Cultural diversity and mental healthcare

As culture can impact on mental health, it is essential GPs provide culturally appropriate services, write Ruth Barragry and Declan Lyons

The issue of cultural diversity has been receiving considerable attention in Ireland over the last number of years. We have seen many changes in our social and cultural landscape – our population is now the fastest growing in the EU and we have changed from a country of mass emigration to one of net migration.

In the light of such changes, issues around mental health needs are now emerging as major areas of concern. Even with limited data available, it is generally internationally accepted that people from minority ethnic groups are at increased risk of poverty, social exclusion and may experience a greater level of psychological distress than the local population.

GPs serve as the first point of contact for the majority of health service users, with mental health problems indicated in as many as one in four consultations. Furthermore, most mental health problems are dealt with in the community without referral to further specialist services. The GP is therefore the main provider of mental healthcare for the majority of the population. As culture can impact on many different aspects of mental health, it is vital in the current climate that we fully recognise the mental health needs of diverse groups of people and that we are equipped to provide a culturally appropriate service.

The global burden

Mental ill health is truly universal, with mental disorders ranking second in the global burden of disease, following infectious diseases. The WHO’s 2005 report attributed 31.7% of all years lived-with-disability to neuropsychiatric conditions. The five major contributors to this total were:

- Unipolar depression (11.8%)
- Alcohol-use disorder (3.3%)
- Schizophrenia (2.8%)
- Bipolar depression (2.4%)
- Dementia (1.6%).

The WHO has predicted that by the year 2020 depression will be the second most important cause of disability after ischaemic heart disease worldwide.

Every year, approximately 800,000 people commit suicide, 86% of whom are in low-income and middle-income countries, and more than half of whom are aged between 15 and 44 years. These figures may even be an underestimation, since official statistics in low-income and middle-income countries may not be reliable.

The economic costs of mental health problems are also considerable, and estimated to be at least 3-4% of GNP across the EU member states. In addition to increasing risks for communicable and non-communicable diseases,
mental illness is also shown to contribute to both accidental and non-accidental injury and affect outcomes of treatment for physical conditions, including disease-related mortality, and quality of life and disability.

**Mental health in culturally diverse groups**

While it is important not to stereotype people according to particular groups, some distinct groups in Ireland may face special challenges in relation to their mental health.

*Asylum seeker and refugees*

Asylum seekers and refugees may suffer from a significant burden of mental health problems, including: depression; anxiety; psychosis; and post-traumatic stress syndrome.

A 2007 study published in the *Irish Medical Journal* found that asylum seekers were five times as likely to attend with a psychiatric condition as their matched Irish GMS patient, and three times more likely to be assigned a diagnosis of anxiety.

Factors in this group commonly associated with an increased risk of mental ill health include: pre- and post-arrival trauma; social isolation; breakdown of traditional and family support networks; language barriers; change in socio-economic status; fear of deportation; poverty; as well as prejudice and discrimination by the host population.

While some progress has been made in procedural aspects to asylum claims, the process itself can cause significant stress to the individual. Furthermore, the implications for mental health where an individual is attempting to achieve reunification with a partner or with children, can be severe.

Each stage of the process of migration may carry specific risk factors, such as experience of armed conflict, hunger and human rights abuse. Previous studies have indicated that an estimated 10-35% of asylum seekers, refugees and programme refugees seeking refuge in European countries have suffered torture in their pre-migratory state. Children from asylum-seeking families, unaccompanied minors and separated children who apply for asylum in their own right also constitute a particularly vulnerable group, many of whom may present with vague physical symptoms, behavioural disturbances or evidence of developmental delay. Language, educational and other barriers may also be influential in this setting.

*Migrant workers*

Migrant workers in Ireland constitute a very diverse group, with concerns relating to mental health as many of them appear to be living in increasingly ghettoised communities. Illegal migrants are particularly vulnerable to the effects of mental ill health, often living in substandard accommodation, working in unregulated settings and with no eligibility to receive medical services other than in emergency situations. However, owing to their status, little information is currently available.

Research by the Immigrant Council of Ireland has demonstrated that many migrant workers are deterred from using mental health services because of communication barriers as well as lack of knowledge of entitlements. Risks of homelessness are also becoming increasingly evident.

*Irish Travellers*

Irish Travellers have previously been identified as a distinct group with significant mental health issues. The National Suicide Strategy: Reach Out specifically identifies Travellers as a group affected by suicide, particularly amongst men. Forty-one percent of the cohort surveyed by the Donegal Travellers’ Project were diagnosed as suffering from depression. Furthermore, issues related to stigma within the community further act as a barrier to accessing and availing of mental health services, as well as a range of other determinants.

Traveler Primary Health Care Projects, operating in partnership with the HSE, may play a key role in the design and delivery of culturally appropriate and accessible services aimed at promoting mental health.

**The importance of cultural competence**

As doctors and healthcare providers, it is not only vital that we recognise and respect differing cultural concepts in others, but that we are aware of the way our own culture affects the way we practice. A doctor or any other healthcare provider will always bring his or her own personal culture to the therapeutic setting, and will often reflect the attitudes and discriminatory practices of their society.

Diagnosis and treatment of mental disorders depends on the ability of an individual to explain his/her symptoms, and on the ability of the doctor to recognise symptoms and signs of illness and distress. It is therefore as important that we are culturally competent as well as “clinically” competent. Failure to be fully culturally competent can lead to misdiagnosis, inaccurate assessment of severity, and can reinforce barriers to patient’s access to mental health services.

**The influence of culture on mental health**

The concept of culture itself is immensely broad. It can refer to patterns of perceiving and adapting to the world. It can be reflected in values, attitudes, beliefs and behaviours. Religious diversity may also add an important dimension to many people’s cultural identity: therefore, it is not surprising that concepts around mental health may differ greatly across cultures.

The patient’s own subjective experience of mental ill health and explanatory model as to the ‘meaning’ of illness may vary greatly. Variations in the meaning of illness have been recognised to have real consequences in terms of whether people are motivated to seek treatment, their ability to cope, their choice of treatment and prognosis. One way in which culture can affect mental illness is through how patients communicate their distress. In general, patients in different cultures tend to express symptoms in culturally acceptable ways.

Important considerations in an assessment include:

- An understanding that belief systems surrounding mental health vary significantly from culture to culture, as do related treatments/interventions – find out as much about the culture of origin as possible.
- Stigma relating to mental health is greater in some cultures than in others.
- Mental health problems may be presented as physical problems – a holistic approach is extremely important.
- Western models of healthcare emphasise a patient’s autonomy and ‘right to know’ about their diagnosis and treatment. This may not be the case in all cultures.
- Family is defined differently by different cultures, with high value placed on the extended family and the decisions of elders in some cultures
- Male-female roles in families may vary significantly within cultures.
• Stereotyping – be aware of the dangers of incorrectly explaining away signs and symptoms of mental illness or distress as “cultural differences”, making treatment plans based on myths and assumptions, i.e., assuming that older people from a particular group will be cared for by an extended family network when this may not be the case.

Considerations relating to communication include an awareness of non-verbal taboos:
• Some cultures are more comfortable with physical contact than others; firm handshakes can be interpreted as sincere in some cultures but aggressive in others. Individuals from some cultures may be opposed to any physical contact from persons outside of their family.
• Not allowing for silence can be considered rude in some cultures – others may find it comfortable and respectful.
• Eye contact may indicate good rapport in some cultures; in others avoidance of eye contact is a sign of respect.
• Gesturing can have widely different meanings.
• Emotional expression in terms of facial movements, smiling and laughter, pitch, and tone can vary greatly cross-culturally.

An understanding of the difficulties of language assessment:
• Language abnormalities may be difficult to assess if an individual is not fluent.
• Loss of fluency may occur in the presence of depression, psychosis and stress.
• Vocabulary for emotional states can vary greatly across cultures. (The term ‘depression’ itself is absent from the languages of many cultures.)

An understanding of how to make good use of available interpretive services:
• Allow extra time for an interpreted assessment.
• Consider matching the age or gender of the interpreter to that of the patient, if appropriate.
• Ensure that the interpreter does not paraphrase, but interprets literally.
• Direct questions to the patient, not to the interpreter.
• Maintain eye contact with the patient, not the interpreter.
• Ask short, simple questions, one at a time.
• At the end of the interview, ask the interpreter if the patient has any additional questions.

Accurate history-taking:
• Be aware of and familiar with somatic metaphors and atypical presentations of mental illness.
• Be aware of idioms of distress which are culturally patterned (provided they are not applied as cultural stereotyping).
• Be mindful of the risk of misinterpreting religious or cultural beliefs as delusional beliefs.
• Be aware of issues around risk assessment – methods of suicide may differ amongst different communities; it may be necessary to consider popular methods within a particular community.

Accurate assessment of cognition and insight:
• Cognitive tools such as the Mini Mental State Examination are standardised on English-speaking populations, and as such their use may not consider cultural bias.
• Insight may need to be assessed in terms of the patient’s own ‘explanatory model’ of illness.

Summary and recommendations:
Cultural diversity in Ireland has been a hugely enriching experience and has contributed greatly to our economic and cultural life. However, it is accompanied by increasing concern around the mental health needs of various minority groups.

A Vision for Change: Report of the Expert Group on Mental Health Policy acknowledges “specific vulnerabilities or difficulties that should be taken into account in the way mental health services are delivered”. It recommends community development models of mental health in the provision of mental health services, and also points to the need for appropriate interpretation services.

Furthermore, The National Intercultural Health Strategy, the National Action Plan against Racism and the National Action Plan for Social Inclusion 2007-2016, all serve to promote the inclusion of people from diverse backgrounds into all aspects of Irish society.

While there are many examples of good practice already in place, such as the GP Intercultural Health Project, pilot projects in GP interpretation services and cultural media tion projects, there remains a need for:
• Information to be accessible in culturally appropriate formats on a countrywide basis.
• Counselling and interpretative services to be culturally appropriate and available.
• Further de-stigmatisation and awareness-raising of mental health issues.
• Improved intersectoral collaboration with mainstreaming and integration of services so they are truly multicultural.
• Provision of in-service training to GPs and psychiatric service providers.
• Cultural competence training as part of the medical undergraduate as well as postgraduate curriculum.
• Development of an appropriate research base so that mental health services to culturally diverse groups can be needs-driven.
• Full participation of marginalised communities and their representative organisations in policy making.

Ruth Barragry is a GP trainee with the TCD/HSE Specialist Training Programme in General Practice; Declan Lyons is a consultant psychiatrist at St Patrick’s Hospital, Dublin.

References available on request.