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Mental health, health care utilisation of migrants in Europe

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Abstract

Background – Migration during the 1990s has been high and has been characterised by new migrations. Migration has been a key force in the demographic changes of the European population. Due to the different condition of migration in Europe, variables related to mental health of migrants are: motivation for migration, living conditions in the home and in the host country.

Aims – To give an overview on (i) prevalence of mental disorders; suicide; alcohol and drug abuse; (ii) access to mental health and psychosocial care facilities of migrants in the European region, and (iii) utilisation of health and psychosocial institution of these migrants.

Methods – Non-system review of the literature concerning mental health disorders of migrants and their access to and their consumption of health care and psychosocial services in Europe.

Results – It is impossible to consider "migrants" as a homogeneous group concerning the risk for mental illness. The literature showed (i) mental health differs between migrant groups, (ii) access to psychosocial care facilities is influenced by the legal frame of the host country; (iii) mental health and consumption of care facilities is shaped by migrants used patterns of help-seeking and by the legal frame of the host country.

Conclusion – Data on migrant's mental health is scarce. Longitudinal studies are needed to describe mental health adjusting for life conditions in Europe to identify those factors which imply an increased risk of psychiatric disorders and influence help seeking for psychosocial care. In many European countries migrants fall outside the existing health and social services, particularly asylum seekers and undocumented immigrants.

Keywords: Migrants; Mental health; Access; Psychosocial services consumption

1. Background

Migration is a process during which a person moves from one cultural setting to another in order to settle for a longer period of time or permanently [26]. The number of migrants in the world has more than doubled since 1975, with most migrants living in Europe (56 million), Asia (50 million) and Northern America (41 million). In 1990, migrants accounted for over 15% of the population in 52 countries. Most of the migration was from developing to developed countries [14].

During the 20th century, Europe has experienced three major periods of movements: around the time of the First and Second World Wars and during last decade. Migration during the last decade has been high. The period characterised is by migrations from Eastern and Central European countries and from the Commonwealth of Independent States. Today different pattern of migration can be distinguished: the Northern and the Southern model. The Northern model is composed of Northern European countries (e.g. United Kingdom, Netherlands, Germany and Sweden among others) with long experience of immigration. The Southern model is composed of Southern European countries for which the immigration phenomenon is relatively recent (e.g. Spain or Portugal). The composition of immigration by countries is very different. The majority of immigrants in Central and Eastern Europe and Scandinavian countries come from elsewhere in Europe. Germany's immigrants like Austria's and Finland's are mainly from Central and Eastern Europe. The Mediterranean countries, the UK and Netherlands attract a high proportion of immigrants beyond Europe (Table 1).

Migration takes many forms, including forced and voluntary movement even if it is difficult to distinguish between

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Table 1
Estimated average annual numbers of migrants to selected Western European countries

	Average annual number of migrants (thousands)		
Receiving country	1990-1994	1995-1999	2000-2005
Migrant inflows			
France	120	128	191
Spain	33	66	483
Net migration			
Belgium	27	24	35
Denmark	10	15	10
Finland	8	3	5
Italy	60	115	.
Netherlands	54	49	48
Norway	8	11	12
Sweden	32	10	28
United Kingdom	22	82	101
Net migration by citizenship			
Germany	646	201	117
Foreigners	364	84	117
Citizens	282	117	60

Source: Calculated from the Population Division of the United Nations Secretariat, International migration flows to and from selected countries: 2005 Revision (POP/DB/MIG/FL/Rev.2005), database in digital form [55].
Note: One dot (.) signify data unavailable.

forced and voluntary migration; the reasons for migration often include both elements. While precise figures for the number of people moving for economic reasons remain elusive, it is estimated that over 200 million people move every year to find work and a better life. Of these at least 30 million are so-called undocumented immigrants.

Migrants can be defined in various ways, e.g., as internally displaced, asylum seekers, refugees, migrant worker, people with permanent or with temporary residence permits, tourists or foreign students, people without documents; and in some countries it is even more difficult, e.g. in Germany; German resettles from Eastern Europe there are in the UK, France and Italy. In some countries, people who did not migrate themselves but their parents or grandparents are called migrants (e.g. in Germany).

EU member states have been practicing a policy of closing borders throughout the 1990s. However, the policy of closed borders does not stop migration. While the percentage of migrants mainly in the urban inner areas of the big European cities may increase up to 40% like in Stuttgart and Frankfurt, Germany.

2. Migration und mental health

Cultural factors can play an important role in the diagnosis and treatment of individuals with psychological reactions to extreme stress. In particular, therapists need to consider that different cultures often have different concepts of health and disease [30, 38].

According to Wittchen *et al.* [57], approximately 27% of all Europeans between 18 and 65 years of age were affected by at least one mental disorder in 2004, and roughly a quarter of these individuals were in treatment. It can be assumed that persons of immigrant origin suffer from mental illnesses at least as frequently as non-immigrants [17,36]. Indeed, there is some indication that the rate of specific disorders such as psychoses [15] is higher among immigrants and their descendents due to their immigration-related experiences.

The difficult process of integration has been considered to be associated with a higher vulnerability for mental health problems [18,42], nonetheless the prevalence of mental disorders has not been found to be elevated among migrants in general.

Mental health of migrants seems to be influenced by experiences in their home country; the process of migration itself and by the living conditions in the new country. Among others, Sluzki [51] proposed a model of migration which defined migration as a process in the following stages:

- pre-emigration;
- migration;
- post-migration with the sub-stages:
  - overcompensation;
  - decompensation;
  - acculturation or assimilation.

Risk factors for mental health in the pre-emigration stage are associated with living conditions in the country of origin and may include violence, war and torture. Risk factors for mental health in the migration stage itself may include duration of the migration itself and experiences of violence. Risk factors for mental health in the post-migration stage include living conditions, legal and social frame in the country of immigration.

Both, legal and social status of migrants in the country of immigration is highly correlated with their perceived mental health [33]. Differences in social status depend on differences in income and/or capital [7,8]. Low social status is for non-migrants and for migrants associated with high risk for physical and mental health as well as for health related behaviours like smoking and drinking habits [43]. In Germany, nearly every second household with migrants, but only every third household without migrants lives below the official EC poverty line of 40% of the equivalence income. Knowledge about mental health of migrants in Europe still is limited due to lack of data [28]. From routine surveys migrants are often excluded in Europe. Studies carried out

are mostly clinical with limitations due to small samples size. Studies show diverse results.

First epidemiological studies on psychiatric disorders in immigrants date back to 1932 [47] and showed twice the risk for psychosis among Norwegian migrants immigrating to the United States as that for native-born Americans and Nowegians living in Norway. The increase in the rate of psychosis among migrants especially from Morocco, Suriname, Netherlands Antilles, Caribbean, Finland but not in other immigrant groups (Turkish, Western and Eastern European countries) is one of the most consistent findings. The mean weighted relative risk for developing schizophrenia among first-generation migrants of studies between the years 1977 and 2003 was 2.7 (95% confidence interval 2.3-3.2) [10]. In a Swedish cohort study from 2004, risk ratios for all ethnic minorities were diminished – and among non-Europeans virtually eliminated – by adjusting for socio-economic differences [23]. Studies investigating perceived discrimination to mental health found that discrimination perceived by ethnic minority groups may contribute to their increased risk of schizophrenia among some groups [56].

The rates of depressive disorders seem to vary according to migrant status. Using fluency in language as a proxy measure of acculturation, it appears that acculturated individuals are more likely to be depressed [21]. The findings of Mikolajczyk *et al.* [44] suggest that the differences in depressive symptoms between Non-Latino Whites and Latino adolescents disappear at least in some strata after adjusting for socio-demographic and social support variables. In a study on Soviet migrants to the US, Miller *et al.* [45] were able to show that a higher acculturation – measured according to language proficiency and "American" behaviour – was associated with lower depression scores. Longitudinal studies on mental health of migrants from Mexico to the US showed worsening mental health associated with length of stay in the USA [22]. Studies investigating perceived discrimination to mental health found that discrimination perceived by ethnic minority groups in Western Europe, or some factor closely related to it, may contribute to their increased risk of schizophrenia.

In general, the psychometric instruments used in studies on migrants mental health are not always culturally validated. The translations available often have not been validated for the respective cultural and linguistic groups. The problematic nature of standardised diagnostic tests in intercultural psychotherapy becomes particularly clear when we consider that most tests were designed with specifically Western notions of disease and symptoms in mind; their applicability to people of non-Western origin is thus limited [5].

Up to now, longitudinal studies on mental health of migrants are rare in the European région. The results of available studies are correlated with methodological patterns like e.g. small sample size, no control groups, limitations to only one ethnic group, no power calculation. In some studies, risk factors and confounders are not clearly separated.

3. Migrants and suicide

High rates of suicide and attempted suicide among migrants in EU countries are reported and have been linked to their high rates of depression. In the Netherlands, where unemployment rates among migrants in the early 1990's were high, the suicide rate among children of migrants was also higher than in the general population [13]. In Rotterdam, children of Turkish immigrants were reported to be five times as likely as Dutch children to commit suicide, and Moroccan young people were three times more likely to do so. In the United Kingdom, suicide rates for women from the Indian sub-continent tend to be higher than for men, especially among girls and women aged 15-34 [27]. The data also suggest that second generation migrants may be at greater risk of suicide than their first generation parents [24]. A recent study indicates that there are substantial differences in suicide mortality between native Dutch and migrant groups in the Netherlands. Of the major non-western migrant groups in the Netherlands, suicide mortality was significantly lower among Turks and Moroccans, whereas it was higher among migrants from Surinam [16]. Turks living in Germany have also a lower suicide mortality than Germans. Possible explanations include a high level of social coherence in the Turkish community and religious prohibitions. However, the high suicide rate among Turkish girls and young women could indicate the presence of social or cultural conflict situations [50]. Suicide mortality is usually higher among men than among women. In socially disadvantaged groups, this relationship can be reversed, but ethnic groups differed.

4. Migrants and addiction

Knowledge about addiction of migrants in Europe is limited due to lack of data.

Nevertheless, until the mid-1990s, experts in the field of addictive disorders paid little attention to the subject of addiction in migrants. In Germany, for example, there are still no nationwide statistics on the prevalence of addiction in this population group, although data from individual cities suggest that the number of migrants with addictive disorders corresponds to, or even exceeds, their percentage of the general population [4].

The literature has cited a number of barriers to access, including language difficulties, lack of knowledge about the public system of addiction treatment, mistrust of government institutions [12], and fear of losing residence rights [19] or even of imprisonment [48]. However, access barriers can also result from a culturally different understanding of the causes and treatment of addictive behaviour [49].

Kleinman [30] developed the concept of "explanatory models" of morbidity in association to addiction. The explanatory model is a model how the understanding of illness and disease is shaped by culturally shaped knowledge. Research on explanatory models of Turkish youth found differences between the disorder concepts of Turkish and German youth. German but not Turkish youths classified eating disorders among severe addictive disorders and associated them with embarrassment and shame. Concerning substance abuse, German but not Turkish youths differentiated between illegal drug abuse and the abuse of alcohol and nicotine. Nearly half of all Turkish youths rejected central medical concepts such as "physical dependence" or "reduced control of substance intake" as completely inadequate to characterize problems of addictive behaviour [49].

5. Access to health care

Limited access to health care and a system fraught with discriminatory practices inhibit some ethnic minorities from gaining access to health care and assurance of equal treatment once they enter the health care system [9]. Immigrant status is associated with lower rates of use of mental health services, even with universal health insurance. This lower rate of utilisation of care likely reflects cultural and linguistic barriers to care [29].

Overall the studies indicate that language barriers are associated with longer visit time per clinic visit, less frequent clinic visits, less understanding of physician's explanation, more lab tests, more emergency room visits, less follow-up, and less satisfaction with health services. The results also indicate that people who are older, poorer, and female tend to have more language barriers compared to those who are younger, wealthier, and male. Improvement of communication between patients and providers in relation to health disparity consists of cultural competency and communication skills [58].

Access to health care for migrants is provided in agreement with national rules. For example, in Germany all insured people are entitled to utilization of health and psychosocial care institutions. Asylum seekers often have restricted access to healthcare utilization. Migrants without legal documents are in some countries not entitled to healthcare utilisation.

The utilisation of more specialised health care seems to be lower among immigrant groups in the Netherlands, particularly for Turkish and Moroccan people and to a lesser extent, people from the Netherlands Antilles. Although underuse of more specialised services is also present among the lower socioeconomic groups in the Netherlands, the analyses indicate that this only partly explains the lower utilisation of these services among immigrant groups [52]. Nevertheless, persons of immigrant origin in Switzerland or the United States, for example, are considerably less likely than their non-immigrant counterparts to consult professional health care services [35,39,59].

6. Migrants' health and psychosocial care consumption

Characteristic of migrants' pathways to psychiatric care are delays in seeking professional help, a lower probability of medical referral, frequent involvement of the police and emergency services and high proportions of compulsory and secure-unit admissions. [53] Immigrants tend to be unfamiliar with the respective health care of the country of immigration in terms of navigating needed services and/or seeking health-related information.

Among migrants to Europe, the problems of adapting to a new health culture are linked to both a lack of information about the health care available and subsequently their experience with that health care system. Health professionals report difficulties in communicating effectively with these populations about symptoms and risk-taking behaviours.

There seems to be a differential utilization of health and psychosocial care by migrants: psychiatric emergency care is used – at least by some groups – more frequently. Rehabilitation and psychotherapy are less used by migrants than by natives.

Utilisation of mental health care among others of migrants is predicted by acculturation characteristics. This result suggests an effect of cultural and migrant-specific factors in help-seeking behaviour and barriers to mental health care facilities. However, studies often do not adjust for factors like age, sex or class. Data from routine registers show more migrants in locked and in forensic wards [25,37]. Some authors suggest that health care of migrants is worse than health care for non-migrants because of these institutions are less frequently used [6]. Also, prevention and screening seem to be used less. Because of the lack of control groups in these investigations, it is unknown whether health and psychosocial care institutions are used differently even after adjusting for age and class.

There is some evidence that the quality of health and psychosocial care for migrants may be affected by access barriers, like structures or financing of health care, linguistic or communicative skills, demands of migrants and expectations of health care providers.

Assessment of professional care of addicted migrants shows less use of psychosocial institutions in Germany. Reasons for the reduced use of these institutions may be associated with lack of knowledge on psychosocial and health care institutions. In some countries (e.g. Germany), drug addiction is a legal reason for expulsing migrants. Educational resources and addiction preventive approaches only partially reach migrants. Barriers to accessing information, specifically written material, are often reported [9,49].

7. Intercultural competence of people working in health and psychosocial care institutions

Some studies suggest that providing health and/or psychosocial care to migrants is accompanied by feelings of uncertainty by providers, as the learned professional behaviour may not be appropriate when caring for migrants. Carers may feel incompetent and consequently efficiency of care may get unsettled.

Therefore, the development of „cultural competence; and of diversity management "may be pivotal for adequate health care for migrants. "Cultural competence" was conceptualized 1989 in the United States of America. The aim was to improve care for children of migrants. This concept was modified often the following years [1]. Cultural competence as concept includes knowledge, behaviour and emotions. The concept was further developed to include generic, medical and psychiatry-specific competences. Generic competences are curiosity, cultural sensitivity and empathy, and ability of adjustment of culturally relevant relations. Medicine-specific competences are diagnostic and therapeutic and knowledge of culture specific symptoms [11]. Psychiatry specific cultural competence includes the ability for cultural guidance in the therapeutic relationship.

To improve quality of care, it was demanded to change health and psychosocial care by means of "intercultural opening"("diversity management"). In most European countries a multiplicity of guidelines and proposals exist proposing measures to improving health care for migrants. 2002 the "German Society for Psychiatry and Psychotherapy" (DGPPN) [41] published guidelines demanding e.g. (i) teams of health care providers from diverse ethnic backgrounds; (ii) use of interpreters; (iii) cooperation of health and psychosocial care; (iv) multilingual information; (v) patient or client involvement into the organisation of health and psychosocial care. Health care consumption rates differ among migrant groups.

Studies investigating health and psychosocial care delivery for migrants in psychosocial institutions showed that interaction of health care providers and health care clients was influenced by social status of clients. Patients with low social status less frequently spoke with health care providers than middle or upper class clients. Besides interaction, communication was investigated as linguistic skills are looked upon as basic skills for communication. Evidence is conflicting whether the importance of linguistic skills is overvalued.

An important consideration may be that most studies of migrants' mental health are based on rates of treated cases. It is known that rates of treated cases are positively related to higher social class [40]. Consequently, migrants may be underrepresented rather than overrepresented in treatment samples.

8. Conclusion and outlook

Still we know little about migrants'mental health. We can often only speculate, why the incidence or prevalence of certain mental disorders is so markedly above or below average in certain groups. The individual, cultural and social factors that play a role here are presumably multiple and mutually interconnected, so that only further and more detailed research can provide an answer. The numbers and patterns do, however, call for extra attention and alertness.

Migrants in most European countries utilise psychosocial and for health care differently from non-migrants [2,20,35,34,39,59,54]. Addressing the mental health needs of refugees and other migrants requires a multidimensional approach that acknowledges the impact of experiences on mental health in the context of migration process. Access barriers may originate in the legal frame, lack of knowledge or in communication problems [35,3,54]. Help-seeking behaviour may differ because of differences in treatment – seeking behaviour and in the explanatory models for mental health or for addiction [30,49].

Structural racism and anti-immigrant practices determine in some European countries the poor working conditions, living conditions, and health of migrants [9,46,32]

There remain gaps in knowledge about the access and use of health services by subpopulations from different cultural groups in terms of their gender, learning practices, ways of navigating services, and help-seeking behaviours.

However, ignoring common ground creates distance between migrant groups and between migrant and non immigrants. Highly needed are therefore quality criteria for studies on migrants health to disentangle effects of ethnicity, migration related experiences and socio-demographic status on mental health of migrants. Prevalence rates based on treatement samples may not yield valid estimates, because of the well-known differences in service consumption and diagnostic uncertainties [15,31,20]. Highly needed are population-based incidence studies utilising defined denominators to get further insight into the association on migration and mental health.

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