

Migration and Mental Health Care

S. Priebe, T. Berhe, V. Iannibelli and D. Claassen

Barts & the London School of Medicine, Queen Mary Newham Centre for Mental Health, London, United Kingdom

The literature on the various associations between migration and mental health is vast. Numerous studies have been published on phenomena of mental health and mental illness in immigrant groups since the seminal paper of Ödegaard (1932), who found elevated rates of schizophrenia in Norwegian immigrants in the United States. Most of the epidemiological research has employed survey methods, comparing rates of mental illness in immigrant groups with rates in the population of the country of origin and the host country. For practical reasons, longitudinal studies assessing mental health and mental illness in groups throughout all stages before, during and after migration, are rather rare. In addition to empirical research, there have been reviews and theoretical papers on the subject, which would fill whole libraries. This paper does not try and provide another review. It may suffice to say that more or less all existing reviews agree that the association between migration and mental health is very complex (eg Bhugra 2004). There are different types of migration (e.g. within countries and between countries, within the same culture and between cultures), different reasons for migration (e.g. voluntary and forced migration), different potential stress factors (e.g. persecution before migration, dangerous migration, difficult adjustment process after migration), and potential effects on the first, second and even third generation of immigrants. The overwhelming majority of the literature looks at migration as a process associated with stress factors that may or may not lead to psychopathology in the individuals concerned. The vulnerability of the individuals on the one hand and their resilience on the other are seen as determining how individual cope with that stress. Migration has seldom been considered as a positive experience (e.g. through self-fulfilment, excitement, stimulation, and widening of social roles) with favourable effects on mental health and mental illness.

As the association of migration and mental health is complex, rates of mental illness in general and of specific mental health disorders in immigrant populations have been shown to be higher than, equal to or lower than those in the general population of the host country. Generalisations appear inappropriate, and every single group has to be investigated specifically. As has been shown for immigrants from the Asian sub continent in England, differences between immigrant groups and the host population are not consistent across all age groups and may vary depending on a number of aspects of the given circumstances of each individual. Again, the conclusion is that generalisation even within one group of immigrants is extremely difficult and that the experience of migration alone is an insufficient criterion to group people and estimate their risk for mental illness.

No matter whether rates of mental illness in defined immigrant populations are higher or lower than in the general population, those immigrants who do suffer from a mental illness pose a special challenge to mental health care. Patients may not seek or accept treatment because of barriers such as an insufficient knowledge of the language of the host country, unfamiliarity with the culture, and lack of information on how to access and utilise services. Mental health professionals can have similar difficulties to diagnose and treat a patient from an immigrant group, who maybe from a different cultural background and not speak the same language. In practical mental health care mental health professions working in services meet patients and their families, and the attitudes and behaviour of the two sides may often not fit. In addition to obvious language problems, there can be different expectations as to how mental health care is supposed to be conducted, different evaluations of what has been happening, and different assumptions about what behaviour maybe appropriate. These differences may or may not be culturally bound, and their nature and degree can vary substantially.

Against this background, this paper considers two questions related to mental health care in immigrant populations:

1. What is the current state of research on mental health care in immigrant groups in three European countries with large immigrant populations, i.e. England, Germany and Italy?
2. How is mental health care practically organised in the area that is culturally the most diverse one in Europe?

Research on Mental Health Care in Immigrant Groups and England, Germany and Italy

Each of the three countries has seen large-scale immigration during the last decade. In the 1960s and 1970s most of the immigrants in England came from other parts of the Commonwealth. Since then the

scale of immigration has steadily increased with appropriately 400,000 immigrants in 1998, the majority of which is due to labour immigration and about 20% to asylum seekers. In Germany, significant numbers of so-called guest workers from southern Europe immigrated since the 1960s. Total immigration to Germany over the last 20 years out numbers every other European country and peaked in 1992 with about 1,400,000 immigrants, with 230,000 of them being "ethnic Germans" from Eastern Europe, 450,000 asylum seekers from other areas, and 410,000 foreign labour immigrants. In Italy, the number of immigrants has increased since 1990. It reached more than 200,000 in 2000. The largest groups have been from Morocco and Albania.

In this review we identified research papers on mental health care in immigrant groups that were published between 1996 and 2003 in peer reviewed journals. We searched four peer reviewed psychiatric journals in Italy, and five each in England and Germany. Additionally, leading international journals were also hand searched for research papers from one of the three countries. Because of the vague connotation of the term "immigrant" we extended the inclusion to all papers reporting research on ethnic minorities, migrants, refugees and asylum seekers in any of the three countries. Theoretical articles, editorials, reviews, debates, case histories, letters and book reviews were excluded. The result was cross checked with a pubmed search using the following search items: ethnic, ethnic minority, multiethnic, migrants, immigrants, cultural, multicultural, transcultural, asylum, refugees. We may still have missed research that has not been published in peer reviewed and listed journals. Yet, one may assume that major research results would have seen the light of peer reviewed publication and, in any case, the searching method was identical for all three countries so that comparisons can be made.

In terms of papers on empirical research studies, the search identified a striking difference in the publication activities between the three countries. We found only two papers fulfilling the inclusion criteria in Italy, eight in Germany, and 82 in the United Kingdom (almost all of which were from England). One study in Italy investigated a sample of female immigrants from different origin and studied the association of quality of life and mental health in the sample (Frighi et al. 1997). The other study identified higher rates of depression in immigrants from Morocco as compared to immigrants from Senegal (Carta et al. 2001). Six out of the eight German papers reported studies on Turkish immigrants covering subjects such as Turkish translations of medication information, differences in psychopathological and diagnostic assessment between German and Turkish psychiatrist, and explanatory models for addictive behaviour in Turkish adolescents (Grube 2001; Haasen and Sardashti 2000). One study looked at a mixed group with a majority of Turkish immigrants and evaluated the effects of a specific treatment programme. One study investigated the relationship between depression and psycho-

social stress among immigrants from Iran, and anotherone showed a lower rate of mental health service utilisation in a mixed group of immigrants as compared to the general population. Six studies were cross sectional assessments, and two employed a case control design.

With respect to the 82 papers from the United Kingdom, it is much more difficult to summarise the targets groups, methodological approaches and findings. Most frequently addressed immigrant groups were those of African-Caribbean origin and from the Indian sub continent (eg Goater et al. 1999; McKenzie et al. 2003). Sixty-six studies employed a cross-sectional design and assessed rates of mental illness, pathways into care, service utilisation and administered treatment in different groups. There were five cohort studies and two randomised controlled trials. Whilst the findings are often heterogeneous, inconsistent and on very specific aspects, some conclusions can still be drawn. There appears to be substantial evidence showing that African-Caribbean patients have higher admission rates to psychiatric hospitals and, in particular, higher rates of involuntary admissions. Similar differences have not been consistently found for other immigrant populations (Bhui et al. 2003; Coid et al. 2000; Commander 1999; Harrison et al. 1999; Harrison 2002). Not surprisingly, the majority of papers reported research conducted in London, where more than 40% of all people from ethnic minorities in the country live.

The review clearly shows that the important issue of mental health care in immigrant populations has – at least in two out of three countries – not been taken up by research groups. As a result, policies and clinical practice can – at least in Germany and Italy – not be based on empirical findings. There appears to be no research culture in the field, and the few reported results are more or less isolated and do not provide a sound body of evidence. On this basis, there can hardly be a dialogue between researchers and practitioners on how to further develop services and clinical practice. Thus, concepts must be based on speculation and mere ideas, which may or may not be right, but are not backed by research evidence. To a degree, one might draw the same conclusion for England. Even in England, policies and practice is arguably not directly based on hard research evidence. Yet, the scale of the problem is clearly different between England on the one hand and Germany and Italy on the other.

As all three countries face large immigrant populations, why does only one of them conduct empirical research in the area? The answer is probably complicated and may touch on aspects of the wider research culture, resources and tasks of academic institutions, and a political dimension. Psychiatry in England has a stronger tradition in empirical research in general, which impacts on research in this specific area. Also, England has more academics who are immigrants themselves. Some of them have a strong interest in the issue and have developed a

specific research expertise. Immigrants in leading academic psychiatric positions are still unusual, although not unheard of, in Germany and Italy. The interest and expertise of research groups is one necessary condition to conduct good quality research, but researchers alone can only do “own account” research and resources for such research are often insufficient to carry out studies of the required scale and with sufficient methodological rigor. What is needed, is an interest of research funders who are able and willing to provide resources and steer research activities. It seems timely for research funders in Germany and Italy to recognise the challenge of mental health services to care for immigrant populations and underpin service development with an appropriate research programme.

Practical Mental Health Care in East London

Newham is a Borough with approximately 250,000 population in East London and culturally the most diverse area in Europe. East London has a long tradition of immigration, which reaches back at least 250 years. It has seen waves of large immigration populations, e.g. Huguenots from France in the 18th century, Jews from Eastern Europe in the 19th century and various groups from south Asia, in particular Bangladesh, in the 20th century. This tradition may have affected the culture and general attitude towards immigrants. Although there have been repeated incidents of racial clashes over the centuries, the overall tolerance and acceptance regarding all immigrants is relatively high and probably unusual.

Newham was the first Borough in the United Kingdom with the percentage of people from ethnic minorities reaching more than 50% of the population. Now, that percentage is over 60% with more than two-thirds of all school children being non-white. The population changes with a high degree of mobility both within England and with other countries and continents. A specific feature of Newham is that there is no single dominant immigrant population, but significant percentages of groups from at least 16 different origins (e.g. Pakistani, African-Caribbean, West African, East African, Indian, Bangladeshi, Eastern European).

Some of the discussion on how best to provide mental health care for patients from immigrant populations centres around the debate on whether the services should be culturally specific or culturally sensitive. There are various pros and cons for each approach. Advocates for culturally specific services argue that such services can deliver specific care because they are more familiar with the patients’ background, expectations and living circumstances. Opponents to culturally specific services suggest they present new forms of ghettos and, in a way, a kind of racism. Also, patients from immigrant populations themselves do often

prefer to be treated in mainstream services. In Newham, there is no chance to establish many culturally specific services, because the number of ethnic minorities is too high. Even if each of the eight psychiatrist consultants in Adult Mental Health Care with catchment area responsibility would be from a different immigrant population, the whole group of consultants would not cover the majority of immigrant groups. Culturally specific services are impossible to establish for shortage of resources and various practical reasons. Thus, the service has to be culturally sensitive, and each service has to deal with patients from many different immigrant groups.

The philosophy of the service is that good quality care eventually is of benefit for people from all groups including immigrants. Also, a genuine interest in other people's background, attitudes and behaviours fostering a positive therapeutic relationship maybe more important than specific knowledge, although the latter will inevitably be accumulated by many professionals over time. The approach is intended to be determined by mutual respect and commitment, i.e. not just tolerance. Many of the staff working in Newham have that respect and commitment, and without it they probably would not work there anyway, because in London there is always the option to work at a different place with a lesser degree of cultural diversity.

This overall approach needs to be supported through policies and, more importantly, a general culture of positive attitudes towards immigrants groups throughout the organisation. A major instrument to support such positive attitude is the staff mix. Services try and recruit staff from immigrant populations, and in some recruitment processes there is a type of reverse racism, i.e. a person from an immigrant population will be preferably recruited if all other aspects are equal between the candidates. This is not meant to be a system of quotas, and the intention is not to have an exact match between the populations served and the staffs mix in the services. The approach rather aims to create an open, respectful and interested atmosphere and the mentioned positive attitude throughout clinicians and management. The whole organisation providing statutory mental health services in Newham, the East London and the City Mental Health Trust, has indeed a cultural staff mix that roughly reflects the percentages of different ethnic groups in the population. However, this does not apply to every single group of immigrants, and some of them are over represented or under represented. More importantly, staff from certain immigrant groups has not been equally recruited to all levels of the hierarchy of clinical and managerial staff. Staff in the kitchen and cleaning services maybe more frequently from immigrant populations, as compared to leading managers and consultant psychiatrists. This is partly due to the available pool of staff on the labour market and the difficulty to recruit very qualified staff for leading positions from some immigrant population groups.

Avoiding discrimination and racism is one aspect. Another one is to exploit the specific strength and resources of different immigrant populations. For example, many patients from South Asian backgrounds live in large families and in communities with strong cohesion and mutual support. If that support is identified, reinforced and utilised, it is often possible to discharge patients from hospital treatment earlier and to provide patients with a form of living that is more autonomous and independent from mental health services than it would be possible for the majority of the general population.

Conclusions

What can be done to improve mental health care for immigrant populations in Western Europe? An obvious answer is the funding of more systematic and higher quality research. In our view, such research should meet the following criteria:

1. It should be of high methodological standard, including clear research questions, operationalised definitions of the investigated groups, transparent selection and recruitment processes, sufficient sample sizes, and a research design that can address the questions appropriately.
2. It should try and identify processes and patterns that help understand different phases of the migration process and its impact on mental illness. Thus, the research should lead to evidence on general and specific aspects of migration, and help to develop cultural sensitivity in services. Such a research will be different from hundreds of isolated studies looking at single aspects of mental illness of service provision in one or two groups in a specific social context. It might rather put the evidence together and yield predictive models for mental healthcare needs in immigrant populations that can be adjusted in line with the specific group characteristics and context.
3. It should have an international dimension. There is no point for each European country to re-invent the wheel. The critical mass of high quality research is small anyway, so that dividing it by national borders cannot be helpful.
4. With respect to practical mental health care, there should be studies that identify and explore positive practice rather than focus on failures of services.
5. It should acknowledge that the aim of mental health care cannot be that the outcome on each group is absolutely identical. Mental health care should rather aim at getting the best positive result in every group, and research methods should capture that.

Research takes time, and good research will be beneficial to service development in various ways. However, there also is a chance just to

learn from each other and visit examples of good practice in the same or other countries. This would be facilitated by more transparent and more easily available information on different service approaches to immigrant populations in different countries. The phenomenon of immigration is to stay with us, and mental health care for immigrant populations will remain a challenge for the foreseeable future. Good research can be helpful, good practice will be absolutely necessary to support integration and the development of a peaceful society with people from different backgrounds.

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