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Migrant mental health and representation in routine administrative registers

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Migrant mental health and representation in routine administrative registers

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Table 1: Migrant focus group demographics

	Focus group 1 (n=10)	Focus Group 2 (n=7)	Overall
Mean age (years)	46.8	50.5	48.3 (range 19-66)
Gender	1 male and 9 females	1 male and 6 females	15 females and 2 males
Born outside UK/Ireland	Yes=4No=6	Yes=2 No=5	Yes=6,No=11

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Table 2: Details on focus group participants job roles

<i>Participant number (PN)</i>	<i>Job role</i>	<i>Length of time in this role</i>
1	Community Development Worker	12 years
2	Manager of a Migrant and Ethnic Minority Support organisation	10 years
3	Health Improvement Worker	10 years
4	Community Interpreter	12 years
5	Migrant/ ethnic minority support worker	7 years
6	Volunteer migrant/ Ethnic minority support worker	2 years
7	Migrant/ ethnic minority Support Worker	5 years
8	Volunteer migrant/ ethnic minority support worker	1 year
9	Health Improvement Worker/ Complementary therapist	6 years
10	Migrant/ ethnic minority Support Worker	0.5 years
11	Manager of a Migrant and Ethnic Minority Support organisation	4 years
12	Manager of a Migrant and Ethnic Minority Support organisation	5 years
13	Manager of a Migrant and Ethnic Minority Support organisation	6 years

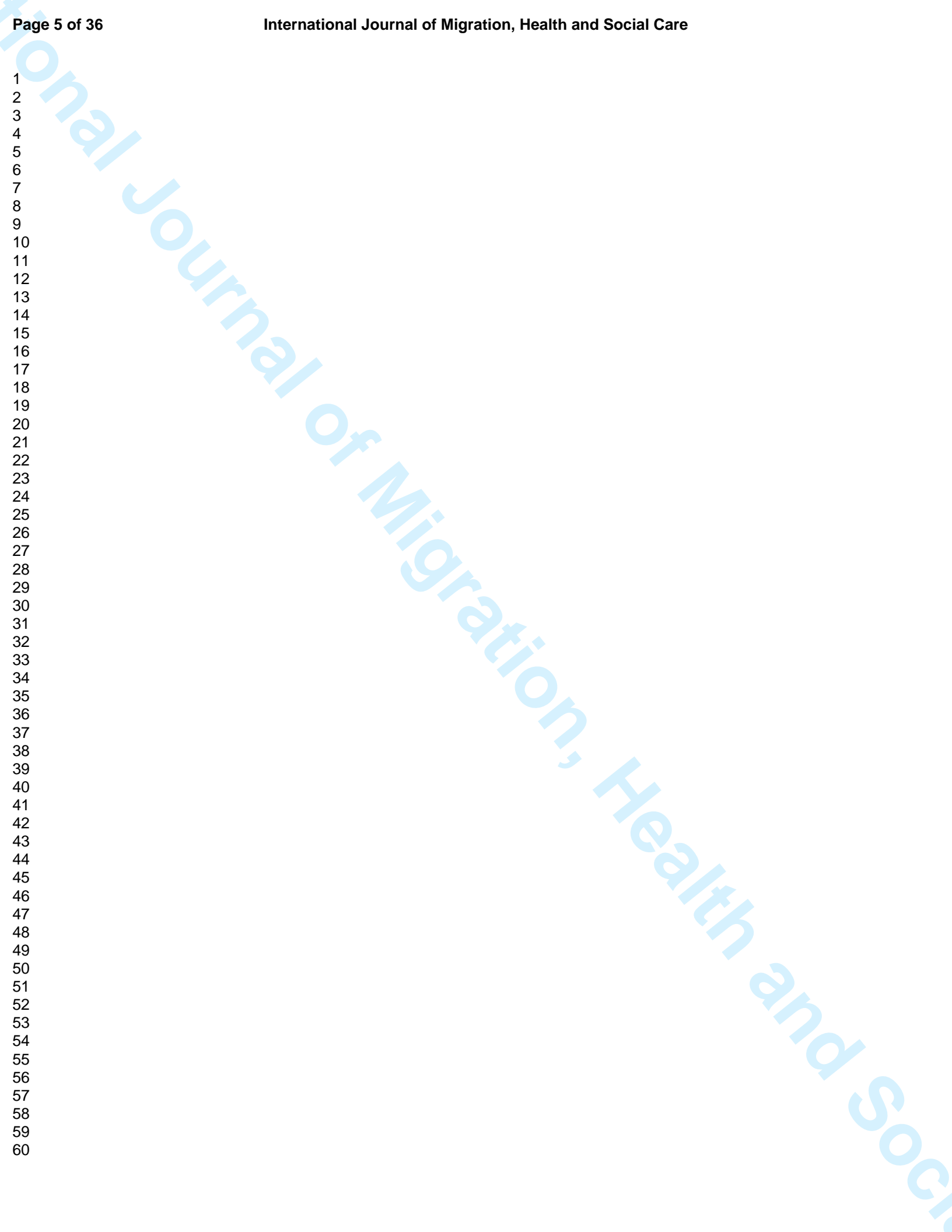
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14	Manager of a Migrant and Ethnic Minority Support organisation	5 years
15	Community Development Worker for migrants/Ethnic Minorities	2 years
16	Health Improvement Worker	1 year
17	Health improvement Worker	3 years

Table 3: Themes and sub-themes identified through framework analysis of transcription

Major theme	Sub theme
1. Issues with the use of GP registration, Census and hate crime data for researching migrant health	1.1 Migrants experience difficulties completing the Census and do not recognise its importance 1.2 Migrants experience issues with registering with a GP 1.3 Underrepresentation of some migrant groups in routine administrative registers 1.4 Challenges in reporting hate crime
2. Barriers to HSC service use	2.1. HSC staff lack cultural awareness 2.2. Issues accessing interpreters
3. Risk factor exposure and mental health status in migrant communities	3.1. Low paid jobs and poor working conditions 3.2. Isolation and lack of support 3.3. Racism/discrimination/negative behaviour towards migrants

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Migrant **mental** health and representation in routine administrative registers

Abstract

Purpose: There has been an increase in the use of registers and record linkages to study migrant **mental** health. However, the accuracy of these registers and the degree to which they are representative of the migrant population in Northern Ireland (NI) are unclear. This study explored: (i) the coverage of the NI migrant population in GP data and Census records, (ii) the issues faced by migrants in terms of registering and accessing the local health system; and (iii) the reporting of racial hate crimes against migrants to police.

Design: Two focus groups of professionals (n=17) who worked with migrants were conducted. Group discussions were guided by a research-informed topic guide and the data were analysed using thematic analysis.

Findings: Three main themes emerged: (i) Issues with the use of GP registration, Census and hate crime data for researching migrant mental health (ii) Barriers to health service use (eg low cultural awareness among health staff and access to interpreters) and (iii) Risk factor exposure and mental health status in migrant communities (e.g. poverty, isolation and poor working conditions).

Originality/ value: Record linkage and registry studies of migrant health and well-being using **Census and health service** sources need to be mindful of the likelihood that some migrants may be missed. The possible underrepresentation of migrants in health registers may be explained by reduced use of such services which may be caused by encountering staff with limited cultural competency and the inability to access an interpreter promptly.

Migrant mental health and representation in routine administrative registers

Introduction

Migration to many European countries has increased substantially in recent years (Dustmann and Frattini, 2011). For example migration to Northern Ireland (NI) more than doubled between 2001 and 2011 (Krausova and Vargos Silva 2014). Such population changes mean that there is an immediate need to improve our understanding about the health of migrants in order to aid research-informed decision making in policy development and service improvement. Migrant health has previously been studied in several Scandinavian countries using register based linkage studies (Hollander 2013, Norredam 2014) and in an attempt to replicate this type of research in a NI context researchers at the Administrative Data Research Centre Northern Ireland (ADRC-NI) at Queen's University Belfast (QUB) are planning to conduct a large-scale linkage study into the health of migrants, initially focusing on mental health. The proposed registers for linkage are the Census, General Practitioner medical doctor (GP) and the Police Service of Northern Ireland (PSNI) hate crime data registers. These registers allow individual prescription medication, for example antidepressants, to be linked to individual socio-demographic and economic data from the Census, as well as to neighbourhood data such as area deprivation from the Census, and neighbourhood hate crime levels from the PSNI. This linkage study could therefore provide high quality data on the incidence of mental health disorders amongst migrant groups in NI, and may also set an example to other European Union (EU) countries wishing to gather an updated evidence base on migrant mental health.

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3 The quality of these register-based studies is thought to be high due to the often whole
4 population coverage, making generalization of findings reliable. These samples are highly
5 representative, have low levels of missing data, and reduce the likelihood of research biases
6 because they are drawn from real life data. Many of these studies have been conducted in
7 Nordic countries where data linkage methodologies are well-established, and these datasets
8 are known to have a high level of quality and accuracy (Patel et al., 2017). Less is known
9 about countries with less-established systems. The risk of compromised data from low
10 quality data – due to poor record keeping, inconsistencies in prescription coding and
11 dispensation (such as cross-border agreements) and differences in the accessibility and
12 availability of health services, Census information, and Police for migrant groups – is higher.
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27 The Administrative Data Research Centre in NI (ADRC-NI) is a relatively recent
28 development, along with Centres across the UK, that specifically focuses on using whole
29 population register-based datasets. This Centre brings together researchers from Queen's
30 University Belfast (QUB), the University of Ulster (UU) and the government body Northern
31 Ireland Statistics and Research Agency (NISRA), to conduct research in the public interest
32 using primarily GP and Census registers, among others. We are interested in determining
33 the strengths and caveats of the Census and GP registers for accurately quantifying migrants
34 and their need for, and use of, mental health services, to inform future research on migrant
35 populations and their mental health needs. Determining the accuracy of these methods for
36 quantifying migrants is important as it will help shape policy and resource allocation.
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49 Despite the fact that many countries such as the UK, France and Spain rely primarily on the
50 Census for quantifying their migrant population, the method may underestimate migrant
51 populations. Research from the United States has shown that non-English speaking
52 individuals are less likely to complete the Census than English speakers and this is likely the
53 case in the UK (US Census Bureau 2012). In NI the use of GP register data may be a more
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3 accurate method of quantifying the migrant population given the current need for residents of
4 NI to be registered with a GP in order to access primary and secondary care services.

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7 However, it is important to bear in mind that there is wide variation in health care systems
8 around the world and only some countries (e.g. within the UK) health care system includes a
9 GP as the central point for accessing primary and secondary care services, including mental
10 health services. Research suggests that some migrant groups living in the UK, such as
11 asylum seekers and refugees, experience difficulties registering with a GP and may be less
12 likely to be registered with a GP (Refugee Council 2013). Limited English language skills and
13 poor access to appropriate interpreters has been suggested as one such barrier for migrants
14 trying to register with a GP (HealthWatch 2015) as well as discrimination and prejudice at the
15 point of access (Phillimore, 2011).
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27 Aside from quantifying migrants in Census and health registers, using these registers to
28 assess mental health, and mental health service needs, faces further challenges. Limited
29 cultural competency of health professionals has been highlighted as a major barrier to
30 migrants accessing mental health services. Some migrant groups may also be particularly
31 suspicious of mental health services and some may have had previous negative experiences
32 of services; all of which are likely to negatively impact migrants' access of mental health
33 services (Franks *et al.* 2007, Keynejed, 2008). Furthermore, mental illness is described
34 differently in different cultures and terms frequently used to describe mental ill-health in
35 English e.g.: "feeling down" or "blue," when translated directly to another language may yield
36 meaningless expressions (Matsumoto, 2010). Without basic knowledge on how mental ill-
37 health is described and perceived in specific cultures health professionals may fail to identify
38 migrants suffering mental illness and migrants may be deterred from accessing professional
39 support for mental illness.
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56 In addition to quantifying migrants and their mental health and mental health service needs,
57 the ADRC-NI studies plan to explore the effect of common risk factors on migrant mental
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3 health, including socio-economic disadvantage using the Census and exposure to hate crime
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5 using PSNI crime registers. Migration has been linked to increased risk of mental ill-health in
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7 many countries (Lindert *et al.* 2009, Bronstein and Montgomery 2011, Borque *et al.* 2011),
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9 and one of the largest contributory factors, alongside socio-economic disadvantage, has
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11 been found to be exposure to racism and discrimination (Veling *et al.* 2007, Be`cares *et al.*
12
13 2009). Quantitative data on the occurrence of racial hate crime in NI, held on the PSNI
14
15 regional hate crime register, suggests that racial hate crime has increased in recent years
16
17 (Police Service of Northern Ireland, 2014). However, it is unclear how accurate these figures
18
19 are, and it is possible that a proportion of hate crime goes unreported. A report "*Voices for*
20
21 *change*" (NICEM, 2014a) which included some qualitative research with Black and Minority
22
23 Ethnic (BME) groups, suggested that racism was a growing issue in NI, but was often not
24
25 reported to authorities. The report highlighted that this under reporting was due to beliefs that
26
27 reports would not be believed or that reporting would make no difference. Further qualitative
28
29 exploration of racial hate crime reporting in NI may be helpful as it will allow a greater
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31 understanding of the level of underreporting, which could better inform the proposed register-
32
33 based linkage study by NI researchers on migrant mental ill-health and its risk factors.
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38 Migrant support organisations employ professionals in roles such as interpreters, nurses,
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40 volunteers and community development workers who provide support to migrants. These
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42 professionals, many of whom are migrants themselves, may be able to offer important
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44 insights into migrant health and well-being and issues related to using routine administrative
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46 registers for conducting migrant health research. Discussions with such professionals could
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48 help improve our understanding on migrant health issues e.g.: experiences of the health
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50 system, filling out the Census or reporting a hate crime. These are the kinds of issues that
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52 professionals working with migrants are faced with every day.
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Aim

To elicit views about (i) the coverage of the NI migrant population in GP and Census records, (ii) the issues faced by migrants in terms of accessing and using the local health system; and (iii) the reporting to police of racial hate crimes against migrants.

Methodology

The reporting of this study was guided by the consolidated criteria for reporting qualitative research, COREQ (Tong *et al.* 2007). This 32-item checklist for interviews and focus groups, allows for the clear and complete reporting of qualitative studies

Study design

This study used focus groups to elicit professionals' views on the topics under investigation. The purpose of this focus group study was to inform a linkage study on the quantification of migrants in registers and the mental health and mental health service need of migrant groups, which plans to utilise GP, Census and hate crime registers to determine if migrants are at risk of mental health inequalities and to determine the strengths and caveats of these registers for capturing migrants' use of and need for mental health services.

Focus groups undertook a simple qualitative descriptive approach. This approach is recommended when a direct description of a specific phenomenon is required and such methods are particularly helpful for researchers wishing to find out the, who, where, what of experiences and events (Sandelowski, 2000).

Ethical approval

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3 This focus group study was given ethical approval by the School of Medicine, Dentistry and
4 Biomedical Sciences Ethics Committee at Queen's University Belfast (Reference number
5 14/54v2).
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12 The associated linkage study was given ethical approval from the Office for Research Ethics
13 Committee Northern Ireland (ORECNI) (Reference Number 15/WM/0212).
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20 *Inclusion/ Exclusion criteria*

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23 Potential participants invited to take part in focus groups were adults (aged 18 years or older,
24 male and female); and were professionals working with migrants in a supportive role
25 (paid/voluntary) or a manager of an organisation that supports migrants.
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32 *Recruitment*

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35 Professionals were invited to participate via the research teams' existing collaborative
36 connections with migrant and health organisations in Northern Ireland including the Northern
37 Ireland Council for Ethnic Minorities (NICEM) and The Public Health Agency (PHA) in NI.
38 Managers and migrant support workers in these settings disseminated a participant
39 information sheet to relevant professionals. Professionals interested in participating then
40 contacted the researcher directly or contacted the Migrant Support Worker/ Manager who
41 provided them with the study information. At this point, participants were given an opportunity
42 to ask further questions. At recruitment the participants were made aware that the researcher
43 conducting the focus groups had a specialised interest in migrant mental health and the
44 focus group findings would be used to inform a related register-based linkage study.
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Data collection

Participants provided written consent on the day of the focus group indicating that they were willing to participate voluntarily in the focus groups and they agreed to the discussions being recorded. Focus groups were conducted in 2015, one was conducted in a migrant support organisation and the other was conducted in a health organisation. Only the participants and moderator were present at both focus groups.

Focus groups were recorded with the use of an electronic audio digital recorder and were moderated by a female researcher, Ciara Close (CC, PhD). CC has received training in qualitative research as well as conducting various qualitative studies including focus groups for previous research projects. CC had not met any of the study participants prior to the focus groups commencing.

A pre-determined topic schedule used to guide focus groups (appendix 1). The researcher took notes during focus groups and these were later added to the transcripts.

Focus groups are normally ongoing until data saturation has been reached, which is often after three focus groups. Unfortunately, due to the time restrictions of this project, this meant that that the number of focus groups had to be restricted to two.

Data analysis and rigour

Focus group findings were analysed using the Newell and Burnard (2006) framework for thematic analysis. Two researchers (CC and TB) analysed the findings using this framework independent of one another and then came together to agree codes, categories and themes.

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6 Ensuring the rigor of qualitative research is very important if qualitative research is to be considered
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8 credible and as such several of the strategies recommended by Creswell and Miller (2000) for
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10 improving the rigor of qualitative studies were used in the current study. This included member
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12 checking, completing a detailed audit trail and peer debriefing.
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18 **Results**

19 *Focus group participants*

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21 The purposive sample of participants that took part in the focus group study included 17
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23 professionals, 2 others had agreed to participate but failed to attend, one of whom contacted
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25 the researcher and informed her she was sick. The two focus groups lasted 60 and 75
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27 minutes respectively and generated lively discussions. A summary of the transcripts were
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29 sent via email and confirmed by each study participant.
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34 The participants were both female (15) and male (2). Most participants worked in paid
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36 employment (15) and just two worked in volunteer roles. All participants were either working
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38 directly to support migrants or were leading an organisation that supports migrants and had
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40 been on average 5.4 years in their current role. Ten professionals attended focus group one,
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42 and seven attended focus group two. The mean age of participants was 48.3 years (age
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44 range 19-66 years) and several were migrants themselves (6/17) (Table 1). Specific details
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46 of each focus group participant's job roles are detailed in Table 2, which highlights the wide
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48 range of participant experience and expertise on the challenges facing migrants living in NI.
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54 *Analysis and Themes*

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3 The data was coded by two researchers independent of one another; this was done manually
4 without the use of specific software. Three major themes and nine sub-themes became clear
5 on examining and coding the focus group data (Table 3).
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11 **Major theme 1: Issues with the use of GP registration, Census and hate crime data for**
12 **researching migrant health.** When focus group participants were asked questions around
13 the representativeness and accuracy of GP, Census and hate crime registers, a key theme
14 that emerged was “Issues with the use of GP registration, Census and hate crime data for
15 researching migrant health,” under this major theme, four sub-themes became apparent:
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23 *Sub-theme 1.1: Migrants experience difficulties completing the Census and do not recognise*
24 *its importance.* Some focus group participants indicated that some migrants have issues
25 completing the Census and these included language barriers and issues in accessing an
26 interpreter:
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33 “The language barrierphone [call for Census completion] is in English and you never
34 know will people do it [access an interpreter]...it’s another step for them [non-English
35 speaking migrants],” **PN1**
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41 “I think I do have a comment on this. For the past two Census’ they have used interpreters
42 and my problem is that these centres in the community - they don’t help people. As [sic]
43 although the Census did a super job there are some people that did ring for an interpreter
44 and it didn’t happen,” **PN 2**
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51 Some participants indicated that the importance of the Census, and the need to complete it,
52 is not recognised by some migrants:
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3 “Some people don’t have the status to stay here so they don’t see it as important to fill in the
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5 Census,” **PN 15**
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10 “Sometimes when a person comes here as a migrant worker and in their heart they don’t
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12 plan to stay long, but the reality might be different, but when you asking them for their data
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14 they will say ‘but I haven’t been here that long’,” **PN12**
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20 *Sub theme 1.2: Migrants’ experienced issues with registering with a GP.* It became clear that
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22 some groups of migrants encountered difficulties registering with a GP. For EU migrants this
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24 centred on being asked to produce paperwork to register with a GP that EU migrants are not
25
26 required to possess in order to reside in NI:
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30 “Mostly Portuguese working in factories in the Dungannon area.... Some of them had tried to
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32 register for the local practices but for different reasons were not able to. For example for
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34 some of them it was because they didn’t have a passport because they travelled on an ID
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36 card so that was a problem,” **PN4**
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40 “Sometimes it’s an awareness issue when they go to reception. Sometimes they are asked
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42 for ID or sometimes they would ask for a visa or a document. But for me as a Polish person I
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44 don’t have a document with a visa as I don’t need itbut they could say because you don’t
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46 have a document with a visa then you can’t register ...so it is really down to lack of
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48 awareness ...and if someone had an issue with a visa this would put them off registering,”
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50 **PN 14**
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3 There was also an apparent lack of awareness about the local health system in NI, with
4 some migrants unaware they had to register with a GP and others unclear about what to do
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7 and where to go when a GP surgery is unable to take on new patients:
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11 *“At the beginning when they are applying for asylum...even just the knowledge and*
12 *awareness of how to register with the GP [is lacking], and it really depends on what GPs [sic]*
13 *and some GPs have no space...who [sic] have too many and can't take on anyone new,”*
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17 **PN1**

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21 *“They don't know where to go, that is a barrier [to GP registration],” PN9*
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25 *“The other barrier is not realising that they have to do it [GP registration],” PN16*
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31 There was also sense that many migrants do not see the importance of registering with a GP
32 and some go elsewhere if they have a health problem:
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37 *“Yes in India you don't have your GP only if you were sick would you go to the GP and then*
38 *you could go to a consultant to see an ENT consultant [or] whatever it is that is wrong with*
39 *you, so you don't have to wait for you GP to refer ...so if they come healthy they may not see*
40 *the need to register,” PN12*
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47 *“I would say that some migrant workers may be late to register with the GP - they are young*
48 *and healthy they come to work and then there is no urgency there to register and they will*
49 *just go to pharmacy and get some medicine,” PN15*
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3 *Sub theme 1.3 Underrepresentation of some migrant groups in routine administrative*
4 *registers. There was a sense that some migrants may not appear in registers that collect*
5 *routine data of the population because they do not have legal access to services:*
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11 *“But some of them [undocumented migrants] don’t want to come out ...because if they use*
12 *health services then you may become known to immigration ...and that’s why people may be*
13 *just washing dishes for hours to keep them in money,” PN1*
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20 *“It very difficult to pinpoint the undocumented ones but I would say it’s mainly in the fishing*
21 *and hospitality industries you would find that those are [sic] but generally people don’t speak*
22 *about that ... but definitely it’s the fishing and hospitality that I feel they are mostly in,” PN4*
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27 *“There will be a lot of Philippine people who come over to work on the boat and are not able*
28 *to access any services except A & E,” PN5*
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33 *1.4 Challenges in reporting hate crime. There was a general consensus that that hate crime*
34 *was frequently underreported to authorities, for various reasons. Some migrants felt*
35 *disheartened by the lack of prosecution of perpetrators of hate crime and this was a*
36 *commonly cited factor in underreporting:*
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43 *“The PSNI [Police Service Northern Ireland] set up a bilingual advocacy service, from which*
44 *we are part of, you know one of the tasks is to encourage the reporting of hate crime so*
45 *people are there trying to encourage people to report, but the reporting is one thing, but then*
46 *if they don’t get prosecuted then, or prosecuted for a lesser offence than the hate crime, or*
47 *the charges have been dropped, then that discourages people [to report] again,” PN12*
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55 *“They [a migrant family] have been getting these comments for years but the police said*
56 *unless there is something written on the wall or the property is damaged there is nothing we*
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3 can do about it. It's been to court and Victim Support have been sending them letters to say
4 I am sorry about what is happening to you, and they went and got their own solicitor and
5 everything, and she was absolutely devastated when she was here the other night, it's just
6 that feeling of complete powerlessness and not knowing what to do and who to turn to, they
7 have been given this advice and exhausted all avenues that they [can] think [of], [then] for
8 the same thing to happen two nights later," **PN 7**

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18 Other focus group participants reported that they believed that in NI there was a higher
19 tolerance for verbal abuse and this may play a role in underreporting:
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26 "But then again when you look at it in comparison with the indigenous population - from my
27 nursing [experience] those who have got a good kicking or a head injury being in the wrong
28 place, that was already tolerated [before migration increased] and in existence between the
29 two sides [Catholic and Protestant communities] so that wasn't very healthy to begin [with],"

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33 **PN5**

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38 "I was at a conference 18 months ago and some of their remarks by people from other
39 countries and other ethnic backgrounds is that when they first came here, that in NI we had a
40 very high tolerance for verbal abuse and people slinging insults at one another, and I
41 suppose that's a legacy of the Troubles [civil conflict in NI] for want of a better word, so there
42 is this polarisation already in society...somehow they have normalised a level of conflict that
43 would be unacceptable in most other societies," **PN3**

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54 Other narratives suggested that for some migrants underreporting may be related to fear of
55 drawing attention to themselves, and that initial reporting of racial hate crime tends to be to
56 community leaders as opposed to formal authorities:
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5 “It’s [underreporting] also is related to the fear of drawing attention to themselves,” PN16
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11 “Sometimes they [migrants] may feel more comfortable going to someone in the community
12 that has their language [to report *hate crime*],” PN12
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17 **Major theme 2: Barriers to local health service use.** Participants discussed at length
18 migrants’ experiences of the NI health system, and these discussions were focused on areas
19 in need of improvement:
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24 *Subtheme 2.1: Lack of cultural awareness among health staff.* Large differences between
25 GPs in Great Britain and NI in the quality of health staff knowledge about health issues more
26 prominent in migrant communities, particularly *Female Genital Mutilation (FGM)*, were
27 identified:
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37 “An example of one of the women who would be more vocal where she was in with the
38 Doctor - and they had to call another Doctor in as they had never seen anything like this
39 [FGM] before whereas in the [rest of the] UK it is completely different [better],” PN7
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46 Some participants identified that the lack of cultural awareness of health staff may be related
47 to limited cultural competence training in NI:
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54 “It’s the perception that we don’t have that problem here [FGM] it is a learning curve and
55 [health] Trusts need to have some training on FGM to make staff aware of this issue,” PN1
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1
2
3 “They [social workers] don’t know a lot about the issues these people [migrants] face...part of
4 it is about competence, we are not training social workers up on this [cultural awareness],”
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7 **PN2**
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12 Sub theme 2.2. Issues accessing interpreters. For some migrants they may have to wait long
13 periods of time for health service appointments due to difficulties in accessing interpreters in
14 a timely fashion:
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20 “But what I am saying is that for some languages it is taking up to a week to get an
21 interpreter in the appropriate language,”**PN6**
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27 Other interpreter issues identified were non provision of interpreters and the inappropriate
28 use of telephone interpreting:
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31 “The issue of accessing interpreting goes in circles. It was good for a while but because of
32 the [government financial] cuts and the drive for savings on cost effectiveness it’s been
33 pulled back again, and now there is more pressure on using telephone interpreting very
34 inappropriately, as there is a time and place for everything,” **PN4**
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41
42 “I was with a girl [on the phone] and her friend was at the doctors and was trying to make an
43 appointment and they won’t provide an interpreter...and she is having to give the information
44 on her behalf,” **PN7**
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51 **Major theme 3: Risk factor exposure and mental health status in migrant communities**
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53 **in the NI context.** Although not the primary focus of this study, the challenges facing
54 migrants in NI and the impact on their wellbeing clearly emerged as a theme and area of
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2
3 great concern for participants in the focus groups, particularly in relation to specific
4
5 differences in the NI context compared to other regions and countries.
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9 *Sub theme 3.1. Low paid jobs and poor working conditions.* It became apparent during focus
10 groups that migrants may be more exposed to risk factors for mental ill-health in NI. Some
11 participants discussed how migrants were subjected to poor working conditions and low paid
12 jobs:
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18
19 “You have more Moypark [food factory] type working sometimes in 24 hour shifts and very
20 extreme working conditions,” **PN2**
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23
24 “Also for those working in those jobs [factory work], sickness are part of disciplinary
25 procedures, these people would rather go to work than risk this, they miss a day’s work then
26 it’s a disciplinary,” **PN4**
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31
32 “Recent groups that have come in and mostly to very low wage jobs,” **PN3**
33
34

35 “[The year] 2000 onwards a lot of low paid jobs that migrants are doing...we are now facing
36 huge problem in acute poverty and debt, and add in [it has an impact on] the big issue health
37 and well-being,” **PN2**
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43 *Subtheme 3.2 Isolation and lack of support*
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45 It became evident that migrants’ across the board may be isolated living in NI, and a few
46 participants identified that support structures for migrants may be an area for development:
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51 “I think in relation to those [undocumented migrants] no one has any real support, not from
52 the police and not from society,” **PN2**
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3 “This is where I would love to see structures put in place...I mean people who are isolated in
4 this country. Even if they look like the local indigenous population there are still issues,” PN5
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9 Sub theme 3.3. Racism/discrimination/negative behaviour towards migrants. There was a
10 strong sense from focus group participants that racism/ discrimination and other negative
11 behaviours towards migrants were ongoing and growing issues in NI:
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16
17 “Add in the big issue health and well-being which takes in [is impacted by] all these issues,
18 mental health being one of the key ones, and the increasing polarisation between the local
19 [majority population] and those minority because of the mentality ‘they take our house, they
20 take our jobs,’ so you have all those racist attack, hate crime, and discrimination,” PN2
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29 “Yeh [sic] there will be children playing with each other until one day the child says I can’t
30 play with you no more because my mummy said you are all bad,” PN12
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38 “My sense is that racism is increasing particularly with all the publicity at the moment about
39 the Syrian refugees needing supported [sic] and countries to take them, there seems to be a
40 huge polarisation of views from people who want to help to others that don’t want this to
41 happen, and some of the remarks people will make quite openly saying quite racist things,”
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45 PN3
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49 Discussion

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51 This study used a qualitative methodology to explore the barriers and challenges facing
52 migrants in responding to the Census, registering with the health service and reporting hate
53 crimes, in order to inform population research using administrative data registers in NI. A key
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60 theme that emerged from the present study is that the use of data from registers for

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3 researching the number, mental health and needs of migrants in NI may be problematic with
4 the potential for missing specific groups of migrants. The use of GP and Census registers for
5
6 quantifying the size of the migrant population may lead to an underestimation as several
7
8 issues related to migrants' ability to register with a GP and to complete the Census were
9
10 identified.
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15 The findings regarding the inability of some migrants to register with a GP in NI concurs with
16
17 existing research elsewhere. HealthWatch (2015), a UK organisation set up to make sure
18
19 that the local health systems listens to people's views and experiences, found that only one
20
21 out of 36 practices offered an interpreter for non-English speakers when trying to register
22
23 with a GP, and 19 practices advised patients to come back with a friend or family member
24
25 who spoke English. The use of family members as interpreters, particularly children, is a
26
27 concern as it is likely to reduce help seeking for sensitive health issues such as mental
28
29 health (Kirmayer *et al.* 2011). The findings regarding EU migrants being refused registration
30
31 at GP surgeries in NI due to not holding a passport or visa document is alarming. This
32
33 suggests that there are inconsistencies and lack of knowledge in the GP registration process
34
35 between GP surgeries. Therefore, to ensure consistency and improve the quality of health-
36
37 based registers, it may be beneficial for GP surgeries to receive training in the rights of EU
38
39 and other migrant groups to access primary care services, particularly reception staff that
40
41 frequently assist patients with registration. Research using this register in its current form
42
43 must acknowledge these biases and inconsistencies in their interpretation of findings.
44
45 Migrant numbers in GP records are likely to be underestimated. Consequentially, incidence
46
47 of mental health disorders is likely to be affected. From the findings of this research,
48
49 underestimation of mental health difficulties for undocumented migrants (such as rejected
50
51 asylum seekers) and short-stay migrants (such as seasonal workers or students) are
52
53 probable, whilst healthy migrants who are unfamiliar with the NI GP registration system may
54
55 also be underestimated in health records. Register-based research in NI must take this into
56
57 account, with particular attention to the underrepresentation of undocumented migrants who
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2
3 are likely to have worse mental health given their insecure circumstances and lack of access
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5 to support (Gray, 2012).
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9 In addition to barriers in registering for health services, this study also highlighted many
10
11 negative experiences in accessing health care services, which may also reduce the accuracy
12
13 of GP records, such as the issuing of antidepressant prescriptions, with a knock on effect on
14
15 research that uses this data to identify individuals suffering from mental ill health. The
16
17 findings of this study highlighted sub-optimal access to interpreters and lack of cultural
18
19 competence within the health care workforce. Research strongly supports that culturally
20
21 competent health staff has many benefits for patients which include increased health care-
22
23 seeking behaviour and better adherence to medical advice (Lehman, et al. 2012). The lack of
24
25 cultural awareness of health staff in NI reported by study participants suggests that health
26
27 professionals may require additional training in cultural awareness. Despite an increased
28
29 emphasis on cultural competence training for health professionals in recent years, the
30
31 implementation of this training varies widely across programmes (George *et al.* 2015). This
32
33 study suggests that NI has not kept up with population changes with respect to different
34
35 migrant groups and their needs. Increasing the cultural competency of health staff will likely
36
37 lead to improvements in migrant's experience of the health system, which will encourage
38
39 help seeking, make GP records more reflective of reality and ultimately lead to improved
40
41 migrant mental health.
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47 In terms of the Census as a source of information on migrants in NI, our study suggests there
48
49 are challenges in completing the Census for these groups. Our findings in relation to
50
51 language being a barrier to Census completion are supported by research conducted by the
52
53 US Census Bureau (2012). Over 3% of the NI population do not speak English as their main
54
55 language and in England and Wales the percentages of residents reporting that English is
56
57 not their main language is even higher at almost 8% (NISRA, 2011, ONS 2011). Without
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1
2
3 having adequate knowledge of the official language of the country a person is residing in, the
4 additional steps required to obtain the Census in the appropriate language may prove difficult
5
6 and may explain why those migrants not fluent with the official language of a country may not
7
8 be fully represented in the Census. Similar to our findings, the research by the US Census
9
10 Bureau (2012) found that migrants may not recognise the importance of completing the
11
12 Census and some may perceive the Census as being only relevant for the settled majority.
13
14 Findings in relation to migrants' difficulties completing the Census suggest that better support
15
16 systems are needed to ensure that those with limited skills in the main language of the
17
18 country are helped to complete the Census. It may also be important to ensure that migrants
19
20 are better informed about the purpose of the Census and the importance of its completion.
21
22 Implementing these steps may aid improved representativeness of these migrants in future
23
24 Censuses and improve the quality of future linkage studies using Census registry data. This
25
26 is important as the current quality of register-based linkage studies using Census will be
27
28 greatly affected by the likely underrepresentation of several migrant groups. **Those most**
29
30 **likely to be unrepresented in the Census are those with limited skills in English. This is of**
31
32 **particular importance for research on migrant mental health** as those with limited host
33
34 country language skills have been shown to be at additional risk of acculturation stress,
35
36 which has been linked with poor psychological well-being (Liebkind *et al.* 2000, Yeh and
37
38 Inose 2003). Therefore, underrepresentation of non-English speakers in the NI Census could
39
40 mean that those at higher risk of mental ill-health may not be accounted for within the linkage
41
42 study, which potentially may lead to inaccurate interpretations when comparing the risk of
43
44 mental ill-health in the migrant versus the settled majority population.
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48
49 **Aside from GP registration and Census completion, this study aimed to explore the reporting**
50
51 **or underreporting of hate crime in order to inform register-based research on the effect of**
52
53 **hate crime on the mental health of migrants.** Global research strongly indicates that hate
54
55 crime, racism and discrimination impact negatively on migrant mental well-being (Veling *et al.*
56
57 2007, Bécares 2009, Bosqui *et al.* 2014). Therefore, it is imperative that research into migrant
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1
2
3 mental health take these into account when conducting migrant mental health research. In
4 many countries residents are encouraged to report experiences of racial hate crime to police
5
6 authorities, who frequently compile a register of reported racial hate crimes. This is
7
8 considered important in helping police authorities keep a check on whether racial hate crime
9
10 is being tackled effectively. However, concerns were raised by focus group participants
11
12 regarding the use of the hate crime register data in assessing the impact of hate crime on
13
14 migrant mental health, with many participants drawing attention to the fact that hate crime is
15
16 often underreported. This is supported by research in England and Wales which suggests
17
18 that only 40% of hate crime is brought to the attention of police and just 20% is officially
19
20 recorded (College of Policing, 2014). Our findings in relation to the reasons for
21
22 underreporting of racial hate crime also concur with previous research conducted in NI and in
23
24 the EU (European Agency for Fundamental Rights 2012; NICEM 2014). Commonly cited
25
26 reasons for not reporting a racial hate crime to police were due to failure of a previous report
27
28 of hate crime/racism leading to prosecution, or specific to the NI context, due to legacy
29
30 issues related to civil conflict known as “The Troubles.” This was thought to lead higher
31
32 tolerance to abuse. Tackling racial hate crime and increasing the reporting of racial hate
33
34 crime are seen as important priorities in many EU countries and steps are continually being
35
36 taken to eradicate racial hate crime and to make countries more cohesive. However, despite
37
38 concentrated efforts in recent years in NI to encourage the reporting of racial hate crime e.g.:
39
40 hate crime telephone line, the present findings strongly suggest that more work is needed.

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43 **For register-based research using hate crime data, researchers must acknowledge the**
44
45 **limitations of these data and that recorded hate crimes are likely to underestimate the reality**
46
47 **of hate crimes, racism, prejudice, hostility and discrimination faced by migrants in NI every**
48
49 **day.**

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55 **The final theme which emerged from this study indicated that the mental health of migrants**
56
57 **and their exposure to risk factors was of particular concern to our participants, and highlights**
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1
2
3 the importance and need for good quality robust research on the mental health of migrants in
4
5 NI. Migrants were identified as being more likely to be exposed to risk factors which
6
7 increased their risk of mental ill-health including low paid jobs and poor working conditions,
8
9 isolation, lack of social support and experiences of racism. The poor working conditions that
10
11 many migrants in NI experience was highlighted by several participants who reported on
12
13 circumstances where migrants worked long hours for low wages and were also unable to
14
15 take off work to visit the doctor for fear of disciplinary action. These experiences could have a
16
17 serious impact on migrant mental health. Poor working conditions of migrants in the UK have
18
19 been shown to be associated with depressed mood and hopelessness (Wu et al. 2010). Low
20
21 paid jobs that many migrants enter into when they arrive in NI may mean they are more likely
22
23 to be living in poverty and more likely to experience debt, all of which are associated with
24
25 mental ill health (Jenkins et al., 2008). The findings regarding migrants being isolated and
26
27 lacking social support is also concerning, as are the findings on racism being an ever present
28
29 and growing issue. These findings suggest that the current systems in place to make NI a
30
31 more cohesive society after the Good Friday Peace Agreement in 1998 are failing and further
32
33 efforts may be needed to improve migrant integration with the settled NI population. The
34
35 need for robust research on the mental health of migrants in this context is clear.
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40 To conclude, findings from this study suggest that research drawing on data from routine
41
42 registers such as Census and GP registration to research migrants and their respective
43
44 mental health needs may underestimate the size of the migrant population, the incidence of
45
46 mental disorders compared to the settled majority, and migrants' need for mental health
47
48 services. Our findings suggest those migrants which appear most likely to be unrepresented
49
50 in these registers are non-English speaking migrants, recently arrived migrants with limited
51
52 knowledge of the health system and undocumented migrants. The under-representation of
53
54 these particular groups of migrants is concerning as these migrants are likely to be the most
55
56 adversely affected by traumatic migration routes and acculturation stress. It is therefore
57
58 important that the possible underrepresentation of the mental health needs of these
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populations is considered carefully when interpreting the findings of register-based studies in NI. Finally, the findings from the study also identified a need for further research on migrant mental health, highlighting higher exposure to risk factors for mental ill-health.

Limitations

The primary limitation of this study is the fact that the findings are only directly applicable to the NI population. However, they may prove helpful for guiding researchers proposing similar linkage studies in other countries. Furthermore the study is limited by the fact that the focus groups did not continue to the point of data saturation, and focused only on professional's views. Due to time and resource constraints it was not possible to organise groups with migrant groups themselves, with a particular need to speak to undocumented, short-term and non-English speaking migrants. Future register-based research would benefit from these insights.

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Appendix 1: Topic schedule

1. Tell me about the diversity of migration experiences in Northern Ireland which you are aware of

2. Tell me about your knowledge of the scale of undocumented or irregular migration to Northern Ireland

3. Describe to me what you know about migrant's general knowledge, experience and perceptions of the Census- *prompt- Are there any groups of migrants that may not be complete the Census?*

4. Describe to me what you know about migrant's general knowledge, experience and perceptions of registering with a GP practice- *Prompt- Tell me about any groups of migrants that may not be registered with a GP?*

4. Tell me about migrants' experiences of the health and social care system-*Prompt-Tell me any areas of the Health and Social Care system that may require improvement in order to enhance migrants' experiences of Health and Social Care?*

5. Tell me what you know about the scale of unreported experience and exposure to racism and discrimination- *Prompt-Tell me your views on whether incidences of racism and discrimination are increasing or decreasing?*

6. Tell me what you know about migrant's experience and perceptions of reporting racism and racist hate crimes-*Prompt-Tell me about your views on whether racial hate crime is being reported accurately?*

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