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Features of a migrant sample in the Psychiatry Ward, Novara, Italy: focus on language proficiency

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Summary

Objectives. Migrants may experience barriers, including language, in the access to psychiatric care and this may result in a higher rate of utilisation of emergency services. The aim of this paper is to describe real-world data of a sample of migrants admitted to our Psychiatry Ward, with a specific focus on language proficiency.

Materials and methods. We included migrant patients admitted to the Psychiatry Ward of the Maggiore della Carità Hospital (Novara, Italy) from January 1st, 2016, to December 30th, 2019. We recorded personal data, anamnestic data, data about current inpatient admission, data related to migrant status. Patients were assessed at admission (T0) and discharge (T1) with two outcome scales (Health of the Nation Outcome Scales - HoNOS and Clinical Global Impression - CGI). Italian-Language Proficiency (LP) (comprehension and spoken) was assessed for each patient.

Results. 145 migrant patients were admitted to our Psychiatry Ward, in most cases after an access to the Emergency Room (74.48%); 26.21% were compulsory admissions; patients' mean hospital stay was 10.39 days. The main diagnosis at discharge, according to ICD9 criteria, were Schizophrenia (33.10%), Personality disorders (18.62%) and Neurotic or stress related disorders (17.24%). After the assessment of LP, patients were subdivided in two subgroups: high LP (HLP, N = 68) and low LP (LLP, N = 77). These two subgroups presented differences in diagnosis, therapy, educational level, employment status, reason for migrations, necessity for cultural mediator, number of years in Italy and scores at the outcome scales both at T0 and T1.

Conclusions. The present preliminary findings support the expected importance of LP among immigrant psychiatric inpatients. Further investigations are needed to deepen knowledge on this topic.

Main implications: the present work supports the importance of migrants' mental health in the real-world setting. In particular, psychiatrist working in acute settings should be prepared to manage migrant patients and to collaborate with cultural mediators in order to make a correct diagnosis and to implement adequate treatment interventions. The importance of language proficiency should not be overlooked because it may represent a significant barrier, influencing access to healthcare services, therapeutic adherence and clinical outcome.

Key words: migrants, language proficiency, transcultural psychiatry, acute psychiatric patients

Conflict of interest
The Authors declare no conflict of interest.

Introduction

Healthcare professionals are working in a world which is becoming increasingly multi-cultural, therefore, in the last years, interest has raised regarding migrants' healthcare needs and use of resources, also in the field of mental health. Compared to natives, migrants may show higher rates of mental disorders and, at the same time, a lower use of mental health services [1-4]. While culture certainly plays a role in the presentation of psychiatric illnesses, in migrant populations biological, psychological and social factors are involved as well in the differences in incidence and prevalence of psychiatric disorders. Migrants and refugees of all ages may have complex stories of war, torture, critical migratory journeys: pre-migration trauma is predictive of mental disorders, but the post-migration context can play a relevant role regarding mental health, as well [5,6]. For instance, migrants have been reported to be more vulnerable than natives to psychosis, post-traumatic stress disorder (PTSD) and suicidal behaviours. Despite these facts, migrants may experience many obstacles in the access to healthcare services and this may result in a higher rate of utilisation of emergency services which are frequently the first place for help-seeking, also for non-urgent reasons. The Emergency Room may be the place where the first contact with a mental health professional has place, and migrants may be admitted to the Psychiatry Ward in the General Hospital in an urgent or coercive way, because of acute or severe psychopathological conditions[7,8]. Psychosocial approaches targeting the life conditions of migrants, refugees and asylum seekers should start since the early phases of care, avoiding the achievement of an emergency condition [5,9].

One of the barriers to healthcare is language knowledge [10], which is especially important for mental health care, since diagnosis as well as treatment greatly rely on interpersonal verbal communication. Poor language proficiency (LP) may limit migrants' cultural and social adaptation in the host country and may also contribute to risk for, or manifestations of, psychiatric disorders [11-15]. On the other hand, poor LP may reduce the likelihood of migrants' access to health services [15,16], and leads to misdiagnosis, because it may hinder clinicians' understanding of the patients' speech and overall situation. Finally, language barriers may lead even to a wrong use of the psychopharmacologic treatment[11]. For all these reasons, the need for a close collaboration among clinicians and cultural mediators and/or interpreters should be emphasized [17-19].

Many unaccomplished clinical needs still remain in this field, which warrants more research to deepen the understanding of these complex topics, and to help in the assessment and care of patients with different cultural backgrounds. Therefore, this paper aims to describe real-world data about the clinical and socio-demographic features of a sample of migrants admitted to our Psychiatry Ward, with a specific focus on the issue of language proficiency.

Materials and methods

The study sample included migrant patients admitted to the Psychiatry Ward of the Maggiore della Carità Hospital, Novara, Italy, from January 1st, 2016, to December 30th, 2019. No inclusion or exclusion criteria were adopted. Data were retrieved from clinical charts and clinical assessments; with more detail, the following information was recorded for each patient: personal data (gender, age, country of origin, marital status, children - if any, educational level, housing status, working status, religion, social support); anamnestic data (family history of psychiatric disorders; personal history of comorbidities, substance or alcohol abuse, previous hospitalizations; psychiatric history in the country of origin, being in charge of Italian psychiatric services and/or social services); data about current inpatient admission (number of days spent in the psychiatry ward, compulsory or voluntary treatment, type of access to the hospital, comorbidity with substance abuse, diagnosis at discharge according to ICD 10 criteria, pharmacological therapy); data related to migrant status (reasons for migration, years spent in Italy, residency permit, the necessity of a cultural mediator during hospitalization).

Furthermore, patients were assessed at admission (T0) and discharge (T1) with the Health of the Nation Outcome Scales (HoNOS) and Clinical Global Impression (CGI). The CGI scale was developed by the National Institute of Mental Health (NIMH) to allow, in clinical trials, a brief clinical evaluation of the patient's overall functioning before and after treatment [20]. The HoNOS scale was created in 1993 in England as part of the Royal College Research Unit's "Health of the Nation" project for the evaluation of the results of mental disorder treatment in adults; the Italian version was validated in 2001 [21].

Last, Italian Language Proficiency (LP) (comprehension and spoken) was assessed for each patient: two different psychiatrists rated level of language knowledge on a Likert scale ranging from 1 (very poor knowledge) to 10 (very good knowledge); in case of discrepancy, this was resolved through discussion with a third psychiatrist, to reach a shared score. Based on the LP median scores, patients were then divided into two subgroups: Low Language Proficiency (LLP), with a score equal to or below the median, and High Language Proficiency (HLP), with a score above the median. Quantitative data were presented as mean values, while categorical data as absolute frequencies and percentages. Comparisons between the LLP and HLP groups were performed with the Mann Whitney test, while categorical data were compared using the Fishers' exact test. The level of statistical significance was set as $\alpha = 0.05$. Software used for statistical analysis was GraphPad Prism 6.

The work has been performed in accordance with the principles of the 1983 Declaration of Helsinki; the need for a local ethics board permission was waived as the study was observational and included nothing beyond standard clinical practice and routine assessments.

Results

During the study period, 145 migrant patients (9.96% of the 1456 total psychiatric inpatient admissions) were admitted to our Psychiatry Ward: N = 37 (25.51%) in 2016, N = 34 (23.44%) in 2017, N = 39 (26.89%) in 2018 and N = 35 (24.13%) in 2019.

Personal data

The sample included N = 73 (50.34%) males and N = 72 (49.66%) females; overall, the sample mean age was 37.69 years (age range: 16-81 years, standard deviation: 13.02). Patients' Countries of origin were grouped as follows: European Union (N = 52; 35.86%); North Africa (N = 20; 13.79%); Southern-Central Africa (N=19; 13.10%); Europe (no European Union) (N = 14; 9.65%); North America (N = 11; 7.59%); Middle East (N = 11; 7.59%); Central America (N = 10; 6.89%); Western Africa (N = 6; 4.13%); East Asia (N = 1; 0.69%); Central Asia (N = 1; 0.69%).

Regarding marital status, N = 71 (48.96%) patients were unmarried, N = 54 (37.24%) married, N = 20 (13.79%) divorced or widowers; N=76 (52.41%) patients had children. The distribution for educational level was the following: N = 71 patients (48.96%) had a primary school licence, N = 45 (31.03%) a secondary school one and only N = 13 (8.96%) had a degree; this information was not available for N = 16 patients (11.03%).

Most patients (N = 102; 70.34%) lived in their own home, while N = 24 (16.55%) lived in therapeutic communities, N = 13 (8.96%) were homeless and N = 6 (4.14%) lived in the house where they worked as a caregiver. In the Country of origin, N = 101 (69.65%) patients were employed or students; this information was missing for N = 24 patients (16.55%). Nonetheless, at the time of hospitalization, N = 75 (51.72%) patients were unemployed even though most of them (N = 118; 81.38%) had previously been employed or students in Italy.

Regarding practised religion, most patients were Catholic Christian (N = 62; 42.76%) and Muslim (N = 37; 25.52%); a minority of cases were Orthodox (N = 10; 6.89%), Hindus, Buddhists, Jews (only one patient each), N = 12 patients (8.27%) were atheist. This information was not available for N = 21 patients (14.48%). More than half of patients (N = 89; 61.38%) had a family or friends support network at their arrival in Italy: this information was missing for 20 patients (13.79%).

Anamnestic data

Only N = 25 patients (17.24%) reported a family history of psychiatric disorders (this datum was unknown for N = 12,8.27%). Comorbidity with medical illnesses were reported by N = 34 patients (23.45%). There was a history of drug or alcohol abuse and at least one previous psychiatry ward admission in N = 59 (40.69%) patients and N = 74 (51.03%) patients, respectively. Most patients (N = 106; 73.10%) had no previous psychiatric history in their countries of origin. N = 77 (53.1%) and N = 33 (22.76%) patients were already treated in Italy by Psychiatric Services and by Social Services respectively; N = 26 patients (17.93%) were treated by both.

Data about current inpatient admission and inpatient treatment

Admission to the Psychiatry Ward happened after access to the Emergency Room in most cases (N = 108; 74.48%); following a psychiatric outpatient visit at the Community Mental Health Centre for N = 20 patients (13.79%); after transfer from another hospital in N = 13 cases (8.96%); and N = 4 (2.76%) in other ways (for instance, sent by their psychiatrist). Admission was on a compulsory basis for N = 38 patients (26.21%), and voluntary in all other cases. In N = 48 cases (33.10%) patients had a current comorbid substance abuse (cannabis in N = 39; poly-abuse in N = 9 patients) and in N = 36 cases (24.83%) a current comorbid alcohol abuse. Patients' mean period of hospitalization was 10.39 days (range: 0-40 days, standard deviation = 7.76). The main diagnosis at discharge, according to ICD9 criteria, are presented in Table I.

Regarding psychopharmacological treatment at discharge, antidepressants were prescribed to N = 42 patients (28.96%), mood stabilizers to N = 21 (14.48%), first-generation and second-generation antipsychotics to N = 54 (37.24%) and N = 34 (23.44%) patients, respectively. N = 45 patients (31.03%) were discharged after receiving a first generation (N = 33; 22.76%) or a second generation (12; 8.27%) long-acting injectable (LAI). Last, N = 7 patients (4.82%) were discharged without any prescription of psychopharmacological treatment.

Table I. Diagnosis at discharge according to ICD9 criteria.

Diagnosis (ICD9)	N (%)
• Schizophrenia, schizotypal and delusional disorders	48 (33.10%)
• Disorders of adult personality and behaviour	27 (18.62%)
• Neurotic, stress-related and somatoform disorders	25 (17.24%)
• Mental and behavioural disorders due to psychoactive substance use	20 (13.79%)
• Mood (affective) disorders	17 (11.72%)
• No diagnosis of psychiatric disorder	3 (2.07%)
• Mental retardation	2 (1.38%)
• Organic, including symptomatic, mental disorders	2 (1.38%)
• Behavioural syndromes associated with physiological disturbances and physical factors	1 (0.69%)

Data related to migrant status

Reasons for migration to the host country included job search (N = 75; 51.72%), family reunification (N = 45; 31.03%), adoption (N = 12; 8.27%) or other/unknown reasons (N = 13; 8.96%). At the moment of hospital admission, the average length of stay in Italy was 12.49 years (range 1 to 38 years, standard deviation = 8.23). In most cases, patients had a residence permit (N = 129; 88.96%), while 16 (11.03%) were undocumented migrants; N = 4 (2.76%) were in Italy as asylum seekers; N = 3 (2.07%) had a temporary residence permit. Regarding migrants' LP, its mean value was 6.95 at admission to the Psychiatry Ward. The intervention of an interpreter/cultural mediator during hospital stay was required in N = 12 cases (8.28%).

Outcome scales

Main results of the HoNOS are presented in Table II. Medium CGI scores were 4.09 and 8.4 at admission and discharge, respectively (severity = 2.5; overall improvement = 1.9; efficacy index = 3.9). Mean values of HoNOS scores were 15.96 and 9.78 at admission (T0) and discharge (T1), respectively, with a significant decrease from T0 to T1 (p < 0.0001).

Comparison of the two subgroups of patients subdivided according to LP

As described in the methods, the total sample (N = 145) was subdivided into two subgroups according to the LP median value (= 7): N = 68 (46.89%) patients were rated as HLP, while N = 77 (53.10%) as LLP. The two subgroups were then compared on all the variables assessed for this study (personal and anamnestic data, information about hospitalization and migrant status-related information); statistically significant results are shown in Table II.

The comparison of the two subgroups yielded statistically significant differences in the HoNOS scale scores, as presented in Table III, while for the CGI a statistically significant difference emerged only for global improvement: mean LLP = 1.76 (IC: 1.59; 1.94), mean HHP = 2.06 (IC: 1.85; 2.26) (p = 0.034).

Table II. Comparison between HLP and LLP migrants.

		LLP (N = 77)	HLP (N = 68)	P value
Diagnosis (ICD9) % (N)	Mental and behavioural disorders due to psychoactive substance use	18.18% (14)	8.82% (6)	**0.0019**
	Schizophrenia, schizotypal and delusional disorders	**37.66% (29)**	27.94% (19)	
	Mood (affective) disorders	15.58% (12)	7.35% (5)	
	Neurotic, stress-related and somatoform disorders	12.98% (10)	22.05% (15)	
	Disorders of adult personality and behaviour	7.79% (6)	30.88% (21)	
	Other (non-psychiatric problems, organic mental disorders, behavioural syndrome, mental retardation)	7.79% (6)	2.94% (2)	
First-generation LAI % (N)	Yes	31.16% (24)	13.23% (9)	**0.0164**
	No	68.83% (53)	**86.76% (59)**	
Educational level % (N)	Unknown	18.18% (14)	2.94% (2)	**0.0234**
	Primary school	48.05% (37)	**50% (34)**	
	High school	27.27% (21)	35.29% (24)	
	Degree	6.49% (5)	11.76% (8)	
Employment status in country of origin % (N)	Unknown	19.48% (15)	13.23% (9)	**0.0006**
	Employed	**58.44% (45)**	41.17% (28)	
	Unemployed	15.58% (12)	11.76% (8)	
	Students	6.49% (5)	33.82% (23)	
Reasons for migration % (N)	Unknown	6.49% (5)	5.88% (4)	**0.0012**
	Work	**63.63% (49)**	38.23% (26)	
	Family	27.27% (21)	35.29% (24)	
	Other	2.59% (2)	20.58% (14)	
Necessity for cultural mediator % (N)	Yes (or family members)	19.48% (15)	0% (0)	**< 0.0001**
	No	80.51% (62)	100% (68)	
Mean numbers of years in Italy (mean, IC)	7.97 (6.63; 9.31)		17.60 (15.79; 19.42)	**< 0.0001**

Table III. Comparison Between HLP and LLP migrants (HoNOS scale).

		LLP (mean level; IC)	HLP (mean level; IC)	p
T0	Problems in everyday life activities	1.649 (IC: 1.367; 1.932)	1.235 (IC: 0.954; 1.516)	**0.04**
	Problems in the living conditions	1.662 (IC: 1.355; 1.97)	1.132 (IC: 0.82; 1.448)	**0.0136**
	Problems in the availability of resources for work and recreational activities	1.688 (IC: 1.395; 1.98)	1.162 (IC: 0.882; 1.44)	**0.0129**
	Total score	17.12 (IC: 15.72; 18.52)	14.65 (IC: 13.31; 15.98)	**0.0085**
T1	Somatic disease or physical disability problems	0.5195 (IC: 0.288; 0.751)	0.1765 (IC: 0.045; 0.308)	**0.0275**
	Problems in everyday life activities	1.558 (IC: 1.239; 1.878)	1.088 (IC: 0.818; 1.358)	**0.013**
	Problems in the living conditions	6.065 (IC: 5.138; 6.992)	4.676 (IC: 3.79; 5.56)	**0.0358**

Discussion

In this study, we focused on a real-world sample of migrant inpatients, a group which is widely acknowledged to be at risk for mental disorders but still understudied. During the four years of the study, 145 migrants were hospitalized in the Psychiatry Ward of the Maggiore della Carità Hospital in Novara; the number of foreign patients did not change significantly from year to year. This is in line with the "2019 Immigration Statistical Report" that described a substantial stability and no significant expansion of the foreign population residing in Italy in the last years [22].

Personal data

In line with Italian data, in our sample, the gender ratio was balanced and migrants admitted to the Psychiatry Ward were younger compared to the global Italian native population; actually, migrant patients' mean age in our sample was 38 years, while that of the foreign population in Italy was = 35 years and that of the Italian population = 46 in the same period. Migrants admitted to our Psychiatry Ward in most cases came from European (European Union or not) and North African Countries, in agreement with data from the National Institute of Statistics about the provenance of migrant populations in Italy [22].

Concerning employment status, while most migrant patients were employed or students in their own country, about half of them were unemployed at the time of their admission to the Psychiatry Ward. Regrettably, it seems that many migrants lose their socioeconomic status when arriving in the host country, as a consequence of the difficulties they may face in working conditions and career opportunities. Data from the National Institute of Statistics confirm that a great proportion of migrants do low-skilled jobs [22].

The main religion practised by the migrant patients admitted to our Psychiatry Ward was Catholic Christian (42.76%) in line with the data of the foreign population in Italy where the main religion is Catholicism (52.2%).

Anamnestic data

As regards medical and psychiatric history, it is interesting to note that a fair number of patients had a previous history of drug or alcohol abuse; literature data on this topic show that migrants may be at risk for alcohol and substance use for reasons including coping with traumatic experiences, co-morbid mental health disorders, acculturation challenges and social and economic inequality [23,24].

Most of the patients did not report a psychiatric history in their home country, but about half of them were treated by psychiatric services or had been previously admitted to a Psychiatry Ward in Italy. This gap between the psychiatric history in the home and in the host country could be explained, as already pointed out, by the fact that migrants seem to be more prone to certain psychiatric disorders, also because of their migration-related history and difficulties settling down in the new countries [25].

Comparison of the two subgroups of patients subdivided according to LP

Interestingly, after dividing the migrants' sample into two subgroups based on the level of LP, we found a higher rate of patients diagnosed with psychosis in the LLP group. It is well known that migrants have a strongly increased risk for schizophrenia, which is associated with psychosocial stress factors such as social isolation and exclusion [25], but our data seem to suggest that this greater proportion may be especially higher in the LLP group of patients. Some hypotheses can be suggested for this phenomenon; on the one hand, language and communication skills are critical in the acculturation process and during the resettlement phase in the host country: poorer abilities could be related to greater difficulties, possibly leading to social isolation and supporting the social defeat model of schizophrenia [26,27]. On the other hand, meeting with LLP patients may face psychiatrists with specific critical issues, as psychiatry relies more than other medical

disciplines on speech and verbal communication. The classic literature [28] about migrant patients suggests that sometimes a clinical presentation characterised by bouffées with persecutory delusions could correspond to a depressive equivalent, as described by Collomb [29]. While cultural issues in the presentation of psychiatric disorders cannot be overlooked, limited language fluency, understanding and knowledge, could make it challenging to discriminate between clinical pictures, possibly leading to an overdiagnosis of psychotic disorders [12,30].

It is also worth mentioning that only in a small proportion of cases there has been the intervention of cultural mediators. This could be explained by the current difficulties in our healthcare system in finding such resources in a short time and even more in emergency conditions. A close collaboration involving clinicians, cultural mediators and interpreters is warranted to overcome both language and cultural barriers that can hinder a thorough and reliable assessment of patients and, as a consequence, the implementation of an adequate treatment plan [31-33].

The two subgroups of patients showed also further differences as far as pharmacological treatment is concerned: if we consider atypical LAIs, there is a general tendency not to receive these drugs by migrants, particularly those with HLP. We can assume that this can be due to the lower rate of psychosis diagnoses in this group, or to the fact that speaking fluently the language may help to understand the advantages of psychopharmacological treatment and, therefore, may lead to better compliance to oral therapies.

Regarding reasons for migration, we found out that work was the main issue for both groups but especially for LLP: this could be explained taking into account that LLP were already workers in their origin country, but it remains an open clue. These data were partially confirmed by the previous migration policies debate formulated by the International Organisation for Economic Co-operation and Development (OECD). This debate reported that low-educated migrants and their native peers had comparable employment rates, differently from highly educated migrants who showed lower employment rates than those of their native counterparts, and, when employed, in almost 50% of cases they were likely to be overqualified for their job.

Noteworthy, analysing the HoNOS scores, our data showed that LLP patients had higher scores and therefore greater severity at admission, in all social and living conditions but also as far as clinical conditions are concerned. Differences between the two subgroups were still evident at discharge: poorer improvements were those concerning social conditions, which may be difficult to address during the period of hospitalization and also not likely to change in a short time.

Another key finding of this investigation was about the CGI global score at discharge: in the LLP subgroup, the global improvement was considerably lower compared to the HLP one. Considering that psychiatric treatment

involves medication but mainly relational issues, the language barrier may represent a significant challenge for the possibility to adequately intervene in this subgroup, that represents a vulnerable group of patients.

Some limitations of the present study should be underscored. The sample size and the monocentric design limit the possibility to generalize results. No comparison has been proposed here between the migrant and native population admitted to the Psychiatry Ward during the study period. Some information and data were missing because sometimes patients unwilling to provide information, while other times because of lack of documentation. Nonetheless, real-world data are proposed here, with a specific focus on LP, which seems to emerge as a possible target of interventions delivered for this vulnerable population. In conclusion, the present findings, despite the limitations described above, support the importance of LP for migrant psychiatric inpatients [11,15,16].

Conclusions

In conclusion, the present preliminary findings support the expected importance of LP among immigrant psychiatric inpatients. Further investigations are needed to deepen knowledge on this topic, encouraging additional studies and consideration of language assessment and training as part of the comprehensive support of psychiatric patients. Overcoming language barriers fin mental care setting is therefore essential to the quality of care provided.

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