PILLAR 3

STATE OF THE ART

[REMEDI]
[GPs' recommendations to patients with mental health problems and diverse migration backgrounds]

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Introduction

Medical sociologists paint an alarming picture of the mental health status of people with a migration background in Belgium. While higher prevalence rates in depression have been observed in minority populations as compared to non-minorities, people with a migration background also constitute a highly underrepresented group in both ambulant and residential mental healthcare services. Given these concerns, it is important to examine why minority patients are disproportionately absent from mental healthcare services. In the REMEDI project, we focus on the potential role of provider behavior. Generally, general practitioners (from here on referred to as GPs) are the first contact for patients with mental health problems, especially in settings with a (partial) stepped-care model. As gatekeepers, they decide to refer or not refer patients to specialized mental healthcare services based on their assessment of the severity and impact of the observed symptoms. However, these recommendations may be biased due to unconscious stereotyping beliefs among GPs. Such stereotypes could lead to differences in treatment and referral decisions of GPs, ultimately causing discrimination in the medical setting.

State of the art

1. Disparities in the use of mental healthcare services.

Along with the tremendous increase in ethnic diversity in European countries, equity of care for people with a migration background has become a major policy goal. However, recent figures reveal that there is still a long way to go in this respect. One worrying finding is that people with a migration background are underrepresented in ambulant and residential mental healthcare services (Bell & Zech, 2009; Lepièce, Reynaert, Van Meerbeeck, & Lorant, 2014; Lindert, Schouler-Ocak, Heinz, & Priebe, 2008; Satinsky, Fuhr, Woodward, Sondorp, & Roberts, 2019), despite the higher prevalence of depression in minority populations as compared to non-minorities (Levecque & Van Rossem, 2015; Missinne & Bracke, 2012; Van Roy, Vyncke, Piccardi, De Maesschalck, & Willems, 2018).

Previous studies have mainly explained the underutilization of mental healthcare services by people with a migration background in terms of cultural and linguistic barriers (Kirmayer et al., 2007; Ohtani, Suzuki, Takeuchi, & Uchida, 2015; Snowden, Masland, Peng, Lou, & Wallace, 2011). It has been argued that specialized mental healthcare services have been designed with little consideration of ethnic diversity, causing distrust towards these services among minority communities (Appleby, 2008). Other factors that have been mentioned as contributory causes include structural barriers such as lack of financial resources, long waiting lists and limitations in health insurance coverage (Brown, Ojeda, Wyn, & Levan, 2000; Owens et al., 2002).

However, some studies indicate that even after accounting for these cultural and structural barriers, substantial ethnic disparities in (mental) healthcare utilization remain evident (Lepièce, Zdanowicz, Jacques, Reynaert, & Tordeurs, 2014; Stepanikova, 2012). This observation has encouraged researchers to look for other potential explanations. In the United States, mounting attention has been directed to the impact of provider bias (Burgess, Fu, & van Ryn, 2004; FitzGerald & Hurst, 2017; Khosla, Perry, Moss-Racusin, Burke, & Dovidio, 2018; van Ryn, Burgess, Malat, & Griffin, 2006).

2. Provider bias

GPs have a crucial role in the detection, treatment and referral of patients with mental health problems. As gatekeepers, they can either facilitate or impede further ambulant and resident mental healthcare services, especially in settings with a (partial) stepped-care model. However, GPs treatment recommendations may be biased due to unconscious stereotyping beliefs (Lepièce, Zdanowicz, et al., 2014; van Ryn & Fu, 2003). Even well-intentioned GPs who are internally motivated to be unprejudiced may apply stereotypes when assessing patients, which in turn could lead to differences in treatment and referral decisions.

The provider bias can be understood from the theory of social categorization. According to this theory, people tend to mentally categorize and judge others based on attributes such as gender, ethnicity and social class in order to successfully process the complexity of daily life (Brewer, 2007; Hamilton, 2015). Such categorization and judgement processes could lead to stereotyping. When individuals are assigned to a certain group, the characteristics and beliefs associated with this group are unconsciously activated and applied to the individual (Devine, 1989; van Ryn & Burke, 2000). These stereotypes then carry the potential to influence people's attitudes and expectations of others. While no one is completely immune to heuristic processes such as social categorization, healthcare providers may be especially prone to stereotyping (Burgess et al., 2004; Smedley, Stith, & Nelson, 2003) as the clinical setting is characterized by conditions (e.g. time pressure, fatigue and information overload) that hamper cognitive decision-making and increase the unintentional use of mental shortcuts (Stepanikova, 2012). Thus, even well-intentioned GPs who are internally motivated to be nondiscriminatory may therefore have a greater tendency to unintentionally apply stereotypes when assessing patients (Burgess et al., 2004).

The problem with group-based generalizations is that they particularly occur in relation to out-group members (Dovidio & Fiske, 2012; Fiske, 2002). People tend to disfavor and perceive members of other social groups in a category-based manner, whereas in-group members are more likely to be judged in terms of their individual characteristics. Accordingly, GPs may evaluate otherwise identical patients from various social groups in different ways and consequently perpetuate health disparities in several interconnected ways (Balsa, McGuire, & Meredith, 2005; Burgess et al., 2004; van Ryn & Fu, 2003). First, in unintentionally assessing patients from the out-group differently, they may influence the help seekers' views of themselves and their place in the world (van Ryn & Fu, 2003). For instance, GPs who have lower expectations of their patients (owing to their ethnicity, class or any stigmatized characteristic), may devote less time to discussing the symptoms and the treatment strategies with them, which in turn may well contribute to help seekers' expectations for improvements in their conditions and discourage their adherence to medical treatment (Lepièce, Zdanowicz, et al., 2014). Second, GPs often function as gatekeepers and may influence health disparities by impeding access to specialized healthcare services (van Ryn & Fu, 2003). This is particularly true in the Flemish case, where patients have unregulated access to specialists, but gatekeeping elements are introduced through financial incentives (Reibling & Wendt, 2012). Public and private health insurance companies only offer (partial) reimbursement of mental healthcare services if patients have been referred by GPs. However, if GPs regard specialized healthcare services as inappropriate for their patients (e.g. due to the lack of culturally sensitive care), they could unintentionally contribute to health disparities (Drewniak, Krones, & Wild, 2017).

The issue of provider bias has been most heavily studied in the United States, with a particular focus on the impact of patients' race (Hall et al., 2015; Khosla et al., 2018; Maina, Belton, Ginzberg, Singh, & Johnson, 2018; Moskowitz, Stone, & Childs, 2012; Stepanikova, 2012; van Ryn & Fu, 2003). Many researchers have shown that healthcare professionals tend to hold biased perceptions of patients of colors (i.e. Black American, Hispanic, American Indian and Asian patients) that are stereotype consistent but personally inaccurate (Burgess et al., 2004). Van Ryn and Burke (2000) were among the first to show that physicians are likely to perceive African-Americans to be less intelligent, less educated, less likeable, less friendly, and less able to adhere to treatment recommendations. Similarly, Mayo and colleagues (2007) demonstrated that Hispanic patients are viewed to be noncompliant with medical advice and unlikely to accept responsibility for their own care. The results of these studies, however, cannot be easily transposed to other countries, given America's long history of racism and segregation and its specific healthcare setting (Lepièce, Reynaert, et al., 2014). Yet the literature on provider bias towards patients with a migration background in the European context is rather limited. Moreover, the few studies that did investigate this issue in European countries have all been directed to examining potential discrepancies in the treatment of patients with diverse migration background with *functional limitations* (e.g. Drewniak, Krones, Sauer, & Wild, 2016; Lepièce, Reynaert, et al., 2014). To the best of our knowledge, there are no studies empirically testing discrimination of patients with a migration background and *mental health problems.*

3. Methods to study the provider bias

In the past, multiple methods have been developed to assess a provider bias. Perhaps one of the most straightforward ways is by *archival analysis of existing records* of actual referrals. However, in many countries this is not a feasible option, due to unavailability of reliable health care data. Ethnicity and migration background are often not recorded or registered automatically (Shavers et al., 2012), as is the case in Belgium. Moreover, when using official records, additional issues of data accessibility have emerged since the recent EU General Data Protection Regulation (GDPR). A recent study that was not based on the analysis of secondary data circumvents these problems, but contained only one Belgian city as a case-study (Bursztein Lipsicas et al., 2013). However, results based on one selected area are not necessarily generalizable.

To assess unequal treatment qualitative *in-depth interviews* with GPs and patients have been used as well (e.g. Hanssens, Devisch, Lobbestael, Cottenie, & Willems, 2016). Yet, besides being time-consuming, these methods generally tend to capture perceptions, opinions and multiple ways of self-representation rather than actual behavior, which raises doubts about potentially socially desirable answers. The same critique applies to methods used to assess perceived discrimination from the patients' perspective (e.g. Hanssens, Detollenaere, Van Pottelberge, Baert, & Willems, 2017). Such social desirability effects can be partially mediated through *direct observation* of consultations or analysis of video recorded consultations (Stevenson, 2014). While this method stands out for its rigorousness, it is again rather time-consuming and, in the case of video observations, also an expensive method due to the investment in equipment and man-hours required for the data analysis (Stevenson et al., 2019). Another disadvantage of this method is that the realized sampled is more likely to be biased, because more discriminatory or prejudiced health care services will be more reluctant to participate in the study.

Furthermore, some tests have been developed to measure potential bias and discrimination through *situation tests* in which a fictitious patient attempts to make an appointment via email or telephone, or sometimes even through mystery visits by actors portraying patients. Examples are phone-based field experiments or audit studies (Sharma, Mitra, & Stano, 2015) and patient mystery visit studies (Shields et al., 2009). These approaches raise ethical questions (Zschirnt, 2019): can researchers deliberately take up medical professionals' time without their awareness, thereby taking time from real patients, who might be in need of help? Furthermore, situation tests are also limited in that they can only measure a possible differential treatment at the entry level to services or institutions (Verhaeghe & Van der Bracht, 2017) and not in a further phase of health care seeking.

Most of the studies in the United States that focused on racial bias in the healthcare system have used the *Implicit Association Test* (IAT) (Greenwald, McGhee, & Schwartz, 1998). The IAT asks GPs to quickly pair value-laden words (such as wonderful or terrible) with images showing black versus white patients (Stepanikova, 2012). While the IAT has been widely used (Maina et al., 2018), it runs the risk of making the focus on racial attitudes transparent (Stepanikova, 2012). When GPs take an IAT test, they can become aware of the purpose of the study and motivate socially desirable responses to black patients. Nevertheless, this test could help to identify possible bias in GPs' referral decisions and/or recommendations (Maina et al., 2018). Moreover, another reason to include an IAT test in the REMEDI project is that it constitutes an eligible inclusion criteria for systematic reviews on discrimination studies, as the one carried out by Dehon et al. (2017) focusing on provider bias. From the REMEDI perspective, the strategic question is whether we can avoid using such a tool without dampening the validity of our study and our publication chance.

Finally, researchers have also used video vignettes to measure a provider bias. Video vignettes are scripted, fictional situations in which actors mimic real-life scenarios, such as doctor-patient consultations (Hillen, van Vliet, de Haes, & Smets, 2013). They are used to investigate the causal effect of specific variables by manipulating certain features or conditions of the video recorded stimulus in a standardized way, while controlling for others (Evans et al., 2015). Video vignettes assessing referral allow to study possible unequal treatment in a later phase, which is impossible with situation or correspondence tests. Also, a major ethical advantage of (video) vignettes research is that participants deliberately agree to dedicate their time to participate in a quasi-experimental survey. Vignette studies can be situated in the subfield of assumption methods ('between subject designs') in the broader arena of implicit bias studies. While assumption methods are no actual measures of implicit bias (as opposed to IAT), it is widely recognized that they do allow to detect the possible presence of implicit bias while simultaneously probing for related behavior- in our case unequal referral (Fitzenberger, Schnabel, & Wunderlich, 2004).

More information on the use of video vignettes in the context of the healthcare system, can be found in Ceuterick et al. (2020). This article has been written as part of the MIND THE GATE project, on which the REMEDI project is based.

4. How to tackle the provider bias?

Stereotypes are not fixed mental states, but instead malleable and dependent on social conditions (McGregor & Gray, 2002). In this respect, Blair (2002, p. 248) argued that 'automatic stereotypes and prejudice are also responsive to the social demands of the situation and the nature of one's relationship with other individuals'. This implies that the provider bias can be reduced. Nonetheless, the question remains how to tackle it?

Contact with patients with a migration background. According to Allport's (1954) contact hypothesis, repeated positive and constructive contact between in-group and out-group members may facilitate the development of positive attitudes toward each other, especially under conditions that include cooperation, common goals and equal status (Penner et al., 2013). Thus frequent contacts with patients with a migration background may have the potential to reduce provider bias (FitzGerald & Hurst, 2017). However, a negatively perceived relationship can make the stereotypes worse (Pettigrew, Tropp, Wagner, & Christ, 2011) and thus increase unintentional discrimination. It therefore seems relevant to assess the quality of the patient-GP relationship.

Reducing social distance. According to Maina and colleagues (2018), successful interventions to reduce the provider bias should '*blur the line between the in-group and out-group by focusing on common identities*', meaning that they should reduce social distance between GPs and patients with a migration background. Social distance is defined by Boguñá, Pastor-Satorras, Diaz-Guilera, and Arenas (2004) as '*the degree of closeness'* , as well as '*the acceptance that an individual or group feels towards another individual or group in a social network*'. Common identities tend to bring people together in social groups, while differences in social characteristics between individuals appear to drive them apart and lead to social distance. Social distance has also been defined as an indirect measure of potential discrimination or as '*the relative willingness of a person to participate in relationships of varying degrees of intimacy with a person who has a stigmatized identity'* (Mathias et al., 2018). Thus, it has been hypothesized that reducing the social distance between GPs and patients with a migration background would decrease unintentional discrimination.

Cultural competence training. Being culturally competent has been reported as a way to decrease discrimination towards patients with a migration background. By improving GPs' cultural competence, e.g. through training, they might pay more attention to the needs of their patients in making decisions about treatment and referral within the (mental) health care system. The definition of cultural competence is multiple and broad. Indeed, the cultural competence is the '*ability to work and communicate effectively and appropriately with people from culturally different background'* (Alizadeh & Chavan, 2016). Cultural competence is also '*a combination of attitudes, knowledge and skills'* and '*it is not evident how and when the right balance between these elements can be achieved*" (Seeleman, Suurmond, & Stronks, 2009). But it is also an ongoing process '*meaning that competency capability can be*

continuously enhanced over time' (Alizadeh & Chavan, 2016). When the cultural competence movement emerged, its main issue was to reduce disparities by specifically improving care for people of color or other disadvantaged populations (Saha, Beach, & Cooper, 2008). So, the ultimate aim of cultural competence, in that context, should be that GPs provide better quality, equal and respectful care for ethnic minority patients and native patients with mental health problems and thus reduce racism and finally, decrease unintentional discrimination in primary health care (Watt, Abbott, & Reath, 2016).
One way to assess GPs' cultural competence is by using a validated scale and comparing the management of GPs with or without a cultural competence training.

5. What is missing from the literature?

5.1. Too much focused on attitudes

Most of the studies on provider bias have focused on GPs' **attitudes** towards patients with a migration background (Drewniak et al., 2017; Mayo et al., 2007; van Ryn & Burke, 2000), while less attention has been devoted to **racially biased behavior** (Stepanikova, Triplett, & Simpson, 2011). A study of Schulman and colleagues (Schulman et al., 1999) showed that GPs were less likely to recommend cardiac catheterization for black females than four their white counterparts with similar symptoms. In addition, Stepanikova (2012) demonstrated that GPs are less likely to refer blacks to a specialist when they are under high time pressure. In fact, these studies suggest that GPs hold biased perceptions of patients of colors that lead to clinical decisions that disadvantage minorities. Yet, to the best of our knowledge, no studies have examined racially biased behavior related to mental healthcare recommendations.

5.2. Too much focused on race

Since most of the studies on provider bias have been carried out in the United States, attention has been predominantly focused on the role of 'race'. However, in European countries, the term 'race' is often perceived as inherently problematic due to its association with fascist regimes that dominated Europe during the 1930s and 1940s (Drewniak et al., 2017). In contrast, in the United States, race is an automatically activated social category because of its historical and political significance (Penner, Dovidio, Manning, Albrecht, & van Ryn, 2018). The historical notions of race date back to the 17th century, when African slaves arrived in the American continent. Since then, the oppression of people of color has been rationalized and reproduced by a well-institutionalized racial framing that draws on normalized notions, such as stereotypes, narratives and images (Feagin & Bennefield, 2014). Consequently, American physicians have typically been socialized in a culture with deep-rooted racial stereotypes that are difficult to remove from the subconscious (Stepanikova, 2012).

Such a racial framing has largely been abandoned in continental Europe in favor of societal narratives centering on the concepts of 'ethnicity' and 'migration status' (Levecque, Garcia Benavides, Ronda, & Van Rossem, 2012). This has been particularly true since 2015, when Europe faced an unprecedented influx of asylum seekers coming from war-torn countries. This so-called refugee crisis has been a catalyst for anti-migration protests and electoral successes of radical right-wing populist parties all over Europe (Rea, Martiniello, Mazzola, & Meuleman, 2019). Flanders (Belgium) represents an illustrative example, where almost 20 percent of the population voted for the extreme-right populist party 'Vlaams Belang' in May 2019, a party that has pushed the political debate towards openly anti-migration stance. In this light, it is important to shift the focus of research on provider bias in European contexts away from documenting the impact of 'race' towards examining the influence of 'ethnicity' and 'migration stratus' – which represent different theoretical constructs (Schenk, 2007). The REMEDI project therefore assesses disparities between native patients, patients with a second generation migration background and patients with an asylum seeking background.

5.3. Lack of a sociological perspective

Studies investigating provider bias most clearly align with a social-psychological perspectives, drawing on individual, cognitive and psychological models of bias as explanations for treatment disparities (Spencer & Grace, 2016). However, such studies overlook the fact that GPs are embedded in a broader social context, and accordingly, that clinical decision-making processes need to be contextualized among the factors beyond the individual. Following this line of reasoning, the REMEDI project investigates whether the occurrence of a provider bias differs between Flanders, Wallonia and Brussels. As the Belgian regions differ in many relevant respects, it will be possible to estimate whether the presence of a provider bias is context-dependent.

A first difference concerns the share of minority residents: Brussels hosts a much larger number of people with a migration background than do Flanders and Wallonia (Statistiek Vlaanderen, 2018), which makes it very likely that GPs working in the capital region interact more frequently with minority patients. Second, a recent report of the Belgian Healthcare Knowledge Center (2019) reveals substantial variation between the regions when it comes to indicators on mental health. For instance, suicide rates appear to be considerably higher in Wallonia (19.8 per 100,000 population) compared to Brussels (10.2) and Flanders (16.0), suggesting that mental health problems are most common in Wallonia. A third remarkable regional difference is the density of GPs acceding to the agreement between INAMI – RIZIV and sickness funds. The density appears to be much lower in Brussels (4.95 per 10.000 insured people in Belgium) than in Flanders (7.40) and Wallonia (6.81) (Federaal Kenniscentrum voor de Gezondheidszorg, 2019). This could be of relevance to our study as various researchers have shown that health professionals tend to resort more to stereotypes as cognitive shortcuts under high time pressure (Drewniak et al., 2016; Stepanikova, 2012) (. Last, the regional organization of the mental healthcare system differs. While centers for mental healthcare in Flanders (i.e. centra voor de geestelijke gezondheid [CGG]) constitute a second line of care, centers for mental healthcare in the Walloon region (i.e. services de santé mentale [SSM] are situated at both the first and the second line (Federaal Kenniscentrum voor de Gezondheidszorg, 2016).

5.4. Lack of empirical evidence on the mechanisms to tackle provider bias

Empirical evidence on the effectiveness of strategies to tackle the provider bias is scarce. The REMEDI project aims to address this shortcoming by empirically testing the potential of a 'life history intervention', which is expected to reduce the social distance between GPs and patients with a migration background (Burgess et al., 2004). According to Burgess (2007, p. 883), GPs interested in patient's life history, are likely to focus on 'the individual attributes of a particular patient, as opposed to categorization, in which the provider perceives the patient through the filter of his or her group membership (e.g., race)".

In practice, we will present participating GPs the opportunity to click on a link that provides more information about the life history of the patient. More specifically, we will present information about the biopsychosocial aspect of the mental illness, its impact on daily life (e.g. loss of employment) and the possible causes and consequences of the illness. In doing so, we will collection data on the behavior of the GP (will (s)he click on the additional information about the life story of the patient, about the management of the mental illness in Belgium by the primary health care for (non-)migrant patients, on the difference of referral and/or recommendations and/or unintentional discrimination when GP is interesting by the life story of his/her patient with mental health problems).

6. Research objectives

In sum, the REMEDI project is motivated by the effort to reduce disparities in healthcare. Our ultimate goal is to eliminate accessibility barriers to specialized mental healthcare services for minority patients by identifying and interpreting attitudes and recommendations of GPs and by translating them into constructive knowledge and a training tool that will eradicate unconscious stereotyping. More specifically, it aims to provide an answer to the following key questions:

A) *Do patients' ethnic background and migration status influence GPs' attitudes and recommendations regarding treatment and referral?*
B) *Does the possible occurrence of unintentional discrimination differ between Flanders, Wallonia and Brussels? And if so, which contextual factors could possibly explain this?*
C) *How do GPs discursively construct their decision making regarding patients with a migration background suffering from mental health issues? How do GPs accounts of these patients add to the discursive* justification, *perpetuation and contestation of the measured attitudes, opinions and actual treatment and referral practices?*
D) *Does 'a life course' intervention have the potential to reduce potential bias and unintentional* discrimination *towards patients with a migration background and mental health problems?*

To address these research questions, the REMEDI project will apply a mixed-methods study in which both quantitative and qualitative approaches will be used for triangulation purposes. The quantitative data collection will consist of online survey questionnaires that comprise a scripted video vignette. Three different video vignettes will be used in which every factor (e.g. gender, age and physical characteristics) will be similar, except for ethnicity and migration status. The qualitative data collection will entail a combination of in-depth semi-structured interviews and focus groups with GPs who agreed to partake in a follow-up study.

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