrants to the IND, yet I hadn’t heard of this at any point throughout the research. It seemed
that accessing a doctor was attainable, however within the consultations I began to see some
inefficiency and that the best practises were not in place. I joined Saeed in the Kruispost
consultation room, he explained his symptoms and the doctor completed a quick examination
and a few lifestyle questions such as eating habits, smoking and drink use etc. were clarified.
Saeed outlined that he was a Somalian and a Muslim and thus does not smoke or drink, yet I
had seen him do both. Drugs were prescribed yet Saeed then explained, in frustration, that he
had various packets of drugs already yet nothing was working; his upcoming surgery and
former doctor visits were then explained in detail. The doctor considered this, as he had not
yet known about his current medication use, and prescribed stronger medication.

The confusion of multiple courses of medication and no clear indicator as to the root cause of
his illness frustrated Saeed. There seemed to be no clear path of medication and road to
recovery provided by a medical centre and followed by Saeed throughout his treatment. The
doctor assured Saeed that if he was to eat three times a day, regardless of whether he feels he
can, he would feel much better. No reason for the cause of his illness was given; when Saeed
asked further inquiries about his illness the doctor gave no response and avoided the question.
This mirrored my experience in the Rainbow Group consultations; I observed for two hours a
walk in doctor consultation; each lasting no longer than five minutes. Each time drugs such as
codeine, Valium, antibiotics and other pain killers were given, however no in-depth
consultation in order to find the root of the cause of illnesses took place. This can also be
drawn upon Vincent’s explanation as to the minimum help delivered in health services such
as dental care; “the dentist would probably not fill a hole but they would take the tooth out,
the minimum work is done”.

The aforementioned closing down of a medical centre in order to pressure other doctor’s
private practises to begin to treat uninsured patients illustrated that there is tension within the
medical sector as to who will treat the uninsured: “I think the arrangement, that people can
also choose to go to a normal general practitioner, that would be very good. A lot of people choose to stay with Co so that’s fine.” (Karin, Rainbow Group). It seemed very difficult for an undocumented migrant to attain a consultation in a private practise. The voluntary organisations, which many opt to, seemed too busy to deliver best practise. The funding can also be insecure, the Kruispost practise is in the middle of the Red Light District which eludes to shabbiness and the building seemed old and partially run down. Referrals of undocumented migrants to a medical specialist, like Verbruggen (2001) outlined, are frequently refused as there is little understanding of the Linkage Fund and the access to its finances. If the application process for funds are explained and understood, then a medical specialist may not want to fill in the paperwork and refuse care on those grounds.

Overall, my experience of undocumented migrants and their access to physical health care was that it is the independent, predominantly voluntary. Actors who ensure that it exists. Dr. Co Van Melle’s practise is explained by Karin:

The patients are very fond of Co. A lot of the patients are very dependent and they really need him for their medication. Co gives out different medication than they do at the GGD, so that’s another reason why they opt to go here also. When they can’t get their medication from a doctor they buy it on the street - it’s quite unpleasant and it can lead to a lot of trouble.

This can result in doctors having to be able to see the good work that is being carried out and ‘the wood from the trees’; as to whether patients are attending due to truly being in need, or whether - like Karin outlined, homeless drugs addicts are using Dr. Co Van Melle in order to not buy addictive drugs from street dealers. Another example is Kruispost waiving their financial donation policy for consultations when truly needed. What has been illustrated is that voluntary organization are in practise in order to stop marginalized Dutch residents being further pushed into precarious situations. Private practitioners do consult undocumented migrants yet there are few; reasons being that they are unaware of the Linkage Fund, or they would rather consult insured patients for reasons of ease. The Dubieuze Debiteuren is also in use, as it was ultimately used to waiver Saeed’s surgical costs.
3. Mental Health Access

3.1 Saeed Nasser Qadi

Much like physical health access Vincent explained; “If it’s urgent – 112, if it’s not, then a GP. They don’t have to take uninsured patients, but they do exist. Kruispost have more contacts for long term treatment”. Within my meeting with ASKV, Karel explained how an undocumented migrant’s mental health worsens after their arrival to the Netherlands, which complements the literature that I had read. Saeed stated when walking around Vluchtgarage how hard it was to see his friends who lived there change over time. He outlined that undocumented migrants become bored in their lives, fed up with their situation and that the negative living atmosphere in the Vluchtgarage changes them for the worse. Those from low educated backgrounds or countries in the worse turmoil, such as Liberia, are the worst affected migrants for declining mental health he explained. This mirrors Torres - cantero et al’s findings, that once illegality is eradicated other societal inequalities transpire restricting equal access to healthcare. The longer he lived within the Vluchtgarage, the tenser it became he described - leaving every few weeks to stay with his brother in Rotterdam. Saeed stated that leaving the premises every few weeks was how he kept his sanity.

Alcohol and drugs that can decrease mental health fuel the tense living situation within the Vluchtgarage. Saeed proudly told me that he rarely drank and didn’t use drugs; it transpired however through his other residents, legal advisors and support workers that he has been suffering from alcoholism and his living situation had continue to decrease rapidly. After the eviction from the Vluchtgarage, I had heard that due to his alcoholism his aggression led him to be banned from night shelters. Vincent told me of him starting fights and his mental health becoming very unstable. This is an extract from Vincent’s email to the Equator Foundation psychologist which was sent in an attempt to speed up the intake:

As probably known Saeed been involved in incidents in the Vluchttoren, where he still resides. Overnight all his belongings were stolen, instigators found it was a traumatic incident in which he was injured and the police in Vluchttoren stated another resident has been shot. Saeed spent 2 nights at the Police station where he was questioned about his involvement and where he was medically examined. Then he was sent away again. His bloody clothing was seized for investigation. Previously, He also at Bed, Bath, and Bread location was involved in
a fight and he is not allowed back there. He cries himself to help because he cannot handle it anymore. I am surprised that the police sent him back into the street without treatment/care.

The response to this email stated that they cannot speed up the intake process, and only when the intake does take place can they then decide if any treatment will be given. A visit two months later to Saeed allowed me to witness his mental health decline personally. I was to take him and Bakker (another resident), from the Vluchttoren to the Equator Foundation. The Vluchttoren was the replacement Vluchtgarage due to the police evacuation. On my arrival Saeed seemed notorious in the Vluchttoren, as when I was asking to locate him people rolled their eyes and stated they didn’t know where he was. He was found in his bedroom still asleep and he initially refused to get out of bed. He seemed to be using substances heavily as he was not wholly coherent and sometimes staggered whilst standing. He was short tempered and dismissive. Saeed brought me to a room where he asked for money to buy a train ticket to get to the appointment - the person explained to me however that he always asked for money off him and they can no longer give him more. The Vluchttoren resident explained that every day he has to go ‘somewhere’ to see ‘someone’ who will help him but nothing is happening and we cannot keep giving away money like this. I did explain that I was a representative of an NGO and I was escorting him to the psychologist however he stated ‘he hears it every day’. Saeed became incredibly angry and aggressive - kicking, punching walls and hitting his own head etc., he was throwing his bag and items everywhere. I was highly intimidated and didn’t want Bakker’s appointment to be hindered by Saeed’s behaviour. I decided to leave the situation as even if we were to get money from the We Are Here finances I felt he wouldn’t have been willing to cooperate on the way to the appointment.

Saeed’s present mental illness is a partial outcome of his illegality, Saeed was refused as there is doubt concerning his claimed nationality to which he admits he doesn’t consider himself to be either. His decision of the refused refugee status was not overturned in his appeal. Due to the Dublin Convention 1990 he cannot claim asylum status elsewhere in Europe. Saeed told me personally that he is frustrated with living a half-life; he cannot work and yearns to have ‘a woman’ and a ‘normal life’. He has missed appointments in the Equator Foundation and Karol at ASKV outlined how his organization will not help people who they cannot see any potential success with. Saeed is banned from some night shelters. We Are Here seem frustrated with him and have previously kicked him out leaving him without shelter. This homelessness, substance abuse and mental deterioration are a partial outcome of
the IND’s strict stance on refugee admittance; this societal refusal seems to have led to anger issues and depression.

I witnessed drugs impacting people during my observation in the Rainbow Group. Karin explained how Co Van Melle prescribed medication that other doctors would not prescribe. Karin stated that many are dependent on these substances, and if Co Van Melle didn’t prescribe these that the other option would be to buy them on the street, off an illegal corner dealer, which can be stressful and troublesome. This substance use was evident within some of the patients I observed in the clinic; one patient in particular, which was disorientated and disruptive throughout several consultations - Co Van Melle, stated that he should ‘stop being sleepy’. Throughout my visits to the Vluchttoren and Vluchtgarage where the We Are Here residents live, I saw in every room men drinking and using drugs. I attended a church service which was held for the eviction, yet throughout there was constant disruption due to people under the influence of alcohol and drugs. It seems from the church service, the disruption in the Rainbow Group consultations, and Bakker’s delayed departure, that the influence of others substance abuse and mental illnesses can hinder and impact progressive and positive changes in other undocumented migrant’s lives.

3.2 Mental Health Service Accessibility

Upon arrival to Amsterdam - Karel, a refugee support worker in ASKV, explained that undocumented migrants (apart from maybe having normative personality disorders) can have specific mental health disorders which are particular to their group of migrants such as PTSD (Post Traumatic Stress Disorder) and other trauma induced illnesses. These mental disorders result in difficulties in telling a consistent story to the IND (Immigratie- en Naturalisatiedienst/Immigration and Naturalization Service) upon arrival. The IND bases their acceptance of asylum status on consistent, believable stories. Within my Equator Foundation interview with Oukje, a psychologist treating undocumented migrants, she stated that those with mental illnesses find it difficult to tell a consistent story as their memory is ‘all over the place’ and that part of the trauma is that they don’t want to talk about it: “I can imagine they make stories up as the real stories are too painful and embarrassing to tell and they are too scared that if their story comes out, people will know about it”. Oukje concluded that simply looking at the most consistent stories does not result in looking at the most
deserving; this is an issue that was discussed within my visit to ASKV also. It was discussed that the IND need further training in recognising mental health disorders in asylum claims.

Medisch Opvangproject Ongedocumenteerden/Medical Care Project Undocumented (MOO), which is a mental health division within ASKV and is stated by Karel to be the busiest mental health service for undocumented migrants. This service treats all forms of mental health illnesses, it has been around for longer than other mental health services for undocumented migrants resulting in it being more well-known. Karel explains how the most complicated cases are referred to MOO. They, alongside the Equator Foundation, accept patients on referral: this usually derives from an undocumented migrant attending a GP and exclaiming that they are not feeling well. A social worker in Kruispost explained to me that the doctor can usually recognise the symptoms of mental illness and will refer the migrant to a specialised service. The waiting list for MOO is presently a year and a half and all of Moo’s services are free. The ASKV provides in house care, where migrants can reside within the designated housing upon accepting treatment. Staff will call around, assist them with cleaning and household chores, ensure that they have money, that their legislative procedures are being reviewed and provide overall social support. Migrants can reside in these houses for a few months, usually eight, to ensure that others can access the service also.

To differ – the Equator Foundation specialises in trauma treatment; thus it does not extend its services to those suffering from mental health illnesses other than PTSD and other trauma related illnesses. If a migrant is diagnosed with a personality disorder, depression, anxiety etc. they will be referred to MOO. The Equator Foundation does state that if there is an issue that impacts an undocumented migrant’s functioning they will try to solve it. The support psychologists offer here are specific to the illnesses experienced by asylum seekers. The training the psychologist's receive are all while on the job, as Oukje explained that there are no mandatory courses in Universities for cultural awareness or training to work with translators. Cultural Sensitivity is the term used in the Equator Foundation to describe the specific and distinct trauma experiences that these migrants have:

Cultural sensitivity is how you come up with an explanation to what you’re suffering from. It differs from where you come from, what your family's situation is and how easily you can
talk about things, what kind of things you’re ashamed of also if you show your emotions or not. (Oukje, Equator Foundation)

Within MOO and the Equator Foundation there are no fees encountered for undocumented migrants if you are uninsured as treatment is received through the ZIN (Zorginstellingen in Nederland/Healthcare in the Netherlands). There are no strict rules of access as Oukje stated that there have been no issues experienced with ZIN and fee waiving. If an asylum seeker received permission to remain in the Netherlands then they will receive treatment in the Equator Foundation through an insurance company. Oukje from the Equator Foundation explained that there is a high level of bureaucratic processes to undergo if the fee is covered by an insurance company and complications often arise.

The current treatment plan within the Equator Foundation was only implemented in September 2014; it consists of a three month ‘stabilization period’ in which the migrant is taught the tools to be able to cope with their trauma and rebuild their mental health. The second period is ‘trauma treatment’; this is where the psychologist undergoes an in-depth treatment into the trauma that the migrant endured, this period which lasts six months was described during my interview with Oukje as being very distressful for the clients. The final period is the three months called ‘future focus’; these final months focus on any remaining psychological issues and concluding the treatment. Any psychological issues that are remaining are dealt with through referral to another psychological organization such as ASKV’s MOO.

A support structure is in place for undocumented migrants who are suffering from trauma induced mental instability, yet it can be seen within the data gathered that the limited time period available does not allow for many migrant’s to complete a full recovery. Those who still have ongoing mental health illnesses are referred, from the Equator Foundation, to other institutions. It was explained by the Equator Foundation that referrals to other institutions are highly problematic due to increasingly long wait lists within the medical sphere.
5. Barriers

5.1 Communication

One limitation that I encountered was the information flow of available services. Another potential communication hinderence I perceived was that between the undocumented migrants and the policy practitioners/health workers. A close knit connection within migrants by ethnicity was evident within the Vluchtgarage as all of the rooms were divided by nationality; this was a natural occurrence Saeed explained. If undocumented migrants reside within ethnic enclaves then cultural traits are preserved and less integration occurs. As Devillanova (2008) illustrated in the study of undocumented migrants and utilization of social services based on ethnicity that group norms and thus the use of services differ due to nationality.

I will now aid this finding of national utilization by (the critiqued) Trompenaars and Hampden-Turner’s (1997) illustration of cultural differences and how ethnic groups can vary in finding solutions in problems and dilemmas. Understanding that their findings generalized I hope that the theory will aid to understanding the context at hand. They list five dimensions as to how different cultures can differ in relation to each other. The second listed cultural difference ‘Individualism versus Communitarianism’, means to what extent a person regards themselves as an individual or as part of a group. As I may have found a large communitarianism culture in the Vluchtgarage, this applied theory can illustrate that if an individual residing within those premises is suffering from ill health, they may not see it as a priority to seek health care as issues which impact their community take preference. A second listed cultural difference is ‘Neutral versus Emotional’; this is applicable for psychological health care as it is concerns to what extent a person expresses their emotions. Trompenaars and Hampden-Turner (1997) explain that this expression differs by country, this is important for psychologists to understand in treatment, that if a migrant is not expressing their emotions as much as their Dutch client does that this does not mean that there is a lack of engagement, progress or further underlying health issues in the treatment.

To further illustrate communication flows being hindered from undocumented migrants to policy practitioners, the concept of ‘Attitudes to Time’ by Trompenaars and Hampden-Turner (1997) can be argued. They state that these attitudes differ by culture, which was a large
attribute to undocumented migrant’s mental illness - future uncertainty. Trompenaars and Hampden-Turner’s (1997) explicitly list the Dutch mentality as one of time being in a straight line, a series of events in which the past and future do not matter as much as the present. This differs to many other nationalities, whose timeline is described as being in a circle in which the past, present and future all interlink and affect one another. This argument would state that the understanding of time by policy makers and psychologists, as it is in a Dutch context, would predominantly be in a straight line. The future uncertainty which is heavily impacting daily life and attributes to the ill psychological health of many undocumented migrants and asylum seekers in Amsterdam must not be misunderstood and misinterpreted by solely viewing the situation from a Dutch linear perspective. Miscommunication and inadequate understanding may prevail.

Divisions within society of undocumented migrants can not only lead to miscommunication between their group and the policy practitioners and creators, but also this division can lead to barriers in communication flows between networks leading to the prevention of information which may be of assistance. As Saeed claimed to identify as Saudi Arabian and not as Somalian, he was not residing in any of the rooms designated by nationality, but rather on the ground floor in what seemed to be a room for individuals rather than an ethnic community. Saeed may therefore miss vital information through weak ties which can inhibit vital access to resources and upward mobility. Another issue concerning the impact that communication flows can have arose within my ASKV interview was that, as people often find out about refugee services through word of mouth - people may have very high expectations upon arrival due to stories of good fortune. Both high and low expectations due to stories of experiences within social networks can hinder the process of seeing healthcare, if there is a negative experience this may also deter an application for psychological treatment.

5.2 Private Practitioner Registration

A second hindrance to health care access for undocumented migrants that I encountered within Amsterdam was that many are not, and more importantly cannot, register with a private practitioner. This issue arose in both Rainbow Group and with Saeed’s case, was that undocumented migrants were hesitant to register with a GP (General Practitioner), and they continue to attend health care practises that are designated for uninsured patients. This can be
problematic if one’s health deteriorates as the health care practises that are for uninsured patients are run on a voluntary basis and can be more susceptible to staff changeovers, lack of funding and closure, as illustrated by the closure of De Witte Jas Health Centre’ in 2001. This was reflected in the Rainbow group interview with assistant Karin; she stated how one advantage for the sector would be if uninsured people would register more with a General Practitioner. She stated it’s important that they have the information that they can register as Vincent stated that he knew of a few within the Amsterdam area that do accept uninsured patients. Karin stated that they stay with Co Van Melle as they are familiar with his practise and are fond of him as a doctor; this mirrors the findings that it is difficult for those who undergo the transition to becoming undocumented as they have to alter their knowledge of services which are available to them. Although all GPs can accept uninsured patients, they often consider it to be too much hassle to undergo, as they are unaware of the bureaucratic procedure involved.

When Saeed was applying and preparing for his surgery it was a hindrance to not have a concise record of his doctor visits from one practice. Saeed stated that the reason for this was that he didn’t trust practitioners; he explained to me that when people promised him help and a resolution for his problems that he felt they were rarely delivered. There was no willingness of Saeed to register with a doctor due to his negative experiences when asking for assistance within the Netherlands, which may in itself, be evidence of little competency within the health and general advocacy sector. This may elude that even if Saeed can register with ease and be treated, that he may not be willing to. I may have witnessed this issue of inefficiency within the Rainbow Group’s health practise as there was a fast turnover of consultations and little time taken to find the root cause and potentially not uncovering the root cause of the illness- however as I only saw a few consultations through English I cannot generalise for the entire practise.

If an undocumented migrant is seeking mental health care for trauma, this can be obtained with relative ease within the Equator Foundation; the waiting list is around one month at the moment. The reason for this short waiting list is due to psychological treatment being limited to one year. This is restricted as previously it was stated that patients would frequently not finish the stabilizing period and were rarely ready to deal with the trauma that they underwent. This illustrates that many migrants are not receiving the satisfactory
psychological treatment, as they are not equipped with the sufficient tools to cope with their mental health.

Within my interview in the Equator Foundation, it was stated that it is very difficult for a migrant to obtain physical health care upon referral. My interviewee explained that it is well known within the office that if a referral is made for a migrant to go to a private GP, or a hospital for physical health care, that there are always complications. Many doctors are unaware how to file for the financial aid. As they, alongside many others, don’t know the answer to: ‘What is considered medically necessary?’ When a doctor arrives at the website, Oukje explained that the Dutch language used results in doctors being deterred in applying for coverage as it seems that the cases are never ‘severe’ enough. Google translates it as: Conditions in applying for the scheme: “The concern is, in the opinion of the healthcare professional, medically necessary”. In seeking further clarification I contacted the Royal Dutch Medical Association/KNMG’s (Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst) advisory board and asked what is deemed medically necessary; there was an ambiguous response and when asking for further clarification no answer could be obtained. Through my thesis research I could not find any clear and coherent answer from medical professionals as to what is medically necessary. Within the Equator Foundation however it is understood to be something that is recommended, certainly something that is very far from a life or death situation.

5.3 Other Existing Barriers to Efficient Medical Care

Another hindrance to medical care for undocumented migrants was the situation concerning, what is referred to as the new 5 euro rule. This rule has resulted in a 5 euro cover charge required by the Dutch government for all purchased medicines. There was a ‘Medicine Pot’ introduced to ensure that those with very low finances can still access their required medication, even if they cannot afford the 5 euro. Karin stated in Rainbow Group that there are still many issues surrounding this, in which pharmacies are refusing to give medicine without the 5 euro cover charge. She stated there was very little communication within the different institutions about waiving the 5 euro change which leads to constant issues and that “the interests of the best healthcare practices were not in highest importance”.

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Within the Rainbow Group office there was a large glass window which led me to feel that the doctor/patient confidentiality did not apply to this practise. The office stood close to Centraal Station in Amsterdam which resulted in a busy street outside, many pedestrians peered through the window and people were loitering by the door. There was, at times, little privacy due to the large window looking out to the busy street and disturbances from other inebriated patients coming into the room. Another issue within consultations was that Dutch was not undocumented migrant’s first language resulting in barriers to both physical and psychological consultations. Migrants are hindered in expressing and describing their symptoms. Translators can be sought however important details can be lost in translation. Bakker had little English or Dutch; this was why I was required to voluntarily bring him to and from the Vluchttoren to the Equator Foundation. This again illustrating that although trauma related medical care can be sought in Amsterdam without charge for undocumented migrants, voluntary assistance is still heavily required for many.

Obtaining permission to remain on medical grounds was stated by Vincent to be quite difficult as even if it is received it is constantly reviewed and is not a permanent solution, something that Saeed pressed as being of utmost importance. Karel however showed me within the system how ⅓ of their clients from MOO received permission to remain on medical grounds, it is important to note that these are pre-selected migrants already within the medical sphere. The IND were previously noted in literature as not taking a migrants ill health into consideration: when proposing this to my interviewees, there was a mixed response as to whether they have seen any improvements first hand or have heard of any being put into practise. Karel outlines that many asylum seekers are still refused due to unrecognised mental illnesses:

these are people who might very well have had their request for asylum denied because they were unable to present a coherent story, as the way that the IND look at an application is very much revolving around consistency.

6. Chronological Advancements

One improvement that has occurred is, Karel explained, is an increase in the Government’s recognition for ASKV’s services, this has been shown through a rise in funding. The Dutch
Government don’t offer any daily social support services for undocumented migrants, yet now they are actively referring to ASKV’s services. Karel stated that their active use of the services indicates the recognition for the need of these. He hopes that the scale of the problem is now becoming recognised and most importantly a solution to the cause is forthcoming. There are many traumatised people on the street who cannot continue to live homeless for societal health and safety. Subsidies are made for MOO’s housing unit and Government housing units are being availed of by undocumented migrants; Vincent is acquainted with a lady who lives in the Netherlands illegally and is currently residing in Government housing: “there’s a lot of traumatised people on the street so it’s in the interest of the council so that they can help the people and get them off the street.” This is a positive possibility for those who have little potential of legalization and have ill mental health - that a long-term Government housing is a possibility, as MOOs housing is short term. This possibility was only known in Amsterdam as Vincent was unaware of the situation nationwide; he outlines that the situations like these social services for undocumented migrants is dependent on how much investment the city council is willing to designate.

Many social movements have also recently occurred. Within Amsterdam there are various institutions willing to aid undocumented migrant's situations, such as Fisher Advocates, who complete pro-bono legal aid within the Vluchtgarage. The Bed Bath and Bread movement, started partially by Fisher Advocates, is also a positive movement for basic human rights for undocumented migrants in Amsterdam, as one would struggle to keep mental stability without such fundamental necessities. Night shelters were created in response to this movement, such as those run by Harrie Herrfs.

The IND was stated by Karel to have been more considerate and observant towards migrant’s mental health during the asylum application process, to ensure that a diagnosis is detected if required:

Some improvements have been made in recent years in terms of being more aware of it, being more observant and diagnosing at an earlier stage of the application process; as to whether someone might have mental difficulties or not.

Another institutional movement has been the wavering of the 5 euro for uninsured non EEA migrants within Amsterdam by the Medicine Pot, further ensuring that medical care is
available for all regardless of residence permit or income. The Equator Foundation have recently approached the Government, on behalf of ARQ (Psychotrauma Expert Group), to try and have the awareness raised of the ZIN’s (Zorginstituut Nederland/Care Institute Netherlands) procedures and accessibility for financial aid in order to treat undocumented migrants. The Equator Foundation has also requested for an increase in funding to have the ability to expand the number of the current patients in treatment. IMMO (Institute for Human Rights and Medical Research) is an independent body that has taken the initiative to complete medical research on behalf of undocumented migrants. This completed research is in order to give clarity and back up claims of inconsistent stories, and also hopes to assist in the positive outcomes of appeals on behalf of undocumented migrants.

5 Social V.S. Psychological Problem

5.1 The Impact of Diet and Nutrition

Saeed further outlined during my observation that he does not eat properly and that he carries around a large amount of stress on a daily basis. Anxiety, stress and other mental burdens can lead to loss of appetite. An unhealthy diet or under-eating will impair both one’s physical and mental health. It is outlined that prolonged under-eating may result in irrational thinking, depression, panic and obsessive behaviour. Many studies of under-eating focus on anorexia nervosa or bulimia, I cannot conclude as to whether my respondents had an eating disorder; yet a prolonged unhealthy diet will impact one’s physical health. The body will not be provided with enough nutrients and cannot maintain a state of fit mental and physical health. “Your personality, thoughts and feelings are directly affected by what you eat” (Jade, 2009). To apply this to the studied context, undocumented migrants may be eating too little either due to ill health or inaccessibility. Saeed stated that organizations bring food and drink to the Vluchtgarage but they are inedible or unhealthy, Saeed explained how he doesn’t eat the donated food, he gives it away.

GP’s are noted to recognise ill mental health; this may have been the case in my visit with Saeed to Kruispost. Although Saeed was suffering from stomach problems and ill mental health, the GP stated that the best solution was to eat three times a day. Saeed’s response
however was that he has no appetite and cannot eat. Not eating in turn can lead to a decline in mental health. Karel agreed that mental health declines for various reasons upon arrival:

Their precarious situation leads to mental decline. When there is absolutely no prospect of improvement after a certain number of years - this mess with people’s heads in an incredible way. This is something that we encounter very often.

### 1.2 Admittance to Support Services

An undocumented migrant is not always guaranteed help from NGOs which specialises in aiding refugees and asylum seekers. Within my interview in ASKV, Karel made it clear that if the organization does not see any possibility of a migrant obtaining legality, they will not offer any of their legal assistance and social support services to them, as they claim that others with a brighter perspective can miss out on needed help. The explanation was that migrants with little hope of legalization cannot be ‘helped’ and energy and efforts are considered wasted. It is admitted however that as ASKV is ‘the end of the road’ for many, this rejection of aid can be very difficult to come to terms with for undocumented migrants. This is not the same for MOO’s sector, which specializes in mental health, as migrants with the unlikelihood of legalization may still receive psychological treatment. This differs to the Equator Foundations psychological services that, alongside ASKV, state that they will not offer their services to migrants who are seen to have social and not psychological problems. The psychologist, Oukje, who I spoke to agreed with this approach. Oukje outlined that it is family separation, homelessness, the overall contemporary structural boundaries to resources that undocumented migrants face – that it is these structures which leads to depression and that counselling cannot solve these issues.

Another problem, within discussions, is that a lot of the problems are caused by social situations. That’s it’s not a psychiatric problem but a social problem – they’re living on the streets, they’re in a difficult position and that’s what is causing them to get depression etc. So you cannot treat it with psychiatric treatment, it’s a social problem that the government needs to solve, problem not a psychiatric problem. That’s what makes it difficult: It’s a bit true I think as of course these are connected as their situation does have an influence on their symptoms. (Oukje, the Equator Foundation)
The reason given was that the causes for ill-health will continue to remain after treatment. It was stated that the Government needs to solve this and not independent psychology clinics. This transpires into an issue of concern: undocumented migrants, who are considered not to be within attainment of legalization, are not given access to undocumented migrant support services. The boundaries of exclusion are drawn also within these organizations supporting some of the most ostracized from society; selective admittance can be seen both within the Government and NGO services.

The Dutch government have constructed illegality and put it into practise by restricting access to almost all resources and services. Irregular migrant’s having the ability to obtain permanent legality is being presented to society through the media as increasing in difficulty to obtain. This is put into practice through declines in the acceptance of asylum seekers. There may be a perceived level of undeserving concerning many undocumented migrants within the networks of policy makers, the IND and migration lawyers that is seeping through the networks down to street level bureaucrats and finally to support NGOs for migrants. The overload of work due to the lack of assistance by the Dutch government seems to be creating a hierarchy of deservingness within refugee NGOs and private institutions. It is stated within the Linkage Act 1998 that the right to legal advice is granted for undocumented migrants - yet ASKV, arguably the largest provider of legal advice for undocumented migrants, only offer their services to those who they see as being eligible. Other services, such as the Equator Foundation also incorporates this culture of selective admittance – it is stated that after their first interview/intake with the migrant, that only then it can be decided what services can and cannot be offered. If their psychological services are provided to the migrant, a limited time is designated for treatment due to many patients being too traumatized to complete the required treatment.

The manager of the night shelters with whom I spoke to outlined that when undocumented migrants are residing within the shelter allocated specifically for migrants with mental illnesses – they are within a relatively stable situation. Nonetheless he described that he has seen many migrants who are simply unable to be treated psychologically; that many of the undocumented migrants whom he has come in to contact with are ‘damaged’ and can never live a normal life. Night shelters may be a temporary solution for those who cannot reside within the Vluchtgarage due to their mental health, yet males can only stay in certain shelters, even though they are the largest demographic group. The reason behind separate shelters
exist, as confirmed within my interview with Harrie Herrfs who runs several night shelters, is that many women require the designated gender shelters due to former traumas which are frequently experienced which were performed by males such as rape and torture. Karel, the ASKV employee explained when discussing their houses available for undocumented migrants ... “a number of houses that are segregated; some may have been attacked by men and we need to provide for that.” This can aid to reinforce the societal perception that males are violent and a danger to women.

As previously outlined, Saeed explained that this damaged state happens over time to those in the We Are Here group, and that the main recognizable factor is substance abuse ranging from alcohol to class A drugs. He stated that accepting that his friends have changed is something that he continues to struggle with. The substance abuse and subsequent personality changes are possibly triggered by the boredom and frustration caused by the structural barriers to resources. Those from low educated or the more precarious sending countries, such as Liberia, are stated the worst to be affected by substance abuse and ill health. This finding reflects that completed in Madrid, Spain by Torres-Cantero et al. (2007). Physical violence was stated to occur on a regular basis, illustrating again how the living and, as Oujke argues, social conditions can have a negative impact on one's health.

6. Interplay of Actors

This section of my thesis will discuss the influence of the key actors involved in this context upon one another to summarise and reinforce the importance of the web of interaction and affects that they cause upon one another in society.

6.1 Policy Creators

The first within this section to be discussed is the influence that policy creators and practitioners have concerning their influence of the access for undocumented migrant’s access to health services. The main influence within this context is the Linkage Act. This administrative action can be reflected, as aforementioned, within Elias’ (1994) insider/outsider relations. Elias’ study can be applied as there may be unease when unwanted newcomers enter Dutch society. This unease could be grounded within a perceived change of
habitus or lack of resources, such as social welfare - due to a potential shortage occurring if unwanted migrants can access it.

Through administrative procedures the Dutch government have tightened access to residence permits and granting permission to remain for asylum seekers (Verbruggen, 2001). These restrictions will now be explained through Fassin’s moral economy of immigration policies (2005). What is the cause for the moving of the boundaries of deservingness? It is understood that the repetition of traumatic tales of war and anguish can lose their magnitude over time – this would be applicable in practise for policy practitioners such as those working in the IND of which an undesirable result being partial apathy and indifference of asylum stories. The boundaries of humanitarianism and politics begins to become more evident within the decision making process of granting refuge. The moral economy in relation to suffering or threatened human beings has been shifting in recent decades throughout Europe. As this thesis concerns undocumented migrants and their access to healthcare it cannot delve in to this complex stance of what the contemporary moral economy is in the Netherlands however it does not seem to be based upon medical care or political asylum. Upon reviewing legal refuge cases I came across an incident in 2014 when an Asylum Seeker fled from the Netherlands to Germany: according to the Dublin Convention 1990 he should have been returned to the Netherlands however Germany ruled that he could not have done so due to the risk of facing inhumane treatment by the Dutch government (DutchNews.nl 2014).

This treatment and exclusion of undocumented residents to basic social rights could be creating a new vulnerable group within Dutch society with high financial needs; such as legal, health care and detention costs. These detention costs are currently undergoing a cost reduction process resulting in migrants being left to live on the streets rather than being transported on charter flights to their country of origin. This forced homelessness, as many migrants are recognised as not being able to be sent back to their country of origin, has the potential to create highly precarious situations. These migrants cannot legally work and thus, within the eyes of the state – cannot legally provide food or shelter for themselves. This must either be provided for them through voluntary social services, or money must be obtained in illegal ways. Male migrants may be seen as having the ability to survive on the streets of Amsterdam, they could be presumed to have lived through worse in their war-torn sending country which feeds the ‘tough’ masculine identity. A stigma embedded within islamophobia
can create the ‘dangerous’ and male chauvinist damaging stereotype (if he is to be from a Muslim country of origin) which can fuel any justification for the creation of illegality.

The recognition of this mistreatment by the Dutch state and the impacts on the undocumented migrants begin to get recognition from the surrounding society. During the eviction of the Vluchthqarage, the media began to follow the ‘story’ and portrayed images of vulnerable people being mistreated due to no fault of their own. The illegality within the story was lifted from the undocumented migrants and the illegal actions were then placed on the Dutch government in a response to this mistreatment. The Dutch government in reply to this social movement taking place, to aid undocumented migrants within Amsterdam, opened more night shelters in order to show that these migrants are not left on the streets. This demonstrates the impact that different actors have had in Amsterdam through the demands of human rights. Through restrictive movements by the state, social movements are caused. Using the concept of stigmatization and the fear of the outsider I have tried to elude as to why the Dutch state is no longer providing care, and why such groups such as We Are Here are residing in such inhumane conditions.

Many undocumented migrants continue to reside on the streets however as residing in night shelters are refused, a permanent solution is demanded. Saeed stated that everyone has promised him a solution that they will fix his situation and offer him more prosperity in Amsterdam; but he stated that no one delivers their promise. Many migrants who have had their asylum procedure rejected are trying, alongside their legal advisors, to find different access routes. This created limited legality results in endless waiting and paperwork. Undocumented migrants living this limited legality can often live dysfunctional lives which can easily damage their physical health and cause long term damage to their mental health. As Harrie Herrfs has outlined that he has seen many undocumented migrants which are ‘damaged’ mentally.

6.2 Trust and the Medical Sector

This section will discuss the impacts that the policy creators and practitioners have had on undocumented migrants; how they have created a lack of trust and frustration towards state social services. Dysfunctional living in this context can incorporate boredom, substance
abuse, unhealthy eating, little exercise and stress and anxiety from unstable living residence. While completing participatory observation with the We Are Here group, Saeed told me that he finds ill mental health contagious in the Vluchtgarage. He frequently has to leave the Vluchtgarage to refrain from acquiring it. I saw this contagion first hand; Saeed’s episode of violence and disruption was a hindrance for Bakker when he was hoping to attend his first meeting with the Equator Foundation. Saeed slowed Bakker’s departure and caused a huge distress. If I did not make the decision for Saeed to stay behind due to the disorganization on his part, I fear that Bakker may have missed his psychologist appointment.

In my first and second observation I did not see Saeed as a substance abuser, as untruthful or as violent. He missed my first appointment with him however I gave him the benefit of the doubt and I believed his justifications and stories. He was difficult to get in contact with nonetheless. Then through emails, and in my last meeting in particular with Saeed, It became evident as to how his behaviour was. It seemed that all of the miscommunications and lack of punctuality had an underlying reason - a mix of his substance abuse, overall living conditions and his ill psychological state.

Saeed stated that the Vluchtgarage was causing him stress and anxiety yet he also explained how it was his home and that he will be incredibly unhappy when he is to leave. In his own words, he outlined that he will be devastated and will cry to himself. It is evident that he considered the Vluchtgarage his security and his home. It was one of his only stabilities and for this to be withdrawn from him evidently caused a high level of distress and further precariousness. As Goffman (1963) has shown, if a person has little feeling of self-worth due to a placed stigmatization of illegality, unemployment and ill health - to achieve motivation to better your situation can be difficult. For these reasons, even if health care is obtainable for undocumented migrants, it may not be obtained. Perceptions and norms differ within social networks; Saeed stated within my in formal interview that he doesn’t bow down to the white people like some Africans do, he doesn’t follow their orders and consider them above him like he sees some other We Are Here Vluchtgarage residents do. He states that he ‘sees through white people’s lies and false promises’, thus his perception of mistrust may not be shared entirely.

This was found within Verbruggen’s (2001) research that 50% of midwives in the Netherlands had come across an undocumented migrant who had no prenatal health checks.
Within the Linkage Act 1998, illegality is removed for midwifery services. It is therefore evident that even if there is no legal barrier, some undocumented migrants are not seeking health care when needed. Trust was highlighted to me as an issue by Saeed as to why he does not attend doctor’s consultations and check-ups. This is also heavily focused within Karin’s interview, that although uninsured patients can register with and attend other private doctors, they choose not to and rather stay with Dr. Co Van Melle as he is considered trustworthy. This lack of trust, as Saeed states, stems from authoritative personnel within the Netherlands putting these migrants in the ‘illegal and thus undeserving’ situation initially, followed by false promises of aid and assistance. To not have this medical support within your life when it is needed, due to constructed illegality, can ensue deterioration of health causing some migrants to need extensive state care due to them being a danger to society, such as specialised housing by the state government. This ‘danger to society’ can come in the form of severe mental disorders, with side effects such as paranoia and aggression, or by having severe physical health illnesses such as contagious infections and diseases.

6.3 Deliverance of Care

This section will discuss the impacts of the minimal care delivered by the state and the lack of trust within the undocumented migrants networks –how does this impact on the deliverance of care? The mistrust and frustration of limited legality may impact the psychological treatment that migrants are receiving; this may be in the form of missed appointments and a lack of cooperation through treatment, or the opposite - that the patients become reliant on the treatment. This is something that was highlighted by the Equator Foundation, that patients develop a dependency on psychological treatment. The duration of patient treatment was cut due to increasing waiting lists for treatment, both in MOO and the Equator Foundation. Waiting for a year and a half for urgently needed psychological treatment can be detrimental to one’s health, especially if they continue to reside within precarious situations. Yet the government is actively using the services, illustrating the awareness that undocumented migrants are living in precarious situations and some are desperately in need of psychological treatment. The services that offer healthcare to undocumented migrants are frequently run on a voluntary basis due to a lack of funding, the scale of this voluntary work can be illustrated by Kruispost which has eighty employees of which around seventy are volunteers (OudeZijds.nl, 2015). To conclude, there are
inefficiencies in the deliverance of care; the first is due to a lack of state funding which creates a heavy reliance on volunteers and societal good will and the second is the refusal of admittance by private GPs resulting in very long waitlists.

Little awareness of the Linkage Fund or Dubieuze Debiteuren for financial aid to treat undocumented migrants continues to exist. The five million within the Linkage Fund that medical care workers can avail of to avoid debt, is not an amount that was suggested to meet the demand, it was the amount that was saved from making it illegal for undocumented migrants to claim social welfare. This lack of awareness is hindering the voluntary run and specialist refugee services and explaining the application process is time consuming. Oukje explanted that institutions such as the Equator Foundation upon referral to physical health or more specialised care need to explain the Linkage Fund application procedure over the phone in order for an understanding of the process and potential acceptance. This is due to the ZIN not creating enough awareness. “Undocumented migrants are becoming more and more dependent on the few people who are willing and able to render these services, even though there are no juridical or financial obstacles” (Verbruggen 2001).

No training is given within universities for these specialized clients, the first contact a psychologist has with intercultural, ethnically sensitive and translation practises is on the job training. One of the reasons for undocumented clients for not completing treatment, Oukje explains, is the clients having psychologically ‘unfixable’ problems. I understand that when I ask an employee of an institution about their limitations of practise that I may not hear the answer that it is the institutions themselves who are incompetent to deal with problems at hand; such as undocumented migrants not being able to complete the ‘stabilization’ and other trauma treatments within the timeframe. The institution wants to maintain their funding and positive appearance. In an interview I am not guaranteed to receive a truthful portrayal and honest response by asking a psychologist within the institution being studied.

I understand that I, like the many others, told Saeed stated that I would help his situation as much as I could but failed to deliver any positive changes. This can be illustrated when I was to accompany him to his appointment in the Equator Foundation. As I also had to bring Bakker, who was ready to leave on time and did not impede or disrupt the departure, I felt that I could not wait in the Vluchttoren until he found money to commute to and from the Equator Foundation; Saeed’s psychological state hindered him reaching the treatment.
Yet when a positive outcome occurs it can ripple, giving hope and may even impact similar cases. The overall culture within the institutions which are not designated refugee organizations seems to be one of, what Elias would call ‘paralyzing apathy’: “The effects of this [mistreatment] on to the ‘outsider’ group [undocumented migrants], can transpire into paralyzing apathy by those within the dominant group due to it become normalized” (Elias 1994). This impacts goodwill volunteers who are overloaded with an unbalanced proportion of the undocumented migrants who seek health care; there is no juridical reason behind this, other than a culture within the private Dutch healthcare workers of not accepting uninsured residents.

How can the current inefficient situation, of undocumented migrants and their health, be improved? It can be improved by providing the undocumented migrants with stable living situations. One such way in which this can be achieved allowing migrants to work, former programs such as the Street Corner Cleaner program, which allows alcoholics to work as a street cleaner in exchange for coffee, beer and payment, has been stated as a success by the Dutch government (Leurs, 2013). It offers routine and purpose for addicts while in recovery, this can be replicated by offering undocumented migrants food, shelter and a small payment in exchange for their labour. Improving ones social situation can improve one’s psychological situation which is often correlated to a physical situation.
Conclusion

To conclude, many migrants who have had their asylum procedure refused are recognised by the Dutch state as residing in the Netherlands without having the right to stay and without the possibility to leave (Verbruggen, 2001). The current demographics, much like those found by Gerritsen et al (2006), of undocumented healthcare users seem to be young males of African origin. The ‘natural filter’ is outlined by Karel from ASKV:

The number of first time asylum seekers is much more balanced between men and women. If you look at failed asylum a seeker, who stays behind, single men who cannot return either to work … again I’m generalising but they’re not responsible for an entire family. They’re just much more likely to stay behind. If the initial asylum application is maybe 60/40 by the time people reach the stage of being at risk of immigration detention the statistics have already gone to 95/5. 95% of people in immigration detention are men. There is a huge filter after that initial rejection.

Many migrants who are seeking asylum have been refused legality due to inconsistent stories and background data; my respondent Oukje from the Equator Foundation stated that this “is part of the whole disorder, is that your memory is all over the place. You have no idea about times and what happened first”. Oukje further stated that those with the most consistent stories, which are partially what the IND bases their status requirements on, are not those who are the most deserving. Migrants are known to not tell the truth as they are too ashamed, embarrassed or scared to tell what ‘really happened’. Mental illnesses can often develop or existing illnesses can deteriorate due to these precarious undocumented living situations. These mental illnesses include furthering the effects of their PTSD, depression and panic anxiety.

The findings of this thesis also included the contemporary accessibility of online health information, something that was not included in former literary works. The communication flows of the information needed to seek health care seem also to be sent through word of mouth and sometimes by NGOs such as ASKV. The communication flow of healthcare information was found to have limitations, this is embedded within the close social cohesion based upon ethnicity found within the We Are Here. This close social cohesion also offers
social support and access to resources, meaning if someone doesn’t belong to a majority group – such as Saeed, this accessibly can be limited.

The interpretation of ‘necessary health care’ was not fully understood, however healthcare employees outlined that this term should not deter private practises in delivering services. In order for the best health practices to be delivered the weight of the uninsured needs to be evenly distributed. This must be further explored, especially within the private healthcare practise, in order to bring further clarity in the contemporary ambiguity. Ambiguity has the ability to be used in bending rules for positive outcomes and to deliver more than what is expected; yet this thesis found that what was being delivered within the private sector was very little.

Health services are predominantly delivered to undocumented migrants by goodwill volunteers. These independent organizations are a short term, small scale solution to larger issues. One of these issues being the Linkage Act which is preventing healthcare access. The scale of this is results in many undocumented migrants being turned away from services run on a voluntary basis due to the over demand: “even we have to say to a certain group that this is never going to work out and we can’t really help you” (Karel, ASKV).

To summarise some of my important findings: first there is a lack of aid by the Dutch state such as funding even though there is an acknowledgment for the need of the services, secondly undocumented migrants can be unwilling to seek healthcare due to a lack of trust for institutions and thirdly that a lack of communication prevails within the healthcare organizations (ZIN, private practises, pharmacies and amongst refugee organizations). This research acquired in-depth interviews with healthcare practitioners, observations of healthcare in practise and also in-depth unstructured interviews with undocumented healthcare users. The years of field experience accumulated within the interviewees is substantial; giving this thesis a judicious insight in the causation and the implications that may arise from the contemporary situation.
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