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Psychiatric Care in Restricted Conditions for Work Migrants, Refugees and Asylum Seekers: Experience of the Open Clinic for Work Migrants and Refugees, Israel 2006

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Abstract: In the last few decades, the State of Israel has become a target for work migrants, refugees, asylum seekers and victims of human trafficking, as part of the trend of world immigration. Immigration is a process of loss and change with significant socio-psychological stress, with possible effects on the immigrants' mental health. The Physicians for Human Rights – Israel (PHR) Association operates a psychiatric clinic as part of the Open Clinic for Work Migrants and Refugees. This article will present major clinical issues regarding psychiatry and immigration in Israel according to the data collected at the clinic. Trauma and stress-related psychopathology was found to have a high prevalence in immigrant patients treated at the clinic; prevalence of PTSD (post-traumatic stress disorder) in immigrants was high (23%) and even higher in refugees (33%). Female immigrants are at higher risk for psychiatric hospitalization. The relative rate of African patients at the clinic is significantly higher than patients from other continents. A significant association was found between psychiatric hospitalization and suicide attempts.

Immigrant patients present a combination of psychiatric, socio-economic and general medical conditions, which demands a holistic view of the patient. The evaluation of an immigrant patient must take into account the stress related to immigration, gender, culture of origin and the risk for suicide and hospitalization. Treatment recommendations include awareness of cultural diversities, acquiring information regarding the pre-immigration history, preferably using cultural consultants with background in the immigrants' culture and community. Decision-making about medication and diagnostic evaluation should be as inexpensive as possible. Basic human needs (food, shelter) and family support should be included in the decisions about treatment.

Introduction: Immigration to Israel

The total number of immigrants world wide has doubled since the 1970s, and reached 175 million in the year 2002 (1). Most of the immigrants move from developing, poorer countries to more developed and economically established ones. Among those immigrants are work migrants, refugees and asylum seekers. A work migrant is any person who is engaged in a remunerated activity in a state of which he or she is not a national. A refugee is a person who escaped to a foreign land in order to avoid danger or persecution (2). An asylum seeker is a person who has left his/her country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on his/her application (3). According to the UN High Commissioner of Refugees, in the year 2004, the total number of refugees was 9.6 million, 838,000 asylum seekers and about 1.5 million stateless people (4).

As a part of the world trend of immigration, Israel has become a target country for immigrants. Since the late 1980s, hundreds of thousands of work migrants have arrived in Israel. This was encouraged by local geopolitical changes (closure policy in the occupied territories and toughening the criteria for work permits for Palestinians following the first and second *Intifadas*). These workers are mainly employed in low-wage, physically and

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psychologically stressful jobs, which most of the well established population prefers to avoid (construction, agriculture, nursing, cleaning).

In 2002, the Knesset committee report estimated the number of foreign workers in Israel to be 258,396 people (approximately 5% of the population in Israel), of whom about 60% did not hold a work permit (5). At the end of 2005 there were approximately 178,000 foreign workers in Israel; approximately 98,000 entered Israel with a work visa, and 80,000 entered Israel with a tourist visa. Ninety-five percent of those holding a work visa come from 12 main countries, including Thailand, The Philippines, Romania and China (6). Males represent 61% of the immigrants. The average age of the workers is 37.4 years. According to estimates, the number of work migrants' children staying in Israel without a residence status is approximately 4,000 (7).

Only about 40% of the work migrants living in Israel have a legal working visa. Some pay large sums of money to middlemen in their origin country in order to work in Israel and on occasion they find themselves penniless or even without a visa. Others come to Israel as tourists and start working without a visa. Further reasons for the absence of a work visa include: working in certain jobs that are not approved for migrant workers by the government, switching from one employee to another (up until 2006), expiration of the work visa and the deportation policy since 2002. The absence of such a visa puts the migrant worker in a position in which he or she is under the possibility of deportation and without medical insurance.

Health services in Israel for work migrants are supplied by private insurance companies, competing to lower the costs of the insurance premium for the employer, who selects the insurance company. In principal, the insurance coverage for migrant workers includes a package of services that is based on the national health insurance law, yet the insurance companies try to reduce the expenses of health services provided to migrant workers. According to the warrant arranging the health insurance, the insurance company does not have to cover services for a disease that had developed before the worker's arrival to Israel, and there is no obligation to rely on past documents in order to establish findings. According to the law, loss of working ability longer than three months requires the employee to leave Israel. Thus, the most serious patients are sent back to their country without medical care.

In August 2002 the State of Israel founded the "Immigration Police" and launched an arrest and deportation campaign against work migrants which subsequently resulted in physical injuries, disability and mental trauma.

In recent years, refugees and political asylum seekers have started to arrive to Israel. The UN refugee commission along with the advisory committee of the Ministry of Interior Affairs examines their requests and decides whether to grant them refugee status. Few actually receive such status. Some of the permits are for humanitarian refugees, temporary permits given to the citizens of four African countries that suffer from civil wars (Sierra Leone, Congo, Ivory Coast and Liberia). When the war in their country ends, they will be asked to leave Israel. According to international law, seekers of political asylum submit a personal request and they must prove that their fear of persecution in the origin country is well established. During the months and years in which the request is being processed, the asylum seekers receive temporary and work visas, but they are not entitled to social or basic health services. If they are recognized as refugees, they will receive only a temporary resident status, which does not entitle them to any social or health services. Even refugees staying in Israel with UN-protecting documentation have no social rights and they are exposed to racism, humiliating treatment and police brutality.

The number of women who are victims of human trafficking in Israel is unknown, but is estimated to be in the thousands, mainly from the former Soviet Union states. Between the years 2000–2002 over 1,200 women who worked in the sex industry were deported. Women who choose to testify against the traffickers and panderers are entitled to stay in special shelters, and are given protection and some social and health services.

According to estimates, 20–25% of the HIV carriers in Israel are work migrants. Most of them are asylum seekers who do not hold visas (8). Carriers and patients are not entitled to receive the common medical care customary in the Western

world, guaranteed to the residents of Israel that may prevent deterioration and death. Their options for treatment are limited, and they must rely on donations or participate in research funded by AIDS centers. Besides their daily struggle, carriers suffer gravely from social isolation. Women with HIV are entitled to antiretroviral treatment (even those without visa) up to six months after giving birth, in order to prevent vertical infection during pregnancy, birth and lactation period.

The Open Clinic

The Open Clinic was founded by the Physicians for Human Rights – Israel (PHR) Association in 1998 to serve work migrants, especially those without visas. The clinic, located in south Tel Aviv, is based on the work of volunteers, who provide primary medical services six times a week for whoever requires it. Physicians from a variety of specializations (family physicians, pediatricians, gynecologists, psychiatrists, etc.) volunteer at the clinic or treat patients in their clinics free of charge or for a minimal fee. Nurses, administration volunteers, translators as well as physiotherapists, dietitians and acupuncturists participate in the work in the clinic. After over six years of activity the clinic holds more than 15,500 patient files. Approximately 60% of the visitors to the clinic are treated by the family physician while the rest by other specialists. In 2005, 2,571 visits were recorded, and 677 new files were opened. In the first half of 2006, a total

Table 1. *Demographic Data of the Patients in the Psychiatric Clinic*

Sex	Male	70 (41.4%)
	Female	99 (58.6%)
Age		37.2 years (±SD 9.5)
Time in Israel before treatment		Average: 4.9 years (±SD 4.9)
Family Status	Married	68 (40.2%)
	Single	69 (40.8%)
	Divorced	18 (10.7%)
	Widowed	8 (4.7%)
Spouse in Israel	Without spouse in Israel	111 (65.7%)
	With spouse in Israel	48 (28.4%)
Average number of children		Average – 1.28 (±SD 1.55) (Information regarding 161 patients)
Parents	Number who are parents	84 (49.7%)
	Number whose children are in Israel	41 (48.8% of the patients who are parents)
Employment during psychiatric care		
	Employed	59 (35% of all patients)
	Unemployed	82
		(2 other patients are children under 18)

SD – standard deviation

number of 2,019 visits to the clinic were recorded, and 573 of these patients had their first visit during that period. The number of psychiatric visits during this period was 78 (compared with 63 visits at the same period the year before). The number of asylum seekers and refugees treated at the clinic is 387.

This article will present data regarding patients who need psychiatric treatment at the Open Clinic, in light of stressful life events and restricted conditions of treatment. The following data is based only on the files from the clinic. Naturally, this information does not represent the general mental health of the immigrant population in Israel.

Methods

Data collection & analysis

Data were collected from the Open Clinic's psychiatric and general medical files. This was the only means of acquiring information. No manipulation of the population at hand was performed, and no control group was recruited. Data were coded and entered into SPSS version 11. Logical cross examination was made to confirm data. Details that were not available were recorded as missing. Distributions and correlations were calculated. Chi square test and Fisher exact test for categorical variants were made for examination of correlations. The strength of correlation was calculated by Odds Ratio. Correlations were considered statistically significant at p-value < 0.05.

Results

Demographics and clinical aspects

The psychiatric service documentation dates back to December 2001 and holds 169 files. There is no uniform outreach policy, yet follow-up visits are made according to the clinical needs and within the patients' ability to arrive. Of the 40 files opened during the last six months of 2006, only three patients stopped attending. The total dropout rate is estimated to be more than 50% (partially due to the deportation policy). Female patients are the majority (58.6%). The average age of patients is 37 years (similar to the average age of work migrants according to the Central Bureau of Statistics). Only about 40% are married, and only 28% live with a spouse in Israel. Further demographic data is presented in Table 1. The patients come from various countries. Distribution of patients according to continent of origin is shown in Table 2.

Table 2. *Distribution of Patients According to Continent of Origin*

Continent of origin	Percentage
Africa	44%
Eastern Europe	20%
Asia	15%
South America	9%
Middle East	7%
Western Europe	2%
North America	1%
North Africa	1%
Australia	1%

The distribution of common diagnoses in Axis I is shown in Table 3 (for further explanation about the multiaxial assessment of DSM-IV-TR, see reference 9). The most common diagnoses of mental disorders in our clinic include PTSD (23%) and adjustment disorder (18%). The core trauma is almost equally divided between traumatic events that happened in the country of origin (mostly political persecution) and in Israel (terror attack victims and less frequently sexual violence, accidents and violent actions of the Immigration Police). Other common diagnoses include major depressive disorder (15%) and psychotic spectrum (15%).

Ten patients reported substance or alcohol abuse, the majority of them men (7 out of 10). Those living in Israel without their spouse and children have a greater tendency for alcohol and substance abuse and dependence. One of the patients who reported substance abuse has been hospitalized due to an acute psychotic state.

Nine patients (of them, 7 women) were diagnosed as having a personality disorder (Axis II).

Medical psychiatric treatments
The most common medication prescribed was antidepressants (mostly SSRIs). The second most used medications were anxiolytics and sedative hypnotics. Of the antipsychotic medication, most patients received first generation neuroleptics.

Suicide attempts
Nine patients (5.23%) have tried to commit suicide. In addition, one patient was referred to the psychiatric clinic by a family physician, but committed suicide before arriving there. In general, statistical analysis shows only trends in light of the small number of suicide attempts (n = 9), so it was impossible to draw clear conclusions. Women were more likely to attempt suicide as compared to men (7 vs. 2). No statistical difference was noted regarding country of origin, time spent in Israel before the suicide attempt, the psychiatric disorder (Axis I or II) or substance and alcohol abuse. Being unmarried was a risk factor for suicide attempts (5 singles, 2 divorced vs. 2 married).

Table 3. *Distribution of the Common Diagnosis in Axis I*

Diagnosis	Percentage
Post-traumatic stress disorder	23
Adjustment disorder	18
Major depressive disorder	15
Anxiety disorder	9
Psychotic disorder	9
Substance and alcohol dependence/abuse*	7
Schizophrenia	6
Somatization disorder	5
Acute stress disorder	5
Other**	3

*Patients with substance and/or alcohol abuse diagnosis are about 7%, but none of them was referred or came to the clinic on those grounds. This diagnosis in all of the cases was an additional diagnosis (co-morbidity).
**Other include: Primary sleeping disorders 2 (1.2%), Type 1 Bipolar disorder 1 (0.6%), Eating disorder 1 (0.6%), PDD 1 (0.6%)

Psychiatric hospitalization in Israel
Out of all the patients in the clinic, 20 patients (11.8%) were hospitalized at least once in a mental health center in Israel. (In the absence of exact information regarding hospitalization prior to arriving to Israel and in light of the difficulty of relying on verbal reports from the patients, it was impossible to consider hospitalization before their arrival.) Women were hospitalized more than men (80% vs. 20%). Patients without a spouse in Israel were hospitalized more often (60%). As for the family status, married people were hospitalized the least (30% vs. 70% of unmarried). Yet, these differences did not reach statistical significance (a tendency only).

The majority of hospitalizations were due to a psychotic disorder or schizophrenia. Sixty-five percent of the patients who suffered from an acute psychotic state or a psychotic exacerbation of schizophrenia were hospitalized in Israel.

A significant association was found between psychiatric hospitalization and suicide attempts (CI = 1.75–29.56, OR = 7.2, $p<0.0.1$).

General medical condition
Psychiatric patients may also suffer from general medical conditions. Description of the patients' general medical condition is presented in Table 4. The documentation was not always complete in the general and psychiatric files.

Out of cancer patients, one patient received chemotherapy and one received chemotherapy and radiotherapy. Out of the nine patients (5.3%) tested positive for HIV, two patients (1.2%) received antiretroviral treatment. In one case HIV induced psychosis was reported.

Refugees and asylum seekers
Thirty patients in the psychiatric clinic requested to be recognized as refugees or asylum seekers. The majority were men (63.3%). Only 33% were married, while the rest were either divorced or single. Most of them lived without a spouse in Israel (67%). About half of them were employed. Six patients (20%) were positive for HIV, and they constitute

Table 4. *Distribution of Physical Diseases*

Physical Disease	Percentage
Hypertension	(5.9%) 10
HIV Carrier	(5.3%) 9
Epilepsy	(3.0%) 5
Cancer	(2.4%) 4
Thyroid gland problems	(1.2%) 2
Wide angle Glaucoma	(1.2%) 2
Heart insufficiency	(0.6%) 1
HBV	(0.6%) 1
Tuberculosis (not due to HIV)	(0.6%) 1
Toxoplasmosis (not due to HIV)	(0.6%) 1
	Total: 36

two-thirds of the HIV carriers in the psychiatric clinic. The two patients who did receive antiretroviral treatment were refugees.

The prevalence of PTSD among this population was higher compared with the general psychiatric clinic population (33.3% vs. 20.9%, $p = 0.1$). Psychotic state was also a common diagnosis (28.6% vs. 16.8%, $p > 0.05$). Psychiatric admissions were more prevalent among the asylum seekers and refugees (25% vs. 16.8%, $p > 0.05$). One refugee tried to commit suicide.

The diagnosis of malingering was never encountered in our sample, although because of obvious secondary gain, there have been cases in which symptoms seemed to be aggravated.

Sexual violence and abuse

Eight female patients (4.7% of all patients, 8% of the female patients' population in the clinic) reported sexual assault or rape. Another four women reported being beaten by their spouse (which was in fact the trigger for the change in their mental status and their referral to the psychiatric clinic). Another two women who were victims of human trafficking were treated in the psychiatric clinic.

Discussion

Descriptions of the relationship between immigration and mental health date back to the 1840s, but only after the 1930s have scientific investigations taken place, with the epidemiological work of Ødegaard as referred to in Murphy (10). Clinical evaluation of an immigrant patient must be careful not to impose a nosological diagnostic category developed for a particular cultural group on members of a different culture. This "category fallacy" (11) may lead to medicalization of identified symptoms by clinicians in a cultural group that has no coherence with Western common mental illness symptomatology. For example, "paranoid beliefs" according to Western psychiatry have culturally sanctioned value among Africans, and, therefore, assigning them pathological significance may be a mistake (12). With this methodological limitation in mind, we address DSM-IV-TR criteria in our work at the clinic with the necessary care.

Among adult immigrants and refugees, the main mental problems reported are anxiety disorders, particularly PTSD and depression (13). PTSD is the most common mental health problem among asylum seekers and refugees (14, 15), and the rate may be as high as 90% (16). A clinical entity of chronic and multiple stress syndrome (Ulysses Syndrome) describes immigrants who have gone through dangerous voyages on their way to their immigration destination. The clinical presentation is of depressive symptoms with mixed atypical characteristics, including anxious, somatoform and dissociative symptoms (17).

In accordance with the data in the literature, the most common psychiatric disorders among the patients at the clinic are on the anxiety spectrum, including acute stress disorder (ASD) and PTSD, with diagnosis rate of 5% and 23% respectively. PTSD among refugees and asylum seekers in the clinic is even higher (33.3%). It is probable that some of the ASD cases would have gone on to develop PTSD, but due to the inability to complete the follow up (i.e., difficulties in coming to the clinic on a regular basis, deportation), the full clinical picture was not apparent. The second most common diagnosis in our sample was major depression disorder (15%).

This may not come as a surprise when considering the stress and the dramatic changes with which the immigrant is confronted. In many ways, immigration may be similar to the mourning process (18), with loss of family, friends, property, former status and social role. Obviously, adaptation to a new environment (with different climate, language, culture, nutrition) may cause serious stress. Stress may also be due to living in crowded, unsafe inner city neighborhoods, where most immigrants reside. Immigration becomes even more complicated for refugees or asylum seekers, due to the exposure to life-threatening situations in the country of origin and the inability to return to their home.

In addition to all these stressful factors, our patients lack social support and face low socioeconomic status; only 28.4% were reported to have a partner in Israel and not more than 35% of the patients were employed during the psychiatric treatment. Patients without a spouse in Israel were more prone to hospitalization than those with a spouse (12 patients out of 20). Married people were the least likely to be hospitalized, even in cases where their spouse did not live in Israel. Naturally, the majority of the patients who do work are employed in simple, stress-related, low paying jobs, and often the employment is illegal and temporary. Some patients manage to work despite being in a very difficult mental state. Only a minority of those not working are supported by social security (for example, survivors of terror attacks). Thus the financial status of the majority of patients is very complicated. The absence of a steady source of livelihood also affects the ability to buy medication on a regular basis, let alone basic human needs (food, shelter). Sometimes medical changes are achieved only due to the availability of certain medications at the clinic. This may imply that the patients receive sub-optimal medical treatment.

Women constitute 58.6% of the patients in the clinic, despite the smaller percentage of women among work migrants. This may reflect the inclination of women to seek medical and mental help, or the stressful conditions of life and gender-based discrimination with which women have to cope. At least 10% of the female patients were exposed to violence with a sexual background. Apparently these numbers are under-estimations due to shame and cultural context. Not surprisingly, more women than men have been psychiatrically hospitalized in Israel and more women than men have attempted suicide.

The stress of immigration may not be related to an increase in mental illness or to the same level of stress across all migrant groups (19). The ratio of African immigrants who are treated at the psychiatric clinic is higher than their relative percentage in the immigrant population. According to the Israeli Central Bureau of Statistics, the main countries of origin for work migration are Romania and parts of Asia, while the minority of immigrants arrives from Africa. At the clinic, most of the patients are African (44%); the second largest group is from East Europe (20%) and the third is Asia (15%). This may reflect the more profound cultural gaps, the customary help-seeking norms, the endemic areas of wars and conflicts, or the "ethnic density" effect, in which the incidence of psychotic disorders, suicide and psychiatric hospital admission rates is elevated among members of minority groups living in areas with lower proportions of ethnic minorities (20). The cultural gap may evoke distress that is termed "culture shock." DSM-IV-TR diagnosis of "culture shock" is used for acculturation problems, when the focus of clinical attention is a problem involving adjustment to a different culture. This condition arises when individuals find themselves in a new culture in which they feel completely alien and experience reactive symptoms including anxiety, depression, isolation, fear and a sense of loss of identity.

Schizophrenia and psychotic states constitute together 15% of the diagnoses in our clinic. Schizophrenia is a common diagnosis among migrants and immigration is an important risk factor for schizophrenia (21). According to our data, patients suffering from a psychotic disorder or acute exacerbation of schizophrenia are at a high risk for hospitalization. We found an association between psychiatric hospitalization and suicide and vice versa; a person who has been psychiatrically hospitalized had a higher risk for a suicide attempt.

There have been reports of high suicide rates among immigrants worldwide, suggesting an epidemiological trend related to voluntary and forced migration (22). We cannot draw conclusions from the data in our sample as the number of patients

who tried to commit suicide was small (n = 9). Known social risk factors for suicide, include living alone without family support, isolation, recent loss and lack of employment (23), as Emile Durkheim described: "the suicide rate varies inversely with the integration of social groups of which the individual forms a part" (24).

Schizophrenia, psychosis, major depressive episodes and adjustment disorder are related to an increased risk for suicide (23). These disorders constitute the major burden of mental illness in our clinic, and all these risk factors (both social and clinical) are relevant for the population of patients in the clinic. Studies have consistently reported a significant association of adjustment disorders with suicidal behavior (23), with females predominating over males.

Our experience is similar to the data concerning general population that females of all ages try to commit suicide more often than males (23).

Appendix: Recommendations and Special Considerations in Psychiatric Treatment of Immigrants

Immigrant patients vary in many aspects, including the motivation for migration, legal status and the way of arrival. Thus, they are not always regarded as a homogenous group. However, many stress factors are common, such as low and unstable socio-economic status, lack of wide social support, unfamiliarity with the local culture and language, difficulties in accessing health services, etc. Therefore, it is not unwise to discuss them as a group with special needs and considerations.

Language, communication and cultural differences

The majority of our patients speak only basic Hebrew, if at all. Although intakes and follow-ups are sometimes done with translators, there is still difficulty in extracting and expressing exact information. Even precise literal translation could miss out on cultural contexts and meanings both the patient and the clinician are trying to communicate. Moreover, cultural differences may occur in the way the two sides describe or consider physical illness, psychological distress and psychiatric symptoms.

These differences make the clinical evaluation a challenge; there is always the possibility of non-recognition of a mental illness by health care professionals, that may reflect a mismatch between the patient's cultural means of expressing distress and the signs and symptoms of a particular diagnostic syndrome sought by the clinician (25). On the other hand, culturally acceptable means of expressing distress may be attributed to a pathological explanation by the professionals. At times it may be very difficult to differentiate between physical illness with extraordinary manifestations, delusional somatic disorder, somatization disorder and affective disorders with somatic manifestations.

Recommendations for working with immigrants include incorporating awareness of cultural diversities and differences in worldviews and norms in establishing a clinical impression, withholding the racism that is sometimes shared by both clinicians and patients. Clinicians may find it useful to assess the patients' explanations of their illness. It is very important to acquire information regarding the pre-immigration history, since the background may differ greatly among patients, from an immigrant who came from an urban society to one who came from a simple agricultural-tribal society. It has been proven that experiences related to war and status of employment before the immigration were important risk factors for post-immigration psychiatric symptoms (26). Using the service of cultural consultants with background in the immigrants' culture and community was been found to be effective in reaching accurate clinical assessment and in improving services (27). Psycho-education is important; increasing knowledge about mental illness among immigrants and to educate and assist them in understanding cultural norms and health practices in their new environment. Yet, it is important to educate professional health suppliers about immigrants' traditional cultural practices and to train them for specific appropriate interventions (12, 28).

Stressful economic state

As most of our patients find it hard to make ends meet, an important guideline consideration in the clinic is the financial one. Many of the visitors cannot afford certain medications, and one

must consider thoughtfully which prescription the patient will receive. Sometimes a cheaper generic medication is a good alternative for the more expensive original one. Decision-making about purchasing medication by the clinic is narrowed down by a limited budget that cannot answer the demands of all of our patients. The use of advanced laboratory or imaging studies (CT, MRI, immunological tests) should be carefully evaluated.

Absence of support system

Another major problem is the absence of personal and communal support systems, including social and psychological services. In addition, the community and religious support system (which is very important in the life of the immigrant community) has diminished greatly in the past few years due to the deportation policy. It is possible that the disintegration of the communities caused further distress. All of this may contribute to the stress of immigration, influence mental health and affect the outcome (hospitalization, suicidability). Lack of support systems demands a wider perspective in evaluating the clinical situation of the patients. Issues such as basic human needs (food, shelter), family support, childcare, etc., should be included when decisions about treatment and follow up are made. For example, when referring a patient to the ER, one should remember there is a chance that his or her children are left alone at home, without anyone to look after them. In making a follow-up appointment certain considerations should be taken into account, such as the distance to the clinic, availability of transportation and the time consumed away from employment.

Lack of civil definition

Many of our patients do not have work permits or visas. They live with a fundamental sense of persecution, which is re-enforced by the Immigration Police actions and the deportation policy. Helping the patients with the process of documentation (i.e., referral to lawyers who specialize in the field of immigration, supplying expert medical opinion) may improve the overall condition and consolidate the therapeutic relationship.

Conclusion

In the last decades, the State of Israel has constituted a target for work migrants, refugees and asylum seekers. Immigration involves a process of loss and change with significant socio-psychological stress, which affects the mental health of the immigrants. Physicians for Human Rights (PHR) Association operates a psychiatric clinic that is part of the Open Clinic for Work Migrants. At the psychiatric clinic we treat weak populations of patients in many aspects (unemployed, without family). The patients are not a homogenous group of immigrants. They come from different countries and suffer from various physical and mental disorders, sometimes even a combination of physical, psychiatric and social problems. These patients present a challenge to psychiatric diagnosis and treatment.

The manner of immigrants' acceptance by the target country of immigration and the post-immigration environment can have an immense effect on the immigrant condition and his or her mental health, especially among refugees and asylum seekers. The level of socially effective support in the country of immigration is an important determinant of the severity of possible disorders (29). The process of obtaining documentation may also affect mental health. It has been proven that a longer duration of asylum procedure is an important risk factor for psychiatric problems (30).

In 1991 Israel signed the UN treaty for financial, social and cultural rights, which declares: "States are under obligation to respect the right to health by, interalia, refraining from denying or limiting equal access for all persons, including prisoners, or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative, and palliative health services; abstaining from enforcing discriminatory practices as a state policy" (31). A multidimensional intervention by the clinician, and at times even at a national level, could be crucial to improve the health and well-being of immigrants in Israel.

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