Employment and Mental Health of Three Groups of Immigrants to New Zealand

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This paper reports findings on employment and mental health from the first phase of a longitudinal study on the settlement of three groups of skilled immigrants to New Zealand: 36 from the People's Republic of China, 36 from India and 35 from South Africa. They were interviewed face-to-face after having been residents of New Zealand for an average of 5 months. A questionnaire collected demographic data and employment related experiences. The mental health instrument used was the General Health Questionnaire 12 (GHQ-12).

The results indicated that migrants' mental health levels were low and independent of their mean number of months residence in New Zealand. Even though unemployment is usually a cause of mental distress, there were no significant differences between employed and unemployed migrants and also no differences among the three immigrant groups. The lack of difference related to employment success suggests that another source of low mental health – perhaps the difference in motivational factors for migration, as explained by Kunz's (1973) kinetic model of migration - may have been affecting the South Africans who were 83% employed.

During the last decade New Zealand, in common with North America and Australia, has placed increasing policy emphasis on attracting highly qualified migrants. Since the 1991 introduction of a points system for immigration which emphasises professional and trade qualifications and business and work experience, New Zealand has received large numbers of educated and skilled immigrants. Recent reports, however, have highlighted significant unemployment levels among new Asian immigrants, and raised concerns about the waste of human resources and its costs to society (Boyer, 1996; Ho, Bedford & Goodwin, 1997). As immigration is an essential element in New Zealand's economic development and growth, the successful settlement of migrants, including their economic integration and mental health, is an important issue. However, employment success and its relationship to the mental health of these skilled settlers have received little research attention.

Beyond New Zealand, the adverse effects on mental health of migration have been widely researched and established. There is evidence in the international literature that migrants go through different stages during their resettlement and some of these stages are characterised by a higher level of mental health risk than others. Most research supports an initial euphoric period, which may last three months, six months or one year (Sluzki, 1986). This is followed by increasing mental health difficulties with the occurrence of a peak or crisis at any time from six months to two and a half years or even up to six years after arrival. A second response pattern proposes that immigrants pass through some stressful periods with some mental health improvements over time (Pernice & Brook, 1996a; Scott & Scott, 1989).

Various studies have attempted to explain why some migrants experience a deterioration in mental health and suggest that it is due to transition and adjustment difficulties in the new society. A broad range of factors associated with relocation to another country have been identified, each of which can influence the degree and direction of stress behaviours which affect mental health. These factors include: the circumstances of migration (being a refugee or immigrant) (Pernice & Brook, 1994); the type of immigrant group and its attitudes towards various modes of acculturation (Krishnan & Berry, 1992); social supports, both within the migrant group and within the new society; language; and discrimination and prejudice within the host country (McDonald, Vechi, Bowman & Sanson-Fisher, 1996; Pernice & Brook, 1996b). The importance of

employment issues among other factors in the settlement process has been highlighted by Pernice and Brook (1996b) who suggest that for both refugees and immigrants settled in New Zealand on average for 5 years, the experiences of discrimination, unemployment and lack of support in the society of settlement was related to depression and anxiety levels. In their study, British immigrants experienced significantly better mental health than Pacific Island immigrants and refugees. Similar results were reported by McDonald et al.(1996). They collected data on the Latin American community in the Hunter Valley and stated that marital status, unemployment, perceived discrimination and dissatisfaction with life in Australia were associated with low mental health scores. Studies from Israel, the United States, Canada and Britain, where employment status was found to be significantly related to immigrant mental health and distress levels, support the New Zealand and Australian research (Baider, Ever-Hadani & Denour, 1996; Hurh & Kim, 1990; Naidoo, 1992; Husain, Creed & Tomenson, 1997).

Although employment problems are considered to generate similar mental health outcomes for any individual in society, Aycan and Berry (1996) suggest that unemployment of immigrants, results not only in the typical incidence of psychological problems but also in adaptation difficulties. They reported that adapted immigrants were those who experienced satisfaction with their employment condition. The authors state that having work not only provided an income, but status and identity which enabled the individual to establish relationships with others in society. This was considered critical for highly educated immigrants, because settlement and adaptation is facilitated by social interaction. Failure to obtain appropriate employment was linked to low mental health levels, contributed to social isolation and financial hardship, and generated deep-seated dissatisfaction and resentment towards the new society.

Against the background provided by the research outlined above, this paper explores the relationship between employment status and mental health for three groups of immigrants admitted to New Zealand under the point system, namely highly skilled settlers from the People's Republic of China, India and South Africa. New settlers from these origins were among the leading groups of immigrants to New Zealand in recent years and their differences in terms of ethnicity, English language use and financial resources facilitate a comparative perspective on employment experiences and mental health. The following hypotheses were tested:

1) Immigrant participants who are employed will have better mental health than those who are unemployed and looking for work.

2) Mental health among the three immigrant groups will differ. As the South Africans come from a predominantly European and English-speaking background, they will have a higher rate of employment success and will have better mental health than participants from either the People's Republic of China or India.

3) The mental health of immigrant participants will be positively related to their duration of residence.

Method

Participants

This paper is based on data collected in the first phase (May-August 1998) of a longitudinal study which is a core element of 'The New Settlers Programme' (see Trlin, North, Pernice & Henderson, 1998). For the purposes of this study, a sample size of approximately 36 principal applicants in each of the three groups, approved for residence in New Zealand under the terms and conditions of the General Skills Category (see New Zealand Immigration Service, 1995), was sought. In the absence of reliable, comprehensive sampling frames, random sampling techniques could not be used. It was known, however, that new, highly qualified migrants tended to settle primarily in Auckland (Friesen, 1993) and to a lesser degree in Wellington. Therefore participants who had taken up permanent residence in New Zealand between August 1997 and July 1998, were recruited both in Auckland and Wellington. Information about the aims and objectives of the New Settlers Programme (NSP) was disseminated via a variety of methods which included: a) networking with ethnic associations/organisations, b) the inclusion of project brochures in postings of newsletters from ethnic associations, c) presentations at ethnic community conferences, d) the posting of NSP brochures by the New Zealand Immigration Service (NZIS) to recent arrivals who met the criteria of the project. All of these contacts/materials included an invitation for participation in the research.

The new settlers who volunteered to participate in the study were 36 principal applicants from the People's Republic of China with a mean age of 34 years (*SD* = 3; *Range* = 16 years), 36 from India with a mean age of 37 years (*SD* = 7; *Range* = 22 years), and 35 from South Africa who were on average 41 years old (*SD* = 6; *Range* = 28 years). In all three groups most of these principal applicants were male: Chinese 67%, Indians 81%, and South Africans 80%. They were highly educated and most settlers (94% of the Chinese, 94% of the Indians, 66% of the South Africans) had either a degree and/or post-graduate qualification.

Instruments

Two instruments were used. The first was the New Settlers' Questionnaire Schedule (NSQS), an instrument informed by the migrant research literature and a longitudinal survey of immigrants to Australia (Bureau of Immigration & Population Research, 1996). It included demographic information, questions on the immigration process, housing, social participation, general health and employment-related experiences.

The second instrument, included in the NSQS, was the General Health Questionnaire 12 (GHQ-12), which has been widely used in unemployment research in both Britain (Warr, 1987) and New Zealand (Pernice & Long, 1995a, 1995b, 1996). However, the unmodified GHQ-12 has not previously been used with any of the three immigrant groups

in this study. Lacking these baseline data the same values were used which resulted from employment studies of various cultural groups (Pernice & Long, 1996). Banks et al.'s (1980) Likert method of scoring (0-3) has been used to provide a continuous severity measure, with higher scores on the GHQ-12 items indicating lower levels of mental health. Banks et al. reported that their scoring method is preferable for use with both employed and unemployed persons. Employed people with positive mental health have mean GHQ-12 scores in the range 5 - 8, whereas distressed unemployed people have mean scores in the range 9 - 15. The alpha coefficients reported by Banks et al. (1980) ranged between .82 and .90. The alpha coefficient for participants in this study was .85.

Procedure

In March 1998 the NSQS was pilot tested with participants from each of the three immigrant groups to test its suitability and some minor changes were subsequently made. Over the period May to August 1998, approximately 1 – 9 months after taking up residence in New Zealand, the participants were contacted and personally interviewed by the researchers at a time and place convenient to both parties. As the majority of the participants had met an English language requirement introduced in October 1995 (see New Zealand Immigration Service, 1995), it was considered appropriate to administer the instruments in English. One member of the research team (Henderson) spoke some Mandarin and was able to explain and clarify the instruments to Chinese respondents if necessary. The study had been approved by the Human Research Ethics Committee of Massey University in 1997, and complied with the University's code of ethical conduct.

Table 1. Mental health scores across employment status groups of immigrants (all countries combined)

Employment Status	Number	Mean GHQ-12[a]	Std.Dev.
Full-time employed	42	11.3[b]	6.2
Part-time employed - not looking for work	4	12.5	3.7
Part-time employed - looking for work	6	12.7	4
Unemployed looking for work	36	13.8[b]	5.3
Unemployed - not looking for work	14	12.9[b]	6.4

Notes:
[a] GHQ-12 scores range from 5 to 8 in employed populations in NZ and UK; increasing scores correspond to lower mental health.
[b] ANOVA among the three groups with adequate sample size to test showed no significant differences at $p < .05$

Results

Hypothesis 1 (mental health of employed versus unemployed - immigrant groups combined)

All employment status categories had low mental health (see Table 1). As there were only a few cases in two of the categories, the analysis of variance was run to test mean differences in GHQ-12 scores among the full-time employed *($n = 42$, $M = 11.3$, $SD = 6.2$)*, the unemployed looking for work *($n = 36$, $M = 13.8$, $SD = 5.3$)* and the unemployed not looking for work categories *($n = 14$, $M = 12.9$, $SD = 6.4$)*. There were no significant differences *($F(2,89) = 1.80$, p ns)*.

Hypothesis 2 (mental health differences among national groups)

All three immigrant groups had low mental health (see Table 2). An analysis of variance showed no significant differences in mean GHQ-12 scores across the three immigrant groups *($F(2,104) = 3.34$ p ns)*. There were 36 Chinese *($M = 12.2$, $SD = 4.3$)* in group 1, group 2 consisted of 36 Indians *($M = 13.1$, $SD = 6$)* and group 3 had 35 South African immigrants *($M = 12.3$, $SD = 6.8$)*.

Employment success (%) of immigrants from China, India and South Africa. At the time of the interviews, 11% of the Chinese, 25 % of the Indians and 83% of the South Africans were in full-time employment.

Hypothesis 3 (duration of residence and mental health)

At the time of their interview (May to August 1998), participants from the People's Republic of China had resided in New Zealand under the terms and conditions of the General Skills Category for an average of six months (M = 6.3 months, SD = 3.1), the Indians for an average of five months (M = 5.2 months, SD = 2.8) and the South Africans for almost five months (M = 4.8 months, SD = 2.4).

The effect of length of residence on mean GHQ-12 scores was tested in two ways: a) by t-test, comparing immigrants who resided in the country for either less than six months *($M = 12.6$, $SD = 5.9$)* or more than six months *($M = 11.8$, $SD = 4.8$)*; and b) by analysis of variance

Table 2. Mean GHQ-12 scores of immigrants from the P. R. of China, India and South Africa.

Immigrants	Number	Mean GHQ-12[a]	Std. Dev.
Chinese	36	12.2[b]	4.3
Indians	36	13.1[b]	6.0
South Africans	36	12.3[b]	6.8

Notes:
[a] GHQ-12 scores as defined in Table 1.
[b] ANOVA showed no significant differences at $p<.05$ among immigrant groups.

comparing immigrants in three duration of residence categories (0-3, 4-6 and 7 or more months). Immigrants had low mental health across all duration of residence categories. There were 29 participants in the 0-3 months category *(M = 13, SD = 5.6)*, 47 in the 4-6 months category *(M = 12.3, SD = 6.1)* and 29 who had resided in New Zealand for 7 months or more *(M = 11.8, SD = 4.8)*. No significant differences were found *(F (2,102) = .49, p ns)*.

Discussion

The present study investigated mental health, as measured by the GHQ-12, and its relationship to employment in a group of recent immigrants to New Zealand from the People's Republic of China, India and South Africa. All participants were voluntary immigrants and highly skilled with the majority (85%) having a basic degree or post-graduate qualification. As the sample size was relatively small and potentially unrepresentative, the findings need to be considered with appropriate caution.

Hypothesis 1 (mental health of employed versus unemployed)

Hypothesis 1 was not supported. Unemployed immigrants had low levels of mental health, a finding which was consistent with both New Zealand (Pernice & Long, 1995a, 1995b) and Canadian research (Aycan & Berry, 1996). Full-time employed migrants, however, experienced levels of mental health similar to those who were unemployed and looking for work.

Two possible explanations are offered. First, although employment is generally positive for mental health, underemployment is a potential risk to psychological well-being (Aycan & Berry, 1996). Some migrants reported that they were underemployed and did not work at the level for which training had prepared them. They had accepted the jobs in which they were employed as an initial stepping stone into the labour market, jobs which also provided them with local knowledge and work experience. Other immigrants stated that they had accepted any kind of job offered, in order to support their families and to avoid financial difficulties. Their current working conditions were perceived as unsatisfactory, badly paid or inferior to previous employment in their country of origin. In fact, on a scale of 7 response items on feelings about the job, 17 out of the 42 full-time employed migrants reported on items 3, 4 and 7 that their 'job was ok' or that 'they did not care about the job, it is just a job' and two stated that 'they hate it, it is the worst job they ever had'.

The second possible explanation utilises the evidence cited by some researchers that occupational stress in the workplace has dramatically increased in all western countries. Work stress, including migrant occupational stress, has become a major concern in psychological health research (James, 1994). A third possible explanation, not workplace related, will be presented in the discussion of hypothesis 2.

Another interesting feature of the unemployed immigrants in the study was that there was no evidence of a delay in the onset of poor mental health. The immigration stage model (Sluzki, 1986) defines a three, six or 12 months period of optimism and positive mental health. In fact, after an average of only five months without work, unemployed new settlers in this study already had a mean GHQ-12 score of 13.8, almost identical to the mean GHQ-12 score of 13.9 for long-term unemployed New Zealanders (see Pernice & Long, 1995a, 1995b). It seems that unemployed skilled immigrants are at risk at an earlier time for high levels of anxiety and distress due to failed expectations, an uncertain future and the resulting financial strain. Immigrants are no longer entitled to a social welfare benefit or a student allowance during their first two years in the country (other than a possible emergency benefit) which can be a real threat to well-being.

Hypothesis 2 (mental health differences among national groups)

Low levels of mental health were evident among all three immigrant groups. While South Africans had indeed experienced greater employment success as hypothesised, they also experienced low mental health. This result was surprising.

It was expected that South African immigrants would have similarities with immigrants from Britain (see Pernice & Brook, 1994) due to their cultural affinity with the majority of New Zealanders. The difference between South African and British immigrants may lie in the reasons for migration. Kunz (1973) developed a kinetic model which contrasts 'push' forces and 'pull' forces as motivations for migration. At one extreme is the completely involuntary 'push' force migrant (refugee) while at the other end of the continuum are voluntary 'pull' force migrants attracted by opportunities such as enhanced job opportunities and/or quality of life in the country of settlement. Another feature of voluntary immigrants is that they have the choice of returning to their home country. This describes the experience of many British migrants who came to New Zealand for an improvement in their quality of life. The majority of South Africans in this study, however, reported leaving their country of origin for reasons such as increasing political instability, violence and crime. These are all examples of 'push' forces. While the South Africans reported that the New Zealand lifestyle and culture were attractive, these 'pull' forces do not appear to have had as much weight in their decision to migrate as the 'push' forces. South Africans may, therefore, be considered semi-voluntary migrants and as such may feel quite ambivalent about leaving their country of origin. Although they have the choice of return, it would be a more problematic and difficult move than for British immigrants.

This contrast between 'push' and 'pull' migrant motivation may help explain why the South Africans' mental health was no better than that of the two Asian groups. The Chinese reported that their reasons for migration were centred on 'change/challenge' or better opportunities, which are both pull forces. Likewise the Indian immigrants' motivation was to improve opportunities, quality of life and occupational status. These two groups would appear

therefore to have been less affected by mental distress related to factors of the 'push type' which were present for the South Africans.

Hypothesis 3 (duration of residence and mental health)

Given the relatively recent arrival of all respondents, this hypothesis was tested using the limited range of cross-sectional data. No positive relationship between mental health and duration of residence could be established. However, the generally low mental health of these skilled immigrants does contradict the occurrence of an euphoric/optimistic initial period (Sluzki, 1986) and supports Pernice and Brook's (1996a) New Zealand's immigrant research, where the concept of a symptom free or euphoric period was also firmly rejected.

Summary

The mental health data collected from three groups of recent skilled immigrants to New Zealand indicated that mental health levels during their first months of residence were no better for the employed than for the unemployed. Migrants in both categories experienced mental health levels similar to those of the general unemployed population in New Zealand. For those who were employed, this could be due to underemployment, occupational stress or a combination of these factors.

Low levels of mental health were equally evident among migrants from all three national origins. While most South Africans had employment success, in contrast to the Indians and Chinese, this did not prevent them from having low mental health. This may have been a result of South Africans having different motivational factors for migration.

No positive relationship between mental health and duration of residence could be established from the data available. However, the generally low mental health during the first few months in New Zealand does not support a euphoric/optimistic initial period as proposed by the stage model. Baseline values have now been established and future trends and patterns in mental health for the three groups of participants will be assessed as an important feature of this longitudinal study.

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ERRATUM

In the last issue of the Journal (V.28, 2, page 68) an article carried a dedication to Karen Stanley-Hunt. The dedication incorrectly identified the person who was charged with her killing as her former partner. The person charged and subsequently convicted of her killing was not her former partner. The author and the New Zealand Journal of Psychology wish to apologise unreservedly to Ms Stanley-Hunt's former partner and to members of the families for any hurt or embarrassment this error may have caused.