Mental Health Inequalities in Europe - Migrant Mental Health

An Associated Event of the UK Presidency of the EU Health Programme

Radisson SAS Hotel, London Stansted Airport, UK

7-8 November 2005

The first day of a two-day seminar on Mental Health Inequalities in Europe, held at the Radisson SAS Hotel, London Stansted Airport, UK, on 7-8 November 2005, was dedicated to Migrant Mental Health. Delegates from 30 European countries were welcomed to the event by Professor Kamlesh Patel, Head of the Centre for Ethnicity & Health, University of Central Lancashire, UK. He expressed the hope that the day would help services "to respond to the challenges that are borne out of the particular mental health needs of minority and migrant communities".

The UK has experienced several waves of migration over the last 50 years, Professor Patel pointed out. One of these, in the late 50s and early 60s, included people from black and ethnic communities who were responding to a call for labour after the World War. A second significant wave is the more recent arrival of what the UK terms 'refugees and asylum seekers'.

"Many of the second wave of migrants have not left their homes willingly, but have been forced to escape wars, torture, famine and destitution," said Professor Patel. "Many suffer from Traumatic Stress Disorder; others the distress associated with loss, change and upheaval. Many unfortunately do not find a sympathetic response in the countries to which they travel."

Loneliness, isolation, loss, unworthiness, uselessness, fear, frustration, poverty, alienation, a traumatic past and a very uncertain future are some of the specific issues that impact on the mental health of recently arrived refugee and asylum seekers in the UK.

Whether people migrate to the UK because they want to come, or whether they have little choice, Professor Patel stresses that their experience of health and social care services, especially mental health care, needs, and continues to need, urgent improvement.

"Our intention is to encourage a wide debate on the subject and to focus on the needs of these first generation or new immigrant individuals and communities," he said. "We need to think of ways we can address and tackle the distress that they experience and the way in which they access services."

Mental Health Inequalities in Europe

Associated Event of the UK Presidency of the EU Health Programme

7-8 November 2005

MENTAL HEALTH INEQUALITIES IN EUROPE - DAY ONE
ASSOCIATED EVENT OF THE UK PRESIDENCY OF THE EU HEALTH PROGRAMME 7-8 NOVEMBER 2005

1

Address by Rosie Winterton MP
Minister of State for Health Services

The enormous opportunity presented by the growth of Europe and the increasing mobility of its populations was a starting point for the Minister of State.

She pointed to the contribution being made by migrants to the UK economy "that runs into billions every year" and to their own economies when they send money home or return with new skills and experience.

However, she also recognised the enormous stresses migration places on individuals. This is a message, she said, that needs to be put over to communities who often take in people from other countries without understanding the challenges they face.

International co-operation in fostering awareness, reducing stigma and promoting social inclusion had been signalled with the signing of the European Declaration on Mental Health at a WHO conference in Helsinki in January 2005, said the Minister.

The UK will take forward this work with cross-Government action to tackle inequalities and to reduce social exclusion, but also with the development and implementation of new service models for community mental health.

"So we are taking action," said the Minister. "In January we published a five-year plan for tackling the inequalities that can blight people's lives. The important thing is that the programme brings together most of the key stakeholders including Government departments, the independent sector and the organisations charged with regulating services and enforcing standards."

Narrowing health inequalities is essential, she said, in creating a Europe that offers social justice and prosperity for all. "That is why I think events like this are so important - they help us share ideas and understand what works best in different countries."

Mental Health in an Increasingly Mobile & Enlarged Europe
Chaired by Professor Bill Fulford, University of Warwick, UK
The IOM Position Paper on Psychosocial & Mental Well-Being of Migrants
Dr Danielle Grondin, Director Migration Health Department, International Organization for Migration, Geneva, Switzerland

In December 2003 the IOM presented a policy paper entitled *Psycho-social and Mental Well-being of Migrants* to its Member States.

The paper's objectives are to raise awareness of the implication of migration processes on the mental well-being of migrants and to streamline psycho-social and mental health activities within the Organization. It also aims to improve the quality of the service delivered both to migrants in need of support and to Governments and others in need of advice.

Dr Grondin said migrants now represent 2.9 per cent of the global population. All types of migrants are represented in Europe, including asylum seekers, refugees, labour migrants, irregular migrants, trafficked or smuggled migrants.

> "Sense of loss is an important indicator for mental ill-being in migrant populations and unfortunately it is usually overlooked."

"Regardless of the type of migrant, we have to look at the person," she said. "Migration is usually a major life event, whether the movement is voluntary or involuntary. To some it can become a

crisis, so the condition of the journey, the so-called 'migration related stresses', as well as the different stages of the journey itself, carry with them specific risk which can lead to increased vulnerability to mental ill-being among migrant populations."

Dr Grondin outlined some migration-related stresses, including experiences before departure, such as war, poverty, and human rights violations. Once uprooted, the migrant also often suffers what she describes as 'social mourning' - loss of home, separation from family and community, loss of a sense of belonging, loss of job, career, and position in their community at home or in society.

"So sense of loss is an important indicator for mental ill-being in migrant populations and unfortunately it is usually overlooked," she said.

When migrants settle in host countries, language barriers and cultural alienation further hinder communication and lead to a feeling of loneliness and helplessness. Failure of host communities and societies in dealing with the experience of human rights abuses and traumatic events hinder successful integration into host communities and successful contribution of migrants to the societies in which they live.

Healthy social behaviour is, to some extent, dependent on an individual's mental health. In this respect, Dr Grondin said, the IOM believes that programmes designed to promote mental well-being could prevent a range of problems within society.

The IOM has developed guiding principles to apply to mental health programmes in the context of migration. These include adapting programmes to specific target populations and cultures; designing programmes by working with the community; and ensuring that any programme should be set up with its future integration into the national structures in mind. Adopting a multidisciplinary approach, as well as ensuring interagency co-ordination and partnerships, also feature among the guiding principles.

Refugee Trauma and Beyond
Professor Renos Papadopoulos, University of Essex, UK

Prof Papadopoulos questioned whether it is misguided to "look under the lamp-post" of existing mental health, psychiatry and psychology terminology in trying to understand and address the refugee situation. "What is the refugee situation in its own right?" he asked. "If we see it from the traditional psychological perspective, we end up gravitating towards the idea of trauma".

Prof Papadopoulos suggested it is important to look at refugee trauma in terms of at least four phases and not to be limited only to the phase of devastating events.

The first phase is what he terms "anticipation" - when people hear that something terrible has happened in a village near them, for example, and have to decide what to do, what to take with them and where to go. These decisions mark not only the fate of the family, but also the fate of generations to come.

The second is the phase of devastating events and the third that of survival. The latter covers a period when refugees are safe, but they experience trauma because they have no access to information, don't know what has happened to their loved ones, and their fate is dependent upon warlords, politicians etc.

"This is actually quiet suffering and it can be very soul-destroying," he said.

"Finally, we have the adaptation phase, which is when refugees arrive safely in another country," said Prof Papadopoulos. "It seems to me that perhaps this phase may be even more traumatic than all of the others put together."

The professor stresses the importance of being aware of the "whole sequence of traumatic events", and not just the impact of the devastating events. Also he emphasises the need to look not only at the individual but also at the wider contexts that include the family, community and culture.

He concluded by saying that our task should be to focus in refugees not only on their trauma but also to trace their resilience as well as what he terms "adversity activated development". This is when functions, sensitivities, abilities, strengths and motivation emerge for the first time as a result of the experience of adversity.

"As well as looking at how we treat the pathology, we also need to consider how we can activate this type of development which leads to a new sense of purpose in life and a new meaning," he said.

Ethnicity, Migration and Mental Illness

Chair: Dr Danielle Grondin, International Organization for Migrants, Geneva, Switzerland

Ethnicity, Migration and Psychosis in a UK Context

Dr Craig Morgan, Institute of Psychiatry, London, UK

Results of the Aesop (Aetiology and Ethnicity in Schizophrenia and Other Psychosis) study of ethnicity and psychosis, conducted for the past eight years at the Institute of Psychiatry in London and other centres in the UK, were presented by Dr Morgan.

He pointed out that research looking at ethnicity and mental health has been dominated by consistently reported high rates of schizophrenia and other psychoses among the African Caribbean population in the UK, and equally consistently reported high rates of compulsory admissions to hospital amongst the same population.

Findings from recent studies have shown that the excess of psychosis is not restricted to first generation migrants but is also evident in second and subsequent generation migrants.

Data from the AESOP study, focusing solely on Nottingham and London, has confirmed a marked increase across all psychoses in the African Caribbean population and in the black African population. This is particularly marked for narrowly defined schizophrenia and for manic psychosis.

Most commentators believe that the reason is to do with social environment. The fact that incidence rates for psychosis in the Caribbean are similar as for the white British population in the UK supports this view, showing that population differences and genetic risk are unlikely to account for the reported excess.

The Nottingham and London data shows that separation from parents early in childhood – particularly from the father – is associated with an increased risk of psychosis. It also shows that social exclusion is associated with this form of mental ill-health.

Dr Morgan offered some caveats. "What we have done here is establish associations and no more," he said. "The findings are suggestive and intriguing and certainly merit further investigation.

"In relation to separation from parents, what is likely to be important is not so much the fact of the separation itself, but the fact of what goes before and what comes after. Separation is likely to be a marker for prior family discord and subsequent adverse consequences in terms of economic hardship and so on. So it is perhaps better to think of the separation variable more as a risk marker than as a risk factor."

Dr Jean Paul Selten,
Associate Professor, Department of Psychiatry, Utrecht, Netherlands

The increased risk of migrants developing schizophrenia, along with analysis of the possible reasons for it, was reported by Dr Selten.

A meta-analysis of all incidence studies of schizophrenia in migrants, carried out by himself and Swedish colleague Dr Cantor-Graae, has confirmed the higher risk in migrant populations. However, it is notable that second generation migrants have a higher relative risk (4.5) than their first generation counterparts (2.7).

"We think that the explanation for this is that it is more humiliating to be unwelcome in a country that you were born in, than if you had come to it from somewhere else," said Dr Selten.

> ## "It is more humiliating to be unwelcome in a country that you were born in, than if you had come to it from somewhere else."

"We also looked at whether the skin colour of the migrants was of influence for the risk and we made a remarkable finding. Studies conducted in Europe showed that if you live in Europe and your skin colour is black, your risk of becoming a schizophrenic is five times as high as for white Europeans. And this, I think, points to the possible role of racism and discrimination."

However, the most problematic group in the Netherlands are second generation Moroccan males. Their risk is eight times increased. In Denmark, the Greenlanders are at an even higher risk – 12.4.

"What these groups have in common is that they are very unsuccessful in a society," said Dr Selten. Adding that an increased risk is also found among people raised in cities and in people with a low IQ, Dr Selten posed the hypothesis that long-term exposure to "social defeat" explains the increased risk of developing schizophrenia found in all these groups.

He went on to say that experiments in rats have shown that if a male rat is put into the cage of another rat, the resident will attack him and prompt him into submissive behaviour. If this experiment is repeated several times, and the rat is injected with drugs, such as cocaine or amphetamine, it produces an increased amount of dopamine.

Schizophrenic patients injected with amphetamine also produce a lot more dopamine than a healthy person, leading to the conclusion that schizophrenic patients, in some aspects, resemble defeated animals.

"Our hypothesis is that chronic exposure to social defeat leads to sensitisation of the mesolimbic dopamine system and that psychosis may be a long-term consequence," Dr Selten concluded.

Mental Health & Social Exclusion in Minority Groups

Chair: Dr Parimala Moodley, The Royal College of Psychiatrists, UK

The impact of social exclusion, racism and discrimination on the experiences and mental health of minority groups

Dr Kwame McKenzie, University College London, UK

In a presentation on racism and its impact on mental health, Dr McKenzie began by pointing out that there are different rates of some mental illnesses across different migrant populations. In asylum seeker and refugee groups, there are high rates of common mental disorders, including post traumatic stress disorder and high rates of mental distress, which do not meet any diagnostic criteria.

In recent migrants, there are high rates of adjustment disorders. In the UK, in first generation migrants, high rates of common mental disorders, psychosis and suicides (nb. only in some ethnic minority groups) can be observed.

In the second generation, common mental disorders may be less evident, but there are higher rates of psychosis and increasing rates of suicide.

So what are the reasons for these increased rates of various illnesses? In the asylum seeker/refugee population, Dr McKenzie highlighted the impact of the reasons for migration and the migration process itself. The asylum system and the asylum seekers' social and economic status are also relevant.

For the second generation, thwarted aspirations and the stress due to dual cultural heritage are both important factors to bear in mind.

Dr McKenzie sought to define racism, suggesting it combines discrimination - the idea that you can treat people differently because they look different – with an oppressive system of racial relations in which one racial group benefits from dominating another. Racism, he said, is a complex concept, including inter-personal events, socio economic disadvantage due to race and institutional racism, experienced by those in receipt of public services, health and the criminal justice system.

> **"Racism is common, it's complex and it's a risk factor for mental illness in migrant groups."**

UK government surveys show 65 per cent of people from ethnic minority groups believe that employers discriminate against them and 14 per cent of the black and minority ethnic population in England and Wales have suffered serious racist abuse or attack in the last year. Between 25 and 40 per cent of people say they would discriminate against somebody else because they were African, or of Caribbean or south Asian origin.

In mental health services, Dr McKenzie pointed out that someone is much more likely to be treated against their will, given an injection as opposed to tablets, and to end up in secure services if they are black. They are also less likely to be given psychotherapy. This, he says, is institutional racism. There are four hypotheses of how racism can affect someone's health – through socially inflicted trauma; economic and social inequality; inadequate, inappropriate or degrading medical care; and targeted marketing of commodities that can cause harm to health, such as alcohol and tobacco.

"Racism is not just a stressful one-off event; it's a three-stage model," said Dr McKenzie. "You get a stressful event; then you get increased stress because you realise that it's unfair; and then you get another level of stress because you often can't do anything about it."

Studies looking at the impact of racism in mental health show that victims of racism are likely to have low scores on well-being, depression and psychosis. Victims of verbal abuse are three times more likely to suffer from a psychosis, while victims of a racist attack are five times more likely to suffer from a psychosis.

"Racism is common, it's complex and it's a risk factor for mental illness in migrant groups," Dr McKenzie concluded. "It seems to be a major public health issue. The real question is why aren't we doing more about it?"

Dr David Ingleby,
Professor of Intercultural Psychology, Department of Interdisciplinary Social Science, Utrecht University, Netherlands

Prof Ingleby began by observing that although The Netherlands pioneered multicultural mental health care in the 1980s and 1990s, the action now seems to have shifted to the UK. However, as an 'expatriate Briton' he views the emphasis on racism in the work of researchers such as Dr McKenzie as "typically British and American". In the rest of Europe, these topics are usually discussed in terms of discrimination, marginalisation or social exclusion.

"We should use the term racism more carefully. It's appropriate when describing discrimination based on notions of genetic superiority and inferiority - prejudices rooted in a colonial past or, in the case of America, in slavery. However, it confuses the issue to talk about racism when prejudice is aimed at a person's culture, ethnicity or religion. Tackling these forms of discrimination is no less important.

Prof Ingleby points out that discrimination is closely linked to social exclusion and disadvantage and that it is very hard to disentangle the effects of all these factors from each other.

> **"I think there is very little chance of European Governments getting over consistent messages about diversity and multi-culturalism…"**

He said that a positive case has to be made for social inclusion and acceptance of diversity and that this is a political issue - how strong is a country's commitment to diversity? "Unfortunately I think there is very little chance of European governments getting over consistent messages about diversity and multiculturalism, because they are in confusion and are strongly polarised," he concluded. "The messages from health experts are very important, but in the last resort, it's a question of values and political choices."

Access to Care & Health Care Utilisation among Asylum Seekers & Refugees

Chair: Professor David Sallah, National Institute for Mental Health in England

Dr Jean Furtos and Dr Christian Laval, Lyon, France

The different types of accommodation offered to asylum seekers and their links to psychological services was referred to by Dr Furtos.

In night refuges, hostels and emergency shelters, he said, it is impossible to provide continuity of care. If little is known about how asylum seekers move from one place to another, the professionals treating them do not pick up on violence, either to themselves or to others, or the deeper psychiatric symptoms they suffer from, such as psychosis.

Multi-purpose accommodation, including so-called hotels, shelters and rooms offered by local charities, is usually aimed at single men, rather than families. In this setting, psychological support is available if needed. "It remains, however, at a low level due to the length of waiting time for treatment and uncertain social conditions," said Dr Furtos. "Specialist psychiatric care is still offered only at a time of crisis."

The third type is specific accommodation, offered while the asylum procedure is under way. A much more integrated social system exists in these centres.

"If health is a common right to be valued, access to care becomes part of the right of asylum," said Dr Laval.

Dr Laval said that the plight of asylum seekers causes many problems for health professionals. "In many psycho-social clinics one observes the malaise among staff," he said. "It is a kind of internalised suffering, carried on behalf of the asylum seekers." Uncertainty about what is expected of different professionals adds to this problem.

Professionals also feel paralysed by the horror of asylum seekers' experiences. "They feel that they have been mistreated themselves," said Dr Furtos. "They are sharing a breakdown of social links and of personal identity, even though they know they have to keep a necessary distance and neutrality."

But some professionals' feelings are also related to failures within the welcoming country. The professional is part of an imperfect structure and that is difficult to live with.

The result for the professional is two-fold. The negative outcome is tension, stress and burn-out. The positive outcome is that the more ill at ease they feel, the more they want to let the hierarchy know, and to make them put things right.

Ann McDonald,
National Resource Centre for Ethnic Minority Health, Scotland, UK

For overcoming language barriers, it is important to use professional interpreters, and not children or family members, because each person has their own story and they have to be able to tell it in confidence.

Orientation is about letting people know where services are and how to access them, while the belief system is to do with offering culturally competent services. In dealing with asylum issues, it is important to signpost services to other agencies that can give appropriate help. The role of local communities is vital and this means breaking down myths and barriers and helping people understand the issues asylum seekers face.

Other issues include working closely with police and fire services in order that people in uniform are seen as a helpful service rather than a threat. It is also important to understand that some behaviours, such as leaving children at home unaccompanied, is not necessarily a child protection matter, but one of education and support. Many families come from countries where there are dangers such as landmines, so it may have been safer to leave children at home. The work of healthcare staff from primary care services encourages education, prevention and promotion of health services.

Dealing with issues including anxiety, depression, sometimes caused by the effect of separation from other family members, they experience "culture shock".

A longitudinal study involving 123 families is currently under way to assess how well these people have integrated into the community and what their uptake of services is. A services action plan will be based on the research results.

Over the past five years, the number of asylum seekers and refugees in Glasgow has risen from around 400 to more than 12,000. "This has meant that healthcare professionals have had to learn very quickly on their feet how to get services in place for families," said Ann McDonald.

In Scotland, a Global Model of Care has been derived from inter-agency working health, education, police and asylum services, working together with voluntary agencies, churches and faith groups. The word "global" spells out the knowledge required to address the needs of asylum seekers - geography, language, orientation, belief system, asylum issues and local communities.

Geography is important because it opens communication channels, allowing asylum seekers and refugees to discuss in detail where they have been and where they are going, both physically and psychologically.

Mental Health of Women and Children in Immigrant Families

Chair: Dr Rachid Bennegadi, Minowska Institute, France

Access to culturally competent care and key indicators of child and family well-being

Professor Nora Ahlberg, Professor and Research Director,
Norwegian Centre for Minority Health Research (NAKMI), Oslo, Norway

"The control of immigration has changed its form towards humanitarian refugee concerns and family reunion," said Prof Ahlberg. "However, the complexity of the situation is not always understood due to limited data or a lack of knowledge about how culture works."

A complex web of influences applies to the psycho-social vulnerability of migrants and there is a danger that the health and social service sector could cause additional harm through a simplistic understanding of the problems of integration.

The meaning of health and illness is elusive and culturally bound and often defined by its absence. "People may consider themselves quite healthy despite medical symptoms," Prof Ahlberg pointed out.

Problems faced by migrants are often accumulative and include changes in both socio-cultural and economic circumstances. "Migration is also age-selective and creates breaches in the care surrounding old people and children, in particular," said Prof Ahlberg. "Parents may become dependent on their children for translation and information about the new society."

Varying symptomatic and mental illness profiles present challenges to health and social services. Migrants seem to be more vulnerable to lifestyle-related disease than the majority population, even if they might drink and smoke less. Psychological symptoms, such as anxiety and depression, are also more prevalent among non-Western migrants.

Mental health is the complex interaction of biological, psycho-social and cultural factors. "We speak of a relatively young and thus healthier population, which shows variation among nationalities, but when migrants get sick they seem to be hit harder than others, a fact that points towards possible problems within the system," said Prof Ahlberg. She suggested this arises, in part, because of lack of understanding between migrants and health professionals causing "mutual avoidance behaviour".

All in all, it is difficult to generalise about health and migration, not least because illness narratives might conceal cross-cultural, class-related and communicative problems. The mix of inter-disciplinary factors is complex and generally badly understood within the mainstream health system. Migration and subsequent minority positioning is a major life event which might trigger accumulating mental and symptomatic health problems.

"However, it is important to point out that migrants are not foremost illness carriers," Prof Ahlberg concluded. "For those who manage well, migration is a source of renewal, but during relocation many confront circumstances that increase their vulnerability to infections and psycho-social or lifestyle-related health problems."

Dr Anders Hjern,
MD, Adjunct Professor, Centre for Epidemiology,
National Board of Health and Welfare, Stockholm, Sweden

Dr Hjern's presentation centred on his research in 1986/87 involving 63 children – mostly six year-olds – who had recently arrived in Sweden.

Experience preceding the families' arrival in Sweden initially gave rise to many psychosomatic and psychiatric symptoms. A year later, the trauma was fading, at least in the children. The main problems had become the asylum enquiry itself and poor accommodation.

When the families were re-visited six years later, life in Sweden had become the main focus of their lives. This was a period of economic crisis and high unemployment.

In 2002, Dr Hjern compared children who were either born in Chile or Iran, the two main countries during the 1980s where Sweden's refugees came from, with a group of children from Swedish-born parents. Suicide rates, psychotic disorders and use of drugs were all higher in the former group.

His next step was to discover the reasons for this. Following up children who now shared a mean age of 29, he discovered that the Iranians had done extremely well in school and almost half of them had a university education. This was not the case for the Chileans. When he looked at employment trends, he discovered that, although 50% of Iranians had a university education, 50% did not have an income. The Chileans did better, but they didn't do as well as the Swedes.

"I think this says something about where in the labour market you are accepted if you have foreign heritage in Sweden," said Dr Hjern. "It's ok to clean floors but it is not ok to be a dentist. We Swedish people still think that we are the champions of human rights in the world. It's therefore very difficult for us to realise that discrimination and racism is a big problem in our country as well."

8

MENTAL HEALTH INEQUALITIES IN EUROPE – DAY ONE
ASSOCIATED EVENT OF THE UK PRESIDENCY OF THE EU HEALTH PROGRAMME 7-8 NOVEMBER 2005