How general practitioners manage mental illness in culturally and linguistically diverse patients: an exploratory study

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Background

General practitioners (GPs) see a range of mental illnesses and a diversity of patients, including patients from culturally and linguistically diverse (CALD) backgrounds. The aim of this study was to understand the barriers and facilitators GPs encounter when managing mental illness in CALD patients.

Methods

Semi-structured interviews with 10 Melbourne GPs were undertaken between May and July 2013. Data were analysed thematically.

Results

GP barriers included difficulties in recognising initial symptoms, communicating the diagnosis and using interpreter services. Facilitators included cultural concordance between the GP and patient, practice-based initiatives targeting CALD patients, and areas of further education for GPs and CALD patients.

Discussion

Cultural concordance between GPs and CALD patients is likely to be effective in facilitating management of mental illness. Further research is needed on interpreter use and scaling up practice-based initiatives to improve service delivery. At a population level, GPs thought it necessary to improve mental health literacy in CALD communities.

Keywords

mental disorders; cultural diversity; general practice

With one in four Australian residents born overseas, Australia is one of the most culturally diverse countries in the world and more so than New Zealand, Canada, the United States (US) and the United Kingdom (UK).[1] The term 'culturally and linguistically diverse' (CALD) refers to people born overseas, people with limited English proficiency, children of people born overseas, refugees and asylum seekers.[2] Widely used in Australian government policy and service initiatives, the term is applied in recognition of these communities often facing unique cultural and linguistic barriers that may impede their access to services, including health services, resulting in poorer outcomes.[3] Ensuring equitable access for the whole population to appropriate services is a priority for government.

Unfortunately, current research shows that CALD communities have lower rates of health service utilisation, especially for mental health (26/100,000, compared with 48/100,000 in the general population).[4] Reasons for under-utilisation include language barriers, lack of health information, lack of understanding of appropriate healthcare pathways, Medicare ineligibility, healthcare costs, different cultural understandings of mental illness, normalisation of distress and stigma.[5–8] Additionally, health provider factors such as under-diagnosis, misdiagnosis, variations in professional nosologies and difficulties accessing appropriate specialist care and services have also been found to have an impact on treatment and health-service use.[6,7,9–14]

One way to improve CALD patients' access to mental health services is through bettering the care delivered by their general practitioner (GP). CALD patients visit their GPs at least once a year and express a preference to see their GPs more than mental health specialists, thus making the GP an important first point of contact with the healthcare system.[13,15] GPs see a range of mental illnesses, as well as a diversity of CALD and other patients, and their capacity to make an appropriate initial

assessment, diagnosis, referral and treatment of mentally ill CALD patients is critical.[10,16] The aim of this study was to investigate GP perspectives on the barriers and facilitators they encounter in their management and care of CALD patients with a mental illness, a topic on which little is currently known.

Methods

An exploratory qualitative design was applied.[17] Data were collected from May to July 2013. GPs practising in high-CALD suburbs in south-east Melbourne were targeted; inclusion criteria were that GPs had to be practising in these suburbs and be treating CALD patients with mental illness. Initially, GPs in the local government area (LGA) of Greater Dandenong were targeted as 56.1% of the population of this LGA is overseas-born.[18] However, because of low response rates (a total of 4, 22% response rate), GPs in the LGAs of Monash and Whitehorse, where percentages of overseas-born residents are 39.7% and 33.5%, respectively,[18] were subsequently targeted. An additional six GPs subsequently responded (7% and 13% response rates, respectively).

A faxed invitation, using practice contact details in the GP database at the Department of General Practice, Monash University, was sent to GPs. Additional faxes were sent using GP contact details found on the internet. A total of 10 GPs accepted the invitation. One GP subsequently did not participate.

Semi-structured interviews of 45–60 minutes were completed during clinic hours. GPs received a $120 gift voucher for their time. The interview schedule was based on a review of the literature and piloted on two GPs. There were no changes to the interview schedule used in the second pilot and so these pilot data were incorporated into the final study to increase numbers. Thus, there were a total of 10 interviews. Questions focused on the issues GPs faced in the diagnosis and management of mental illness in their CALD patients and their requirements for further training in the area (*Table 1*).

Interviews were recorded, professionally transcribed and then thematically analysed.[19,20] Initial codes, developed by the first author, were shared with the second and third authors for coding verification, feedback and thematic grouping. Final codes were entered into NVivo ver. 10 for further analysis and data storage. Approval was obtained from the Monash University Human Research Ethics Committee (CF13/977-2013000475).

Results

GPs were from a range of demographic backgrounds and saw patients from equally diverse cultural backgrounds (*Table 2*). GP-identified barriers to delivering effective mental healthcare for CALD patients included difficulties in recognising initial psychiatric symptoms, challenges associated with communicating a mental illness diagnosis and problems with using interpreter services. Facilitators included cultural concordance between the GP and patient, implementing practice-based initiatives to improve the delivery of mental healthcare to CALD patients and identification of areas of further education for GPs and CALD patients. Thematic saturation was not achieved because of the low number of participants.

Barriers to effective mental healthcare

Seven of 10 GPs identified depression and anxiety as the most common types of mental illness they saw in their CALD patients but they could not say if the prevalence and severity of these illnesses were greater or lesser in CALD versus non-CALD patients. This was because GPs said they grappled with differences in illness presentation, making it difficult for them to correctly identify presenting symptoms in their CALD patients.

> 'Depression presents in different ways in different cultures too. The Africans might not say they're depressed and they would present with multiple physical complaints and you can't even sometimes use the word depression. Some of the Afghans are happy with [the term] depression, some of them present with much more physical complaints as well, but then they would also have fainting turns and jerking and do things that seem crazy to us, but it's just an expression of their stress.' (Dr 4, female).

Compounding variations in symptomology was the stigma associated with mental illness and CALD patients' attempts to normalise their distress by either downplaying the severity of their symptoms or delaying presentation until they were very unwell.

> 'For them maybe it's more of a stigma or they perceive it as a weakness rather than actually realising that … it is an

Table 1. Examples of questions in the interview schedule

1. Are there any challenges you face in reaching the diagnosis? If so, what are these challenges? [Probe on: clinical judgment, diagnostic tools, family input]
2. How do you communicate with your CALD patients? Do you have any challenges dealing with matters such as:
   a. Patient education regarding mental wellness and illness
   b. Acceptance and compliance with diagnosis and treatment
   c. Dealing with stigma
3. How confident are you in managing mental illness in CALD patients? Are there any areas in which you would like to improve? If so, in which specific areas?
4. Are there any ways your practice might improve its service to CALD patients? If so, what are they?
5. Are there any ways services might be improved for CALD patients with a mental illness?

illness … [and] they will try to, you know, just maybe … through family support and just with their own inner strength or prayer (if they believe) and they will sort of try and just use those methods rather than actually be more open to things like counselling or medications to try and overcome the issues and sometimes they will only present if they're really unwell.' (Dr 9, female).

'She [patient] thinks that everyone is going through that [depression] and then that's normal. She told me, "I think that's normal" but the way that she was telling me, the fact that she's crying and all the symptoms were very clear that she is depressed. And I was surprised that she said that, "I think that's normal"'. (Dr 7, female)

GPs said that variation in presentation of symptoms and stigma not only made the initial assessment challenging but also made communicating the diagnosis and need for commencing treatment difficult.

'The issue is whether they are comfortable talking about it and coming around to it. I do touch upon it probably just as often as [for] non-CALD patients [but] whether or not they respond positively to that discussion is another matter … there are stigmas associated with mental illness, more so in CALD communities.' (Dr 6, male).

As evidenced from the above quotes, GPs faced cultural rather than language barriers when communicating with CALD patients. This could be because CALD patients had some English-language proficiency and nine of the 10 GPs interviewed spoke at least one language other than English (these languages only matched the languages that their patients spoke in six cases; *Table 2*).

'With the language most of them are fluent or certainly have a working knowledge of English. A minority have very little English and often come with a member of their family or friend who's fluent in English. And in very rare occasions maybe ones or twice a year we would book an interpreter either by telephone or in person.' (Dr 10, male)

GPs said interpreter use was infrequent; six GPs said that they almost never used the interpreter services and only two GPs reported frequent use of interpreters. Reasons for non-use were either that GPs were bilingual or multilingual and/or that there were structural barriers associated with using the service.

'Trying to use telephone interpreters, it's very much better than not at all. You get interpreters that seem to easily understand what you're saying; others that don't sometimes [and] the patient

Table 2. GP and patient demographics

GP	GP gender (M/F)	GP ethnicity	Overseas trained	Languages spoken in addition to English	Ethnicity of CALD patients	Languages spoken with CALD patients
Dr 1	M	South-African Indian	No	–	Chinese, Indian, Sri Lankan, Eastern European	English
Dr 2	F	Chinese	No	Cantonese	Italian, Greek, Middle-Eastern	English
Dr 3	F	Chinese	No	Cantonese and Mandarin	Chinese, East-Asians, Eastern Europeans	English, Cantonese, Mandarin
Dr 4	F	Anglo-Saxon	Yes	African language, French	Afghan, Sri Lankan, Sudanese, (mainly refugee populations)	English
Dr 5	F	Sri Lankan	Yes	Tamil, Urdu, Hindi	Sri Lankan	English, Tamil, Urdu, Hindi
Dr 6	M	Vietnamese	No	Vietnamese	Vietnamese	English, Vietnamese
Dr 7	F	Middle-Eastern	Australian and overseas trained	Arabic	Italian, Greek, Middle-Eastern	English, Arabic
Dr 8	F	Indian	Yes	Russian, Hindi, Gujarati, Marathi, Portuguese	Indian, Eastern-European	English, Russian, Hindi, Gujarati, Marathi.
Dr 9	F	Indian	Yes	Hindi	Greek, Italian	English
Dr 10	M	Italian	No	Italian	Indian, Chinese, Italian	English

can understand enough English and they say, 'No they're not interpreting right.' It just takes an awful lot longer and … another issue is it would be a lot easier to have everything on hands-free so that you can talk a lot quicker that way, but usually they can't hear you so you've got to be passing the handset from one to the other.' (Dr 4, female)

GPs who did not speak the preferred language of their CALD patients said they relied on the patient's accompanying English-speaking relative to provide interpretation and support. However, the presence of family members in the consultation raised issues of consent and confidentiality. When questioned about this, most GPs said that consent and confidentiality were not major concerns, easily resolved through consensus.

'I always ask the patient, "Are they [family members] coming with your permission? So can I say everything in front of them?"' (Dr 5, female)

'Usually, if they don't want the family member to know what they're talking about and they're happy with the interpreter or something or other, they'll say something and then the person just goes out of the room.' (Dr 4, female)

Facilitators of effective mental healthcare

Amplifying the cultural concordance between themselves and their CALD patient was a strategy that GPs found useful to improve communication around diagnosis and facilitate ongoing treatment and management.

'We are Muslims so we understand Islam ... I find it very easy when I'm talking to other Muslim people because we know what to say, we know what they expect to hear, we know words that we've been taught.' (Dr 1, male).

However, cultural concordance did not mean that GPs and patients had to directly 'match' or share a common culture, language and/or religion (although some did so). Rather, GPs leveraged their ethnicity, religion, experience practising overseas, speaking languages other than English and/or existing cultural knowledge and experience to effectively communicate with their CALD patients. Some GPs said the fact that both they and their patients were part of non-dominant cultures aided communication between them.

'A lot of the Chinese culture is very similar to the Middle Eastern culture, the Arabic culture. So they tend to respond quite positively to that and if sometimes I'm sharing a little bit of my culture they open up quite easily and talk about their health, about their culture and how that impacts them with their health.' (Dr 2, female)

Two GPs who only spoke English with their patients said that actively showing an interest in understanding their patient's cultural perspective enhanced the consultation and improved outcomes. One GP said:

'I do like to feel that I can understand some important aspects of their culture because it does enhance the consultation, the outcomes.' (Dr 10, male)

Another, who had worked overseas in Africa, said that her previous work experience helped her develop a stronger rapport with her CALD patients:

'Having lived myself in another situation where you don't understand the language, you don't understand the culture and everything, I guess it makes me a bit more patient and also makes me try and understand where they are coming from so that I can better communicate with them.' (Dr 4, female).

Alongside emphasising cultural concordance, some GPs reported that their clinics had implemented practice-based initiatives to improve the delivery of mental healthcare to CALD patients. For example, in one practice that had a high number of refugee patients, group therapy funded by the Medicare Local was delivered in a language other than English. This practice also installed a television in their waiting room, showing health promotion material specifically targeted to refugee patients. Another practice modified their Mental Health Treatment Plan template to be more culturally competent by including a question on it about whether symptoms were perceived to be normal for the patient's culture.

These initiatives were delivered ad hoc and GPs wanted a more systematic approach. Areas of further education for GPs included training on communicating with CALD patients using vignettes pertaining to specific cultures. GPs wanted this education to be delivered through medical schools and via the college.

'Definitely more training I think. More vignettes of how cultural patients have accepted treatment and what they expect, how they see mental health and mental illness and what sort of treatment those people expect … during med school and training all you hear is, "This is what you need to do, this is the techniques, this is the physical exercise, this is the medication that you can use", but never how to implement it.' (Dr 2, female)

'We've got a college out there, a GP college …and we have a lot of GPs who are from different cultural backgrounds as well and I think we need to hear from them.' (Dr 6, male)

GPs also said there needed to be education campaigns to improve mental health literacy in CALD patients. Campaigns from organisations such as *beyondblue* were seen to have had a positive impact on mental health awareness in the general population, but CALD populations lagged behind.

'I think the Australian government has been really good with advertising … like through the TV and things like *beyondblue* and the depression so they tend to be more upfront and be, "Oh okay so I've got depression but we can deal with it". Whereas the CALD patients, they don't have that necessarily.' (Dr 2, female)

Discussion

This study explored GPs' perspectives on the barriers and facilitators they encounter

when managing mental illness in CALD patients. The results show that GP-identified barriers included difficulties in recognising initial psychiatric symptoms and cultural challenges associated with communicating a mental illness diagnosis largely because of differences in illness presentation, stigma, delayed help-seeking and the normalisation of distress. These findings resonate with previous research.[8,10,12–14]

In contrast to earlier studies,[7,13] language was not identified as a barrier to delivering care. This could possibly be because GPs in our sample were bilingual or multilingual and also tended to rely on family members to provide interpretation during the consultation. Infrequent use of interpreter services was related to structural barriers such as lack of hands-free telephones and accuracy of interpretation, also identified in a study by Huang and Phillips.[9] Although GPs said use of family members as interpreters was acceptable to all parties involved, this practice may impede CALD patients from fully disclosing their concerns during the consultations (especially if there are strong power issues within families), thus limiting the GP's capacity to make fully informed decisions related to treatment and management of mental illness. On the other hand, the central role of family in CALD encounters has been identified in the literature and often decisions are not made without the consent of the 'head of the family'.[6] More research is needed on the use of family as interpreters.

Facilitators to delivering effective mental healthcare included the GP having a culturally diverse background and/or cross-cultural experience. GPs said this facilitated communication and led to better health outcomes for CALD patients. Studies have shown that patients prefer GPs from the same cultural background as their own, especially for those with language barriers,[14] as the GP may act as a 'boundary crosser' – part of the ethnic community they serve as well as the health sector – trusted by both groups.[21]

In our study, although there was no direct 'match' in all cases between GP and patient cultures, GPs thought that amplifying the cultural congruities between themselves and their patients mediated the boundary between patients cultures and the health system, thus improving their management of mentally ill CALD patients. Research by Cross et al[6,7] has underscored the importance of the clinician's interpersonal skills to overcome cultural communication barriers by eliciting information from the patient, exploring the patient's perspective on their illness and devising appropriate treatment and management strategies to work towards improving patient health outcomes. Arguably, if these strategies were more systematically applied across general practice they could alleviate some of the aforementioned cultural barriers that GPs described.

To enable such a transition, further education for GPs and CALD patients is important. GPs felt they needed more culture-specific training but care must be taken not to promote cultural stereotyping, which may be counterproductive.[22] Equally important is the need to improve mental health literacy in CALD communities to better the understanding of mental illness, reduce stigma and enable those with mental illness to seek help promptly, strategies that in the long term will also aid GP management of mental illness among CALD patients.

Limitations

The opinions of a small number of GPs who self-select for a study will neither be representative of all practitioners nor generalisable to the entire GP population. Given the study inclusion criteria, these GPs were already more engaged in CALD mental healthcare. Nevertheless, the findings that did emerge are consistent with the literature and serve to extend existing knowledge in several ways (eg language was not a barrier to care, the low use of interpreter services, the challenges associated with using family members as interpreters and the importance of cultural concordance between GP and patient). To ensure data saturation, future research could focus on a more diverse GP sample to determine whether these findings hold true.

Future research should also include CALD patient perspectives. This absence in our data limits our ability to comment on whether CALD patients were satisfied with their GP's management of their mental illness and what further training requirements they saw for GPs.

Finally, the dichotomising of patients as CALD/non-CALD is problematic because it aggregates communities from vastly different cultural backgrounds without acknowledging the differences between these groups and the increasing cross-cultural mixing across CALD and non-CALD populations.[23] We justify our categorisation, arguing that such a dichotomy is supported in health policy and practice (some GPs identified with patients of disparate cultures by virtue of both belonging to a subculture) and that a differentiation between cultures would have been technically difficult given the small sample sizes. A possible alternative would have been to focus on one particular culture but this would have posed greater difficulty in generalising the findings.

Conclusions

The strength of this study lies in the insights it provides into the barriers and facilitators that GPs face in delivering mental healthcare to CALD patients with mental illness. Avenues for further study and training have been identified, such as clarifying the role of family interpreters in the consultation, improving cultural concordance between GPs and patients, and scaling up existing initiatives (eg the development of group therapy utilising CALD providers or developing a video education program for the clinic waiting room). Further research and evaluation of these initiatives could facilitate improvements in the care of mentally ill CALD patients in general practice.

Implications for general practice

- GP-identified barriers to delivering effective mental healthcare for CALD patients included difficulties in recognising initial psychiatric symptoms, challenges associated with communicating a mental illness diagnosis and problems with using interpreter services.
- Concordance between the GP and patient by ethnicity, culture or language is highly effective in facilitating delivery of mental healthcare to CALD populations.
- Further research is needed on the use of family as interpreters and scaling up of practice-based initiatives to improve the delivery of mental healthcare to CALD patients.
- GPs want more cultural training and education campaigns to improve mental health literacy in CALD populations.

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