Identification of Emotional Distress Among Asylum Seekers and Migrant Workers by Primary Care Physicians: A Brief Report

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ABSTRACT

Background: Emotional distress (ED) is prevalent among immigrants. The open clinic of Physicians for Human Rights (PHR)-Israel provides free medical and psychiatric treatment to immigrants without access to the ambulatory health service. In 2010, the psychiatric records represented 1% of the total medical files (N=28,000) in the open clinic. Objective: To compare service users' self-reported ED and its identification by general practitioners (GP) and to identify socio-demographic variables associated with ED.

Method: A convenience sample (N=97) of the general medical service users completed the 12-item version of the General Health Questionnaire (GHQ-12). A score of 11 or above was considered a suspected mental disorder. The GPs' clinical assessment of ED was compared with the self-reported score.

Results: The sample's mean GHQ-12 score was higher than the threshold (M=12.7, SD=6.3, range 0-35). Fifty three percent (n=51) had a GHQ-12 score higher than 11, and 8% (n=8) were identified by the GPs as emotionally distressed and/or in need of psychiatric care. The mean score of the study sample was higher than that found in past studies regarding the Arab-Israeli general population (M=10.8, SD=0.35). Employment was the only socio-demographic variable significantly associated with ED.

Conclusions: ED was high among immigrants, but under-diagnosed by GPs. Employment might serve as a protective factor for ED.

INTRODUCTION

Migration is an ever-increasing global phenomenon with public and individual emotional health implications (1). Immigrants are a heterogeneous group that includes, among others: migrant workers, refugees and asylum seekers (2). Reported rates of emotional distress (ED) and mental health problems vary in different studies and in different immigrant groups, but are usually higher than that found in the general population (3, 4). In contrast to the high level of reported ED, reports show low rates of mental health service utilization (5, 6). Although primary care practice was described as "*de facto* mental health care system" (7), there is a low detection rate of ED or psychiatric disorders as diagnosed by GPs in Israel (8, 9) and elsewhere (10, 11), and particularly among immigrant populations (12, 13). The restricted access to specialized psychiatric services emphasizes the important role of GPs who serve this population (13). If left untreated, these health issues will affect the long-term health of immigrants (14).

Influenced by world trends and the geopolitical climate, Israel has faced waves of non-Jewish immigration, including of migrant workers (both documented and undocumented), mainly from Asia, and asylum seekers, mainly from East Africa (i.e., Sudan, Eritrea) (15, 16). The open clinic for migrant workers, refugees and asylum seekers was established in 1998 by Physicians for Human Rights (PHR)-Israel to deliver free health services to populations that are not eligible for mandatory national health insurance. The clinic provides primary health care and specialized services, including

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Table 1: *Demographic characteristics of participants (N=97)*

		N(%)/Average (SD)			N(%)/Average (SD)
Sex	Male	50 (51.5%)		Unknown	10 (10.3%)
	Female	47 (48.5%)	Employment	Working	71 (73.2%)
Age (years)		37.9 (SD=11)		Not working	22 (22.7%)
Continent of origin	Asia	48 (49.5%)		Unknown	4 (4.1%)
	Africa	39 (40.2%)	Years of education	0-6	7 (7.2%)
	Europe	8 (8.3%)		6-12	28 (28.9%)
	America	2 (2.1%)		12 and above	45 (46.4%)
Questionnaire language	English	70 (72.2%)		Unknown	17 (17.5%)
	Arabic	17 (17.5%)	Religion	Christianity	64 (66%)
	Hebrew	5 (5.15%)		Islam	19 (19.6%)
	Russian	5 (5.15%)		Buddhism	3 (3.1%)
Duration period in Israel (years)		5.04 (SD= 4.3)		Messianic Jews	1 (1%)
Family status - partner	Married	47 (48.5%)		Atheism	1 (1%)
	With partner	9 (9.3%)		Unknown	9 (9.3%)
	Divorced/separated	8(8.2%)	Legal status	When entering Israel	
	Widow/er	5 (5.2%)		No permit	39 (40.2%)
	Single	27 (27.8%)		Work permit	22 (22.7%)
Partner's location	In Israel	34 (35.1%)		Asylum seeking permit	0
	Not in Israel	16 (16.5%)		Tourist Visa	13 (13.4%)
	Unknown	6 (6.2%)		Other permit	7 (7.2%)
Family status - children	Yes	58 (59.8%)		Missing data	16 (16.5%)
	No	33 (34%)	Legal status	When participating in the research	
	Unknown	6 (6.2%)		No permit	23 (23.7%)
Children's location	In Israel	19 (19.6%)		Work permit	11 (11.3%)
	Some of the children are in Israel	28 (28.9%)		Asylum seeking permit	35 (36.1%)
				Tourist Visa Other permit	0 24 (23.7%)
	Not in Israel	2 (2.1%)		Missing data	5 (5.2%)

Table 2: *Pearson's correlations between GHQ-12 scores and demographic variables*

Variable	r
Sex - female	0.018
Asia	-0.134
Europe +America	0.205*
Work visa upon arrival	-0.206*
Tourist visa at arrival	0.150
Current unknown visa	-0.028
Current work visa	-0.031
Current asylum/refugee visa	0.089
Current other visa	-0.113
Have partner	0.043
Partner In Israel	0.073
Have children	-0.078
Children in Israel	0.114
Employment	-0.3**
Education	0.028
Religion- Christian	-0.063
Islam	0.051
Unknown Religiosity	0.122
Less Religiosity	-0.153
Age	-0.125
Duration of stay in Israel	-0.141

* p<0.05, **p<0.01

psychiatric treatment (17). These services are provided by highly motivated medical personnel that work pro bono, from one to five times per month. Between 1998 and 2010, over 28,000 users attended the clinic, of whom 60% were examined by GPs. Of them, 350 were referred for psychiatric evaluation.

We investigated the possible discrepancy between ED in the clinic population and its identification by the GPs. Results of this study might contribute to better identification of ED among immigrants and appropriate treatment for this population.

OBJECTIVES

The study aimed to compare the service users' self-reported ED and its identification by GPs and to identify socio-demographic variables associated with ED.

STUDY DESIGN

The study was approved by the institutional review board (IRB) at Shalvata Mental Health Center, affiliated with Tel Aviv University.

We conducted a cross-sectional survey using a convenience sample (N=97) of the population visiting the primary care service in the open clinic between March-August 2010. Inclusion criteria were: adults (age ≥ 18) and minimal language proficiency (reading and writing) in English, Arabic, Russian or Hebrew. Given the recruiting process, we could not document refusal rates. Patients who were waiting to be examined by GPs were given information regarding the study and were asked to give informed consent to participate in the study. Oral informed consent was approved by the IRB, based on previous similar studies performed in complex study settings (18). Patients were interviewed for demographic data and they completed the 12 item- General Health Questionnaire (GHQ-12). Additional data (demographic and medical) were collected from the patients' records.

The GHQ-12 is a widely accepted screening tool for ED (19) in primary care settings (20) and in culturally diverse clinics (21, 22). It assesses a person's current (the last 30 days) status regarding symptoms in the spectrum of common emotional disorders (i.e., depression and anxiety) and problems with everyday functioning. Scores were calculated using Likert scoring method (ranging from 0-3) (23) with total score between 0-36. ED screening threshold was set to 11, as in previous studies (e.g., the World Health Organization study [(24). We also calculated the average GHQ-12 score, that may be used as a cut point in populations in which the threshold was not previously set (25). We used questionnaires in four languages: the original English version and translated versions in Russian, Arabic and Hebrew which were used in the World Mental Health Survey in Israel (26, 27).

The socio-demographic data collected included: sex, age, country of origin, family status, education, religious affiliation and religiosity, duration of stay in Israel, immigration status in Israel (migrant worker, asylum seeker) and employment.

For the GPs' clinical impression, data were extracted

from the patients' medical records in the clinic (by MD) including: past and current medical conditions, evidence of past or current ED or a diagnosis of a psychiatric disorder, and a current referral for psychiatric evaluation.

STATISTICAL ANALYSIS

Data were collected, coded and analyzed using Excel and SPSS 17. The analyses included the estimation of Cronbach's *alpha* as a reliability coefficient and descriptive statistics, Pearson correlations for unvaried analysis, one-way analysis of variance (ANOVA) for comparing association of independent variables scores, and a multivariable model using linear regression.

RESULTS

The sample (N=97) demographic characteristics are shown in Table 1. The mean GHQ-12 score was 12.7 (*SD*=6.3, range 0-35). It showed good reliability (Cronbach's *alpha* for the whole sample was 0.8).

Using the GHQ-12 with the threshold of 11 or the average score, 51 (52.6%) and 39 (40.2%) patients, respectively, had a score that indicated suspected ED.

Eight patients (8.2%) were documented by the GP as having possible ED, of them six explicitly reported the problem. Patients who were identified by the GP as having current ED/psychiatric diagnosis (n=8, 8.2%) had a significantly higher GHQ-12 score compared to those without a GP's identification or diagnosis (n=91) (*M*=18.9, *SD*=10.4, and *M*=12.3, *SD*=5.5 respectively, F=(2,94) 4.52, p=0.01). Five (5.2%) were referred for psychiatric evaluation.

Ten patients (10.3%) had previous documentation of ED/past psychiatric diagnosis in the GPs' files. Those patients had a significantly higher GHQ-12 mean score than those without (*M*=17.1, *SD*=9.9, and *M*= 12.0, *SD*=5.6 respectively, F(2,94)=3.09, p=0.05).

Pearson's correlations between questionnaires' scores and demographic data showed weak to medium correlations (Table 2). Employment variables (i.e., working visa upon arrival (r=-0.21, p<0.05), current employment (r=-0.3, p<0.01)) showed a significant negative correlation with ED whereas America and Europe as continents of origin showed a significant positive correlation. Employment status was the only variable that had significant effect in a stepwise multivariate linear regression analysis (F=9.2(1,94) , R^2 = 0.09, p=0.03).

The GHQ-12 mean score of the study sample was higher than that found in past studies regarding the Arab-Israeli (*M*=10.8, *SD*=0.35) general population.

DISCUSSION

In this study we sought to identify a possible discrepancy between self-reported ED (using the GHQ-12) of immigrant primary care users and its identification by GPs. Our results indicate that the average score was higher than the threshold set for ED. However, the GPs detection rate of ED was relatively low (8%), and even fewer patients were referred for further psychiatric evaluation (5%). This finding is in accord with previous studies regarding the low identification rate of patients' ED among non-psychiatric physicians (28-31), and in immigrants (12). Possible explanations include time restrictions, communication problems and detection skills (32) and inter-observer bias (i.e., variation among different observers) (20).

Dealing with immigrant populations, possible additional explanations include language barriers, cultural gaps (4) and a "nihilistic approach" by GPs, under the assumption that ED is a natural state for immigrants.

A possible conclusion from these results is the importance of cultural competence training, which may improve the attitudes and skills of health professionals, and may have positive effects on the quality of services delivered to immigrants (33, 34).

There are obvious methodological problems with comparing average GHQ-12 results from different studies. However, the immigrants' average GHQ-12 score was higher than the previously reported for the Israeli Arab general population (26) and for the Arab population in primary clinics (35), possibly reflecting the negative impact of the immigration process. The GHQ-12 score was similar to scores in refugees in other places (e.g., refugees from the Middle East in Sweden [(36)], and among older Somali refugees in Finland [(37)]).

Employment was the only socio-demographic factor that demonstrated a significant and consistent association with GHQ-12 scores. This is in line with previous reports showing that employment is a protective factor for ED among immigrants (4, 38). Employment can contribute to one's sense of confidence and can answer both psychological and financial needs (39).

In contrast to our initial assumptions, other socio-demographic variables (e.g., legal status, sex, age and continent of origin) did not show consistent significant association with the GHQ-12 scores. This may be attrib-

uted to the relatively small sample size of such a heterogenic population that failed to achieve statistical power.

In addition, the affecting variables explained only some of the scores variance (9%). This fact together with the lack of correlations might demonstrate the impact of other unique factors influencing this population (40, 41) and the need further evaluation. One of these factors might be discrimination, previously found to have a major influence on ED in other immigrant populations (42).

LIMITATIONS

The study has various methodological problems, including a relatively small sample size and use of non-random sampling process (a selection bias), which are common in immigrant health research (3).

Limitations regarding the GHQ-12 include high reliability that is attributed by some to a response bias for the negative or ambiguous items (e.g., the lack of differentiation in answering the question "felt constantly under strain" in persons with or without baseline emotional distress, accentuated by Likert scoring method) (43), being a screening tool with a relatively low positive predictive value (44, 45), and the existence and influence of cultural bias (46).

In addition, we used a threshold that was determined in previous studies using a two-phase model, with a second diagnostic stage that was not conducted in our study. Threshold scores differ from one setting and population to another (24, 25). It is possible that a higher threshold would allow better identification.

Despite these limitations, our work is important for better characterizing migrants' health needs and ED. The right to healthcare for immigrants was anchored in international treaties. However, immigrants are an excluded population and may lack resources and opportunities to benefit from suitable health care (13, 46). Identification of ED and its treatment are challenges that both health professionals and policy makers need to address. In the absence of such efforts, migrants' capacity to contribute to host societies will be constrained. Similarly, employment may contribute both to immigrants as a protective factor and to the host society that can benefit from their integration into the work force and prevention of social exclusion.

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