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Refugees' admission to mental health institutions in Norway: Is there an ethnic density effect?

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ABSTRACT

Some recent European research claims that immigrants settle in urban areas with low scores on level-of-living conditions and a high prevalence of health-risk factors, and that these settlement patterns adversely affect their health. Other studies question the association between immigrant segregation and area deprivation on one hand, and negative health outcomes on the other hand, and identify possible beneficial effects of segregation, specifically the *ethnic density effect*. This paper aims to explore the possible ethnic density effect among refugees, a sub-population that often appears relatively vulnerable compared with immigrants in general. The data comprise 30 871 individuals, aged 20–69, with an (post-1989) officially registered refugee status from six major countries, including Vietnam, Somalia, Iran, Iraq, Sri Lanka and Bosnia. Two outcomes are analysed, covering the 2008–2011 period – the probability of being admitted at least once to a mental health institution and the number of bed days during that period. The results show that all immigrant clusters have relatively high concentrations of negative level-of-living conditions. Despite this finding, refugees living in clusters tend to have less use of mental healthcare services. The results suggest that for most refugee groups, living in clusters has positive health outcomes. Many countries use settlement policies to direct the inflow of refugees away from immigrant-dense areas. Norway's settlement policy is no exception, aiming at a geographic dispersal of refugees to avoid the emergence of socially segregated urban ethnic communities. This paper discusses the relevance of such a policy for refugees' overall integration and level-of-living conditions.

1. Introduction

To what extent is residential segregation good, bad or neutral for the health of refugees? This paper addresses the topic by comparing refugees living inside or outside immigrant residential clusters and analysing their risk of admission to mental health institutions. The subject of health and spatial segregation is important in general, especially among minorities (Pickett and Wilkinson, 2008; Bécares et al., 2012; Shaw et al., 2012), although a few studies have focused on the possible ethnic density effects among refugees in particular. It could be argued that the subject of ethnic density is particularly relevant for refugees for at least two reasons.

First, the issue involves the assumed vulnerable health condition of refugees. A synthesis of the literature on the general health of refugees finds that research tends to assume specific and elevated health needs, despite the lack of systematic confirmation (Bradby et al., 2015). The evidence of poor health among refugees is to some extent confined to mental illness, with most studies showing higher symptom prevalence (Lindert et al., 2008, 2009). A literature review covering studies on refugees and mental health service utilisation concludes that research on the topic is scarce (Colucci et al., 2014). An Australian study of refugees' hospital utilisation observes less use of mental health services compared with the native population, but the refugees' utilisation pattern converges towards that of the native population (Correa-Velez et al., 2007). A recent analysis of the use of primary healthcare services confirms the tendency of having poorer mental health among refugees in Norway (Straiton et al., 2016). However, these studies do not include the ethnic density aspect.

Second, refugees in many European countries are subject to geographic dispersal policies (Robinson et al., 2004). These policies are partly motivated by the desire to spread the anticipated burden associated with refugees and to counter segregation. An analysis of the ethnic segregation policies in 15 European countries concludes that the discourses are dominated by images of ethnic neighbourhoods as 'problem areas' deserving policy attention (Phillips, 2010). Similar views are common in the Norwegian debate. Since the 1990s, Norwegian authorities have used the geographic dispersal of refugees as a way to discourage the emergence of socially segregated urban ethnic

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communities (Valenta and Bunar, 2010). The concentration of immigrants in the capital and a few larger cities is not desired by the general Norwegian public and the politicians, who fear that 'social problems may grow to unmanageable proportions' (Brox, 1998), p. 103).

1.1. Health benefits of ethnic density

According to Halpern and Nazroo, (2000), the idea that ethnic density can have beneficial health effects was first published by Faris and Dunham (1939), who observed that psychiatric admission rates increased with the lower concentration of an individual's ethnic group in his or her residential area. The line of reasoning is that refugees living in areas where few people have a similar background are likely to be materially better off, but this advantage may be offset by the psychological effects of stigma (Pickett and Wilkinson, 2008). A review finds that ethnic density in many cases protects against mental disorders although most studies tend to have limited statistical power (Shaw et al., 2012). The review also states that the most consistent protective effect is reported in older ecological studies of mental hospital utilisation in the United States (US). Several British studies, mainly using the survey methodology, have addressed the possibility of the ethnic density effect. A study reports a negative association between ethnic density and psychotic symptomatology but no relation between density and self-rated health (Bécares et al., 2009). The authors claim that ethnic enclaves might function as buffers against the interpersonal racism and discrimination experienced by many immigrant groups. Their stronger sense of community and belonging and enhanced social cohesion result in decreased self-stigmatisation and stress – mental states known to be associated with poor physical and mental health. Other studies in England and Wales have reported conflicting evidence on the existence of the ethnic density effect. A study with data from 1991 confirms the density effect, with lower levels of reported psychiatric symptoms (Halpern and Nazroo, 2000), as does another study in the United Kingdom (Das-Munshi et al., 2010) and a more recent review (Bécares et al., 2012). Another study with data from 1993 and 1994 finds no ethnic density effect on self-assessed health among minority groups (Karlsen et al., 2002). A Swedish study on suicide risk shows that having foreign-born parents protects people against suicide in areas where larger proportions of the population have foreign-born parents (Zammit et al., 2014), whereas another Swedish study could not confirm that ethnic density moderated the risk of psychopathology (Mezuk et al., 2015).

1.2. The 'deprived area' approach: negative health aspects of segregation

Irrespective of individual characteristics, geographic location is considered to have an impact on health conditions, consequently affecting the need for and utilisation of healthcare services. A Swedish study concludes that neighbourhood deprivation influences risk factors such as smoking, physical inactivity, obesity and hypertension (Cubbin et al., 2006). Based mainly on US research, White and Borrell (2011) frame ethnic residential segregation as a 'spatial manifestation of institutionalised discrimination' (p. 439), citing several publications that identify the pathways on which spatial segregation operates to negatively influence health. In a similar vein, Becares and colleagues (2009, p. 70) state, 'The physical separation of relatively affluent whites and deprived ethnic minorities means that the ethnic minority groups are more likely to live in more deprived areas'. They cite studies documenting a wide range of negative health outcomes for individuals in these areas (Bécares et al., 2009). Recent European research claims that immigrants encounter double jeopardy at both individual and contextual levels (Lorant et al., 2008; Reijneveld, 1998; Lindström et al., 2001; Nazroo, 1998). Assuming refugees' segregated settlement pattern that correlates with other geographic properties associated with health-related risk factors, it can easily be argued that segregation might not be beneficial for refugees' health. The author of a Norwegian textbook on social medicine claims that immigration is one of the main causes of the high prevalence of ill health found in specific inner-city areas of the capital (Mæland, 2010, p. 43).

1.3. Institutional context

Hospitals in Norway are tax funded and, with few exceptions, state owned. Inpatient hospital care is free for all registered inhabitants; thus, low income should not affect hospital admission. Requiring a referral from the patients' general practitioners (GPs), admissions to mental health institutions strongly depend on GPs' decisions, but patients' resources, wishes and preferences may also play a role. To secure equal access to GPs, Norway implemented a patient list system in 2001, making it possible for all inhabitants to be registered with particular GPs (or GP offices).

The refugees' settlement pattern in Norway partly reflects the outcome of the process where relatively autonomous local governments respond to the state's request to settle refugees. Based on the latest available figures, 90% of all refugees have agreed to join the official settlement programme and have accepted settlements in municipalities chosen by the authorities (Steen, 2016). Norwegian state authorities regularly monitor refugees' settlement pattern (Thorsdalen, 2014; Østby, 2001) with an emphasis on whether refugees remain in their first municipality of residence. Political documents express the desire to avoid an overrepresentation of refugees in the central areas of the larger cities, particularly the capital region (Norway's official investigations p.88, NOU, 2011:7). Nonetheless, a substantial secondary migration has been observed; refugees who first settled in rural areas tend to migrate to urban areas (Åslund, 2005; Brox, 1998; Djuve and Kavli, 2000; Thorsdal, 2014). Persons with refugee backgrounds first settle in less central municipalities compared with the native-born population, but after five years, the refugees in most groups who have relocated show a more centralised settlement pattern compared with the native-born residents (Thorsdal, 2014).

1.4. Country-specific analyses

Refugees' rates of hospitalisation, as well as settlement pattern and overall tendency to cluster geographically, likely differ according to their countries of origin. Refugees from various countries also represent diversity in terms of arrival dates, country-specific circumstances initiating each journey, and sociodemographic composition. This paper primarily aims to investigate whether living in or outside areas with high concentrations of individuals from the same country of origin has consequences for the risk of being hospitalised. To analyse country-specific variations, the target population includes the refugees who have settled in Norway since 1990, coming from the six most frequent countries of origin.

Evidence from the Netherlands suggests that the ethnic composition of neighbourhoods can have different effects on the mental health of immigrants from various countries (Erdem et al., 2017). Refugees living in a new country for a longer period of time are likely to be exposed to acculturation processes. One study finds that language acculturation protects against depressive symptomology (Arévalo et al., 2015). Another possibility is that acculturation causes refugees' health care utilisation to converge towards the national average (Correa-Velez et al., 2007). As the clustering of immigrants is a result of the migration process after the initial settlement in Norway, this process is possibly selective in ways that affect the risk of hospitalisation. To account for this possibility, acculturation and other sociodemographic variables have been added to each of the country-specific analyses.