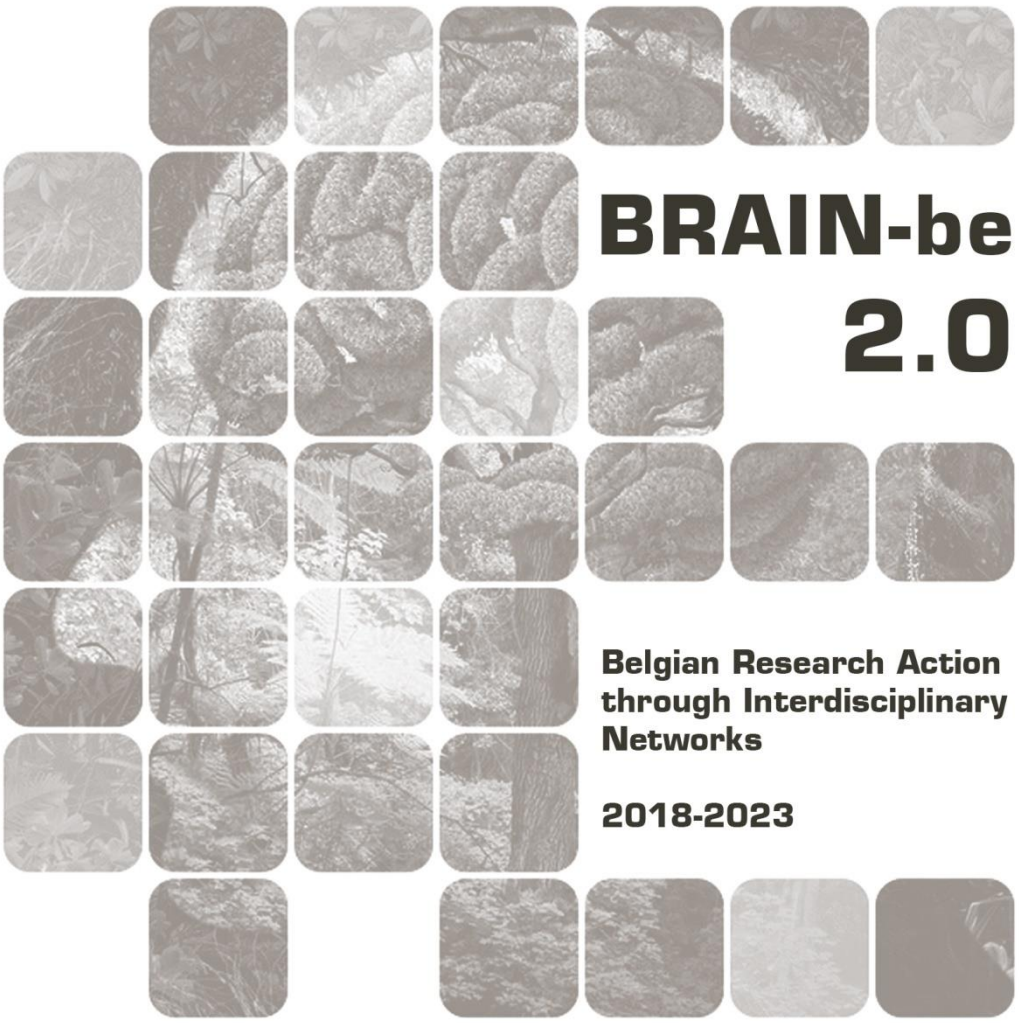

REMEDI

GPs' Recommendations to patients with Mental health problems and diverse migration backgrounds

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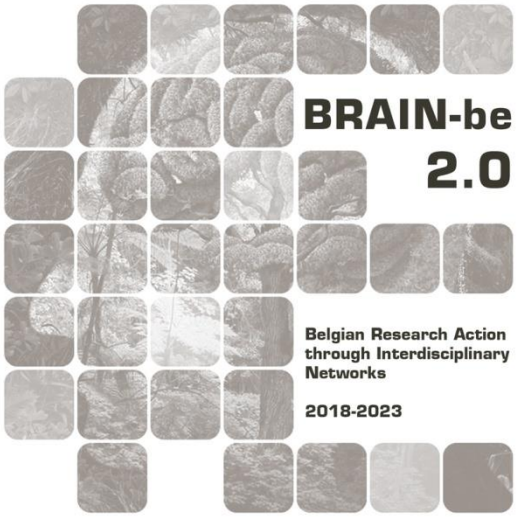

NETWORK PROJECT

REMEDI

Contract - B2/191/P3

FINAL REPORT

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Published in 2023 by the Belgian Science Policy Office

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Wets, C.*, Duveau, C.*, Delaruelle, K., Ceuterick, M., Dauvrin, M., Dumoulin, S., Lepièce, B., De Maesschalck, S., Lorant, V. & Bracke, P. ***REMEDI: GPs' Recommendations to patients with Mental health problems and diverse migration backgrounds***. Final Report. Brussels: Belgian Science Policy Office 2023 – 115 p. (BRAIN-be 2.0 - (Belgian Research Action through Interdisciplinary Networks)) * Equal contribution

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LIST OF ABBREVIATIONS

CHC	Community health centre ('Wijkgezondheidscentrum' or 'Maison médicale')
GLEM	Groupe Local d'Évaluation Médicale (accredited by RIZIV-INAMI)
LOK	Lokale Kwaliteitsgroepen van huisartsen (Domus Medica)
GP	General Practitioner
MTG	Mind The Gate
RIZIV/ INAMI	Rijksinstituut voor ziekt- en invaliditeitsuitkering/ Institut national d'assurance maladie-invalidité
KCE	Federaal Kenniscentrum voor de Gezondheidszorg; Centre d'Expertise des Soins de Santé
EBM	Evidence-Based Medicine

ABSTRACT

In light of the significant increase in migration across Europe over the past two decades, promoting health equity and equitable care for individuals with a migration background has emerged as a prominent policy objective and research focus. However, in the context of mental health, it is often observed that individuals with a migration background, who are generally at a higher risk of depression, are underrepresented in both ambulant and residential mental health care services. Previous research has predominantly sought to elucidate their unmet mental health needs from a patient perspective, highlighting cultural, structural, and linguistic barriers they encounter. In contrast, the REMEDI project adopted a provider perspective to investigate whether general practitioners (GPs) may unintentionally contribute to the underrepresentation of individuals with a migration background in mental health care services. To explore the existence of potential provider bias, the project employed an innovative mixed-methods design, which combined a quasi-experimental video vignette survey with a discourse analysis of policy documents and insights derived from in-depth interviews and focus groups with GPs. The findings obtained from these data collection methods, in conjunction with an exhaustive literature review, formed the foundation for the development of our recommendations. These recommendations were further validated and refined through focus groups involving GPs and policymakers.

1. INTRODUCTION AND STATE OF THE ART

1.1. Europe: a superdiverse context

European countries, including Belgium, have witnessed a significant increase in migration over the past two decades. For example, according to Statbel data, in 2020, Belgium recorded 144,169 newly arrived migrants, and this number surged to 233,629 in 2022, primarily due to the war in Ukraine (Statbel, 2022) . Additionally, data from the "Atlas Superdiversiteit" indicate a growing diversity in Flanders (Vlaams Departement Omgeving, 2023). This dataset has been tracking the number of Flemish residents with a migration background since 1990. In 1990, only 6.5% of the Flemish population had a migration background, a figure that reached 25% by 2020. Moreover, in cities such as Brussels, Antwerp, and Genk, the majority of residents have a migration background. Given this rapid surge in migration in Europe during the past two decades, health equity and equity in care for people with a migration background have become a major policy goal and research agenda.

1.2. The mental health care (use) of people with a migration background

In addition to their physical health, policymakers and health scientists have placed significant emphasis on the mental well-being of individuals with a migration background. This aspect is crucial not only for their overall health but also serves as an indicator of their level of integration. However, research presents a concerning portrayal of the mental health status of people with a migration background in Belgium. Although mixed findings have been reported (Markkula et al., 2017; Mood et al., 2016) , the majority of the studies focusing on Europe in general, or Belgium in particular, indicate **a higher prevalence of depression in minority populations compared to non-minorities** (Delaruelle, Walsh, et al., 2021; Levecque et al., 2007; Levecque & Van Rossem, 2015; Missinne & Bracke, 2012; Van Roy et al., 2018). However, **people with a migration background constitute a notably underrepresented group in both ambulant and residential mental health care services** (Bell & Zech, 2009; Lindert et al., 2008). This paradox places people from minority backgrounds facing mental health problems in a vulnerable position. First, although not empirically supported by all studies, their unmet need for care may result in a higher risk of suicide (Andrews & Henderson, 2000), which is especially concerning given the evidence that Eastern European and non-European immigrants are discharged without further recommended follow-up care after a suicide attempt more frequently than non-immigrants in Belgium (Bursztein Lipsicas et al., 2014). Furthermore, it may reinforce the vicious circle of poverty and social exclusion (Lepièce et al., 2015; Schick et al., 2016). Given the generally lower socio-economic position of people with a migration background, unresolved mental health issues may contribute to further impoverishment through reduced employment opportunities and limited integration (Schick et al., 2016). Lastly, the unmet mental health needs of people with a migration background may not only be harmful to themselves, they may also impose a burden on society through increased rates of absenteeism and unemployment (Gupta & Guest, 2002). Thus, the underrepresentation of people with a migration background in mental health care services demonstrates that the mental health needs of this population are likely to remain unmet, and highlights the need to create more equal access to mental health care services for patients with a migration background (Bell & Zech, 2009; Satinsky et

al., 2019). Therefore, it is important to examine why minority patients are disproportionately absent from mental health care services.

1.3. Provider bias

Although a majority of international and national studies suggests that the underutilisation of mental health care services by people with a migration background is due to cultural, linguistic and structural barriers (Ahmed et al., 2017; Ohtani et al., 2015; Paternotte et al., 2015), some studies have come to focus on the possible contribution of health care providers to disparities in health care utilisation (Lepiece et al., 2014; Stepanikova, 2012). The last decade, several researchers have come to assume that GPs may contribute to ethnic disparities in mental health care use by applying (unconscious) stereotypes, unintentionally resulting in treatment and referral that differs from other patients (FitzGerald & Hurst, 2017). To investigate the role of a potential **provider bias** in the Belgian context, it is especially important to focus on the role of GPs, since they generally are the first contact for patients with mental health problems and often are the only professionals capable of synthesizing information about a patient in a fragmented health care system (Mistiaen et al., 2019). In Belgium as well as in other European countries, GPs are the main gatekeepers determining whether patients should be referred to specialized mental health care services based on their assessment of the severity and the impact of the observed symptoms (Mistiaen et al., 2019). However, GPs' decision-making regarding treatment and referral may be biased due to unconscious stereotyping beliefs (Lepièce et al., 2014; Van Ryn & Fu, 2003). Even well-intentioned GPs who are internally motivated to be unprejudiced may apply stereotypes when assessing patients (Burgess et al., 2004). Such stereotypes could lead to differences in treatment and referral decisions of GPs, ultimately causing discrimination in the medical setting (Lepièce et al., 2014).

On a more theoretical level, (unconscious) discrimination in the primary health care setting may be the result of two different processes. *First,* **external conditions** including characteristics of the primary health care setting, such as time pressure, fatigue and information overload, may all hamper cognitive decision-making and increase the unintentional use of mental shortcuts (Burgess et al., 2004). Pressured by the context and demanding professional circumstances (Burgess et al., 2004; Stepanikova, 2012), GPs might unintentionally discriminate against people with a migration background by relying on cognitive shortcuts. For instance, they can implicitly assume that asylum seekers might be simulating mental health problems to increase their chances of obtaining a legal residence permit (Fassin & d'Halluin, 2005), and therefore decide not to refer their patient to specialized mental health care services. Furthermore, GPs might underestimate the severity of the symptoms among people with a migration background, as these patients may not possess the vocabulary to clearly express their complaints and concerns (Drewniak et al., 2016; Jensen et al., 2011). *Second,* according to social identity theory (Tajfel et al., 1979), people tend to **hold negative perceptions and bias against members of other social groups based on categorization**, regardless of external conditions. In contrast, in-group members are more likely to be evaluated based on their individual positive characteristics. Accordingly, GPs may evaluate otherwise identical patients from various social groups in different ways and consequently perpetuate health disparities (Van Ryn & Fu,

2003). For instance, several studies have shown that health care providers tend to show less positive affect (e.g. less sympathy, less social talk) with patients with a migration background (Aelbrecht et al., 2017) and assume that it is not their responsibility to adapt to patients' cultural health beliefs (Dauvrin & Lorant, 2014). Finally, apart from these two major theoretical arguments, GPs' perceptions of specialized mental health care services as culturally insensitive could carry the potential to impede access to ambulant and resident mental health care for people with a migration background (Drewniak et al., 2017). Yet, on the other hand, a study conducted by Lorant and colleagues (2007) revealed that patients with a migration background in Belgium are often more subjected to compulsory commitment in psychiatric care than native patients. This is not primarily due to them being perceived as more dangerous or mentally ill, but rather because health care professionals perceive a lack of alternative, less restrictive mental health care options for them.

1.4. Provider bias in the Belgian context

Most of the research on unintentional discrimination among health care providers has been carried out in the United States (Moskowitz et al., 2012; Van Ryn & Fu, 2003). However, given the long history of racism and segregation in the United States and its high health care fragmentation, the results of these studies cannot be easily transposed to European regions, such as Belgium. The differences between the United States and the European contexts arise from differing historical backgrounds and discourses on migration (Bourabain & Verhaeghe, 2019). While both Europe and the United States have a history of racism evident in the racialized practices of European colonialism and American slavery, a disparity exists in the terminology that is used. Within this terminology, the term *race* carries inherent concerns. Particularly in continental Europe, race is associated with fascist regimes present during the 1930s and 1940s, whereas in the United States, this term is often used within the public debate (Bourabain & Verhaeghe, 2019) and in the field of social sciences where race is connected to social structures of inequality based on physical differences (Lee & Bean, 2004). Moreover, the oppression of people of colour in the United States has been rationalized and reproduced by a well-institutionalized racial framing (i.e. legal segregation policies) drawing on normalized notions, such as stereotypes, narratives and images (Feagin & Bennefield, 2014). Whilst, in Europe, such history and policy inclusion of legal racial segregation inside territorial boundaries never existed (Foner, 2015). Hence, it can be argued that American GPs have undergone more entrenched socialization in a culture rife with deep-rooted racial stereotypes, which are challenging to expunge from the subconscious, as compared to their European counterparts (Stepanikova, 2012).

While a handful of studies in Belgium and other European countries have investigated potential discrepancies in the treatment of patients with various migration backgrounds with functional limitations (Drewniak et al., 2016; Lepiece et al., 2014), empirical studies examining discrimination of patients with a migration background and mental health problems in the European context are limited. Prior to the REMEDI project, an initial effort was made by the UGent team to address this shortcoming (Ceuterick et al., 2020; Delaruelle, Buffel, et al., 2021). The "Mind the Gate project" (MTG), which conducted data collection in September-October 2018 in Flanders, aimed to assess a potential provider

bias in GPs' assessment and referral of depressive patients with different migration backgrounds in Flanders, using a quasi-experimental vignette study. The current project, REMEDI, sought to expand upon and enhance MTG in three different ways: (a) by carrying out the quasi-experimental vignette study in Wallonia and Brussels as well, enabling regional comparisons, (b) by incorporating a qualitative component to gain a better understanding of the underlying mechanisms, and (c) by adding a policy-oriented component to develop specific recommendations through the organization of several focus groups with GPs and policymakers.

Because of its regional diversity, the REMEDI project, which covered all three Belgian regions, represented a significant expansion from the MTG project, which concentrated exclusively on Flanders. Flanders, Wallonia, and Brussels exhibit significant variations in their (mental) health care systems and migration contexts. Therefore, it was imperative to comprehensively examine the provider bias **in the context of the specific regional settings where GPs operate**. A first difference between the Belgian regions concerns the share of minority residents: Brussels hosts a much larger number of people with a migration background than do Flanders and Wallonia (Noppe et al., 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 Health care Knowledge Centre (Devos et al., 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 RIZIV–INAMI and sickness funds (Devos et al., 2019). 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). This could be of relevance to our project 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 health care system differs. While centres for mental health care in Flanders (i.e. centra voor de geestelijke gezondheid [CGG]) constitute a second line of care, centres for mental health care in the Walloon region (i.e. services de santé mentale [SSM] are situated at both the first and the second line (Eyssen et al., 2016). Given the extent of these differences, the question arises whether there might exist regional variation in the possible level of unintentional discrimination against minority patients with mental health problems.

1.5. Summary

Most studies on the migration mental health paradox, which highlights that despite migrants' increased vulnerability to mental health problems, they are generally underrepresented in mental health care services, typically focus on factors related to the patients themselves. The provider bias assumption, however, suggests that health care professionals can also play a role in contributing to ethnic disparities in mental health care utilization. Except for the MTG project, there has been limited prior research on the potential existence of provider bias within the Belgian context. Recognizing its significant adverse impact on migrant populations, the REMEDI project was initiated to address the

scarcity of research on this topic within the Belgian context. It aimed to build upon and enhance the findings of the MTG project in several ways.

2. OBJECTIVES AND RESEARCH QUESTIONS

Motivated by the aim of reducing disparities in mental health care, the primary objective of REMEDI was to eliminate accessibility barriers to specialized mental health care services for minority patients. This was to be achieved by identifying and understanding the attitudes and behaviours of GPs and translating these insights into constructive knowledge and recommendations aimed at eradicating unconscious stereotyping.

To be more specific, in order to investigate the possible presence of a provider bias among Belgian GPs towards patients with a migration background who are experiencing mental health issues, with a particular focus on depressive disorders, and to assess the potential of interventions and policies to address this bias, the REMEDI project implemented an innovative mixed-method design, which is detailed below.

3. METHODOLOGY

3.1. Innovative mixed-method design

This research project demonstrated methodological innovation by adopting pioneering research methods. Notably, within the field of sociology of health and illness, there has been limited utilization of mixed-method research designs in which both quantitative and qualitative data are collected for triangulation purposes. To bridge this gap, our study employed a mixed-method design in order to examine possible provider bias among GPs and GPs in training in Flanders, Brussels and Wallonia.

In the context of our **quantitative analysis**, we adopted an experimental video vignette design, a novel approach in discrimination research. Specifically, the use of scripted video vignettes in experimental studies has only recently garnered attention from scholars in the social sciences (Ceuterick et al., 2020). Previously, researchers predominantly relied on alternative methodologies such as qualitative in-depth interviews with both general practitioners and patients (Hanssens et al., 2017), others employed situational tests in which fictitious clients attempt to make appointments via email or telephone (Kugelmass, 2016) or written vignette techniques were also employed (Lepièce et al., 2014) to measure potential discrimination within the health care system. However, each of these methods is not without its criticisms. In-depth interviews have been scrutinized for their time-intensive nature and susceptibility to socially desirable responses. Situational tests have raised ethical questions regarding researchers' ability to intentionally occupy GPs' time without their awareness, potentially at the expense of patients in urgent need of consultations. In contrast, we contend that video vignette-based experiments offer distinct advantages over written vignette techniques. They provide a visual representation of symptoms, encompassing both verbal and non-verbal cues, thereby enhancing recognizability and lending greater clinical realism to the vignettes (Ceuterick et al., 2020). Further elaboration on this design is provided below.

The **qualitative component** of our study entailed a discourse analysis of (1) various policy documents related to patients with a migration background and depression in general practices, (2) in-depth interviews with GPs and (3) focus groups with GPs and policymakers. The main aim of the qualitative part of this study was to examine GPs' accounts of patients with a migration background suffering from depression, investigating the potential influence on their decision-making process. Additionally, we aimed to identify broader professional discourses associated with institutions that regulate GP conduct, potentially impacting the narratives provided by GPs. Finally, the recommendations we formulated underwent thorough discussion and validation within the focus groups (as outlined in Section 5).

3.1.1. Quantitative methodological framework – An experimental video vignette design

The quantitative studies we conducted employed an experimental video vignette design. We employed a slightly modified design compared to the one utilized in the MTG project, which is extensively described by Ceuterick et al. (2020).

Video vignettes are scripted, fictional scenarios in which actors simulate real-life situations, such as interactions between general practitioners (GPs) and patients (Hillen et al., 2013). They are instrumental in investigating the causal impact of specific variables by systematically altering certain aspects of the video stimuli while keeping others constant (Evans et al., 2015). The use of video vignettes in assessing attitudes and referrals allowed us to examine potential disparities in treatment decisions made by GPs, a task not feasible with situational or correspondence tests. Additionally, a significant ethical advantage of using (video) vignettes is that participants willingly dedicate their time to participate in a quasi-experimental survey. This approach ensures that GPs' valuable time remains unburdened, preserving the time they could otherwise allocate to other 'real' patients. Vignette studies fall within the category of assumption methods (specifically 'between-subject designs') within the broader field of implicit bias studies. They are widely recognized for their ability to detect potential implicit bias while simultaneously probing for related behaviours, in our case, disparities in referral patterns (Fitzenberger et al., 2004).

We used two different video vignettes, which were randomly allocated among GPs: one portraying a **Belgo-Moroccan patient** experiencing depression according to DSM-5 criteria and the other portraying a depressed **native patient**. Apart from their differing migration backgrounds, both video vignettes were identical in all respects. To create these video vignettes, we collaborated with the same actors who had previously participated in the MTG project. These were specifically selected for their cultural backgrounds and language accents. Originally, our project proposal had outlined the inclusion of a third video vignette, portraying an asylum-seeking patient, following the example set by the MTG. However, upon commencing the project, we reconsidered the design and made the decision to forgo the asylum-seeking patient vignette. This change allowed us to introduce a second experimental design: **the humanization intervention**. The primary objective of this intervention was to assess the

effectiveness of "humanizing the patient" as a strategy to mitigate provider bias in the medical decision-making processes of GPs (Sljivic et al., 2022). "Humanizing the patient" involves adopting a more empathetic and patient-centred approach, which includes placing importance on aspects such as considering the patient's life story, embracing a holistic perspective, practicing fairness, engaging in active listening, and demonstrating respect for the patient's dignity, individuality, and humanity. Our assumption was that humanizing the patient could serve as an effective strategy for addressing provider bias and unconscious discrimination.

To incorporate the humanization intervention into our quasi-experimental design, we developed four distinct humanizing life-story scenarios for the intervention group of GPs. Each GP belonging to this experimental group received one of these scenarios, which was provided as a written text containing information about the patient's life story. The first life-story scenario introduced the patient by name and included various specifics about the patient's family composition, place of residence, and employment status. The second scenario provided insights into the patient's needs and treatment preferences. The third scenario included details about the patient's experience of job loss. Lastly, the fourth scenario contained information about the patient's marital separation. While the four scenarios contained distinct information, they all served the overarching purpose of humanizing the patient. Consequently, they can be effectively grouped together for analysis and evaluation.

In summary, we employed a balanced **2x2 factorial experiment** (see Figure 1) by combining the two experimental conditions, manipulating both the migration background of the patients and the humanization intervention among Belgian GPs. The links to the video vignettes used in the REMEDI project are provided below:

- Native Dutch-speaking patient: https://www.youtube.com/watch?v=VLHuXxXNM68.
- Native French-speaking patient: https://www.youtube.com/watch?v=dvSbtq0GrvU.
- Belgo-Moroccan Dutch-speaking patient: https://www.youtube.com/watch?v=NA2fKo-2VTs.
- Belgo-Moroccan French-speaking GPs: https://www.youtube.com/watch?v=6JosPdLTVDs.

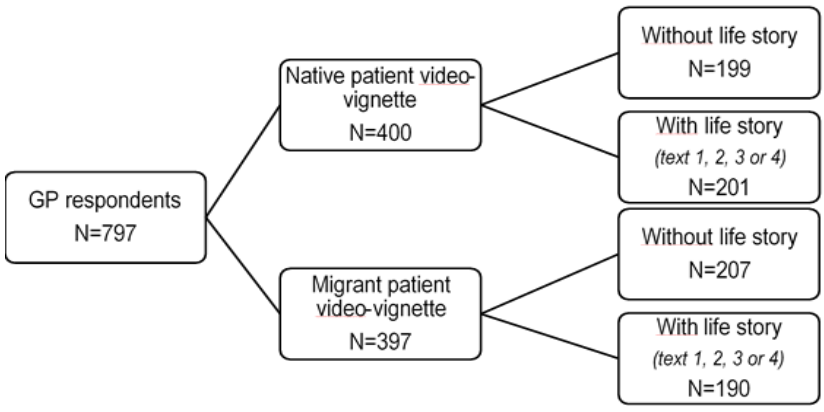

Figure 1 - Balanced 2x2 factorial

In addition to the experimental design, our conducted survey encompassed various socio-demographic and contextual factors. Additionally, it included inquiries about GPs' attitudes, recommendations, cultural competence, and more, as outlined in the Appendix (see online publication). This comprehensive approach allowed us not only to examine the potential existence of provider bias but also to assess how GP-related factors might influence it.

Initially, our plan was to distribute the surveys exclusively among licensed GPs in Brussels and Wallonia, as data from licensed Flemish GPs had already been collected as part of the MTG project in 2018. However, the outbreak of the COVID-19 pandemic necessitated a reconsideration of our data collection strategy. Due to the pandemic's impact, we had to delay the quantitative data collection because GPs were overwhelmed with their work and were reluctant to participate during this time. Consequently, we were only able to gather our data in 2021, resulting in a three-year time gap with the data collected in Flanders. This time gap posed challenges when making comparative claims. Moreover, the COVID-19 pandemic had a significant impact on people's well-being, including that of GPs. GPs may therefore have had different attitudes towards depressed patients with a migration background compared to three years earlier. This made it even more challenging to draw meaningful comparisons with the 2018 MTG data.

To overcome these challenges, we made two key adjustments to our data collection strategy. First, we expanded our outreach to not only include licensed GPs in Brussels and Wallonia but also GPs in training, ensuring a sufficient participant pool. Second, we extended the survey distribution to encompass GPs in training in Flanders as well. This expansion not only increased our participant numbers but also facilitated a simultaneous comparison between Flanders and Wallonia. We opted not to contact licensed GPs in Flanders as they may have previously participated in the MTG project, potentially making them familiar with our study's design. The data was collected between April and July 2021 using Qualtrics. GPs were recruited through several means, including telephone contact, e-mails sent by representatives of professional GP organizations[1] and snowball sampling. We achieved a final sample of 797 respondents after removing incomplete questionnaires.

3.1.2. Qualitative framework

The qualitative component of our study employed a discourse-analytic approach to investigate (1) Belgian policies concerning patients with a migration background and depression in general health care practices, and (2) GPs' accounts of their personal experiences and perceptions regarding patients with a migration background who face mental health challenges within their practices. Additionally, we explored strategies to address potential barriers in providing care to these patients. It's worth

[1] FAMGB (Fédération des Associations des Médecins Généralistes de Bruxelles), Fedasil, SSMG (Société Scientifique de Médecine Générale), FMM (Fédération des Maisons Médicales), ABSyM/BVAs (Association Belge des Syndicats Médicaux/Belgische vereniging van Artsensyndicaten), BHAK (Brusselse Huisartsen Kring), Huis voor Gezondheid Brussel, ICHO (Interuniversitair Samenwerkingsverband HuisartsenOpleiding), HOP, groups for GPs in training on social media, and several medical universities in all three Belgian regions.

noting that the document analysis was not originally included in our proposal. Initially, our plan was to solely conduct in-depth interviews and focus groups. However, due to the COVID-19 pandemic, we had to reassess our qualitative design. This decision was prompted by the challenges we faced in reaching GPs during the originally planned data collection period, which coincided with the second wave of the pandemic. Consequently, we chose to postpone the in-depth interviews and focus groups, and to incorporate **a document analysis encompassing various Flemish and Dutch-written federal policy reports and articles**. This allowed us to analyse the broader professional discourse that is inevitably intertwined with the institutions governing GPs' conduct and, in turn, shaping the narratives presented by GPs. The data encompassed a range of documents related to health care policy in the field of general practice and primary care concerning depression and patients with a migration background that were issued by pertinent scientific and professional organisations. The data collection comprised two collection rounds to assemble our data. At first, we identified the relevant organisations related to this topic. This led to the inclusion of several policy reports issued by Domus Medica and KCE. Second, we shifted our focus specifically to scientific and governmental organisations relevant to the issue of policy documents related to the topic of interest. Consequently, various articles of the scientific journal of Domus Medica (*'Huisartsnu'*) and BeCare E-Magazine were identified during the second round of the data collection. The documents were identified by applying a list of search terms related to topics of depression, mental health and patients with a migration background. Given the adherence to regulations of EBM regarding applicability of outdated medical knowledge by both Domus Medica and KCE, we decided to include only documents published within the 10 years preceding the data collection period. Consequently, this criterion resulted in a final selection of 18 documents spanning the period from 2011 to 2021 to be included in our discourse analysis (see Table 2, Study 3). These policy reports and articles were analysed by deploying a discourse analysis based on the **principles of Foucauldian discourse analysis** (Willig, 2013). Given that dominant discourses can favour legitimizing constructions of social reality (Willig, 2013), it is advantageous to apply Foucauldian discourse when analysing policy documents related to patients with a migration background and depression in general practices. This data analysis method enables a critical examination of how policy formation is intertwined with broader societal changes and the involvement of stakeholders (Sharp & Richardson, 2001). Therefore, it constitutes a valuable analytical method in (health) policy research. Foucauldian discourse analysis will allow us to scrutinize the predominant perspectives and power dynamics embedded in policy documents by which GPs' accounts may be influenced. Moreover, it enables us to question the legitimation of certain existing power relations.

Furthermore, the accounts of GPs were collected during **in-depth interviews and focus groups**. This qualitative approach enabled us to examine the discursive construction of patients with a migration background suffering from depression and the coherent decision-making process towards these patients of Belgian GPs. Therefore, 39 in-depth interviews with Belgian GPs were conducted in Flanders, Brussels and Wallonia. The interview participant comprised 29 general practitioners, along with 10 general practitioners who had recently completed their medical studies and were currently in one of three training years to attain full qualification as GPs (referred to as 'GPs in training'). Our sample encompassed both GP working in urban and rural areas, with the awareness that GPs working

in urban settings typically have more exposure to patients with a migration background and asylum seekers. Furthermore, the participating GPs were affiliated with solo practices, group practices or community health centres and medical houses. The interviews were conducted between December 2021 and June 20022 by Camille Wets (CW), Camille Duveau (CD) and a masters student, according to their respective mother tongue (Dutch and French). During the in-depth interviews, we focused on the personal experiences and perceptions of GPs related to treatment and referral of patients with a migration background and asylum seekers. To stimulate GPs to reflect upon their personal experiences and to elicit further discussion, we included **a video vignette depicting a depressed Syrian asylum-seeking patient**. Here, we were inspired by a study of Blackburn and Stathi claiming that "vignettes facilitate the exploration of topics which are often considered sensitive due to moral and ethical dimensions" (2019, pp. 167-168). This video vignette was part of the original survey-design of the MTG project. However, it was left out of the quantitative design of our study due to difficulties regarding sample size. The audiotapes of the in-depth interviews were audiotaped and transcribed verbatim. Lastly, the final transcripts were checked against the original audiotape and pseudonymised according to the informed consent protocol participants agreed upon.

The purpose of the **focus groups with GPs** was twofold: (1) we aimed to examine the discursive construction of patients with a migration background suffering from depression and the coherent decision-making process towards these patients (similar to the aim of the in-depth interviews), (2) these focus groups were organised in order to discuss and validate a set of recommendations related to mental health care for patients with a migration background in general practices. The focus groups proceeded according to a predetermined topic guide. This topic guide encompassed **the discussion of three main recommendations** that were developed from an initial thematic analysis of a section of the in-depth interviews regarding the difficulties and barriers GPs encounter when having a consultation with patients with a migration background and asylum seekers with mental health issues. The recruitment process of participants consisted of invitations extended to 'local quality groups' of GPs (LOK and GLEM) and CHCs with a proposal to organise a focus group regarding patients with a migration background in one of their meetings. In total, eight focus groups with GPs were organised comprising 79 participating GPs working in solo practices, group practices and community health centres. In order to facilitate participants' preparation, we sent out the set of established recommendations a week prior to the focus group. All focus groups were digitally audio recorded and transcribed verbatim. A first thematic analysis was conducted in order to (1) prepare two focus groups with policymakers to validate the discussed recommendations and (2) rework the final recommendations we discuss later in this report.

This qualitative data was also analysed by applying a **critical discourse analysis guided by the principles of critical discursive psychology** (Edley, 2001; Potter & Wetherell, 1987; Wetherell, 1998). The aim of this analysis was to (1) examine how GPs discursively construct their decision-making regarding patients with a migration background with depression and (2) identify how GPs discursively position these patients. In this way, the focus of this analysis was on the discursive resources GPs draw upon when talking about consultations with patients with a migration background suffering from

mental health problems and the related decision-making process. Consequently, the main focus was on the ways in which discursive resources are articulated by GPs and how they potentially perpetuate meanings and practices concerning their treatment and referral recommendations for these patients. A discourse analysis inspired by the epistemological framework of critical discursive psychology allowed us to critically examine GPs' accounts by considering both the situated nature of accounts and the institutional and social structures in which these accounts are constructed (Burr, 2015). As GPs work within the realm of dominant social institutions, an analysis guided by the principles of critical discursive psychology enables us to unravel the power relations and broader professional discourses influencing GPs' accounts of these patients. Consequently, we can question the way in which these accounts may influence their decision-making regarding treatment and referral for these patients.

By combining the in-depth interviews and focus groups, we aimed to enable ourselves to fully grasp the range of possible sensitivities surrounding the topic of provider bias. The **triangulation** of this qualitative data allowed us to look for underlying differences in the discursive positioning acts of GPs on the sensitive issues related to consultations with patients with a migration background and mental health issues in general practices. Moreover, we claim this approach is methodologically innovative as previous qualitative studies among GPs have combined these methods cumulatively rather than comparatively. In this way, one of the major aims of the qualitative studies we have conducted was to increase the validity of the quantitative results.

3.2. Work packages and timeline

The project contained the following work packages (WP), as can be seen in Figure 2.

WP1 consisted of a preparatory phase during which we sought for ethical approval *(1.1)*, refined and practically organized recruitment procedures *(1.2)* and organized a start-up meeting with the follow-up committee *(1.3).* **WP2** entailed the collection of the quantitative data through online survey questionnaires. GPs and GPs in training in Brussels and Wallonia and, GPs in training in Flanders were contacted to complete the online survey *(2.1)*. During the period of April to July 2021, we called 6112 GPs and GPs in training and asked for their email addresses to send them the link of the survey. We also provided time for follow-up reminders *(2.2)*, this was especially of importance due to the influence of covid-19 related restrictions complicating the daily work processes in general practices. Two weeks after initial recruitment, they received a first reminder if they did not complete the survey yet. After one month, they received a second reminder. By the beginning of August 2021, we closed the online survey. Furthermore, we closely monitored the progress of the data collection and performed preliminary analyses to get an early appraisal of the study findings *(2.3)*. Lastly, once the data collection was closed, we conducted our first analysis between September and December 2021 *(2.4)*.

WP3 entailed the collection of the qualitative data through in-depth interviews and focus groups with GPs. In the period from July to September 2021, we developed the semi-structured questionnaire for the in-depth interviews *(3.1)*. Due to a subsequent surge in COVID-19 cases that posed challenges in GP recruitment, the original timeline of the qualitative data collection was disrupted. Therefore, we

initiated the data collection through in-depth interviews in Flanders *(3.2)* in December 2021. While the in-depth interviews with GPs in Wallonia and Brussels *(3.3)* resumed after COVID-19 restrictions were eased in March 2022 and GPs experienced reduced pressure. Finally, the conduct of in-depth interviews was ended by June 2022. Given the difficulties we experienced in the recruitment of GPs due to COVID-19 related restrictions, we decided to familiarize ourselves with the method of discourse analysis and critical discursive psychology (that would later be applied onto the qualitative data). Therefore, we applied a Foucauldian discourse analysis method to a qualitative dataset of Belgian policy reports and documents regarding mental health care in general practices and ethnic diversity *(3.4)*. Moreover, during the time of data collection, we performed a preliminary thematic analysis of several of the interviews in order to prepare the topic guide for the focus groups with GPs *(3.5)*. We initiated to recruit participants of the quantitative study to take part in our focus groups. However, this recruitment method did not deliver the expected results. Therefore, in order to recruit GPs to participate in the focus groups, we contacted several LOKs, GLEMs and community health centres *(3.6)*. Finally, we conducted eight focus groups with GPs in Brussels, Flanders and Wallonia between October and December 2022 *(3.7)*. A preliminary thematic analysis was applied as a preparation for the focus groups with policymakers. In the beginning of March 2023, we organised a focus group with Dutch-speaking policymakers and a focus group with French-speaking policymakers *(3.8)*. **WP4** entailed the submission of our findings for publication in international peer-reviewed journals *(4.1)*. Furthermore, our findings were regularly communicated to the follow-up committee.

Furthermore, within WP5, we conducted dissemination activities where we presented our findings to a wider audience. First, the (preliminary) results of our study were presented during several international and national conferences *(5.1)*. Second, we organized the REMEDI symposium in the beginning of September 2023 to present the results of this research project to a broader audience of policymakers, general practitioners and other stakeholders in the field of mental health care *(5.2)*. Moreover, CD shared the results from the quantitative data collection through various media channels *(5.3)*. In January 2023, RTBF published an online article sharing an interview with CD elaborating on the quantitative results of the project[2]. In addition, she registered two 30-minute podcasts at RCF Radio to present the results[3]. Furthermore, *Le Soir* invited CD for an interview together with Paul De Munck (President of the *Groupement Belge des Omnipraticiens [GBO]*) and a Brussels GP to present different stances of view on the results of the REMEDI research project[4]. Lastly, in order to inform French-speaking GPs and stakeholders in the field of general practice, CD published a synthesis of the

[2] The article is available online: https://www.rtbf.be/article/sante-mentale-il-vaut-mieux-sappeler-dubois-quealaoui-pour-etre-pris-en-charge-par-son-generaliste-11139521.

[3] The first podcast is available online: https://www.rcf.fr/culture-et-societe/solidaides?episode=338119, the second podcast can be found here: https://www.rcf.fr/culture-et-societe/solidaides?episode=338219.

[4] The article was published both in print and online at this link: https://www.lesoir.be/507391/article/2023-04-14/la-sante-mentale-des-personnes-issues-de-limmigration-mal-prise-en-charge.

results of the REMEDI project in *Le Journal du Médecin*[5]. Given the delay of the qualitative data collection, the findings of the qualitative data collection will be shared in a comparable manner. Since this exceeds the strict timing of the project, CW is pursuing to write a synthesis including the qualitative results of the project to be published in *HuisartsNu* with the objective to inform Dutch-speaking GPs and stakeholders in the field of general practice *(5.4)*. CD and CW are both preparing doctoral dissertations associated with the REMEDI project *(5.5)*. CD's dissertation will primarily delve into the project's quantitative outcomes, with the defence scheduled for October 2023. On the other hand, CW's dissertation will predominantly centre around the qualitative findings and is anticipated to be completed by September 2024.

[5] The French synthesis on the results of the REMEDI project in *Le Journal du Medecin:* https://www.lejournaldumedecin.com/gestion/inconsciemment-les-medecins-generalistes-discriminent-les-patients-migrants/article-normal-68941.html?cookie_check=1685087277

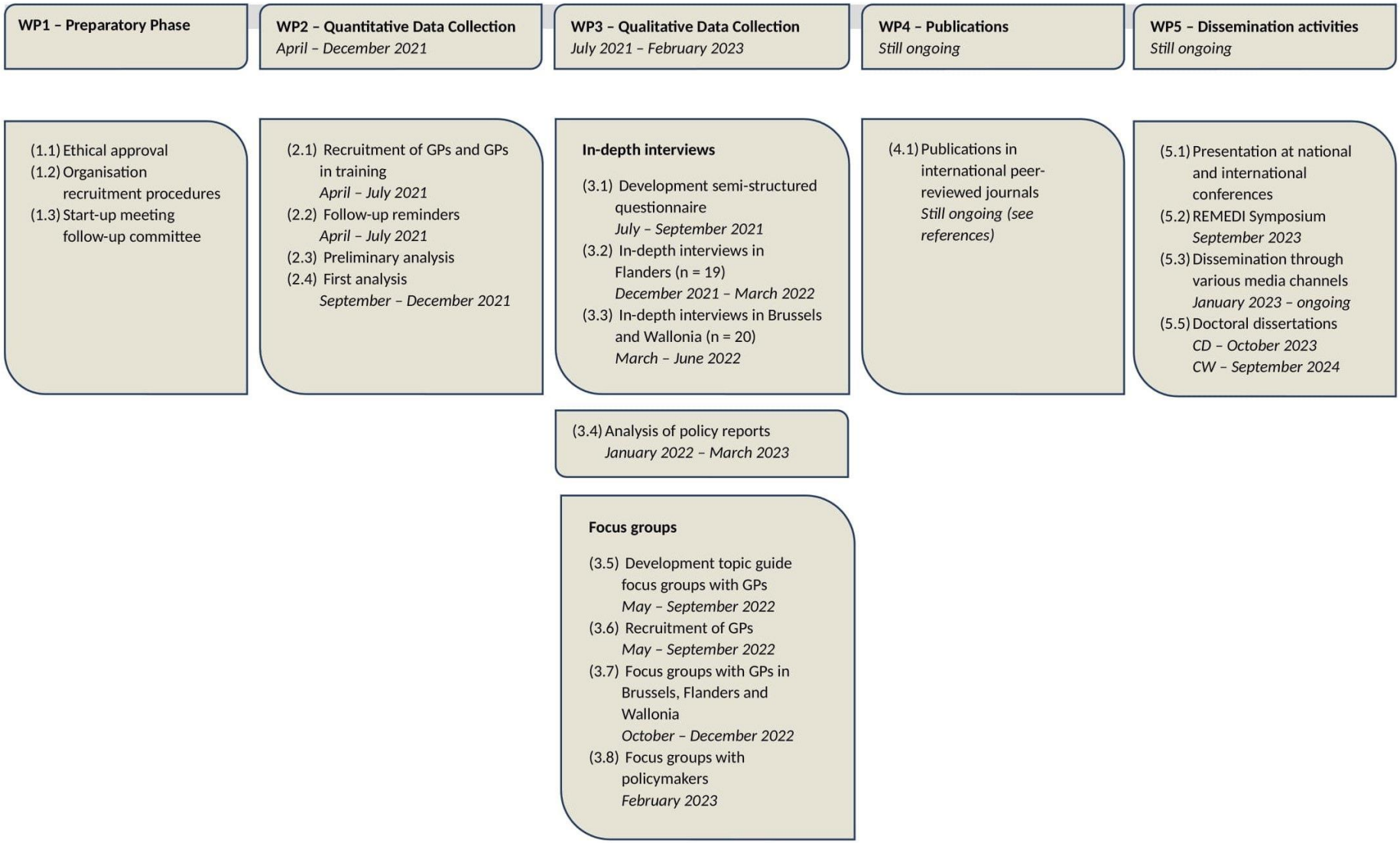

Figure 2 - Timeline

4. RESULTS

Some of our research findings have been detailed in four scientific papers, which are provided below. These papers primarily discuss the identification of provider bias in the Belgian context, factors associated with it, and the effectiveness of the humanization strategy. Notably, the results from the focus groups, which pertain to policy recommendations, have not been documented in scientific papers but are presented in Section 5 of this report.

4.1. Short summary of the studies

The first two studies shed light on the existence of provider bias in the Belgian context towards depressed patients with a migration background. For triangulation purposes, the studies used different approaches to identify it. The first study employed a quasi-experimental design to quantitatively examine this bias. The second study adopted a qualitative approach to explore how Belgian GPs discursively construct their decision-making processes regarding patients with a migration background suffering from depression and position these patients. The first study additionally examined factors related to the provider bias. The third paper took a slightly different perspective by recognizing that the existence of provider bias in the Belgian context may result from broader discourses in our society regarding depressed patients with a migration background. It, therefore, analysed Flemish and Dutch-written federal policy documents on which GPs might rely when assessing these patients. Finally, we evaluated the potential of the humanization intervention to reduce provider bias in the final study. The boxes below provide brief summaries of the key findings of the papers.

STUDY 1: Individual, interpersonal and organizational factors associated with discrimination in medical decisions affecting people with a migration background with mental health problems: the case of general practice.

This study employed a quasi-experimental design that featured two distinct video vignettes: one depicting a native depressed patient and the other portraying a Belgo-Moroccan depressed patient. GPs were tasked with assessing and providing treatment recommendations for the patient depicted in the video vignette they viewed. Furthermore, the study analysed GPs' assessments and recommendations in relation to individual, interpersonal, and organizational factors. The findings revealed several significant differences. **Patients with a migration background were more frequently diagnosed with PTSD, and their mental illness was perceived as less severe by GPs**. Additionally, GPs were **less inclined to prescribe a combination of psychotherapy and medication for patients with a migration background**. Moreover, various factors at different levels were found to be associated with these differences: older GPs were slightly more influenced by cognitive shortcuts and tended to associate the patient's migration background with a PTSD diagnosis as a comorbidity of depression. Furthermore, GPs with a migration background were more inclined to prescribe both medical and non-medical treatments for patients with a migration background. Another important finding was that a higher perceived workload and lower trust in patients with a migration background significantly increased the likelihood of GPs diagnosing these patients with PTSD.

This study has been published in *Ethnicity & Health.*

STUDY 2:

In this study we examine **Belgian GPs' accounts** of patients with a migration background and asylum seekers suffering from depression and their related decision-making process. Since GPs work within the realm of dominant social institutions, this analysis will allow us to unravel the power relations and broader professional discourses influencing their accounts of these patients. Furthermore, GPs' discursive accounts of patients with a migration background suffering from depression may influence their decision-making regarding treatment and referral for these patients. Therefore, this study seeks to offer a unique contribution to the research on ethnic disparities in mental health care, by employing a critical discourse analysis inspired by the principles of **Critical Discursive Psychology (CDP)** in order to (a) examine how GPs discursively construct their decision-making regarding patients with a migration background suffering from depression and (b) identify how GPs discursively position patients with a migration background suffering from mental health problems like depression. We identified three interpretative repertoires available in GPs' accounts about consultations with patients with a migration background and asylum seekers and their related decision-making: (a) the legal-political repertoire, (b) the humanising repertoire and (c) the culturalising repertoire. While the legal-political repertoire and culturalising repertoire align with values related to **a neoliberal ideology**, the humanising repertoire corresponds to values related to the **biopsychosocial and patient-centred model** in health care. This highlights the availability of several, sometimes conflicting discourses influencing the accounts of GPs which eventually may lead to the unmet mental health needs of people with a migration background.

This study is currently being finalized, and will be submitted to *Health Sociology Review.*

STUDY 3:

In this study, we focus on **Belgian policies** regarding patients with a migration background and depression in general practices. Professional discourses at the policy level are inevitably linked to institutions that regulate GPs' conduct. GPs' accounts on patients with a migration background may therefore be influenced by these accounts. Therefore, this study applied a Foucauldian discourse (FDA) analysis in order to (a) identify broader professional discourses in general practices, (b) examine how patients with a migration background are discursively positioned and (c) investigate the different balances of power in the relationship between GPs and patients with a migration background. We identified three recurring discourses: (a) the othering discourse, (b) health literacy discourse, and (c) person-centred discourse. Our analysis demonstrated that the former two discourses illustrate the **perpetuation of a biomedical discourse**. While the last discourse is aligned with a counter-discourse associated with the **person-centred care** model in health care. Consequently, our analysis demonstrated the availability of several contradictory discourses throughout the various policy documents on which GPs might rely when speaking about patients with a migration background suffering from depression.

This study has been accepted by *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* and is currently undergoing the proofreading process.

STUDY 4: Unintentional discrimination against patients with a migration background by general practitioners in mental health management: an experimental study

This study assessed the effectiveness of the humanization intervention in addressing provider bias towards depressed patients with a migration background, utilizing a 2x2 quasi-experimental design. To ensure adequate statistical power, the study did not account for the specific humanization scenario implemented in the survey. The results confirmed **the presence of differences in diagnosis, symptom severity assessment, treatment, and referral to mental health care services**, which was consistent with our earlier study. However, the findings also indicated that **humanizing the patient had no impact on mitigating provider bias**. Consequently, it suggests the necessity of considering **alternative strategies** to address unintentional discrimination, which are further detailed in Section 5.

This study has been published in *Administration and Policy in Mental Health and Mental Health Services Research.*

4.2. STUDY 1 – Individual, interpersonal and organisational factors associated with discrimination in medical decisions affecting people with a migration background with mental health problems: the case of general practice

Duveau, C., Wets, C., Delaruelle, K., Demoulin, S., Dauvrin, M., Lepièce, B., … & Lorant, V. (2023). Individual, interpersonal, and organisational factors associated with discrimination in medical decisions affecting people with a migration background with mental health problems: the case of general practice. Ethnicity & Health, 1-20.

INTRODUCTION

Socioeconomic status partly explains why some migrant and ethnic minority (MEM) groups are at greater risk of mental illness. Ethnic disparities remain, however, even after adjusting for socio-economic factors (Bhui et al., 2018; Levecque & Van Rossem, 2015). Racial and ethnic disparities in health care can be explained in several ways, including by the fact that health care professionals themselves contribute to racial and ethnic disparities. Previous studies have shown that general practitioners (GPs) often have an implicitly or explicitly unfavourable attitude toward MEM patients (Drewniak et al., 2016; Duveau et al., 2022; van Ryn et al., 2011). Although GPs' biases are part of the causal mechanism of unintentional discrimination in mental health care, few studies to date have investigated how such biases arise and how they influence GPs' decision-making (Ceuterick et al., 2020; Drewniak et al., 2016). Moreover, there is still little research focusing on healthcare providers' perspectives and their biases' impact on medical decisions in the field of mental health (National Academies Press (NAP), 2004; Spencer & Grace, 2016). As "gatekeepers" who refer patients to mental

health care, GPs play an important role in the identification and treatment of mental health problems and referral recommendations (Anjara et al., 2019; Bower & Gilbody, 2005; Doorslaer et al., 2004). Even unprejudiced GPs may face individual, interpersonal, or organisational conditions that result in discriminatory (e.g. unfair or unequal) decisions (Kite & Whitley, 2016).

The literature also shows that mental health problems are often accompanied by stigma and discrimination, i.e. "*unfair inequalities in power, resources, capacities, and opportunities across racial or ethnic groups*" (Paradies et al., 2015). Stigmatisation and discrimination in turn have consequences associated with mental illness, such as decreasing a person's likelihood of seeking treatment when necessary, which creates a vicious circle (Clement et al., 2015; Mittal et al., 2020; Schunck et al., 2015). Furthermore, people with a migration background (MB) are in double jeopardy because their prevalence of mental health problems such as depression, anxiety, and posttraumatic stress disorder (PTSD) is higher compared with people without a MB (Ekeberg & Abebe, 2021; Missinne & Bracke, 2012). In the context of this research, individuals with a migration background are defined as those who currently reside in a country different from their country of birth, or who have undergone a change in nationality to align with their present country of residence. Additionally, individuals with a MB encompasses those whose at least one parent entered the current country of residence as a migrant, as outlined by the United Nations (United Nations & EUROSTAT, 2006).

Individual, interpersonal, and organisational factors

Spencer and Grace (2016) identified different factors that contribute to discriminatory medical decisions: at (i) the *patient's level* (e.g. age, gender, and ethnicity), (ii) the *physician's level* (e.g. gender, ethnicity, experience, specialty, and implicit and explicit bias), (iii) the *interpersonal level* (e.g. ethnic discordance, i.e. a Moroccan patient who visits a Belgian GP, and interpersonal trust (Cooper et al., 2004; Moskowitz et al., 2011; Poma, 2017)), and (iv) the *organisational level* (e.g. location and type of organisation, time pressure and workload, practice culture and frequency of contact with people with other cultural backgrounds (Stepanikova, 2012)). The relationship between those factors and ethnic disparities in GPs' decisions has been demonstrated frequently in the United States (US) but very rarely elsewhere. In Europe, evidence of the factors associated with ethnic disparities in GP's medical decisions remains scarce despite the huge ethnic diversity of GPs' waiting rooms. Belgium, a European country, is a good case study because the prevalence of depression among those with a migration background, e.g. people with Moroccan or Turkish roots, is especially higher, as compared to other European countries (Levecque et al., 2009; Missinne & Bracke, 2012; Van Roy et al., 2018). It has been shown that discriminatory practices regarding the mental health of patients with a migration background are more prevalent in Belgium than in other European countries (Missinne & Bracke, 2012). Even compared to other European countries (like France or Germany), Belgium has a long history of immigration and has experienced significant migratory flow. A first wave of migration from Morocco took place during the 1960s, at a time of shortage in the labour market. Subsequently, during the 1970s and 1980s, labour migrants gradually transitioned into more long-term residents, with their families opting to establish roots in the host country they had initially migrated to (Van Mol & De Valk, 2016). Today, Moroccan communities constitute one of the most significant ethnic groups in Belgium.

Morocco remains one of the primary countries of origin for people naturalized in Belgium, along with Romania, Poland, the UK, and Italy. However, in 2022, out of the 36,871 asylum seekers who arrived in the country, Moroccan populations were less represented, with a larger number of individuals originating from countries such as Afghanistan, Syria, Palestine, Burundi, and Eritrea. In 2023, nearly one-fifth of Belgium's population (19,7%) holds foreign nationalities as their first registered nationality, and up to 40% of the population of Brussels, the country's capital (Statbel, 2022). Migration is still an important issue today.

There is a need, therefore, to better understand which factors are associated with those discriminatory decisions (Clark et al., 1999). For instance, in the US, racial disparities based on the colour of people's skin have dominated the research agenda, whereas in Europe, the term "race" has been superseded by "ethnicity" (Afshari & Bhopal, 2010). In Europe, ethnicity is mainly defined by a person's country of birth or ancestry and cultural differences such as language (Afshari & Bhopal, 2010).

Aims

This paper assessed the association between GPs' individual, interpersonal, and organisational factors and the differences between medical decisions affecting a depressed patient with or without a MB.

At the individual level, we hypothesised that the medical decisions of older male ethnically discordant GPs who more often placed the responsibility to adapt care on the person with a migration background would be more affected by the patients' migration background (Assari, 2018; Duveau et al., 2022). At the interpersonal level, we hypothesised that GPs who were less trusting of the patient with a migration background would also make less favourable decisions (Moskowitz et al., 2011; Pugh et al., 2021). Finally, for the organisational factors, we hypothesised that decisions made by GPs with a heavier workload would be more affected by the patient's migration background because heavy workloads lead to shortcuts in the decision-making process (Lepièce et al., 2014).

METHODS

Study design

A study with an experimental design, accompanied by an online survey, was carried out in Belgium. The online experiment, facilitated through Qualtrics®, featured a selection between two distinct staged video vignettes, allocated at random to participating GP respondents. The videos both showed a staged consultation with a GP and either a Belgian male patient or a male patient with a Moroccan migration background (Figure 3), both with symptoms of major depression (according to DSM-V criteria). The actor's Moroccan migration background was not explicitly specified; instead, we relied on visual cues to infer this information. Despite being fluent in the languages spoken in Belgium (French or Dutch), the actor exhibited a subtle foreign accent, indicative of a diverse migration background. The actor's appearance alone led GPs to infer that he likely had an ethnic background, potentially originating from Morocco. We chose to only have male actors in the videos because it has been shown that the sex of the patient may play a role in GPs' decision-making, especially with male patients (Scott et al., 1996;

Van Ryn et al., 2006) and, secondly, because it would have doubled the total number of videos in the experiment and, given that GPs are a hard-to-reach population sample, we did not consider that to be feasible.

The two videos and their written introductions were comparable in every way and can be accessed in Appendix (see online publication). The script of the video was approved by an academic expert in experimental psychology and an advisory committee composed of two psychiatrists, two GPs, a psychiatric nurse, a psychologist, and an expert in culturally sensitive care. The video simulated a conversation between a GP and a patient who had come for a second consultation due to a persistent headache for which no physical cause had been identified. Full details of the design of the video vignette are provided elsewhere (Ceuterick et al., 2020). This study was carried out within the framework of the "REMEDI" research project, which aimed to test empirically whether GPs unintentionally discriminate against patients with a migration background and with mental health problems. More details of the project methodology are provided elsewhere (Duveau et al., 2023).

Figure 3. Patients played by actors in the video-vignettes in the survey.

GP respondents were invited to take part in an online survey on medical decisions involving mental health problems in primary care, but they were not aware that the principal purpose of the study was to assess the effect of the patients' migration background on the diagnosis and treatment of depression and referral to mental healthcare services.

The online survey collected participants' demographic characteristics and several individual and organisational factors.

Individual and interpersonal factors

At the individual level, we collected the GPs' age, sex (man or woman), and concordance of ethnic and migration backgrounds. The combination of the GP's birth country and that of their parents into a single variable enabled the classification of GPs into two distinct groups: those without a migration background (comprising GPs born in Belgium to parents of Belgian origin) and those with a migration background (including GPs born abroad themselves and/or having at least one parent born outside Belgium). The composite variable will be referred to as the "GP's ethnicity". We also collected GPs' explicit bias, which was assessed by measuring an explicit attitude of willingness to adapt care to diversity using the Hudelson scale (GPs were given a score ranging from 5, indicating that they placed

the responsibility to adapt care on themselves, to 35, meaning that they placed the responsibility on the patient with a migration background) (Hudelson et al., 2010).

At the interpersonal level, we also wanted to test Allport's theory that the more contacts we have with outgroup members, the more they will trust them and the less prejudiced they will be towards them (Pettigrew et al., 2011). We asked the GPs how frequently they had contact with migration-background patients with mental health problems. This was assessed using a scale ranging from 1 (never) to 5 (every day).

Regarding the interpersonal factors, we computed an indicator of interpersonal trust by asking GPs to what extent they believed that the patient in the video exaggerated his pain/distress (Burgess et al., 2008), made unreasonable demands (Moskowitz et al., 2011), and manipulated the visit to the GP for other purposes (Burgess et al., 2008), using a 5-point Likert scale ranging from 1 (very unlikely) to 5 (very likely). We then calculated the average of those three scores.

Organisational factors

We hypothesize that overwhelmed GPs in solo practices would have less time and thus take more cognitive shortcuts, i.e. simplify decision-making in complex situations, and that their medical decisions would be more affected by the patient's migration background (Lepièce et al., 2014; Stepanikova, 2012). We collected the type of practice (solo or group) in which the GPs spent more than 50% of their working time. We asked them whether their actual working hours matched their preferred working hours to assess their perceived workload, based on a validated scale (Kaldenberg & Becker, 1992). The score for perceived workload ranged from -1 to +1 with -1 meaning that they had a light or normal workload and +1 meaning that they considered their workload to be high.

Outcome measures

After the GPs watched one of the randomly allocated videos, we asked them several questions regarding the patient's diagnosis, the treatment they would have prescribed, and referral recommendations. These questions can be accessed in Appendix (see online publication). Regarding the diagnosis, GPs had to choose up to three diagnoses from among the following: schizophrenia, bipolar disorder, depression, anxiety, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, symptomatic and related disorders, and sleep disorders. In this study, we have only presented the results for diagnosis of depression, anxiety, and PTSD, because the literature demonstrates that the prevalence of these three disorders is higher among patients with a migration background. We also asked GPs to assess the severity of the actor in the video's symptoms on a scale from zero (very minor) to 10 (very severe). Treatment and referral variables were assessed on a 4-point Likert scale ranging from 1 to 4, with 1= not at all likely; 2= unlikely; 3= likely, and, 4= very likely. We asked them how likely they would be to prescribe a medical treatment, a non-medical treatment, and a combination of both for the patient in the video. We asked them how likely they would be to refer him to mental health care services.

Study population

GP participants were recruited by telephone in French-speaking Belgium between April 2021 and July 2021 (n=6112); we reached 2288 GPs, out of which we obtained informed consent to participate from 964. We only kept complete questionnaires with no scored-out answers, leaving us with 797 GP participants. Those who filled out the online survey to the end had a chance to win a €500 gift card. The survey's response rate was 13% (see Figure 4, which presents a flow chart of the GP participants in the survey).

The participating GPs were mainly women (63.5% of those who watched the video-vignette with the patient without a migration background and 64.5% of those who watched the video-vignette with the patient from a migration background), more than 70% were without a migration background, and roughly 45% were trainee GPs from Belgium's Dutch- and French-speaking communities. The average age of respondents was about 38 years (± 15). About half of the participants estimated their workload to be high and about 70% of participants worked in a group practice.

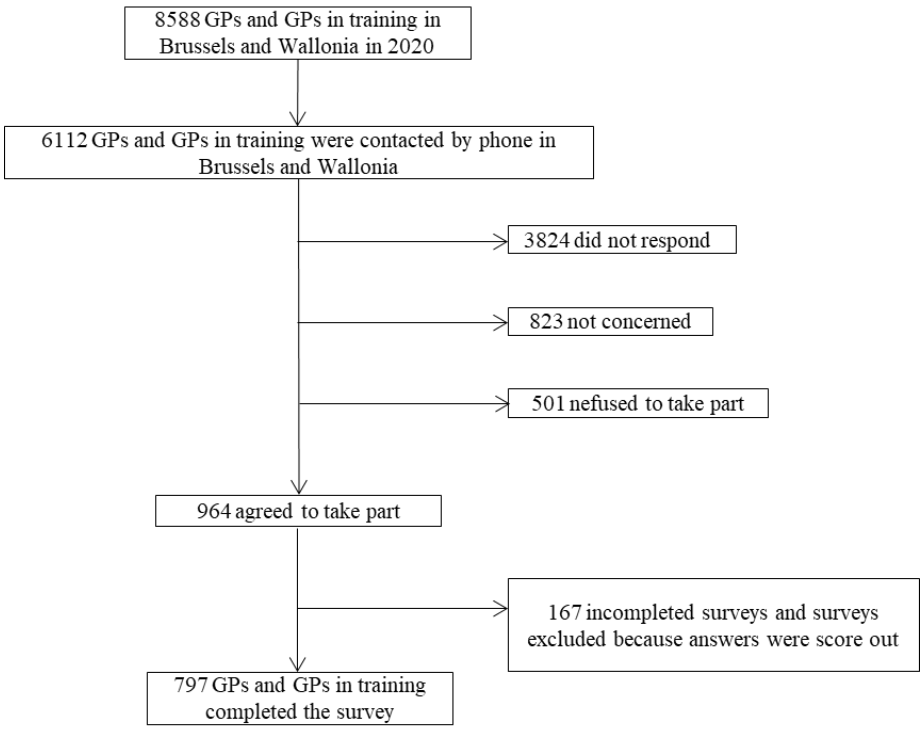

Figure 4. Flow chart showing participation in the sample process.

Statistical analyses

Descriptive statistics were conducted to examine the distribution of our sample. Then, several chi-square tests were computed to ascertain that the 50-50 allocation of vignettes remained unaffected by GP characteristics. Additionally, these tests aimed to verify that the allocation process of video vignettes, facilitated by Qualtrics®, adhered to a random distribution of the GP respondents regardless of their characteristics. We then assessed the effect of the patients' migration background on the GPs'

decisions using logistic regression for categorical variables, such as diagnosis, and an analysis of variance (ANOVA) for the continuous variables, such as the symptom severity and the likelihood to prescribe a treatment. Then, for medical decisions on which the patient's migration background was found to have a significant effect (p-Value <0.05), a moderated multiple regression was run to test two-way interactions statistically by regressing a dependent variable Y (medical decisions) on the independent variable X (migration background), the moderator variable Z (individual/interpersonal/organisational factors) and the product (interaction) term of X and Z (XZ; "migration background" x "factors"). To do so, we tested the interaction effect, between migration background/ethnicity and each factor, on each medical decision. The results of the logistic regression provided estimates for PTSD diagnosis, while ANOVA analyses yielded estimates for both symptom severity and the likelihood of prescribing medical and non-medical treatments. We also conducted a sensitivity analysis for the "frequency of contact with patients with a migration background" variable.

Finally, we calculated the effect size of the actor's ethnic background on medical decisions, using Cohen's d. A Cohen's d of 0.2 is considered as a small effect, 0.5 is a medium effect, and 0.8 is a large one. SAS 9.4 was used to perform all the statistical analyses.

Ethics consideration and consent statement

On 24 February 2020, the study and its methodology were approved. Written informed consent was obtained from all participants.

RESULTS

Table I presents the GPs' characteristics according to the ethnicity of the patient in the video (means, standard deviation, and the statistical test on the allocation of the video). The allocation of the video to GPs was not biased towards any GP characteristics, except for the frequency of contact with patients with a migration background ($F=9.36$, $p<0.05$).

Interestingly, GPs who watched the vignette with the patient with a migration background reported more frequent contact with patients with a migration background. We believe that this was due to the salience of the ethnicity of the actor in the vignette, which worked as a trigger and brought his migration background to the fore.

Table I. Sociodemographic description of the GP respondents according to the patient ethnicity in the video-vignette and statistical test on the random allocation of the video-vignette according to the patient ethnicity, Belgium, n=797.

Respondents' characteristic	Vignette of the patient without a migration background Mean (SD[a]) or %	Vignette of the patient with a migration background Mean (SD) or %	Statistical test F-test or χ2 (p Value)
GPs, n (%)	400 (50.2)	397 (49.8)	
Age (range = 24 - 79), years	38.5 (14.9)	38.0 (14.7)	0.21 (0.665)
Sex			0.08 (0.77)
Men	36.5	35.5	
Women	63.5	64.5	
Language			0.02 (0.88)
French-speaker	70.0	69.5	
Dutch-speaker	30.0	30.5	
GP's ethnicity			0.10 (0.75)
Without a MB (i.e. Belgian)	73.0	74.8	
With a MB (i.e. first or second-generation)	10.8	11.8	
Licence status			2.04 (0.15)
Licensed GPs	52.8	57.4	
GPs in training	47.2	42.6	
Experience (years)	12.3 (14.2)	11.9 (13.8)	0.15 (0.70)
Working schedule			2.07 (0.56)
Full time	88.3	84.9	
Half of normal working hours	3.7	5.3	
< Half of normal working hours	0.8	1.0	
Other	7.2	8.8	
Perceived workload			0.78 (0.38)
Light or normal	48.5	51.6	
High	51.5	48.4	
Type of practice (>50% of their working schedule)			2.23 (0.13)
Solo	32.5	27.6	
Group	67.5	72.4	
Type of area			0.95 (0.62)
Unknown	.	0.7	
Urban	11.2	12.3	
Sub-urban	26.0	28.0	
Rural	62.8	59.0	
Frequency of contact with patients with migration background (1: never to 5: everyday)	3.4 (1.4)	3.7 (1.3)	**9.36 (0.002)**

Respondents' characteristic	Vignette of the patient without a migration background Mean (SD[a]) or %	Vignette of the patient with a migration background Mean (SD) or %	Statistical test F-test or χ2 (p Value)
Hudelson score (5, 35)	21.3 (5.1)	20.9 (5.0)	1.02 (0.31)
Cultural competence training			
No	79.8	80.7	0.10 (0.74)
Yes	20.2	19.3	
The patient exaggerates his distress (1: not likely at all to 5: very likely)	2.3 (0.6)	2.2 (0.6)	0.97 (0.32)

[a]SD: Standard deviation.

Table II presents the results of medical decisions according to the ethnicity of the patient in the video vignette. Overall, we found that several medical decisions differed depending on the ethnicity of the patient in the vignette. We found no difference in depression diagnosis between the two vignettes ($\chi2=1.05$, $p=0.31$). We did, however, find that the prevalence of PTSD diagnosis was significantly higher for patients with a migration background (16% vs. 11% for patients without a MB, $\chi2=4.46$, $p<0.05$), alongside the diagnosis of depression, even though the two videos were similar in every way. The effect size of the patient's ethnicity on the diagnosis of PTSD was measured at 23.9%, indicating a small effect.

The symptoms severity assessment was quite high in both video vignettes. However, GPs systematically estimated the symptoms of patients with a migration background to be less severe than those without a migration background with a score of 7.79/10 and 7.53/10, respectively ($F=7.68$, $p<0.01$), corresponding to an effect size of 23%.

GP respondents were overall in favour of prescribing a treatment to both patients in the vignette. However, GPs were more likely to prescribe medical treatment and to prescribe a combination of medical and non-medical treatment to the patient without a migration background ($F=4.09$, $p<0.05$ and $F=11.55$, $p<0.01$, respectively). The effect size attributed to the actor's ethnicity stood at 26%, suggesting again a small effect of the patient's ethnicity on these medical decisions.

Table II. GPs' diagnostic decisions, treatment, referral recommendations, and time spent on the vignette.

	Vignette of the patient without a migration background Mean (SD[a]) or %	Vignette of the patient with a migration background Mean (SD) or %	Statistical test F-test or χ^2 (p Value)

Diagnosis			
Depression, %	98.5	97.5	1.05 (0.31)
Anxiety, %	42.3	36.5	2.74 (0.10)
Post-traumatic Stress Disorder (PTSD), %	**11.0**	**16.1**	**4.46 (0.04)**
Severity of symptoms, /10	**7.79 (1.03)**	**7.53 (1.18)**	**7.68 (0.006)**
Treatment (/4)			
Medical	**2.95 (0.66)**	**2.85 (0.75)**	**4.09 (0.04)**
Non-medical	3.65 (0.61)	3.71 (0.58)	2.29 (0.13)
A combination of both	**3.60 (0.60)**	**3.44 (0.65)**	**11.55 (<0.001)**
Referral (/4)			
Likelihood of referral	3.26 (0.69)	3.31 (0.68)	0.95 (0.33)
MANOVA (F-test, p Value)[b]	-	-	**3.56 (<0.001)**

[a]SD: Standard deviation.

[b]MANOVA: Multivariate analysis of variance.

Table III indicates the results of the multivariate logistic/linear regression analyses with the effect of individual, interpersonal, and organisational factors on medical decisions and the effect of those factors on ethnic differences in medical decisions. We present three medical decisions in Table III: the diagnosis of PTSD, the assessment of symptom severity, and the combination of medical and non-medical treatments.

Regarding the main effect of the individual factors, we found that being older decreased the likelihood to diagnose PTSD as a comorbidity of depression, but increased the likelihood to prescribe a combination of medical and non-medical treatment. Being a woman GP and having followed cultural competence training decreased the likelihood of being diagnosed with PTSD. At the organisational level, we found that the heavy perceived workload of GPs decreased the prevalence of PTSD, while a high workload increased the symptoms severity assessment and of prescribing a combination of treatments. The results also showed that working in a group practice increased the prevalence of PTSD while working in solo practice increased the likelihood to prescribe a combination of treatments.

At the interpersonal level, GPs who were distrustful of the patient were less likely to give a diagnosis of PTSD for the patient with a migration background and found the patient's symptoms to be less severe.

Regarding the interaction effects of these factors and ethnic background on medical decisions, we found that older and busy GPs and GPs with lower trust towards patients were more likely to give a diagnosis of PTSD for the patient with a migration background than for the patient without a migration background. Older GPs and ethnically discordant GPs were keener to prescribe a combination of medical and non-medical treatments to patient with a migration background. No significant

moderation effect was found on the assessment of symptom severity according to the ethnicity of the patient.

The models were not controlled for the "frequency of contact with migrant patients" variable because we attributed the significant association with the vignette to a methodology bias and the salience of the actor ethnicity. When, however, models were controlled for this variable (results not presented) in a sensitivity analysis (alternative model specification), we observed that the main effect of the "type of practice" variable became non-significant in the diagnosis of PTSD. We also observed that the main effect of heavy perceived workload had become non-significant in treatment prescription.

Table III. The effect of GPs' individual, interpersonal, and organizational factors on ethnic differences in mental health diagnosis, treatment, and referral recommendations, estimated coefficients from logistic regression and ANOVA.

	Diagnosis of PTSD (%Yes)[a]		**Severity of symptoms (/10)**		**A combination of both treatments (/4)[b]**	
Covariates	**B[c]**	**$CI_{95\%}$**	**B**	**$CI_{95\%}$**	**B**	**$CI_{95\%}$**
Main effect						
Age (10 years)[d]	**-0.05****	**(-0.09, -0.02)**	0.09	(-0.03, 0.21)	**0.04*****	**(-0.00, 0.08)**
Women (ref=Men)	**0.74***	**(0.01,1.48)**	-0.13	(-0.39, 0.14)	0.02	(-0.12, 0.15)
GP's ethnicity (ref=Without a MB)	-0.63	(-1.60, 0.35)	0.21	(-0.19, 0.62)	-0.04	(-0.24, 0.17)
Perceived heavy workload (ref=Light)	**-0.81***	**(-1.46, -0.14)**	**0.12***	**(-0.45, 0.39)**	**0.12****	**(-0.01, 0.24)**
Group practice (ref=Solo)	**0.99***	**(0.16, 1.84)**	-0.08	(-0.34, 0.19)	**-0.13***	**(-0.26, 0.01)**
Frequency of contact with patients with a migration background[e]	0.24	(-0.12, 0.60)	0.02	(-0.12, 0.16)	**-0.07*****	**(-0.14, -0.00)**
Hudelson score (5-35)	0.01	(-0.05, 0.07)	0.01	(-0.02, 0.03)	-0.00	(-0.02, 0.01)
Cultural competence training (ref=No)	**0.95****	**(0.27, 1.62)**	-0.43	(-0.86, -0.00)	**-0.38*****	**(-0.55, -0.20)**
The patient exaggerates his distress[f]	**-0.83****	**(-1.43, -0.24)**	**-0.19****	**(-0.40, 0.03)**	0.10	(-0.02, 0.22)
Interaction between patient with a migration background (ref=without a migration background) and:						
Age (10 years)[d]	**0.04***	**(0.00, 0.08)**	0.09	(-0.03, 0.21)	**0.06***	**(-0.00, 0.12)**
Women (ref=Men)	-0.43	(-1.37, 0.51)	0.11	(-0.27, 0.49)	0.02	(-0.17,0.21)

	Diagnosis of PTSD (%Yes)[a]		**Severity of symptoms (/10)**		**A combination of both treatments (/4)[b]**	
Covariates	**B[c]**	**CI95%**	**B**	**CI95%**	**B**	**CI95%**
GP's ethnicity (ref=Without a MB)	-0.53	(-2.28, 1.23)	-0.26	(-0.08, 0.28)	**0.38***	**(0.08, 0.66)**
Perceived heavy workload (ref=Light)	**0.88***	**(0.04, 1.73)**	0.22	(-0.16, 0.59)	0.04	(-0.14, 0.22)
Group practice (ref=Solo)	-0.28	(-1.39, 0.82)	0.046	(-0.34, 0.43)	-0.01	(-0.21, 0.19)
Frequency of contact with patients with a migration background[e]	0.06	(-0.43, 0.56)	*-0.09*	*(-0.29, 0.11)*	-0.05	(-0.15, 0.08)
Hudelson score	-0.03	(-0.11, 0.05)	-0.03	(-0.06, 0.001)	0.01	(-0.01, 0.03)
Cultural competence training (ref=No)	0.07	(-0.83, 0.97)	0.38	(-0.27, 1.04)	-0.00	(-0.26, 0.25)
The patient exaggerates his distress[f]	**4.15****	**(0.40, 1.90)**	-0.11	(-0.42, 0.20)	-0.09	(-0.27, 0.09)

[a]: These estimated coefficients come from a logistic regression, while the other come from an ANOVA. [b]: 4-point Likert scale from 1: not at all likely to 4: very likely
[c]: bold coefficients have a significant p Value; * means p Value < 0.05; ** means p Value < 0.01; *** means p Value < 0.001
[d]: Odds ratio associated with a 10-year increase in age
[e]: 1=less than monthly to 3=at least every week
[f]: 1=not likely at all to 5=extremely likely

DISCUSSION

Key findings

This research aimed to identify individual, interpersonal, and organisational factors that moderate ethnic differences in GPs' diagnosis, treatment, and referral regarding of patients with mental health problems. We hypothesised that less trusting GPs with a heavier workload who more frequently placed the responsibility to adapt care to diversity on the patient with a migration background would make more unfavourable medical decisions affecting patients with a migration background. We also hypothesised that ethnically concordant GPs would make more favourable medical decisions affecting patients with a migration background.

This experimental study found evidence of ethnic differences in mental health care. The results showed that the patient with a migration background was more often diagnosed with PTSD, that GPs found that patient's mental illness to be less severe and that GPs prescribed a combination of psychotherapy and medication less often for the patient with a migration background. Overall, we found a few variables that were associated with differences in medical decisions affecting a patient from a different ethnic background.

Older GPs were keener to diagnose the patient with a migration background with PTSD (as a comorbidity of depression) and were also more likely to prescribe a combination of medical and non-

medical treatment to that patient. GPs who had a migration background were more likely to prescribe medical and non-medical treatment for patient with a migration background. Another interesting finding was that a high perceived workload and lower trust in the patient significantly increased the likelihood of GPs diagnosing the migration-background patient with PTSD. The results of this study did not, however, reveal any moderating factors associated with the symptom severity assessment for the patient with a migration background.

Despite the small effects size, the main findings corroborate those of previous studies, showing that there is a clear effect between ethnicity and medical decisions in mental health (Anderson et al., 2014; Balsa et al., 2005; Bas-Sarmiento et al., 2017; Delaruelle, Buffel, et al., 2021; Duveau et al., 2023). Most of these studies have evidenced provider bias in mental health care but few of them have explained why and how that bias arises. Our study attempted to explain that bias and found that the provider's perceived workload and trust in the patient had a strong effect, especially on PTSD diagnosis for the patient with a migration background.

Individual, interpersonal, and organisational factors

This paper investigated three groups of factors: who the GP is, their dyadic relationship with the patient, and how they are organized. Among the individual factors, we found that age and ethnic concordance had a significant effect on ethnic differences in medical decisions. As shown elsewhere, GPs' age and their experience have an impact on their beliefs and therefore on their decisions (Balsa et al., 2005).

In our study, older GPs were slightly more likely to be influenced by their cognitive shortcuts and to associate the patient's migration background with a diagnosis of PTSD as a comorbidity of depression. Younger GPs may be more sensitive to diversity and aware of their cognitive shortcuts; they are less likely to associate PTSD with a migration background (Hall et al., 2015). It is also possible that older GPs encounter more patients with a migration background with PTSD in their consultations. They might, therefore, automatically associate such patients with a higher prevalence of PTSD, as has been shown in a previous systematic review and meta-analysis (Amiri, 2022). This mirrors other research that examined the impact of the provider's unconscious ethnic biases on the formulation of a differential diagnosis (Ashton et al., 2003). Taken together, these findings resonate with the broader concept of discrimination in mental healthcare. The automatic linkage between migration background and specific diagnoses, such as PTSD in this study, aligns with the larger body of research that highlights how preconceived notions, whether conscious or unconscious, can significantly shape medical interactions and outcomes (Drewniak et al., 2016; Lepièce et al., 2014; van Ryn et al., 2011). The potential influence of these biases underscores the imperative for continued efforts to address disparities in healthcare and tackle discriminatory practices perpetuating unequal treatment (Kapadia, 2023; Spencer & Grace, 2016).

Regarding the interpersonal factors, the level of trust expressed by GP respondents towards the patient did not exhibit variations based on the patient's ethnicity. However, this trust factor did play a role in elucidating the ethnic disparities in medical decision-making. This result was in line with those

of Moskowitz et al. (2011), who underscored the significance of interpersonal trust between primary care providers and patients in clinical consultations and subsequent medical decisions (Moskowitz et al., 2011).

The evident ethnic variation in diagnoses might be related to the disease prestige hierarchy that GPs associate with mental illnesses. This phenomenon, discussed by Album et al. (2017), underscores how the perceived prestige of various diseases can shape healthcare providers' attitudes. Depressive disorders, in particular, tend to occupy a lower position on the scale of disease prestige. This ranking places depressive disorders among the four-lowest-rated conditions, alongside fibromyalgia, anxiety disorders, and hepatocirrhosis (Album et al., 2017). Furthermore, people with mental health problems often encounter stigmatisation from healthcare professionals, leading to double jeopardy for those with a migration background, as noted by previous studies (Clement et al., 2015; Mittal et al., 2020; Schunck et al., 2015).

In light of these cumulative insights, it becomes apparent that concerted efforts and interventions are required to cultivate trust between GPs and patients with a migration background having a mental health disorder. We believe that delving into the qualitative aspect could yield a deeper understanding of GPs' discourse and relationship with patients, particularly those dealing with depression and who are from diverse migration backgrounds. Factors such as culture, language, and non-verbal cues and attitudes, not captured within the scope of our experimental survey, may significantly influence the GP-patient relationship (De Maesschalck et al., 2011).

At the organisational level, GPs with a heavier workload were less likely to diagnose the patient with a migration background with PTSD than the other patients. It can therefore be assumed that a heavier workload is partly responsible for the unintentional bias. Implicit bias may cause subtle changes in healthcare providers' behaviour, such as less frequent eye contact, shortened consultation times, or a lower likelihood of referral (Byrne & Tanesini, 2015). Furthermore, it has been shown that some conscious strategies designed to reduce implicit bias activation are less effective in situations of high cognitive load (Byrne & Tanesini, 2015). This is consistent with a systematic review which concluded that a balanced workload for GPs is an important prerequisite for establishing a beneficial relationship with patients, and thus making less discriminatory decisions (Busch et al., 2019). Finally, we believe that ethnically discriminatory practice is a dysfunctional way of coping with stress and that organisational measures should be taken to reduce GP workloads.

Strengths and limitations

The strength of this study is that it analyses differences in medical decisions using an experimental design that suppresses the confounding factors involving differences in patients' health status. That experimental design standardises symptom presentation differing socioeconomic status, and insurance, to focus on GP decision-making (Kales et al., 2005). We were able to control for differences in GPs' perceptions of PTSD diagnosis, in their assessment of symptom severity, and the prescribed treatment, according to the ethnicity of the patient.

One limitation of this study is the sample composition as it was mainly composed of young women working in group practices in rural areas. As a result, the magnitude of ethnic differences may have been underestimated as older male GPs are more prone to discriminatory practices. Further data collection might be required to include more "average 53-year-old GP" respondents working in a solo practice, who make up the majority of general practitioners in Belgium (PlanCad, 2019). This selection bias, previously identified in a meta-analysis, underscores the tendency of trainees (e.g. younger GPs) to exhibit higher response rates compared to their non-trainee counterparts (e.g. older GPs), probably due to the greater accessibility of the internet for engaging online surveys (Wu et al., 2022). Consequently, our study has exhibited an inclination towards younger GPs, potentially leading to an underrepresentation of the broader demographic of older GPs constituting Belgium's medical landscape.

Our modest response rates (13%) align with the results of a prior study on physicians which ranged from 10 to 13% (Taylor & Scott, 2019). The higher proportion of female respondents within our sample may have contributed to an underestimation of the observed ethnic disparities. A study has shown that male trainee GPs tend to exhibit more explicit ethnic biases towards individuals with a migration background compared to their female counterparts (Duveau et al., 2022). Throughout the phase of data collection, certain GPs declined participation in the survey, citing reasons such as perceived irrelevance of the mental health topic or time constraints. This mirrors findings documented elsewhere (Taylor & Scott, 2019) and offers valuable insights into its non-response to the survey. Theory suggests that older male GPs might harbour latent ethnic biases to a greater extent than their younger female counterparts towards patients with a migration background. However, our study does not allow conclusive determination in this regard. GPs who agreed to participate in our study potentially held predispositions towards these issues and might have displayed a heightened inclination towards mental health care compared to those who did not respond. This consideration underscores the necessity for replication of our study.

Another limitation is that we used staged video vignettes and an online survey to assess the GPs' management of migrant patients. The experimental design removed, or at least neutralised, the patient's context: his/her life story, frequency of eye contact with the GP, physical proximity, etc., as well as the GP-patient relationship, which constitutes a key element of mental health care in GPs' everyday practice (FitzGerald & Hurst, 2017). Previous studies have demonstrated, however, that the use of video vignettes rather than written vignettes may increase the accuracy of the probability estimates made by GPs (Evans et al., 2015).

CONCLUSION

This study expands our knowledge of the individual, interpersonal, and organisational factors that moderate ethnic differences in GPs' medical decisions relating to mental health disorders. This experiment identified explanatory factors of ethnic inequalities in mental health care: the GP's workload and their level of trust in patients with a migration background. While previous studies have focused on patients' trust in GPs, this research can serve as a foundation for future interventions and studies aimed at improving GPs' trust in their patients with a migration background. Further research is also needed to identify which factors influence ethnic differences in GPs' assessment of symptom severity and treatment prescription.

Finally, we believe that this work contributes to a more complete understanding of the effect of GPs' trust in their patients and of heavy workloads on medical decisions, especially regarding PTSD diagnosis. Future research should investigate the role of GPs' trust and workload in more depth in order to develop an intervention to improve the quality of care for patients with a migration background and reduce ethnic disparities in mental health care.

4.3. STUDY 2 – A critical discourse analysis of General practitioners' accounts of patients with a migration background suffering from depression

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INTRODUCTION

Over the past two decades, there has been a significant increase in migration across Europe. Belgium, like several other European countries, has been confronted with a substantial influx of asylum seekers particularly since the onset of the refugee crisis in 2015 (Myria, 2018, 2022). Therefore, the promotion of health equity and assurance of equity in care for people with a migration background and asylum seekers have emerged as significant policy objectives. This need is substantiated by several European studies that identify a higher prevalence of mental health problems such as depression, anxiety disorder and posttraumatic stress disorder among people with a migration background (Hadfield et al., 2017; Levecque & Van Rossem, 2015; Missinne & Bracke, 2012). Paradoxically, various studies have observed an underrepresentation of people with a migration background in ambulant and residential mental health care services (Bell & Zech, 2009; Buffel & Nicaise, 2018; Lepiece et al., 2014). Consequently, this underscores the significance of establishing enhanced accessibility to mental health care for these patients, thereby emphasizing the imperative for equitable care (Satinsky et al., 2019).

Previous studies have explained the underutilisation of mental health care services in relation to cultural, linguistic and structural barriers hindering patients with a migration background (Ahmed et al., 2017; Buffel & Nicaise, 2018; Ohtani et al., 2015; Paternotte et al., 2015). However, some studies have shifted their attention towards the role of provider bias among health care professionals regarding disparities in health care utilisation. Specifically in the US, researchers have focused on a possible provider bias that may contribute to ethnic inequalities (FitzGerald & Hurst, 2017; Van Ryn et al., 2006). In this sense, health care providers may apply unconscious stereotypes when assessing and referring patients with a migration background, consequently unintentionally contributing to disparities in mental health care use (FitzGerald & Hurst, 2017). Moreover, these unconscious stereotypes may also influence the medical encounter between general practitioners (GPs) and patients with a migration background. Although research on provider bias in the European context is scarce, several studies in the Belgian context offer evidence for provider bias among GPs (Ceuterick et al., 2020; Delaruelle, Buffel, et al., 2021; Lepièce et al., 2014). The studies by Ceuterick and colleagues (2020) and Delaruelle and colleagues (2021) draw attention to the significance to concentrate on the crucial gatekeeping role of GPs in order to overcome ethnic disparities in mental health care in Belgium. The Belgian health care system is organised according to the stepped care model. Consequently, GPs are often the first actors patients encounter in primary care. In this way, GPs are the main gatekeepers towards treatment and referral to more specialized mental health care services (Mistiaen et al., 2019).

This study aims to address the underutilisation of mental health care services of patients with a migration background by examining GPs' accounts of these patients and consequently, focuses on language. Language has a constitutive role in the set of social practices encompassing primary healthcare and thus, general practices. Language does not merely reflect the world, it actively shapes and engages in the construction of meaning (McCreanor & Nairn, 2002). Moreover, aligning with the principles of social constructionism, language comprises the power to construct and transform identities, knowledge and beliefs in interaction (Fairclough, 1992, 2013). Therefore, McCreanor and Nairn claim 'the study of language in action is a fruitful approach to understanding how power is manifest, implications for social practices and for social change' (2002, p. 510). This demonstrates the relevance to analyse the accounts of GPs regarding patients with a migration background and depressive symptoms. Since GPs work within the realm of dominant social institutions, this analysis will allow us to unravel the power relations and broader professional discourses influencing their accounts of these patients. Furthermore, GPs' discursive accounts of patients with a migration background suffering from depression may influence their decision-making regarding treatment and referral for these patients. Seymour-Smith and colleagues state 'in an important sense, health and illness are mediated through discourse' (2002, p. 254). This aligns with the epistemology of social constructionism within discourse analysis that discourse is constructive in the way that it enables GPs to actively construct certain versions of the world around them and to use wider societal, institutional or professional discourses allowing them to achieve various social practices (Edley, 2001). In line with GPs' role as gatekeepers is one of their basic responsibilities to provide patients with a non-judgemental medical encounter and a decision-making unbiased by prejudice or stereotypes (Farrell & Lewis, 1990). However, we argue from a social constructionist perspective that the accounts of GPs are constructed by using several discursive strategies to describe and position patients (such as those with a migration background suffering from depression, potentially even in a stereotypical manner (Farrell & Lewis, 1990; McCreanor & Nairn, 2002). For this reason, this study seeks to offer a unique contribution to the research on ethnic disparities in mental health care, by employing a critical discourse analysis of Belgian GPs' accounts regarding patients with a migration background with depressive symptoms. Therefore, we performed a discourse analysis inspired by the principles of critical discursive psychology (Edley, 2001; Potter & Wetherell, 1987) in order to (a) examine how GPs discursively construct their decision-making regarding patients with a migration background suffering from depression and (b) identify how GPs discursively position patients with a migration background suffering from mental health problems like depression.

METHODS

Contextualisation of the study

This article presents part of a comprehensive research project aimed at identifying and analysing GPs' accounts of patients with a migration background suffering from mental health problems, such as depression. The ultimate objective of this project is to formulate constructive recommendations in order to address (unconscious) stereotyping and to remove barriers to treatment and referral, thus ensuring improved accessibility for these patients. Since GPs are the crucial gatekeepers towards more

specialized mental health care services in Belgium, this article subsequently aims to examine the broader topic of discrimination and possible provider bias among GPs. Therefore, the focus of this article is on the discursive resources GPs draw upon when talking about consultations with patients with a migration background suffering from mental health problems and the related decision-making process. Our primary focus is on the ways in which these discursive resources are articulated and how they potentially perpetuate particular meanings and practices concerning their treatment and referral recommendations for these patients.

Data collection

In order to identify the discursive resources, 39 in-depth interviews with Belgian GPs were conducted in Flanders (Dutch-speaking part of Belgium), Brussels (capital region of Belgium with both Dutch and French native speakers) and Wallonia (French-speaking part of Belgium). The participants in the interviews included 29 general practitioners as well as 10 general practitioners who had completed their master studies in medicine and were currently in one of three respective training years to become a fully qualified general practitioner (we refer to them as 'GPs in training'). Moreover, we included both GPs working in rural and urban areas. Given the knowledge that GPs in urban areas have more experience in encountering patients with a migration background and asylum seekers, it is of importance to take this into account during the analysis of the data. Lastly, GPs could be part of a solo practice, a group practice or a community health centre or medical house. Solo practices are independent practitioners with their own practice, while group practices include several general practitioners working together. Community health centres or medical houses are acknowledged interdisciplinary centres. Therefore, these centres need to include at least GPs, nurses, and a physiotherapist. Moreover, these centres often also comprise social workers, primary care psychologists and other paramedical professionals. Their aim is to contribute to an open and solidarity-based society with a focus on diversity in all its aspects. Therefore, these centres adopt the principle of proportionate universalism to provide qualitative care to the health care needs of patients in their surrounding communities (VWGC, 2023). Table IV includes an overview of all participants per type of practice.

Table IV – Overview of interview participants per type of practice

Type of practice	General practitioners/in training
Solo practice	7 general practitioners - 3 Dutch-speaking - 4 French-speaking
Group practice	11 general practitioners - 4 Dutch-speaking - 7 French-speaking 3 Dutch-speaking general practitioners in training
Community health centre or medical house	11 general practitioners - 5 Dutch-speaking - 6 French-speaking 7 general practitioners in training - 4 Dutch-speaking - 3 French-speaking

The interviews allow us to investigate the professional GPs' accounts of patients with a migration background and asylum seekers. The interviews were carried out between December 2021 and June 2022 by the lead author (CW) and second co-author (CD), according to their respective mother tongue. During the in-depth interviews, we focused on the personal experiences and perceptions of GPs regarding treatment and referral of patients with a migration background and asylum seekers. A video vignette was used at the start of each interview, depicting a depressed Syrian asylum-seeking patient[6]. This video vignette was included to stimulate GPs to reflect upon their personal experiences and to elicit further discussion (Blackburn & Stathi, 2019). Moreover, we were inspired by the study of Blackburn and Stathi given their notion that "vignettes facilitate the exploration of topics which are often considered sensitive due to moral and ethical dimensions" (2019, pp. 167-168). The interviews were audiotaped and transcribed verbatim. The final transcripts were checked against the original audiotape and pseudonymised according to the informed consent protocol respondents agreed upon.

Data analysis – Theoretical assumptions of 'Critical Discursive Psychology'

Within this study, a discourse analysis based on the theoretical and methodological principles of Critical Discursive Psychology (here further referred to as CDP) is adopted. In her paper, Wetherell (1998) argued upon CDP as a discursive approach that focuses on both elements of post-structural discourse analysis and discursive psychology. Therefore, CDP includes a combination of the micro-analytic elements specific to discursive psychology investigating how discourse and interaction are

[6] The link to the video vignette used during the in-depth interviews with GPs: https://www.youtube.com/watch?v=Cv8yZgZkxtc&feature=youtu.be

forms of social action, and the macro-analytic elements of post-structuralist approaches considering socio-cultural and historical contexts of discourse (Edley, 2001; Locke & Budds, 2020; Wetherell, 1998). Consequently, CDP enables us to grasp a more complete analytic picture of the research topic. This demonstrates how Wetherell (1998) argued upon the necessity to consider both the situated nature of accounts and the institutional and social structures in which these accounts are constructed. In this way, the concerns more central to macro social constructionism are also considered in CDP by focussing on ideology and subject positions (Burr, 2015).

The focus of this study is on which interpretative repertoires GPs rely constructing their decision-making regarding patients with a migration background suffering from mental health problems. An interpretative repertoire is the first key concept of CDP (Edley, 2001). Potter and Wetherell defined interpretative repertoires as "basically a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events" (1987, p. 138). Since interpretative repertoires encompass a range of linguistic and discursive practices to construct meaning, this definition underlines this are relatively coherent ways of talking about objects and events in the world around us (Edley, 2001). Moreover, interpretative repertoires are characterized by a specific routine of argumentation, description and evaluation that can be recognized by familiar clichés or anecdotes (Seymour-Smith et al., 2002). Edley (2001, p. 198) also calls them 'the building blocks of conversation'. In discourse analytical terms, interpretative repertoires are a range of linguistic resources used within everyday social interaction through which people tend to develop different accounts of events and through which social life is performed (Seymour-Smith et al., 2002). In this way, different interpretative repertoires embody the linguistic a discursive resource that are available to GPs talking about patients with a migration background with mental health problems. Consequently, this leads to the existence of a basis for shared understanding.

Moreover, this study examines how GPs discursively position patients with a migration background with mental health problems in their accounts. This is related to the second fundamental concept of CDP, which pertains to subject positions. This concept finds its origin in the positioning theory, where Davies and Harré (1990) argue that who one is will always shift depending on the positions that are made available through language, in interaction and conversations. This demonstrates how people can be provided with a specific position to speak from and how this position allows them to position others as characters with distinct roles and rights according to the available interpretative repertoires (Davies & Harré, 1990; Seymour-Smith et al., 2002). Moreover, it is also of relevance for our study to consider that by applying a certain interpretation of cultural stereotypes within an interpretative repertoire, GPs can position patients with a migration background in the sense that "they are invited to conform" to this interpretation (Davies & Harré, 1990, p. 54).

A last key concept of CDP related to concerns that are more central to macro social constructionism is that of ideological dilemmas. Billig et al. (1988) characterize ideological dilemmas as situations where our thinking is shaped by dominant ideologies in society. In this way, ideological dilemmas are central to the complex understanding of individuals' subjective experiences and the institutional and social

structures they are embedded in. In the light of our study, GPs can be confronted with ideological dilemmas when encountering ideological contradictions or inconsistencies in their encounters with patients with a migration background or with broader societal or professional discourses. Using discursive devices and practices, GPs can make sense of conflicting ideologies and the relative positions they construct. Hence, the concept of ideological dilemmas emphasizes the notion of individuals actively engaging with and interpreting prevailing societal ideologies. Therefore, GPs' accounts can be oriented around different dilemmas. Consequently, the notion of ideological dilemmas offers the opportunity to examine how the intersection of ideology and discourse shape the sense-making processes by GPs and ultimately, how this influences their construction of their decision-making regarding patients with a migration background with mental health problems. Lastly, in our analysis, it is crucial to consider Edley's (2001) notion of ideological dilemmas, which highlights the awareness that various interpretative repertoires of the same social object can themselves be rhetorically constructed. In this sense, there is no certain claim that different ways of talking about this social object arise independently. Several ways of talking can develop together as opposing positions as part of an unfolding exchange reaching over time.

Data analysis – Analytic procedures

Since the main interest of this article is to identify the ways in which GPs deploy language to construct their decision-making, detailed readings of the body of transcripts were required. Therefore, in a first phase, we focused on familiarizing ourselves with the data through a thorough reading of the transcripts. This allowed us to discern which categories were invoked and in which different ways the topic of interest was discussed. Consequently, we identified the most prevalent themes and ways of talking in the interviews. Since CDP relates to concerns central to both micro and macro social constructionism, we focused on details in the text (i.e., use of vocabulary, modality and pronoun choices) and linguistic elements such as metaphors, figures of speech and rhetoric. This led to the identification of three interpretative repertoires stemming from the recognition of the main repetitive patterns and the utilisation of particular linguistic elements. The analysis proceeded with a focus on the positions that were made available through the identified interpretative repertoires, in order to establish specific subject positions. Lastly, these findings were used as a first framework in order to discern the availability of specific ideological dilemmas in the accounts of GPs and their relation to societal ideologies or broader societal and professional discourses.

FINDINGS

In the following sections, we present the results of our discourse analysis. Given our focus on the accounts of GPs and available discourse, it is important to mention that the quotes we present in this findings section have been translated from Dutch to English or from French to English. The translation of quotes in discourse analysis presents inherent limitations. Translations may not fully capture the sensitivities and nuances embedded in the original language, potentially leading to a distorted representation of the speakers' intent. Therefore, we have exercised caution in translating the quotes in order to ensure a high level of accuracy and integrity in our discourse analyses and to enable

ourselves and the reader to reflect upon the ideas and notions present in the identified repertoires.

We identified three interpretative repertoires available in GPs' accounts about consultations with patients with a migration background and asylum seekers and their related decision-making : (1) *the legal-political repertoire*, (2) *the humanising repertoire* and (3) *the culturalising repertoire*. These repertoires illustrate the presence of interdiscursivity[7] throughout the interviews, since they align with several broader professional and societal discourses. While *the legal-political repertoire and culturalising repertoire* align with values related to a neoliberal ideology, the *humanising repertoire* corresponds to values related to the biopsychosocial and patient-centred model in health care. This highlights the availability of several, sometimes conflicting discourses influencing the accounts of GPs.

Legal-political repertoire

A first repertoire we identified stems from the juxtaposition in GPs' accounts between patients with a migration background and asylum seekers. Although the concept of *"being Belgian"* is often mentioned by GPs, throughout this repertoire it becomes clear how this juxtaposition is mainly concerned with the notion of *"integration"* or *"being integrated"*. GPs refer to patients with a migration background as *"an integrated person"* and *"integrated in society"*, while asylum seekers are discursively positioned as *"immigrants (allochtonen)"* that are not integrated. Nevertheless, the following quote recognizes the notion that GPs may perceive asylum seekers as integrated individuals after they have resided in Belgium for an extended duration:

> *We've got, I don't have any refugees where I'm at for the moment, I might have one or two, but they've been here for years and they're completely integrated and I think they've even been here since they were young, so there are more cultural differences at that point* (male French-speaking GP working in group practice).

One of the GPs claims *"it is a more difficult treatment [for an asylum seeker] than for an integrated person"* (female Dutch-speaking GP working in group practice). This articulates how the juxtaposition between these patients influences the accounts of GPs on treatment for asylum seekers. Moreover, inherently linked to the notion of integration throughout the interviews is the notion of speaking the predominant language. Although this is more nuanced in the interviews with French-speaking GPs, since for a portion of asylum seekers French is already their native language, speaking the predominant

[7] The concept of "interdiscursivity" is widely discussed by Fairclough (2013) and refers to the notion that different discourses or ways of talking are interconnected and consequently, influence each other. Discourse can draw on elements from other discourses (such as wider political, cultural or social discourses) in order to construct meaning and power. In this way, interdiscursivity demonstrates how ways of talking are not isolated but are shaped by a network of discourses operating in society. Fairclough (2013) emphasizes that understanding interdiscursivity is crucial for critical discourse analysis, since it reveals how power is exercised through discourse. When different discourses intersect, they can reinforce or challenge existing power structures. In this sense, Fairclough's exploration of interdiscursivity underscores the complexity of discourse and its role in shaping social realities and power relations.

language is constructed as a necessary catalyst: *"because once they speak the language, all doors almost open, many doors open"* (female Dutch-speaking GP working in CHC), *"language leads to opportunities for work, knowledge about the health care system, functioning in society"* (female Dutch-speaking GP working in group practice).

The notion of integration is also questioned by several GPs, in the sense that they acknowledge possibilities for asylum seekers for integration are limited by several societal and political factors. Although they refer to societal and political factors, it is of interest that GPs often use the pronoun *"we"* when talking about these limitations:

> *It makes me lose my temper, when you experience such things, that people have a clear need for care and that they are not eligible because of political pressure and the like, because we oblige them to meet all the conditions they have to prove everything. [...] We are taking away those people's prospects. And we actually do that to those people all the time as Belgium or as Western countries, that we don't give them a chance to integrate. We have all kinds of demands, we have all kinds of suspicion and suspicion and mistrust. But, we don't give them a chance to settle in and move forward* (male Dutch-speaking GP working in group practice).

The personal pronoun *"we"* could be interpreted in the sense that GPs consider themselves part of the broader societal structures influencing the opportunity of asylum seekers to integrate. However, GPs do not position themselves in a way that would enable them to help asylum seekers to overcome these limitations. Rather, they utter a sense of frustration and disbelief: *"I think that for me, it's something that [opportunity of asylum seeker to integrate being influenced by political and societal factors] strikes me, that challenges me a lot"* (female French-speaking GP working in group practice). We can claim this repertoire aligns with values inherent to a neoliberal ideology on integration and the more conservative perspectives on civic integration. Neoliberalism places strong emphasis on individual responsibility to integrate into society and the health care system, including by learning to speak the predominant language.

Humanising repertoire

Within the GPs' accounts specifically about asylum-seeking patients, we identified the humanising repertoire. GPs acknowledge the difficult situation inherent to being an asylum seeker, by adopting a humanising lexicon that portrays the powerlessness of asylum seekers: *"The fundamental uncertainty is overpowering"* (female Dutch-speaking GP working in CHC), *"that burden of being in a foreign country without many rights, the family that is often left behind. Those worries are so big that they can no longer be bearable"* (female Dutch-speaking GP working in group practice), *"they are people who are lost. They have no point of reference. They don't feel accepted and besides, like here, there's nothing to do, well, they feel all alone"* (male French-speaking GP working in group practice), *"it is a population in which we regularly find very great distress with terrible life courses"* (female French-speaking GP

working in CHC). It becomes clear how the accounts of GPs construct patients with an asylum seeking background in a passive manner by using strong language to emphasize their difficult living situation. Moreover, we identified a pattern of empathic language-use regarding these patients:

> *Finally, I thought to myself, I imagine myself in a country and then here, I am told 'well stay in your corner, don't move, shut up and manage yourself'. We can't live like that, nobody, the Belgians either. That said, I think that's a huge problem in our society. It's all these people that we push, that we force to be inactive* (female French-speaking GP working in group practice).
>
> *The situation that those people are in is, I don't think we would sleep anymore either* (female Dutch-speaking GP working in group practice).

These quotes illustrate the availability of solidarity markers in the accounts of GPs regarding asylum seeking patients. Both a female French-speaking and a female Dutch-speaking GP working in a group practice express understanding of the situation of asylum seekers and establish a sense of shared concern by bridging the gap between their own perspective as GPs and the experiences of asylum seekers (*"I imagine myself"* and *"I don't think we would sleep anymore either"*). Although solidarity markers might be an indication of mobilising support for asylum seekers, GPs construct themselves as "powerless" regarding the situation of these patients:

> *Often we are powerless, but you have to see them and often become, often it is the case that they do not feel that they, that the doctors and other social workers and the like see them, that they are human beings who are completely as human being is regarded with the same rights and obligations as someone else* (male Dutch-speaking GP working in group practice).

When talking about their specific decision-making regarding asylum seekers with depression, this repertoire is also present in their accounts. GPs construct their decision-making with empathic and solidarity linguistic devices, by stating they will have to take into account *"the fragility"* (female French-speaking GP working in group practice) of these patients and their *"migration path"* (female French-speaking GP working in CHC). Most of the GPs agree that a mere medical treatment in this case is not *"the right solution"*:

> *It is clear that the symptomatology that is described [in the video vignette] is something that could not be more common and that we are very powerless to treat it because it makes no sense to treat it with medication, it is treating its share of the time by empathy, by listening, they have to tell what happened to them as long as they haven't filed this, they will have all these physical symptoms, which are related to stress* (female French-speaking GP working in solo practice).

> *But clearly only medicated, with people who've been through what they've been through, who often don't feel ready to actually talk about it, because it's too much, it's too traumatic. I think just putting on a medicated bandage is clearly not the right solution* (female French-speaking GP working in solo practice).

In this way, we identified an interpretative repertoire characterized by several linguistic and discursive devices constructing asylum seekers as direct objects without any agency regarding their situation. While a certain empathy is present in the accounts of GPs, they themselves are positioned as *"powerless"* and are in this way considered to have no agency either. It can be interpreted in the sense that this repertoire is built on the values of empathy, solidarity and the acknowledgement to humanise patients, related to broader health care discourses of the biopsychosocial and patient-centred care model. However, GPs still feel constrained by wider societal factors complicating the care for patients with an asylum seeking background and consequently, attribute responsibility to external factors.

Culturalising repertoire

A last repertoire we identified is related to multiple difficulties GPs experience during encounters with patients with a migration background and asylum seekers regarding their cultural background. This repertoire comprises several notions related to cultural difficulties GPs experience. The following quote resembles these multiple notions:

> *Clearly this kind of complaint: 'I have a headache, I have pain while urinating but finally there is nothing in the urine, I have a stomach ache'. These are really things that we struggle to pinpoint. But we quickly come to turn to the psychological aspect of the symptoms. And there, that poses a problem, because we don't really know how to take care of them at the psychological level, because the vocabulary is not there and because it's mainly culturally, we don't really know how to approach it. These are people who don't really want a psychologist or other support. Finally they often have this desire to have a medicine that fixes everything. And this belief, in my opinion, that the medication will fix everything, even though it is never the case. For psychological concerns, I prescribe very little medication at this level because it does not work. It's a small help, but the most important thing is the therapies that go around it. But no one wants to take them on since no one knows how to approach them and finally knows how to talk to them* (male French-speaking GP working in group practice).

In the subsequent sections, we will employ this quote as a scaffold to discuss the different aspects concerning the cultural challenges encountered by GPs.

COUNTERING THE PHYSICAL TRAIL TO THE PSYCHOLOGICAL TRAIL

First of all, this repertoire is identified in the accounts of GPs about difficulties regarding the understanding of the medical problem as a psychological or mental health issue. This is present in the quote above: *"These are really things that we struggle to pinpoint"*, and is also supported by a statement of a male French-speaking GP working in a solo practice:

> *The entry point is very often centred on general pains and the pains are somewhat diffuse, with its ubiquitous characters but at the same time remaining very very vague. [...] It is not easy to be able to make them understand, to make them admit that the problem is not physical. Often there, indeed, there are difficulties.*

In this way, we have identified a juxtaposition between the health beliefs of patients with a migration background and the health beliefs of GPs. The use of the pronoun *"we"* when talking about GPs, illustrates the construction of a shared sense of belonging which also consolidates the professional positioning in GPs' accounts. This professional positioning is also present in the caption by a female French-speaking GP working in CHC: *"So it depends on whether they can, like me, grasp the idea that perhaps the headaches come from lack of sleep, which in turn stems from the anxiety caused by what's happening behind the scenes".* The construction *"like me"* invokes the position of GPs as the experts with the necessary knowledge to claim there is a psychological problem present. At the same time, we identified a compelling lexicon when GPs are talking about making clear to patients they have a psychological problem: *"to make them understand, to make them admit"* (male French-speaking GP working in solo practice), *"to make them accept"* (female French-speaking GP and female Dutch-speaking GP working in group practice). This pattern aligns with the expertise position of GPs having the powerful knowledge to understand this is in fact a psychological problem and not a mere physical issue. On the other hand, when talking about patients with a migration background in this regard, GPs mainly use pronouns like *"them"* or *"they"*. In this way, the juxtaposition between GPs and patients with a migration background is again consolidated by the language-use of GPs. Here, we also identified a lexicon by which GPs position patients with a migration background as uncooperative:

> *But in fact, as soon as we touch on something more cultural where I think even they do not capture the issues. Well, they go and say 'Why would I go to see a shrink? I have a headache doctor'* (female French-speaking GP working in CHC).
>
> *Well, there are certain patients who don't accept having psychological problems, they come with somatic complaints, and it sometimes takes a very long time to agree to say 'well, okay'* (female French-speaking GP working in group practice).

Another interesting finding related to this repertoire is one of the French-speaking GPs mentioning the concept of "the Mediterranean syndrome":

> *On the other hand, when there is this cultural shock or moreover: they have all the symptoms, finally what is sometimes called the somewhat Mediterranean syndrome. I find, in fact, for me, I'm sure, it must be related to a malaise which means that in some cases, migration brings so much suffering that in fact there are symptoms like fibromyalgia or stuff like that that will cause a lot of pain, in fact, sometimes it's so hard to make the patient understand there might be a psychological component, that it's irritating, in my opinion* (female French-speaking GP working in CHC).

This is a remarkable expression, given the fact that *"the Mediterranean syndrome"* is a dated concept in medicine (Ernst, 2000) and a cultural prejudice that is still present in the French medical world (Lambert et al., 2022). The concept refers to the fact that minorities migrated from around the Mediterranean sea will exaggerate their complaints and pain, leading to a failure of the medical encounter and the coherent decision-making process. In this way, this is a clear example of cultural stereotyping by a GP. We can observe how the GP tries to mitigate this claim by using several hedging devices: *"the somewhat"*, *"for me"*, *"in my opinion"*. These latter two devices try to mitigate what is expressed by acknowledging the personal viewpoint of the GP, indicating this is a subjective opinion and may not be universally held by GPs.

WESTERN MEDICINE IS ALMIGHTY

A second notion related to this repertoire is that of *"Western medicine being almighty"* (female French-speaking GP working in solo practice). As present in the capturing quote above by the male French-speaking GP working in group practice, GPs often refer to the fact that patients with a migration background *"have this desire to have a medicine that fixes everything"*. In this way, the repertoire is characterized by language-use referring to *"the magical aspect of medication"* (male French-speaking GP working in solo practice), *"a small pill that will solve everything"* (female French-speaking GP working in group practice) or even the metaphor of *"magic wand pill to make your headache go away and make you sleep well"* (female French-speaking GP working in group practice). This illustrates the same juxtaposition between the beliefs of GPs and those of patients with a migration background, in this case with a focus on the role of medication regarding mental health issues. Throughout the accounts of GPs, pronouns as *"we"* and *"ours"* are used to construct GPs as experts and in order to recognize their medical expertise: *"We still do have our own way of functioning in our medicine"* (female French-speaking GP working in group practice). In this way, a similar professional positioning of GPs is present as to the notion of countering the physical trail to the psychological trail. Moreover, we identified several expressions of reported speech in which GPs attribute compelling speech to patients with a migration background:

> *But it's true that there, for me, I see among first-generation Africans or Maghreb, it's often, well, Western medicine is almighty: "You have scanners, you have plenty of things, so you must find out what I have in fact." It's a bit more difficult for them to hear that it's something*

> *functional, that there's nothing actually damaged* (female French-speaking GP working in solo practice).

This quote exemplifies how the perception of Western medicine as all-powerful encompasses not only the expectation for medication that can resolve issues, also the belief among migrant patients that Western medicine includes various physical examinations as a solution to their mental health problems is present. Furthermore, similar compelling indirect and direct reported speech is used by several GPs talking about the request for mere physical examinations by patients with a migration background:

> *They will insist, they will imagine, finally they will ask to do a CT scan, an MRI, to go to the neurologist, to say that there is something serious, that we cannot find what they have, that it's, that it's not going well, finally they will be very demanding of essentially medical care. And when we address the fact that there may be a link with insomnia and stress, that post-traumatic stress can cause these kinds of symptoms, very often, people disconnect and go back into the physical. So it's as if they're closing the door like we can't talk about that. […] I can imagine saying, "Yes, we'll do a scan, we'll run tests". For us, it's our way of ruling out serious conditions. And then, if the complaints persist, we would like to address the more psychological aspects, the life-related issues. But then, sometimes, we hit a wall where we don't know what to do, but at the same time, the person keeps coming back with the same complaints. The person closes off that possibility, and that's where we constantly find ourselves confronted. Sometimes it's exhausting because we think "What else do you want me to do for you?"* (female French-speaking GP working in group practice).

By adopting reported speech, GPs are able to also present their personal viewpoint on this matter in an indirect way, shifting the emphasis and responsibility towards the beliefs or perspective of patients with a migration background. Therefore, we claim this represents a discrepancy between the health beliefs of patients with a migration background and those of GPs, from a professional position as medical experts. This aligns with the findings regarding the notion discussed above. The compelling lexicon from the perspective of the patients, also underscores how patients in this repertoire are constructed as active agents engaging in the decision-making process for their treatment. However, given the compelling character of the language-use and the way in which GPs refer to be obstructed by the desire of patients with a migration background for physical examinations and medication, they are not considered as active cooperative agents in the medical encounter.

THE NOTION OF VOCABULARY

Lastly, there is the notion of vocabulary related to this repertoire. In his account above, the French-speaking GP states: *"because we don't really know how to take care of them at the psychological level, because the vocabulary is not there and because it's only culturally, we don't really know how to approach it"*. Similar references can be identified in the accounts of several other GPs:

> *I think people function differently in their way of thinking, their conception of health, of illness and also, as I said, of the healthcare system* (female French-speaking GP working in group practice).
>
> *They have codes that are different, codes of life that are different. They don't necessarily understand, for example, that well, even in the way we practice, huh, it's finally sometimes, sometimes they're going to be more demanding, so they have to be seen right away, et cetera* (female French-speaking GP working in CHC).

The conceptions of *"vocabulary"* and *"codes"* illustrate a semantic difference with *"not speaking the predominant language"* (available in the legal-political repertoire). These concepts refer to the knowledge of meanings and the usage of words in various contexts. Therefore, we can claim this aligns with the notion of *"health literacy"*, to which some GPs literally refer in the interviews. Although speaking the language or language proficiency is also of importance to comprehend information in a medical encounter, vocabulary or codes may refer to understanding specific terminology in communication with health care providers like general practitioners. Consequently, vocabulary is a crucial component of health literacy. The excerpts above may illustrate the discrepancy between the level of health literacy of patients with a migration background and the expected level by GPs, due to different conceptions of health, illness and the organisation of the health care system. Once more, a positioning of GPs as medical experts possessing knowledge and expressing certain expectations towards patients with a migration background is available in this repertoire. While, general practitioners acknowledge they can take on the role of health advocates, the responsibility to fulfil this expectation is appointed to the patients with a migration background themselves by some of the GPs:

> *For me, that is something essential. I think it's something essential to make the patient responsible for his disease. There is often, and there too I find according to cultural origins, the tendency of distinguishing between the disease, which is somewhere external, that we will treat and then everything will be better. And no, as in this kind of situation too, no, that's a whole. And so it's true that it's precisely on this that we try to work and make them understand how they themselves can change certain things to get better for all pathologies; diabetes, hypertension, chronic pathologies that are related to lifestyle. Here too, finally, it is super important. And for me, it is essential that the person can understand what is going on within them to help them also do their share of the work, so to say, in getting better* (female French-speaking GP working in group practice).

Conclusively, we claim this repertoire aligns with values inherent to the biomedical model in health care and neoliberalism. The powerful positioning of GPs as medical experts relates to the biomedical model, while the attribution of responsibility regarding health literacy to patients with a migration

background illustrates values complying to a neoliberal ideology in (mental) health care.

CONCLUSION

The analysis allowed us to identify three interpretative repertoires related to consultations with patients with a migration background and asylum seekers and the related decision-making by GPs. First, *the legal-political* and *culturalising repertoire* align with values related to neoliberal ideology available in the field of (mental) health care. The legal-political repertoire illustrates a contrast drawn between patients with a migration background and asylum seekers, primarily revolving around the notion of (civic) integration. This concept significantly influences how GPs frame their decision-making concerning the treatment of asylum seekers, as it prompts consideration of the challenges faced by less-integrated asylum seekers in accessing health care. Similar neoliberal values are identified in the culturalising repertoire, this is made clear in both the juxtaposition between health beliefs of GPs and patients and the uttered discrepancy between the level of health literacy among patients with a migration background and asylum seekers and the expected level of health literacy by GPs. In these excerpts, GPs are portrayed as medical experts and tend to shift the responsibility the patients themselves. Moreover, a major expression we identified in the culturalising repertoire was that of "the Mediterranean syndrome". This expression was a clear example of cultural stereotyping in which GPs decision-making may be influenced by cultural prejudice regarding patients with a migration background and asylum seekers. Furthermore, it is apparent how this repertoire is built around the dilemma of the need for patients with a migration background and asylum seekers to adapt themselves to Belgian society and the organisation of the Belgian health care system.

At the other hand, we identified the availability of the humanising repertoire in the accounts of GPs. This repertoire is related to broader health care related discourses of the biopsychosocial and patient-centred model. Deploying a humanising lexicon, GPs acknowledge the difficulties inherent to being an asylum seeker and portray them as powerless subjects. This influences their decision-making regarding these patients, since GPs refer to the necessity to take into account "the fragility" of these patients and indicate mere medical solutions are not "the right solution". However, at the same time, GPs also position themselves as powerless in the sense that they feel constrained by wider societal and political factors complicating the care for these patients. In this way, they attribute responsibility to external factors. This illustrates the way in which this repertoire is built around the dilemma of our current migration policy.

Lastly, we claim this analysis articulates the availability of a relatively high level of interdiscursivity. During this analysis we have identified several and sometimes conflicting discourses in the accounts of Belgian GPs regarding patients with a migration background and asylum seekers and their coherent decision-making.

4.4. STUDY 3 – A Foucauldian discourse analysis of Belgian policy regarding patients with a migration background and depression in general practices

Wets, C., Delaruelle, K., Bracke, P. & Ceuterick, M. – This study has been accepted in 'Health: An interdisciplinary Journal for the Social Study of Health, Illness and Medicine' and is – at the moment of finalizing this report – undergoing the proofreading process.

INTRODUCTION

Depression is one of the most present mental health disorders in Belgium. Almost one in ten Belgians (9.4%) suffers from depressive disorder and 4.8% of the Belgian population suffers from a major depressive disorder (Gisle et al., 2018). Within the Belgian population, it is especially important to focus on people with a migration background. Several European studies have found a higher prevalence of mental health problems such as depression, anxiety disorder, and posttraumatic stress disorder among people with a migration background (Bhugra & Jones, 2001; Hadfield et al., 2017). Studies by Levecque and Van Rossem (2015) and Missinne and Bracke (2012) confirm these findings within the Belgian context. Nevertheless, people with a migration background are still underrepresented in both ambulant and residential mental health care services (Buffel & Nicaise, 2018). This underrepresentation shows that the mental health needs of this population are likely to remain unmet, and highlights the need to create more equal access to mental health care for patients with a migration background (Bell & Zech, 2009; Satinsky et al., 2019).

The majority of international and national studies suggests that the utilisation of mental health care by people with a migration background is hindered by cultural and linguistic barriers (Ahmed et al., 2017; Ohtani et al., 2015; Paternotte et al., 2015). In addition, the underutilisation of mental health care services is also due to structural barriers such as a lack of financial resources, long waiting lists and limitations in health insurance coverage (Buffel & Nicaise, 2018). Next to structural and cultural barriers, some studies focus on the possible contribution of health care providers to disparities in health care utilisation (Lepiece et al., 2014; Stepanikova, 2012). The last decade, several researchers have come to assume that general practitioners (here further referred to as GPs) may contribute to the ethnic disparities in mental health care use by applying stereotypes when assessing and referring depressed patients with a migration background that may unintentionally lead to a treatment that differs from other patients (FitzGerald & Hurst, 2017). However, research on possible provider bias among GPs in the European context is limited. Nevertheless, studies suggest evidence of provider bias among GPs in the Belgian context (Ceuterick et al., 2020; Delaruelle, Buffel, et al., 2021; Lepièce et al., 2014). The main findings of their research indicate that GPs generally assess a Belgo-Moroccan patient as less trustworthy and believe this patient shows less therapy adherence compared to a native Belgian patient. Moreover, these studies suggest that GPs hold more pessimistic views on the potential of patients with an asylum seeking background to recover from severe depression. The studies of Ceuterick et al. (2020) and Delaruelle, Buffel, et al. (2021) underscore the importance to focus on the crucial gatekeeper role of GPs to potentially reduce ethnic disparities in Belgian mental health care.

Since the Belgian health care system is organized according to the stepped care model, GPs are the main gatekeepers towards treatment and referral to specialized mental health care services (Mistiaen et al., 2019). In this way, GPs are considered the most important actors in primary care. Furthermore, it is essential to acknowledge the duty of GPs to treat every patient equally. Since GPs take the Hippocratic Oath at the beginning of their careers, they swear: *"To fulfil their duties towards their patients without regard to age, illness or disability, religion, ethnic origin, nationality, political opinion, race, sexual orientation, social status or any other factor and to strive for health care that is accessible to everyone"* (Orde der artsen, 2021).

This article is part of a broader research project with the ultimate objective to identify and interpret GPs' accounts of patients with a migration background suffering from mental health problems, and to formulate constructive recommendations to eradicate unconscious stereotyping and consequently to eliminate accessibility barriers to treatment and referral for these patients. Given the crucial role of GPs in the Belgian health care setting, the broader aim of this article is to investigate the topic of discrimination and possible (unconscious) bias in the context of general practices. We will focus on the emerging patterns evident in policy documents regarding patients with a migration background and depression in general practice to identify broader professional discourses on which GPs might rely when speaking about these patients. We claim it is of importance to investigate the dominant discourses at policy level, resonating the notion by Seymour-Smith and colleagues that *"stereotypes or dominant discourse are powerful in the way that they set the horizon for what can be articulated or thought in any relevant context"* (2002, p. 265). Moreover, the provision of policy documents by professional associations, scientific centres and governmental institutes demonstrates that discourses are inevitably linked to certain institutions regulating the conduct of professionals within the scope of these institutions (Shaw & Greenhalgh, 2008). Consequently, next to their individual experiences and their professional setting, GPs' accounts may be discursively influenced by the wider professional discourses present in policy documents (Shaw & Bailey, 2009). This complies with the social constructionist epistemology within discourse analysis that discourse is constructive in the way that it enables people to actively construct certain versions of the world around them and to use wider societal, institutional or professional discourses allowing them to achieve various social practices (Edley, 2001). Hence, language constructs social realities.

In this way, this present study aims to contribute to the field of research on ethnic disparities in mental health care in an innovative way, by adopting a critical discourse analysis of Belgian policy reports and articles regarding patients with a migration background and depression in general practice. This discourse analysis based on the principles of Foucauldian discourse analysis (Willig, 2013) is performed to (a) identify broader professional discourses in current Belgian policy reports and articles regarding patients with a migration background in the general practice, (b) examine how patients with a migration background are discursively positioned within the current Belgian policy reports and articles and, (c) investigate which different balances of power in the relationship between GPs and patients with a migration background are available in the identified discourses. Finally, these findings will allow us to investigate whether GPs' accounts are discursively influenced by the identified professional

discourses in a later publication. Foucault's notion of the clinical gaze according to Lupton underscores why future research is relevant:

> *There is no such thing as an 'authentic' human body that exists outside medical discourse and practice. Rather, the body and its various parts are understood as constructed through discourses and practices, through the 'clinical gaze' exerted by medical practitioners* (Lupton, 2002, p. 99).

By implementing the notion of mental health to the quote above, the importance to examine whether similar patterns are present in the discursive constructions of GPs and how they are possibly influenced by policy discourse at the institutional level becomes even more clear.

Contextualisation of the Belgian policy setting

In Belgium, several actors provide policy guidelines and recommendations regarding primary care. First, there is the Belgian Health Care Knowledge Centre (KCE). This independent research centre states their mission is to carry out rigorous and objective scientific studies in order to advise policymakers and health care providers, specifically in the field of both health care and health insurance (KCE, 2020). Consequently, KCE is not involved in the process of decision-making or implementation of policy. Second, there is Domus Medica. This non-profit organization promotes the interests of all GPs in Flanders (Dutch-speaking part of Belgium) and Dutch speaking GPs in Brussels (capital region of Belgium with both Dutch and French as native languages) on a scientific and societal level through scientific substantiation and promotion of the development and realization of patient-oriented health care and care policy. One of the pillars of Domus Medica is to conduct scientific research in relation to general practice medicine and interdisciplinary cooperation at the level of primary and secondary care. These scientific reports and guidelines are made available on their website to support GPs in improving their quality of care. Moreover, this professional association has its own two-monthly scientific journal and can be freely consulted by GPs. Also, Domus Medica supports several regional groups of GPs in Brussels and Flanders. These groups are considered as the most important communication channels between Domus Medica and its individual GPs. Each of those regional groups consists of several 'local quality groups' and focus on educating and involving GPs in scientific research (Domus Medica, 2022). In this way, Domus Medica has a major influence on the accounts of GPs, educating and informing them about important topics concerning the field of primary care.

The notion of migration in Belgium

Over the last century, Belgium has known a significant influx of migrants. This migration influx started in the 1960s with a large inflow of Moroccan and Turkish labour migrants due to a shortage of workers (Lievens, 2000; Reniers, 1999). This has led people of Moroccan descent to still be the largest established migrant community in Belgium (Myria, 2018, 2022). Furthermore, given the refugee crisis in 2015, Belgium faced an extensive flow of asylum seekers often in need for protection coming from conflict-affected countries. In this way, Afghans (17%) and Syrians (10%) are the largest group of

asylum seekers, next to Ukrainian nationals requesting for protection (Myria, 2022; Vlaanderen, 2023). In Belgium, a relevant distinction is made between people with a migration background and asylum seekers. In legal documents people with a migration background are often indicated as people from foreign descent, which refers to persons born in Belgium with a foreign or double nationality or born-abroad persons that later obtained the Belgian nationality (Myria, 2022). Notable legal disparities between asylum seekers and patients with a migration background contribute to their different circumstances, potentially rendering asylum seekers more vulnerable to mental health issues (Delaruelle, Buffel, et al., 2021). Unlike patients with a migration background, asylum seekers do generally not qualify for health insurance. The majority of their medical expenses is covered by the Federal Agency for the Reception of Asylum Seekers (Fedasil) or is paid by a public centre for social welfare (Agentschap Integratie & Inburgering, 2022b). Lastly, there is the distinction between the two aforementioned groups and people without a legal residence permit. These people are illegal inhabitants of Belgium and legally different from people with a migration background and asylum seekers in the sense that they are only eligible to "urgent medical care" (Agentschap Integratie & Inburgering, 2022a)."

ANALYTICAL FRAMEWORK

The data collection and analysis of this study were informed by the epistemological framework of a Foucauldian approach to discourse analysis (Willig, 2013). The core of discourse analysis is to critically analyse the use of language and the coherent reproduction of dominant ideologies in discourse (Lupton, 2010), which aligns with Foucault's interest to not exclusively reduce discourse to meaning (Foucault, 2013). Foucault defines discourse as *"including statements and systems of statements that are power-laden, persuasive, employed strategically, and part of social practices, interactions, behaviors, and ways of being"* (Bischoping & Gazso, 2015, p. 131). Foucauldian discourse analysis (FDA) is thus also inherently concerned with the notion of power, since power relations are embedded in this process of in- and exclusion (Khan & Maceachen, 2021). Furthermore, Foucault sees language as but one instance of these power relations and sees texts "*as manifestations of knowledge and power relations that govern social reality"* (Bischoping & Gazso, 2015, p. 130). In this way, power produces the way we construct both ourselves and others in society. Therefore, power is both relational and productive (Foucault, 1990). Simply put by Khan and Maceachen *"Foucauldian discourse analysis is concerned with power, which investigates how particular discourse systematically constructs a version of the social world"* (2021, p. 5). Specifically, FDA considers how language constructs certain realities (Cheek, 1999) and consequently reproduces and legitimizes existing power relations in a specific socio-cultural and historical context (Sims-Schouten et al., 2007; Willig, 2013).

Given that dominant discourses can privilege these legitimizing constructions of social reality (Willig, 2013), we claim it is auspicious to apply FDA to policy documents regarding the topic of patients with a migration background and depression in general practices. FDA is able to critically question how policy formation is affiliated with changes in broader society and stakeholders (Sharp & Richardson, 2001) and, therefore is a valuable analytical method in (health) policy research. FDA will allow us to

address the dominant understandings and power relations available in the policy documents by which GPs' accounts may be guided and, to question the legitimation of certain existing power relations. Considering FDA's concern with power, we claim that two critical elements of Foucault's analysis of power in medical institutions are of importance when discussing the subsequent findings of our analysis. First, we consider the concept of "the clinical gaze", which refers to the specific manner in which medical professionals observe and examine their patients (Foucault, 2003). The clinical gaze, creates the object of knowledge as well as the one who sees or knows. By focussing on specific aspects, the clinical gaze sets a norm of "normality". Consequently, the clinical gaze functions as a principal technology of power that involves gathering information to shape and construct discourses surrounding patients with a migration background and depression in general practices. Therefore, the clinical gaze encompasses a power dynamic, establishing a hierarchical relationship in which GPs exercise authority and control over patients by possessing the medical knowledge and expertise. Moreover, Foucault (2003) claims that the clinical gaze is influenced by broader power structures, such as institutional policy regulations. Related to the clinical gaze, is the concept of "disciplinary power" which elucidates how power operates through diverse institutions establishing specific technologies of power which regulate individuals' conduct. In particular, Foucault's claim (2020) of disciplinary power being both repressive and productive is of importance. Disciplinary power operates through the establishment of norms and rules, contributing to social control and compliance. Moreover, disciplinary power is productive in the sense that it generates new forms of subjectivity and produces knowledge to act upon. Individuals become disciplined subjects who regulate themselves by internalizing established norms and knowledge (Foucault, 2020). Disciplinary power produces medical knowledge which shapes GPs' diagnostic and treatment decision-making.

Data collection

The data for this study consist of different documents related to health care policy in the field of general practice regarding depression and patients with a migration background issued by relevant scientific and professional organizations in the Belgian field of (primary) health care. Two collection rounds were conducted to assemble our data. First, we identified the relevant organizations related to this topic, which led to the inclusion of several policy reports issued by Domus Medica and KCE. Second, our focus shifted specifically to scientific and governmental organizations that seemed relevant to the issue of policy documents regarding the topic. Several articles of the scientific journal of Domus Medica (*'Huisartsnu'*) and BeCare E-Magazine were identified during this collection round. We identified these documents by applying a list of search terms related to the topics of depression, mental health and patients with a migration background (Table V). Furthermore, as Domus Medica and KCE adhere to the regulations of Evidence-Based Medicine (EBM), which acknowledge that medical knowledge is continuously evolving and can become outdated due to new research findings or advancements (Vriesacker et al., 2019), we made the decision to include only documents published within the 10 years preceding the data collection period. In general, publications older than 10 years are perceived as no longer applicable within clinical practice. Consequently, this criterion resulted in a final selection

of 18 documents spanning the period from 2011 to 2021 to be included in our discourse analysis (Table VI).

Table V - Overview of search terms

#	**Search terms in English**	**Search terms in Dutch**
1	Depression	Depressie
2	Feelings of depression	Depressieve gevoelens
3	Mental health	Geestelijke gezondheid
4	Mental health care	Geestelijke gezondheidszorg
5	Mental well-being	Mentaal welzijn
6	Mental health problems	Psychische problemen
7	General practitioner(s)	Huisarts(en)
8	General practice	Huisartsenpraktijk
9	Migrant(s)	Migrant(en)
10	(Patients with a) migration background	(Patiënten met een) migratieachtergrond
11	Asylum seeker(s)	Asielzoeker(s)
12	Refugee(s)	Vluchteling(en)
13	People without legal residence permit	Personen zonder papieren (sans-papiers)
14	Culture	Cultuur
15	Cultural differences	Culturele verschillen

Table VI - Overview of the final selection of included documents

KCE (Belgian Federal Health Care Knowledge Centre)				
Code	**Title of publication in English (title of original publication in Dutch)**	**Reference**	**Type of document**	**Key words in English**
KCE_1	*'Asylum seekers: Options for better equal access to health care. A stakeholder survey' ('Asielzoekers: Opties voor een meer gelijke toegang tot gezondheidszorg. Een stakeholdersbevraging')*	(Dauvrin et al., 2019)	Policy report	'Migrants' or 'asylum seekers'
KCE_2	*'Organization of mental health care for adults in Belgium' ('Organisatie van geestelijke gezondheidszorg voor volwassenen in België')*	(Mistiaen et al., 2019)	Policy report	'Mental health care'
KCE_3	*'Health literacy: which lessons are there to be learned out of the experience of other countries?' ('Gezondheidsgeletterdheid: welke lessen trekken uit de ervaring van andere landen?')*	(Rondia et al., 2019)	Policy report	'Migrants'
KCE_4	*'Organization and financial model of psychological care' ('Organisatie- en financieringsmodel voor de psychologische zorg')*	(Eyssen et al., 2016)	Policy report	'Mental health' or 'mental health care'
KCE_5	*'What health care for people without a legal residence permit?' ('Welke gezondheidszorg voor personen zonder wettig verblijf?')*	(Roberfroid et al., 2015)	Policy report	'Migrants' or 'undocumented migrants/people without legal residence permit' or 'sans-papiers'

Domus Medica (Professional association for Dutch speaking GPs in Flanders and Brussels)				
Code	**Title of publication in English (title of original publication in Dutch)**	**Reference**	**Type of document**	**Key words in English**
DM_1	*'Depression in adults'* *('Depressie bij volwassenen')*	(Declercq et al., 2017)	Policy guidelines and recommendations	'Depression'

Huisartsnu (two-monthly scientific journal by Domus Medica)				
Code	**Title of publication in English (title of original publication in Dutch)**	**Reference**	**Type of document**	**Key words in English**
DMH_1	*'How to reduce health inequality? From strengthening health literacy to policy making'* *('Hoe gezondheidsongelijkheid verkleinen? Van gezondheidsvaardigheden versterken tot beleidsmatig aan de slag')*	(Van Brussel and Bartholomeeusen, 2021)	Article	'Depression' or 'mental health' or 'mental health care'
DMH_2	*'Psychological care for adults. A GPS for mental health care'* *('Psychologische zorg voor volwassenen. Een GPS voor de GGZ')*	(Morsink, 2020)	Article	'Depression' or 'mental health' or 'mental health care' or 'mental health care problems'
DMH_3	*'Medical care of refugees. What is possible during the procedure and psychological problems?'* *('De medische begeleiding van vluchtelingen. Wat is mogelijk tijdens de procedure en psychische problematiek?')*	(Hoogewys et al., 2019)	Article	'Depression' or 'Migrant(s)' or 'Asylum seeker(s)' or 'refugee(s)' or 'culture'

DMH_4	*'Language barriers in general practice. What are the consequences and how can it be improved?'* *('Taalbarrières in de huisartsenpraktijk. Wat zijn de gevolgen en hoe kan het beter?')*	(Jacobs et al., 2018)	Article	'Migrant(s)' or 'culture
DMH_5	*'Tower of Babel in action. Dealing with non-native speaking patients and multiculturalism'* *('Toren van Babel in de praktijk. Omgaan met anderstalige patiënten en multiculturaliteit')*	(Dekeyser et al., 2016)	Article	'Migrant(s)' or 'migration background' or 'patient with a migration background' or 'culture'
DMH_6	*'Culturally sensitive care: how do you do it?'* *('Cultuursensitieve zorg: hoe doe je dat?')*	(Ang and Verpooten, 2016)	Article	'Culture'
DMH_7	*'Culturally sensitive care in general practice. It is not only color that counts'* *('Cultuursensitieve zorg in de huisartsenpraktijk. Het is niet alleen kleur wat telt')*	(Matheusen and Ramboer, 2014)	Article	'Migrant(s)' or 'migration background' or 'patient with a migration background' or 'culture'
DMH_8	*'Diversity in language and culture during a consultation. A tango between practitioners and migrants'* *('Diversiteit in taal en cultuur tijdens de raadpleging. Een tango tussen artsen en migranten')*	(De Maesschalck, 2012)	Article	'Migrant(s)' or 'Culture'

BeCare E-Magazine (three-monthly journal by Belgian Federal government)				
Code	**Title of publication in English (title of original publication in Dutch)**	**Reference**	**Type of document**	**Key words in English**
BCE_1	*'Intercultural mediators in health care. WHO publishes the report of our service.' ('Interculturele bemiddelaars in de gezondheidszorg. WHO publiceert het rapport van onze dienst.')*	(Federale Overheidsdienst Volksgezondheid, 2020)	Article	'Depression' or 'Migrant(s)' or 'refugee(s)' or 'Culture' or 'general practitioners' or 'general practice'
BCE_2	*'Belgium, an example for mental health care in Europe' ('België, een voorbeeld voor Europa in de geestelijke gezondheidszorg')*	(Federale Overheidsdienst Volksgezondheid, 2020)	Article	'Depression' or 'mental health' or 'mental health problems' or 'general practitioners' or 'general practice'
BCE_3	*'Intercultural mediation in Belgian hospitals' ('Interculturele bemiddeling in Belgische ziekenhuizen')*	(Federale Overheidsdienst Volksgezondheid, 2019)	Article	'Migrant(s)' or 'Asylum seeker(s)'

Analysis

This study adopted a Foucauldian discourse analytic approach inspired by the method described by Willig (2013). We used the qualitative data analysis software NVivo 12. Initially, we focused on familiarizing ourselves with the data through a thorough reading of the documents. In the first stage of the analysis, specific sections of text alluding to patients with a migration background in general practices were extracted from the documents. These extractions were the subjects of closer analysis and a first in-vivo coding was performed in order to preserve the verbatim used words within the documents. In this way, it became clear in which different ways the topic of interest was constructed in the text. This search for constructions within the text was guided by both shared meaning, and to a lesser extent by specific lexical comparable elements (Willig, 2013). Consequently, this led to these repeated constructions within the text being grouped together into three reoccurring discourses, according to coherent patterns. In the second stage of analysis, the focus was on the differences between the discursive constructions in order to locate them within wider discourses available in the setting of health care. In the third phase of the analysis, we identified the subject positions that are made available through the various constructions of patients with a migration background in general practices and their location within wider discourses. Subject positions within discourse identify *"a location for persons within the structure of rights and duties for those who use that repertoire"* (Davies & Harré, 1999, p. 35). The last stage of the analysis includes the depiction of the possibility for action that the discursive constructions within the discourse contain. Moreover, this final stage of analysis also investigates the relationship between discourse and subjectivity. Davies and Harré argue:

> *Once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts which are made relevant within the particular discursive practice in which they are positioned* (1999, p. 35).

This refers to the implications for both the involved subjects (here GPs and patients with a migration background) and social practice.

FINDINGS

Three reoccurring discourses were identified throughout the analysed policy documents: (a) *the othering discourse,* (b*) the health literacy discourse* and (c) *the person-centred discourse*. Each identified discourse departs from the sometimes tacit or underlying idea of the presence of certain hurdles for a GP to treat patients equally, as sworn in their Hippocratic Oath. The mere existence of such hurdles goes against the basic duty of a GP to treat every patient equally.

Each discourse is related to another hurdle. However, we claim that *the othering* discourse and *the health literacy discourse* are not mutually exclusive. Since both discourses illustrate the perpetuation of a biomedical discourse in their structuring of text about patients with a migration background in general practices and related hurdles throughout the various policy documents. Moreover, the

hurdles GPs experience related to consultations with patients with a migration background vary among the diversity of patients that is included within these policy reports and articles. The different policy reports and several of the articles distinguish three types of patients who are deemed *"different"* from patients of native Belgian descent and who are explicitly juxtaposed to patients without migration background: (a) patients with a migration background, (b) asylum seeking patients and refugees and (c) patients without legal residence permit.

Patients without legal residence permit are different: the othering discourse

Patients are deemed *"different"* due to several elements. First of all, we identified the categorization of patients based on their origin, illustrated by concepts like "*having another origin"*, "*foreign origin"* or "*immigrant patients"*. However, it is the juxtaposition between patients without legal residence permit and patients with a migration background and asylum seekers that indicates this othering discourse. Within the different documents (mainly the policy reports by KCE) it is made clear that patients without legal residence permit differ from asylum seekers or refugees since they do not have the necessary residence permit that allows them to stay in Belgium, and therefore do not have the same legal rights. This led to the identification of the way in which patients are categorized throughout the documents based on having or not having the necessary legal documents. Consequently, this discourse is characterized by the use of concepts like *"people without documents"* or "*sans-papiers"* and "*legal rights"*. Since these patients do not have the same legal rights, they cannot join a health insurance fund and therefore only have the right to urgent medical care ('*dringende medische hulp'*). Due to this difference in rights, they are often incorrectly forced to accept *"less good care"* or *"the seriousness of their medical situation is frequently misunderstood, which is most often the case for mental health problems"* (KCE_5: 21). This report on health care for people without a legal residence permit continues with a narrow interpretation of the concept of urgent medical care which it is claimed can lead to *"a reduction of medical care to a simple treatment of illnesses and complaints"* (KCE_5: 21). Moreover, the public social welfare centres are the responsible institutions for the arrangement of this statute, which creates another barrier for patients without a legal permit.

Here, GPs and patients without a legal residence permit are positioned in a similar way. There is the acknowledgement that both GPs and patients hit the boundaries of what is legally possible regarding (mental) health care. Little to no agency is appointed to the GPs nor to patients without a legal residence permit. On the one hand, patients without a legal residence permit are positioned as not having the same access to health care due to not having the same legal rights as patients with a migration background and asylum seekers. On the other hand, GPs are put in a position where they do not have the necessary manoeuvrability, not leaving them a lot of space to treat these patients in an equal way as other patients or to provide necessary care. The following quote offers an insight on how this is covered within the different reports:

> *Both the patients without a legal residence permit and the care providers have insufficient information about what exactly is covered by "urgent medical care" and what administrative procedures must be followed for this. Both parties confirm that they have had to learn "by doing" and that is accompanied by a lot of stress, misunderstandings and above all delays in the provision of care* (KCE_5: 22).

Moreover, this discourse is permeated by extracts where GPs are positioned as passive subjects and where is made clear *"what a challenge"* (DMH_3: 25) it is for them to help these patients. An article on what is possible during the procedure of patients applying for international protection concludes:

> *An applicant for international protection in practice takes the GP out of his comfort zone in order to be able to make a correct diagnosis and treatment* (DMH_3: 26).

We can summarize that the responsibility for this situation is appointed to the legal system and the hurdles it creates for GPs in relation to consultations with patients with mental health problems without a legal residence permit. Here, a form of disciplinary power can be distinguished in the sense that the legal boundaries enforce GPs in a subjectivity to perform medical care within the range of what is possible for these patients.

Becoming champions in health literacy: the health literacy discourse

The term health illiteracy ('*gezondheidsongeletterdheid*') is explicitly used throughout one of the policy reports and refers to the lack of health literacy among patients with a migration background and asylum seekers. First of all, the different policy reports and articles acknowledge that patients with a migration background and asylum seekers experience more health issues due to trauma and social problems. There is consensus that these patients experience more difficulties accessing health care because of social problems and due to barriers that are related to their ethnic and cultural background. Consequently, this leads to inequalities in health. In relation to the barriers related to the ethnic and cultural background of the patient, we identified a pattern that several of the policy reports and articles express how these patients' ethnic and cultural background also determines the way in which they define concepts of illness and health. The following quotes give an insight into how this is illustrated within the different articles:

> *A patient's ethnic-cultural background largely determines his so-called "clinical reality" or beliefs about a particular disease* (DMH_5: 129).

> *After all, ethnic and cultural origins determine how someone deals with illness and health and how someone presents their suffering. In technical terms we speak of the "idioms of distress": in every culture has its own symbols, language, rituals or actions to express feelings of sadness or unhappiness* (DMH_3: 26).

Moreover, it is stated in several policy documents that these inequalities in health are reinforced by *"the level of health literacy"* or *"the lack of health literacy"* among patients with a migration background and asylum seekers. In order to legitimize the importance of health literacy, this discourse is characterized by extreme language use. Within several of the excerpts in the analysed documents, these patients are deemed as *"not having the necessary level of health literacy"*. In this matter, it is important to note that this mainly applies to asylum seekers or refugees and first generation migrants and this is ascribed to their lower level of attainment. It is apparent that the documents provide an explanation about the patients' context, in order to show understanding for their situation. However, since there is consensus that health literacy is a necessity in regard to making the correct choices to safeguard one's (mental) health, it becomes clear that these patients are positioned as being less able to make these choices. Given that patients do not live up to the established norm to conform to a certain level of health illiteracy, we identified the availability of disciplinary power in the policy documents. In this way, it is the lack of health literacy of patients with a migration background and asylum seekers that is held responsible for the health inequality these patients experience. Consequently, this influences the power dynamic in relation to GPs, since they are not held accountable for this health inequality. GPs are placed in a position where it is not possible for them to treat these patients in a similar way as other patients, since it is not possible due to these patients *"being health illiterates"*. In this respect, GPs are being exempt of a part of their responsibility.
Next to this, we identified several extracts in the documents that articulate the use of paternalistic discourse. First of all, by indicating *"a mismatch with the health skills"* of patients and deeming patients as *"being a health illiterate"*, it becomes clear that these patients do not comply with the expectations in regard to health skills or the level of health literacy:

> *Failure to find, understand or apply health information indicates a "mismatch". The message is then insufficiently geared to the patient's health skills. If there is such coordination, the patient will understand the information better and be able to apply it* (DMH_1: 326-327).

> *Most people have never heard of health literacy. However, once the term is explained, one wonders how we ever got by without it (…). Once the concept [health literacy] is clear, its relevance becomes clear: without health literacy one cannot watch over their health, one cannot live healthy or cannot make the right life(style) choices. In this case, he is sort of a "health illiterate"* (KCE_3: 4).

Furthermore, there is a remarkable recommendation in a KCE report about health literacy among patients in Belgium and what could be learned from surrounding countries about tackling low levels of health literacy:

> *Educating certain members of a community (e.g. migrants) to become "champions" in health literacy and to disseminate information within the community; build a network of "champions"* (KCE_3: 15).

Although migrants are only an example of a community in this quote, they formulate the recommendation to educate certain members of a community of migrants to become *"champions"* (*'kampioenen'*) in health literacy. This clearly presents the paternalistic way in which migrants are positioned regarding this matter. Since there is the need to become a champion and fulfil certain expectations in regard to health literacy.

We also identified a specific way of positioning GPs that is characterized by strong word-use like: *"GPs are well positioned to strengthen patients"* (DMH_1: 326). In this way, a certain superiority is appointed to GPs, underscoring the idea of a paternalistic discourse. Moreover, by deeming GPs as *"the spindle in Belgian health care"* (KCE_4: 19), they are assigned the position of *"health advocate"* for these patients. By having an insight in the personal life of the patients, GPs can take up this position to support them in gaining the knowledge that is necessary to make the right choices regarding their mental health. Taking on the position of health advocate complements "the position to strengthen patients", in the sense that *"the GP can take up the role of health advocate to bridge the gap between the patient and a society in which health inequality is anchored as a structural problem"* (DMH_1: 328). Consequently, GPs could take up their responsibility as health advocates to overcome this systemic flaw. The different documents portray GPs as *the* professionals with both the necessary knowledge and the right position to contribute to their patients' level of health literacy. Therefore, they are attributed more agency compared to the othering discourse. This way of positioning GPs aligns with the notion of mental health professionals operating as agents of governance, by monitoring and handling specific risks associated with mental health problems (Rose, 1996). Moreover, patients are also afforded some level of agency, however, in a subordinate sense since GPs are portrayed as the professionals that are *"well-positioned"* to educate these patients in regard to health literacy. In this way, GPs are deemed to have a powerful position as agents of governance in relation to these patients regarding the concept of health literacy: *We also need to teach them [GPs] to adapt their communication style, get used to the processes of shared decision-making and help the patients to become more autonomous* (KCE_3: 21).

Lastly, it is remarkable how the different policy reports solely offer superficial guidance regarding health illiteracy among these patients and how to cope with this during a consultation, as illustrated in the following quote:

> *There are elements at the GP level that can play a role in initiating the diagnostic process, such as a trusting and trusting relationship, respectful attitude, avoiding stigma and discrimination, arousing hope and optimism. Also the use of different explanatory models of the problem, the sensitivity to cultural, ethnic and religious backgrounds are important in primary care*

(DM_1: 12).

This quote represents the fact that especially the policy reports contain guidelines to avoid treating patients with a background or asylum seekers differently from other patients. However, these guidelines remain superficial and do not offer GPs real leverage or tools to deploy within these consultations.

A call for reflexivity: the person-centred discourse

It is mainly in the articles rather than the policy reports that we observe a form of reflexivity or even what can be addressed as *"a call for reflexivity"* towards GPs. An article on cultural sensitive care in general practice highlights this reflexivity by presenting some interpretations of GPs of this concept:

> *Being open and receptive to the patient's problems and wishes, but remembering that you have a western Christian culture behind you. That is sometimes an obstacle, but it can also be an opportunity and it takes respect* (DMH_7: 88).

> *If you can provide appropriate care, it gives the patient a good feeling: he feels heard and respected. The basic attitude required for this is the unconditional, positive acceptance of a person* (DMH_7: 88).

These extracts portray the pattern of an active and personal writing-style we identified throughout this discourse. GPs and patients are often addressed using personal pronouns rather than being portrayed by a categorization. Another fitting figure of speech to describe the content of this discourse is the metaphor of the kaleidoscope. Although this metaphor is only present in one of the articles, it underscores the way in which other documents acknowledge the need for reflexivity among GPs and the necessity to focus on the unique patient and their life story (e.g. *"adjusting care to the person sitting in front of us* or *appropriate care"*):

> *Looking through a kaleidoscope: a real danger is that we focus on the culture-specific nature of a particular case. It is important to focus on the unique patient with his or her specific problems in a certain context, a social reality in which care takes place. (…) The image of a kaleidoscope is one point of reference to counter stereotypical and mono-dimensional thinking. The kaleidoscope is a metaphor for the different dimensions of an identity: with every movement, the same "elements" create a different image, a different perspective. We [GPs] must constantly pay attention to the different dimensions that determine the identity of our patient: gender, ethnicity, religion, sexual preference, class, stage of life, profession, … This multidimensional thinking helps to sharpen and improve our consciousness and to realize that not one dimension determines one person* (DMH_6: 136).

The notion of GPs as agents of governance able to support and guide patients (also regarding their level of health literacy) is still available: "*The relationship of trust with the patient gives the GP a unique position to estimate how barriers to a healthy life are intertwined in a concrete life story*" (DMH_1: 325-326). However, by making the appeal for reflexivity and to acknowledge the unique patient, the GP is appointed another level of agency than what was present in the previous discourses. Moreover, by acknowledging the specific experiences of the patients, a more egalitarian positioning of GPs and patients with a similar attributed level of agency is available. This defers from Foucault's initial notion of the clinical gaze entailing a disciplinary power and, establishing a hierarchical relationship in which GPs exercise full control and authority over the patient.

DISCUSSION AND CONCLUSION

The main aim of this study was to identify broader professional discourses on which GPs might rely when speaking about patients with a migration background suffering from depression in general practices. We distinguished three discourses that illustrate the perpetuation of biomedical discourse and a discourse related to the model of person-centred care. In this way, our analysis illustrates the construction of contradictory discursive frameworks throughout the various policy documents. First of all, the analysis implies the alignment with discourse associated with the biomedical model that is still present in Western health care. In *the health literacy discourse*, a categorisation entitlement of GPs is represented that is similar to the dominant position of GPs in the biomedical model; as experts on illness disposing the necessary medical knowledge (Scambler, 2018; Ynnesdal Haugen et al., 2020). In this sense, we argue that the first two discourses discussed above comprise a Foucauldian notion of disciplinary power, being both repressive and productive. In both discourses, disciplinary power is identified since the analysed policy provides a framework of certain legal boundaries or established norms regarding health literacy to conform to. This presence of disciplinary power, however, is also productive since it enforces GPs to regulate their medical care according to this normative knowledge and provides GPs the legitimation to compare individuals against an established norm in order to maintain social order and conformity in medical encounters (Lupton, 2002, 2012; Rose, 1996). Consequently, disciplinary power constitutes social control in general practices. Moreover, this articulates how the clinical gaze of GPs is influenced by broader power structures like institutional policy regulations. This contributes to a hierarchical power relationship in which GPs exercise authority according to their (medical) knowledge provided to them by these institutions and in which patients are passive subjects having to conform to this situation. This implies a power imbalance connected to the biomedical model in health care. On the one hand, guidelines are provided about the necessary knowledge of patients, aligning with the Foucauldian notion of disciplinary power *"that provides guidelines about how patients should understand, regulate and experience their bodies"* (Lupton, 2002, p. 99). On the other hand, GPs possess the medical knowledge allowing them to differentiate between social groups (Foucault, 1984). A similar idea of disciplinary power informs the positioning of GPs as *health advocates* with both the necessary knowledge and consequently, agency to inform and guide patients. This positioning aligns with the notion of health professionals operating as agents of governance, fitting in Rose's analysis of the role of the clinical gaze in the context of governmentality (Rose, 1996, 1998). Governmentality conceptualized by

Foucault refers to technologies, strategies and rationalities through which power operates in order to shape the conduct of others (Foucault et al., 2008; Rose, 1996). Foucault (2008) claims disciplinary power as one of the rationalities of government, informing the exercise of power and governance. This reinforces our argument that GPs are articulated as agents of governance, as they adhere to established norms mandated by broader institutional policies, which regulate their actions and decisions in medical encounters with patients with a migration background. Additionally, a key feature of governmentality is the use of this knowledge which simultaneously constitutes certain forms of expertise as appropriate to act upon (Foucault et al., 2008; Rose, 1996). In this way, GPs are believed to profess this specialist knowledge and skills and consequently, are positioned in the crucial role to help shape problems concerning the non-conformation to established norms. This is present in our results given the appeal to GPs to act as health advocates in order to regulate health illiteracy among patients with a migration background. Conclusively, this demonstrates how medical power is reproduced on an institutional level.

However*, the othering* discourse contains a critique of the legal system and the hurdles it creates for GPs to provide equal care to patients without a legal residence permit. Therefore it unveils a conflict between the interests of GPs and those of the state. Mainly within the KCE reports there is the distinction between patients based on their legal status. Whereas the interests of Domus Medica rely on GPs treating every patient in an equal manner according to their Oath of Hippocrates. We can assume this is due to the economic interests of KCE. As an independent research centre primarily working on behalf of federal governmental related health care matters, KCE mainly focuses on matters related to immigration and right of residence (e.g. urgent medical care). While matters such as integration, welfare and well-being are related to the different regional governments in Belgium. GPs' possibilities to provide equal care being defined by legal regulation aligns with the neoliberalist influence on policy related to health care and medicine since the 1990s. This is characterised by the rise of a regulatory state that creates certain regulations compatible to its economic interests (Allsop, 2006). This neo-liberal ideology is also of influence on the dominant position of GPs, since they become subject to a range of external regulations or clinical governance (Allsop, 2006; Flynn, 2002). Therefore, the clinical autonomy in terms of decision-making by GPs is constrained, which explains the positioning of GPs as passive subjects *"hitting the boundaries of what is legally possible"*.

Unlike the previously discussed discourses, *the person-centred discourse* presents patterns that align with the move towards a person-centred model in Western health care in the recent years. In contrast to the Foucauldian notion of power (Lupton, 2002, 2012), a more egalitarian balance of power is available in this discourse. The changing focus towards the agency of patients can be attributed to a broader shift towards challenging the technologies of governmentality in health care. First, the person-centred model seeks to step away from technologies of power, such as the technology of normalization (Foucault et al., 2008) to compare individuals to an established norm to conform to. Second, it challenges the power dynamics inherent to the profession of GPs and the broader institutional structures. Due to the changing context of health care, passive patients with little agency have shifted towards active agents engaging with the powers that govern them (Petersen, 2003).

However, according to a Foucauldian rationale, the person-centred model can still contain technologies of power that aim to govern patients through self-regulation by active participation of patients in their own care. In this way, it becomes apparent how this last discourse does not merely reject all rationalities of governance. Since GPs are still presented as the experts with specialist knowledge in medical encounters with patients with a migration background. This demonstrates the critical note that this discourse aligning with the person-centred care model, still operates within broader institutional structures of power and governance. Therefore, the quote in the main title of this article (*"Through a kaleidoscope"*) does not only relate to the person-centred discourse we have identified, we also claim it comprises on a meta-level the complexity of broader power structures shaping the clinical gaze and consequently, the conduct of GPs towards patients with a migration background and asylum seekers.

Conclusively, we can claim that a counter-discourse contrary to the dominant biomedical discourse exists in the policy reports. However, due to the small time frame of the included documents (2011 – 2021), it is hard to claim a shifting focus from the biomedical model towards the person-centred model throughout the reports over time. Another potential limitation of this study is the omission of broader dominant discourses, such as European or international health policies (e.g. WHO reports), which could also discursively influence the discourse analysed in this study. Within the broader scope of the research project, our analysis articulates that the topic of discrimination or unconscious bias at the level of GPs is still the elephant in the room. Within the different included documents the topic of how to handle possible prejudices or stereotypes within a consultation room is an almost untouched subject. Since GPs are the main gatekeepers towards correct treatment and specialized mental health care and they are deemed to treat all patients equally, it is important that policy reports transcend superficial guidelines. Finally, we claim that this analysis is the right stepping stone in order to investigate how GPs' professional accounts may be discursively influenced by the broader professional discourses we identified in the analysed policy reports and articles. Moreover, we will need to consider whether these broader professional discoursers are also reproduced by GPs when talking about patients with a migration background or in GPs' interactions with these patients.

4.5. STUDY 4 – Unintentional discrimination against patients with a migration background by general practitioners in mental health management: an experimental study

Duveau, C., Wets, C., Delaruelle, K., Demoulin, S., Dauvrin, M., Lepièce, B., ... & Lorant, V. (2023). Unintentional discrimination against patients with a migration background by general practitioners in mental health management: An experimental study. Administration and Policy in Mental Health and Mental Health Services Research, 50, 450-460.

INTRODUCTION

In Europe, populations with a migration background are at greater risk of mental health problems than native populations, especially depression, post-traumatic stress disorder (PTSD), and anxiety (Ekeberg & Abebe, 2021; Mindlis & Boffetta, 2017; Missinne & Bracke, 2012). Access to appropriate treatment and referral to relevant mental health services have been shown to be limited for migrants (Bhui et al., 2018; Giacco et al., 2014; Kodish et al., 2022).

Migrant populations experience discrimination more frequently, an additional mental health risk factor (Levecque et al., 2009; Missinne & Bracke, 2012). Although mental health problems are often identified by primary health care services, some studies, however, have shown that general practitioners' (GPs') therapeutic decisions regarding patients with a migration background are suboptimal: breakdowns in communication and in the relationship between a migrant patient and a GP can be a frequent source of misunderstanding, the time devoted to a consultation is often shorter for migrants, and GPs' diagnostic, treatment and referral decisions are sometimes biased by their behaviours and beliefs of migrant patients (Gaya-Sancho et al., 2021; Lepièce et al., 2014; Shannon et al., 2016).

GPs' beliefs can lead to unintentional discrimination against migrant patients with mental health problems. GPs' decisions are sometimes based on situational context, level of prejudice, cognitive busyness, training, time pressure, implicit/explicit ethnic biases, and their experience of intercultural contact (Gopal et al., 2020; Kite & Whitley, 2016; Lepièce et al., 2014). Poor humanization in care may strengthen these biases. Humanization of care combines the patient-centred care approach and the person-focused care approach (Busch et al., 2019). Humanization includes consideration for the patient's life story and a holistic approach (more related to the person-focused care approach), as well as empathy, patience, fair-mindedness, equity, active listening, respect for patient's dignity, uniqueness, and humanity (more related to the patient-centred care approach) (Busch et al., 2019).

To date, humanization in health care has received little attention in clinical practice and research. Recently, however, several authors have concluded that more research is needed on the humanization of care by health providers such as GPs and on its impact on their medical decisions (Busch et al., 2019; Pérez-Fuentes et al., 2019). This paper hypothesizes that humanization of care could reduce the risk of unfavourable decisions and reduce unintentional discrimination towards migrant patients with depression. More specifically, by looking at the role of "humanization", this paper examines a potential explanation for the existence of differences in mental health care between patients with a migration background and those without.

To the best of our knowledge, no experimental studies have investigated the effect of humanization on inequalities in the diagnosis and treatment of depression between patients with a migration background and those without. We carried out an experimental study using two staged videos showing a simulation of a GP consulting either a depressed native European patient or a depressed migrant patient. By surveying respondent GPs, we intended to investigate whether GPs treat depressed migrant patients differently to their native counterparts. To do so, we assessed two dimensions of humanization. First, by supplementing videos with life-story text for some GPs, we were able to determine, whether GPs' decisions reflected attentiveness to their patients' needs, preferences and life context. Secondly, based on the time respondents devoted to the video and text, we were able to determine, as a proxy of patience, whether, the GPs in the experimental group considered the life story and whether this time differed according to the ethnicity of the patient in the video.

METHODS

Design

A balanced 2X2 factorial experiment combining migration background and humanization was carried out. Belgian GP respondents were randomly assigned one of the two videos, one of which depicted either a depressed (based on DSM-5 criteria) native patient and one of which depicted a depressed migrant patient. Within those two groups (native patient vs migrant patient), half of the GP respondents received a written text with information about the patient's life story in order to trigger humanization (see Figure 5). Hereafter the term "video-vignette" will be used to refer to the video and the text together. The migration background of the patient was not mentioned, but the actors were typecast for their "Belgian" and "Moroccan" roots, respectively, to elicit implicit ethnic and racial bias and unconscious beliefs.

We created four different life-story texts to be presented to the GPs randomly selected for humanization intervention (see Appendix online publication). Each GP in the humanization-intervention, "life-story", group was presented with one of these four texts. The first life-story text introduced the patient by name and included several details about the patient's family composition, where he lived, and his employment status. The second text provided information about the patient's needs and treatment preferences. The third text included details of the patient's job loss. Finally, the fourth consisted of information about the patient's marital separation. We used four different life-story information in order to avoid the attribution of a changing in medical decisions to one specific information but we wanted to test the effect of life-story information on the whole on medical decisions.

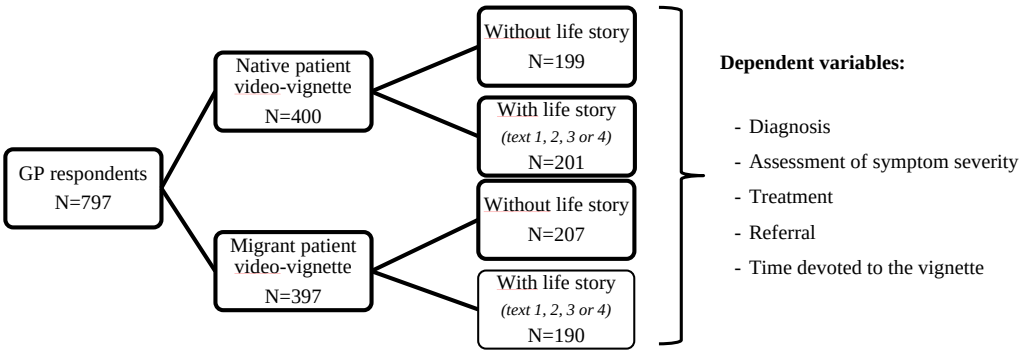

Figure 5 - Balanced 2X2 factorial experimental design and dependent variables

The video-vignettes were similar in every respect, except for the patient's migration status and the humanization intervention in the written introduction accompanying the video. Within the written introduction, some information about the patient was provided for all vignettes. It was stated that the video simulated a conversation between a GP and a patient who had come for a second consultation due to a persistent headache. Practical details of the methodology are provided in Appendix (see online publication).

Population

We chose to recruit Belgian GPs. Belgium is an interesting case study because firstly, it is a country with a long history of immigration and secondly, there is a higher prevalence of depression among migrants, especially those from Morocco, and this difference is more significant in Belgium than in other European countries (Levecque et al., 2009; Missinne & Bracke, 2012). The study was carried out with licensed and trainee GPs practising in two of the three Belgian regions: Brussels and Wallonia. Between April and July 2021, we contacted 6112 of the 8588 registered GPs in Wallonia and Brussels by phone. Out of these, we were able to reach 2288 GPs. Among them, 823 GPs were considered as "Not concerned" because they were no longer practising general medicine; we obtained informed consent from 964 GPs, a response rate of 13%. Incomplete questionnaires and questionnaires with scored-out answers were deleted, leaving a final sample of 797 completed questionnaires (Dutch-speaking trainee GPs are included in the final sample). Figure 6 shows a flow chart of the participants in the study. We also shared the link to the survey in general medicine newsletters and by email with the help of several general medicine associations and other Belgian authorities[8], and with Dutch-speaking trainee GPs from Flanders.

[8] FAMGB (Fédération des Associations des Médecins Généralistes de Bruxelles), Fedasil, SSMG (Société Scientifique de Médecine Générale), FMM (Fédération des Maisons Médicales), ABSyM/BVAs (Association Belge des Syndicats Médicaux/Belgische vereniging van Artsensyndicaten), BHAK (Brusselse Huisartsen Kring), Huis voor Gezondheid Brussel, ICHO (Interuniversitair Samenwerkingsverband HuisartsenOpleiding), HOP (HAIO Overleg Platform), groups for GPs in training on social media, and several medical universities in all three Belgian regions

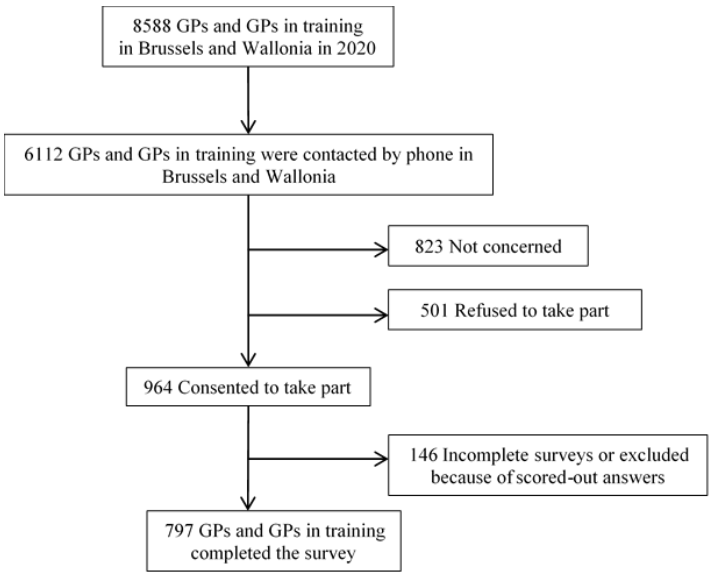

Figure 6 - Flow chart showing participation in the sample process

Independent variables

This paper focuses on two dimensions of humanization: the GP's consideration for the patient's life story and the time that the GP devoted to watching and reading the video-vignette, as a proxy of patience. Those two variables constituted our independent variables. We also surveyed GPs' sociodemographic characteristics, practice, work schedule, and workload, among other factors.

Dependent variables

To assess the effect of the humanization and any subsequent difference in GPs' management of depression in migrant patients, we used four main dependent variables as outcomes: diagnosis, assessment of symptom severity, treatment, and referral.

Diagnosis, assessment of symptom severity, treatment, and referral*:* After watching one of the four randomly assigned video-vignettes, respondents filled out an online questionnaire (hosted in Qualtrics®) about potential diagnoses, assessment of symptom severity, treatments, and referrals for their patient. For the diagnosis, respondents had to choose from a list of seven diagnoses of mental health disorders and could tick up to three different diagnoses. We analysed the diagnosis of depression, anxiety, and PTSD. The GPs then scored, on a scale from zero to ten, the severity of the symptoms staged in the video.

For the treatments, we employed a 4-point Likert scale ranging from very unlikely to very likely. First, we asked them what type of treatment they would prescribe, providing three different options: non-medical treatment, medical treatment, or a combination of both. Then, we asked those who had prescribed medical treatment or a combination of both if they would prescribe benzodiazepines (i.e.

hypnotics, sedatives, and anxiolytics), because literature shows that GPs prescribe drugs more often to ethnic minority patients (Lepièce et al., 2014). Finally, we surveyed how likely the GP respondents were to refer the patient, also using the 4-point Likert scale.

Time devoted to the video-vignette: We measured the time GPs spent reading the introduction and watching the video, using metadata recorded by Qualtrics. The aim of this assessment was to see how the time GPs devoted to the patient differed depending on the ethnicity of the patient in the video and on whether the life-story intervention had been provided or not.

Data analyses

Characteristics of the study population

First, we calculated descriptive statistics. We looked at the sociodemographic distribution of our GP respondents according to sex, age, language, license status, experience, work schedule, workload, type of practice, and the type of area where they practise. Then, we ran several chi-square tests and carried out an analysis of variance using those sociodemographic characteristics to make sure that the allocation of the experimental conditions (migration status and life story) was not affected by selection bias. Table VII in the results section presents a description of our final sample and the results of the chi-square tests and the analysis of variance.

Diagnosis, assessment of symptom severity, treatment, and referral

Secondly, we performed a two-way analysis of variance (ANOVA), which allowed us to gain an understanding of the effects that the two independent variables (migration status and life-story intervention) had on the dependent variables (diagnosis, assessment of symptom severity, treatment, and referral of the patient). We also assessed the interaction effect of the two independent variables on the dependent variables. Then, we computed a multivariate analysis of variance (MANOVA) including all dependent variables at once.

Time devoted to the video-vignette

To assess a proxy of GPs' patience, we analysed whether the time spent on the video-vignettes differed according to the life-story intervention and migration status, using an ANOVA. To do so, we used the difference between the actual average time GPs spent on a video-vignette and the average time expected to be spent on it. This difference was tested with an F-test for each experimental condition. A negative difference meant that GPs spent less time than was, on average, necessary. A positive difference meant the opposite.

All the statistical analyses were performed using SAS 9.4.

Ethical statement

The study and its methodology were approved by the Ethics Committee of the Université Catholique de Louvain (2020/06FEV/070) and by the Ethical Committee of the Faculty of Political and Social Sciences of Ghent University (2020-07: REMEDI (GPs' "REcommendations to patients with MEntal health problems and DIverse migration backgrounds"). At the beginning of the online survey, each GP

was informed about the general objective of the research, including the funding of the research project, and informed consent to participate was requested.

RESULTS

Characteristics of the study population

Table VII presents the descriptive results of our GP respondents. Women represented 63% of our sample, and the mean age of respondents was 38.2 years (± 14.8). Almost 70% of the GP respondents were French-speakers. More than 86% of the respondents worked full-time and half of the sample perceived their workload to be heavy. Among the respondents 66.5% worked in a group practice, while 29.5% worked mainly in a solo practice. Only 11.8% of our sample worked in an urban area, defined as having more than 75,000 inhabitants; the majority of the GP respondents worked in a rural area (<10,000 inhabitants). According to the chi-square and the F-tests performed on the sociodemographic variables regarding the random allocation of the vignette, we did not find any selection bias in the randomization of our independent variables (migration status and life-story intervention).

Table VII - Sociodemographic distribution of GP respondents, Belgium 2021 (n=797) and statistical tests on the allocation of one of the four video-vignettes

Covariates:	**% or mean (SD[a])**	**Test statistic[b] (pvalue)**
Sex		0.48* (0.92)
Male	37.0	
Female	63.0	
Age (years)	38.2 (14.8)	0.35** (0.56)
Language		0.22* (0.98)
French-speaking	69.8	
Dutch-speaking	30.2	
License status		4.45* (0.22)
Licensed GP	55.1	
GP in training	44.9	
Experience (years)	12.1 (14.0)	0.11** (0.74)
Working schedule		15.19* (0.09)
Full-time	86.6	
Half of normal working hours	4.5	
< Half of normal working hours	0.9	
Other	8.0	
Workload		9.21* (0.16)
Light	9.9	
Normal	40.1	
High	50.0	

Covariates:	% or mean (SD[a])	Test statistic[b] (pvalue)
Type of practice (>50% of their working schedule)		9.93* (0.13)
Unknown	2.5	
Solo	29.5	
Group	66.5	
Other	1.5	
Type of area		1.43* (0.96)
Unknown	0.2	
Urban	11.8	
Sub-urban	27.0	
Rural	61.0	
Vignette		NA[c]
Native patient without life story	25.0	
Migrant patient without life story	26.0	
Native patient with life story	25.2	
Migrant patient with life story	23.8	

[a] SD: Standard Deviation.
[b] Statistical test was performed on the GPs' characteristics to check their distribution in the allocation of one of four video vignettes: "" indicates the results of a chi-square test and "**" indicates the results of an analysis of variance.*
[c] NA: Not Applicable

Diagnosis, assessment of symptom severity, treatment, and referral

The results of the two-way ANOVA and the MANOVA for diagnosis, assessment of symptom severity, treatment, and referral are presented in Table VIII. No significant differences by migration background or life-story intervention were found for the diagnosis of depression. By contrast, for the native patient, anxiety was more often diagnosed by GPs who had not been exposed to the life story than by those who had been exposed to it (OR = 1.63 $IC_{95\%}$ [1.10;2.40], result not presented). GPs diagnosed Post-traumatic Stress Disorder (PTSD) more often in the migrant patient and more so in the non-life story group. The assessment of symptom severity was lower for the migrant patient (F = 7.71, p < 0.05), with or without the life story.

For almost all treatments, the decision was less favourable for the migrant patient than the native patient. The prescription of medication was more likely with the native patient than with the migrant patient (F = 4.46 p < 0.05*)*. This result is in line with the observation that GPs were more likely to prescribe benzodiazepines to the native patient than to the migrant patient. This result persisted when controlling for the assessed severity of the symptoms (F = 9.94, p < 0.001, result not presented). We did not find significant differences in the prescription of non-medical treatments (F = 2.32, p = 0.13). GPs from the life-story group referred the migrant patient less frequently than GPs from the non-life-story group. We found the opposite for the native patient: there were more referrals from the life-story group than from the non-life-story group (F = 4.78, p = 0.03). Multivariate analysis of variance

(MANOVA) indicates that migration status had a significant effect on all dependent variables together (F = 4.26, $p < 0.01$) but that the life story did not (F = 0.45, $p = 0.91$). The interaction effect was not significant ($p = 0.16$). The effect of the life story on the medical decision did not, therefore, differ according to the migration status of the patient.

Table VIII - Results of the two-way ANOVA and MANOVA for diagnosis, treatment, and referral

	Without life Story		**With life Story**				
	Native	**Migrant**	**Native**	**Migrant**	**Chi-square or F-value (pvalue)**	**Chi-square or F-value (pvalue)**	**Chi-square or F-value (pvalue)**
	Mean[a] (SE)	**Mean (SE)**	**Mean (SE)**	**Mean (SE)**	***Migration background***	***Life story***	***Migration background*Life story***
Diagnosis[b]							
Depression (%)	99 (0.01)	98 (0.01)	98 (0.01)	98 (0.01)	1.06 (0.30)	1.24 (0.27)	0.80 (0.37)
Anxiety (%)	48 (0.03)	37 (0.03)	35 (0.03)	33 (0.03)	2.88 (0.09)	**5.20 (0.02)**	1.59 (0.21)
Post-Traumatic Stress Disorder (%)	9 (0.02)	19 (0.02)	13 (0.02)	14 (0.02)	**4.55 (0.03)**	0.13 (0.72)	**3.97 (0.05)**
Assessment of symptom severity (/10)	7.68 (0.10)	7.45 (0.10)	7.81 (0.10)	7.49 (0.10)	**7.71 (0.01)**	1.16 (0.28)	0.33 (0.57)
Treatment[c]							
Medical treatment	2.97 (0.05)	2.85 (0.05)	2.91 (0.05)	2.77 (0.05)	**4.46 (0.04)**	1.41 (0.23)	0.14 (0.71)
Non-medical treatment	3.67 (0.04)	3.74 (0.04)	3.64 (0.04)	3.71 (0.04)	2.32 (0.13)	0.58 (0.45)	0.01 (0.93)
Combination of both	3.60 (0.04)	3.43 (0.04)	3.57 (0.04)	3.39 (0.05)	**12.2 (<0.001)**	0.43 (0.51)	0.13 (0.72)
Benzodiazepines (i.e. hypnotics, sedatives, and anxiolytics)	2.06 (0.06)	1.78 (0.06)	1.93 (0.06)	1.77 (0.06)	**8.79 (<0.001)**	1.37 (0.24)	0.55 (0.46)
Referral							
Likelihood of referral	3.20 (0.05)	3.35 (0.05)	3.32 (0.05)	3.26 (0.05)	0.96 (0.33)	0.12 (0.73)	**4.78 (0.03)**
MANOVA[d]	..	..	..	..	**4.26 (<0.001)**	0.45 (0.91)	1.46 (0.16)

Results in bold are significant i.e. have a p-value < 0.05 .

[a] Means, SE (Standard Error), Chi-square, and F-value are adjusted for the GPs' training.

[b] Respondents could choose up to three diagnoses from seven (schizophrenia, bipolar disorder, depression, anxiety, PTSD, obsessive-compulsive disorder, symptomatic and related disorders, and sleep disorders). We have only presented the results for diagnosis of depression, anxiety, and PTSD. Symptom severity was assessed on a scale from zero to 10.

[c] Treatment and referral variables were assessed on a 4-point Likert scale from 1: not at all likely to 4: very likely.

[d] MANOVA means multivariate analysis of variance.

Time devoted to the video-vignette

Table IX shows the results for the difference between the actual time GPs spent on the video-vignette and the time expected to be spent on the video-vignette. Overall, GPs took less time than expected on the four video-vignettes, as the difference was negative. The difference ranged from -1.76 minutes (± 0.10) for the native patient video-vignette with life story to -0.81 minutes (± 0.08) for the native patient video-vignette without life story. The amount of time GPs devoted to the video-vignette did not differ according to the migration status of the patient (F = 0.35, p = 0.56).

GPs who had been exposed to the life story spent significantly more time on the video-vignette (F = 83.43, p < 0.0001), especially for the migrant patient, where the difference was higher than for the native patient video-vignette, -1.56 minutes ± 0.10 and -1.76 minutes ± 0.10 respectively.

Table IX - Difference between the actual time (in minutes) devoted to watch the videao and read the introduction by GPs and the expected time required to it

	Without life story		**With life story**		**F (pvalue)** ***Migration background***	**F (pvalue)** ***Life story***	**F (pvalue)** ***Migration background*Life story***
	Native Mean[a] (SE)	**Migrant Mean (SE)**	**Native Mean (SE)**	**Migrant Mean (SE)**			
Actual timing devoted for each video-vignette (minutes)	3.33 (0.08)	3.58 (0.07)	3.53 (0.10)	3.79 (0.10)	/	/	/
Expected timing for each video-vignette[b] (minutes)	4.14 (0.00)	4.49 (0.00)	5.30 (0.00)	5.35 (0.00)	/	/	/
Difference between the actual time (in minutes) and the expected time GPs spent on the video-vignette	-0.81 (0.08)	-0.91 (0.07)	-1.76 (0.10)	-1.56 (0.10)	0.35 (0.56)	**83.43 (<0.0001)**	3.06 (0.08)

[a] Means, SE (Standard Error) and F-value are adjusted for the GPs' training.
[b] To calculate this average, we added the time of the video to the time needed to read the introduction using a text-to-minutes converter.

DISCUSSION

Main findings

In our experiment, we found pervasive unintentional discrimination in the diagnosis, assessment of symptom severity, treatment, and referral to mental health care services of migrant patients. We therefore conclude that there is a significant association between migration status and medical decisions. These differences are consistent with previous studies that also found that medical decisions were affected by a patient's ethnic background (Centola et al., 2021; Lepièce et al., 2014). Indeed, providers' biases have already led to the unsafe undertreatment of migrant patients (Centola et al., 2021). Previous studies have shown that there is a higher prevalence of perceived discrimination

among migrant patients, who are also more likely to report communication problems due to their ethnicity (Attanasio & Kozhimannil, 2015; Centola et al., 2021). Patient-provider relationship is one of the main components of patient-centred care and, therefore, of humanization. On the whole, unintentional discrimination was rarely reduced by exposure to the patient's life story, one of the dimensions of humanization. Contrary to our original hypothesis, this result was not consistent with the results of previous studies, which found that more humanized care had a positive influence on several aspects of care such as perceived quality of care, positive health outcomes, and treatment adherence (Swenson et al., 2004).

Diagnosis, assessment of symptom severity, treatment, and referral

Our findings on the diagnosis of PTSD match those observed in earlier European studies (Markkula et al., 2017). Epidemiological studies show a significantly higher incidence of PTSD among migrants than among their native counterparts (Aldridge et al., 2018; Ekeberg & Abebe, 2021). This discrepancy could be attributed to the fact that migrants are more exposed to external causes of distress and to disadvantage and discrimination in relation to different social opportunities. When primed with their patient's life story, however, GPs were less keen to diagnose PTSD in migrant patients. One possible reason for this is that humanization removes the diagnostic shortcut whereby migration is associated with PTSD. Previous studies have found that the main cause of PTSD is great psychological distance from a traumatic event that has become central to a person's life story (Janssen et al., 2015). Interestingly, we also found in the literature that PTSD risk factors differ considerably between cultures and countries (Bustamante et al., 2017). It is therefore essential that future studies consider the different migration backgrounds and life contexts of patients in relation to PTSD diagnosis. The lower severity of symptoms attributed to the migrant patient is in line with the findings of a recent study, which are also consistent with those of an experimental study in which physicians concluded that Black patients were less likely to overreport their symptoms than White patients (Delaruelle, Buffel, et al., 2021; Schulman et al., 1999). Potential explanations for this result may also be related to GPs' racial prejudice, their dehumanization of migrant patients, a lack of empathy, or even an assumption that Black patients feel less pain than White patients (Trawalter & Hoffman, 2015).

GPs were less likely to prescribe drug treatment to the migrant patient than to the native one but, there was no difference in non-drug treatment. GPs were, however, less likely to prescribe a combination of drug and non-drug treatments to the migrant patient. An important finding of this study was that the assessment of symptom severity did not explain the lower likelihood of prescribing benzodiazepines to the migrant patient because when we controlled the result with this assessment, the result remained unchanged. Previous studies, however, have shown that (unintentional) discrimination was positively associated with severity of mental health problems and negatively associated with therapeutic adherence (Livingston & Boyd, 2010). We think, therefore, that there is a need to make GPs aware that their unconscious underassessment of the severity of migrants' symptoms may lead to undertreatment, especially for their migrant patients.

GPs prescribed benzodiazepines significantly less often to migrant patients than to native patients. This finding differs from those of a previous epidemiological study on benzodiazepine prescription,

which found that migrants from North Africa were more likely to purchase benzodiazepines than the native Finnish-born population (Kieseppä et al., 2022). That study also found, however, that migrants were also more likely to interrupt their treatment before the end of the six-month period recommended in guidelines on depression (Declercq et al., 2017; Kieseppä et al., 2022). It is possible that GPs presume that the patients will not comply with or purchase their prescription, and therefore decide to prescribe them to migrant patients less often. One explanation for our findings may lie in previous research which shows that GPs consider the prescription of benzodiazepines a form of empathy (Anthierens et al., 2007). The reluctance of GPs to prescribe benzodiazepines to migrants could reflect a lack of empathy towards patients with a migration background.

Contrary to our expectations, GPs were less likely to refer the migrant patient for whom they had been provided with a life story. Qualitative studies might provide some insight. Non-referral by GPs could be explained by a variety of barriers encountered by GPs when attempting to refer their migrant patients. GPs may opt to provide the care themselves because they anticipate that their patients will meet barriers when seeking mental health care elsewhere (Teunissen et al., 2015). In the Belgium context, high waiting time or out-of-pocket payment to access a psychiatrist or a psychologist may explain why GPs are reluctant to refer vulnerable patients.
In the group without the life story, however, we found that GPs referred the migrant patient more often than the native patient. A possible explanation for this is that GPs feel less comfortable treating severe depression in migrant patients due a lack of awareness, stigma, or cultural barriers, as highlighted in the literature (Lindert et al., 2008).

Time devoted to the video-vignette

Our results show that unintentional discrimination in mental health care is only slightly moderated by humanization. GPs who had been given the life story, however, spent significantly more time than the controls reading the introduction and watching the video, especially the one with the migrant patient. There are two possible interpretations of this. One is that GPs paid more attention to the context provided by the migrant patient's life story and humanized him more than the native patient. The other possible interpretation is that GPs who spent more time on the migrant patient's life story may have felt they were under pressure to diagnose, treat, and refer him in the questionnaire. This possibility is supported by previous research which has shown that restrictions on the time allocated to a consultation can lead to dehumanization (Busch et al., 2019). The negligible effect of humanization on medical decisions may also be explained by the association between dehumanization and GPs' low perceptions of their own stress or burnout (Capozza et al., 2016). In other words, patient dehumanization can also occur when GPs are under stress due to overwork.

STRENGTHS AND LIMITATIONS

This study has several strengths. The first is the innovative and original design of the research. To the best of our knowledge, this is the first experimental study designed to assess the effect of humanization as a moderating factor of GPs' decisions regarding mental health problems among patients with and without a migration background in a European context.

This study has two limitations. First, the controlled experimental environment did not replicate the real-life everyday environment of a GP practice. When the use of vignette methodologies for studying health professionals' decision-making has been assessed, authors have concluded that they are generalizable to "real-life" behaviour (Evans et al., 2015). The controlled design might, however, lead to a social desirability bias in GPs' responses, particularly in the highly contested domain of migration and health, and thus underestimate the magnitude of actual unintentional discrimination in primary care. Secondly, GPs who received the life-story intervention could have skipped the information that was provided or may not have considered that information in addition to the video, thus jeopardizing the internal validity of the life-story condition. The metadata, however, did not confirm this. GPs spent longer on the patients when the life-story condition was applied. This intervention could be explored using a qualitative design to further explore the effect of this intervention on GP's everyday practice and to investigate how GPs can use humanization of care to reduce their own ethnic bias.

CONCLUSION

In conclusion, we found unintentional ethnic discrimination in assessment of severity, diagnosis, treatment, and referral of mental health problems by general practitioners. As hypothesized in this paper, however, there is no indication that a lack of humanization is the main driver of those discriminatory practices. Nevertheless, we believe that this experiment should be replicated with the humanization intervention staged in different ways. For instance, future research could stage the life story within the video rather than in the written introduction accompanying the video.

We also think that GPs should carefully assess the symptom severity of their patients in order to avoid the under-treatment or mistreatment of depression, especially in their patients with a migration background.

5. RECOMMENDATIONS

The results presented in Section 4 indicate the presence of a provider bias in assessing, treating, and referring depressed patients with a migration background in Belgium. Moreover, it was also found that the 'humanization intervention' may not be very helpful in addressing this bias. Hence, the question remains: How can we tackle the provider bias and, consequently, address unmet mental health needs among people with a migration background? Based on our in-depth interviews, combined with a literature review, we compiled various recommendations. Following this, a series of focus groups were convened to facilitate discussions and validate this predetermined set of recommendations. This chapter provides a summary of the outcomes from these focus group discussions.

5.1. The organization of the focus groups

The focus group approach is a suitable method for elaborating and deliberating on recommendations because this design fosters discussions centred on potential solutions. It effectively allows for the identification of disagreements and potential hurdles in the implementation process. A total of **eight focus groups with GPs were organised**, with 79 GPs participating. These focus groups encompassed solo practitioners, group practitioners and CHC practitioners. In order to recruit participants, invitations were extended to 'local quality groups' of GPs (LOK and GLEM) and CHCs with a proposal to organise a focus group on patients with a migration background within one of their meetings. Initially, our intention was to recruit participants from the MTG-survey who had expressed interest in participating in a follow-up study. However, the response rate from participants of the MTG-study did not align with the expectations. Therefore, our recruitment strategies were refocused towards local quality groups of GPs and CHCs. Since the recruitment was facilitated by the LOK coordinator, our influence over the exact number of participating GPs was limited. Nonetheless, considering the challenges previously encountered in enlisting GPs for the in-depth interviews, this scenario presented a valuable prospect to assemble a group of experts over several focus groups to discuss the established recommendations and coherent actions.

Table X - Overview focus groups with general practitioners

Code	**Focus group Dutch-speaking GPs**	**Date**	**# of participants**
FG_LOK_1	LOK – Mixed group of GPs	11/10/2022	14
FG_LOK_2	LOK – Mixed group of GPs	10/11/2022	11
FG_CHC_1	Only CHC GPs	10/11/2022	5
FG_CHC_2	Only CHC GPs	17/11/2022	7
Code	**Focus group French-speaking GPs**	**Date**	**# of participants**
FG_GLEM_1	GLEM – Mixed group of GPs	20/10/2022	7
FG_GLEM_2	GLEM – Mixed group of GPs	16/11/2022	11

FG_GLEM_3	GLEM – Mixed group of GPs	01/12/2022	15
FG_SOLO_1	Only solo GPs	08/12/2022	9

In addition to the focus groups with GPs, we organised two separate focus groups with Dutch and French-speaking policymakers. The focus groups with policymakers was organised online to maximise the participation rate. Consistent with the informed consent protocol, full names of the different participants are not disclosed in the document to safeguard confidentiality.

Table XI - Overview of focus groups with policymakers

Code	Focus group policymakers	Date	# of participants
FG_Policy_Dutch	Focus group in Dutch	07/03/2023	6
FG_Policy_French	Focus group in French	02/03/2023	11

Preceding the focus groups, we developed three main recommendations along with coherent actions to be discussed with both GPs and policymakers of interest: (a) promotion of access to quality mental health care for patients with a migration background and asylum seekers, (b) intercultural mediators and professional translators and (c) the elaboration of cultural competences in general practice. These recommendations stem from an initial thematic analysis we applied on a section of the in-depth interviews (associated with the data used in study 2), regarding the difficulties and barriers encountered by GPs in consultations with patients with a migration background and asylum seekers. Lastly, while developing the recommendations, we bolstered their scientific underpinning by drawing upon a range of international and national reports in the domain of (mental) health care for patients with a migration background, asylum seekers and refugees.

To facilitate participants' preparation for the focus groups, the set of established recommendations was disseminated a week in advance. The focus groups proceeded according to a predetermined topic guide: (1) Introduction, outlining our research's main focus and presenting an overview of the work packages, (2) Presentation of the formulated recommendations and cohesive actions, with connections to preliminary findings and a platform for participants to seek clarifications, (3) Individual ranking of the presented recommendations by participants in order of priority to overcome difficulties for patients with a migration background and asylum seekers regarding mental health care, (4) Sequential group discussion of the recommendations based on a predetermined chronological order present in the bundle we had disseminated, focusing on personal and professional experiences of the participants, (5) Participants individually re-ranked the recommendations in light of the group dialogue, (6) Closing the focus group with a miracle question ('Imagine waking up in an ideal world where anything is possible, what would be your ideal recommendation to address difficulties regarding mental health care for patients with a migration background in general practices?'), (7) A concluding inquiry in order to ensure that everyone had sufficient time to voice their opinion.

All focus groups were digitally audio recorded with participants' informed consent. CW moderated the focus groups conducted in Dutch, while CD and Marie Dauvrin (MD) moderated focus groups in French. During the focus groups, the moderators were supported by a team member or a master student taking notes. Comprehensive transcriptions of all focus groups were generated, including participants' pseudonyms to ensure anonymity, thereby facilitating subsequent data analysis.

5.2. Specific recommendations

How are the recommendations structured?

We have organized the recommendations into three overarching themes, which are presented in distinct boxes. Recognizing that these recommendations encompass a wide scope, we have further broken them down into more specific and actionable recommendations. Initially, we present the primary recommendations in the manner they were introduced to the participants in the focus groups. These recommendations were either endorsed or modified based on participant feedback. The corresponding actions that received consensus among participants are listed at the bottom, once again within designated boxes.

Recommendation A – 'Promotion of access'

The first recommendation, as discussed in the focus groups, involves promoting access to quality mental health care for patients with a migration background, refugees, and asylum seekers in need of mental health care. This includes ensuring access to ongoing social and psychological support when necessary. After deliberations with both GPs and policymakers, the initial formulation of the recommendation received endorsement.

Recommendation A – Promotion of access

Promoting access to high-quality mental health care for patients with a migration background, refugees, and asylum seekers in need of mental health services, including ongoing social and psychological support when necessary, is crucial. This approach ensures a sustained and long-term provision of mental health care within general practice for these patients. It relies on efficient referral processes to connect patients with the appropriate mental health services in secondary and tertiary health care settings.

Recommendation A.1.: Expanding the range of specialized mental health care services and pursuing improved integration

The various focus groups underscored unanimous agreement on the importance of Recommendation A.1. However, it was noted by both participating GPs and policymakers that there is an overarching need to enhance the overall accessibility of mental health care services, extending beyond this specific patient group and encompassing the entire Belgian population.

While discussing the necessity to enhance the access to high-quality mental health care, within all of the different focus groups, the issue of long waiting lists when referring patients to mental health care services emerged frequently. Related to the matter of long waiting lists, several GPs highlighted their frequent practice of providing ongoing care for patients with mental health problems through successive consultations. One of the GPs referred to this as a vicious circle wherein patients seek help for psychological complaints at general practices since there is not enough low-threshold access to psychological care. Consequently, the GP recognizes the need for more specialist care for these patients, again hitting the limitations posed by insufficient access to mental health care services therefore deciding to follow-up these patients themselves. Although GPs acknowledge this mainly applies to asylum seeking patients due to financial inaccessibility, they still stress this is also of importance regarding native Belgian patients with mental health problems. Hence, GPs emphasized the urgency to disrupt this vicious circle of insufficient access to psychological care, which leads to GPs encountering patients requiring more specialist mental health care.

> *I believe that the scarcity of available psychological care should not be underestimated, there are waiting lists everywhere, and sometimes issues ending up with the GP, I mean what overflows and then ends up with us [GPs], and sometimes things I think "this is actually not for me anymore, this patient really should be followed up but does not get in". The psychiatrist reacts "Ah no, no, no, I cannot take them" and the psychologist goes "Yes, maybe in three months". But in the meantime, there is this patient waiting and in half a year time you get serious problems requiring admissions. I think that urgent work needs to be done regarding this matter.* (FG_LOK_1)

Furthermore, it is worth noting that all participants in the focus groups expressed frustration over the ongoing need for greater financial resources to improve accessibility and, consequently, the quality of the Belgian mental health care system. GPs and policymakers alike stress the need for increased financial resources in mental health care services as a necessary condition for further action to enhance accessibility for patients with a migration background, refugees and asylum seekers. They claim this approach offers the potential to broaden the range of health care services, particularly referring to primary care psychologists, psychologist and social workers. However, it is crucial to highlight the introduction of the convention for primary care psychologists and more specialized psychologists since 2022, enabling them to provide more reimbursed care to a part of their patients. This convention emerged in order to enhance accessibility towards psychologists and consequently to mental health care services. It is worth noting that the in-depth interviews were conducted between December 2021 and June 2022, which means that not all interviewed GPs may have been aware of this option at the time.

Action – "Financial investments in mental health care services"
The proposed action involves augmenting financial investments in the Belgian health care system to broaden the spectrum of specialized mental health care services and alleviate waiting list concerns.

An additional element linked to the overarching recommendation on enhancing access to high-quality mental health care is the designation of other health care professionals. This topic notably emerged within the discussions with GPs, where the focus gravitates towards two categories of health professionals: (primary care) psychologists and social workers. As elucidated earlier, an augmentation in financial resources within mental health care would represent a crucial first step in broadening the range of health care services and thereby, bolstering their accessibility. The allocation of resources to primary care psychologists can be an important step in this respect, since the out-of-pocket payments for patients seeking their services are relatively lower compared to psychologists, rendering them a more accessible option for vulnerable groups of patients, including those with a migration background, refugees and asylum seekers. Moreover, this investment is also crucial for GPs who are frequently confronted with patients preferring the lower co-payments in general practices over the hourly wage charged by psychologist. This highlights yet again the barriers hindering accessibility of mental health care in Belgium. Lastly, within the focus groups, GPs underscored the significant professional role of psychologists, emphasizing that these practitioners also "*need to be able to deal with refugees, patients with a migration background and asylum seekers*" (FG_LOK_1).

Furthermore, the designation of social workers by GPs pertains primarily to the administrative dimensions of patient care. Here again, several GPs participating in the focus group emphasized this pertains not only for patients with a migration background, refugees or asylum seekers, but can be extended to a wider spectrum of vulnerable patients within Belgian society. Nonetheless, concerning patients with a migration background or asylum seekers, GPs deliberated on the necessity for a smoother integration of social workers to address administrative matters. This is imperative due to the fact that GPs often lack time or consider these tasks as beyond their designated responsibilities, as articulated in one of the focus groups (FG_LOK_2: "That's not our job"). Notably, community health centres generally already engage social workers in their daily work routine. However, the focus groups illuminated that GPs practising within fee-for-service practices, such as solo and group practices, also feel the need to be able to refer these patients more easily to social workers. They aim to actively involve social workers in the comprehensive care process for these patients. In a particular focus group, several GPs engaged in a discussion highlighting the potential pivotal role of social workers as possible "case managers":

> ***GP_1:*** *That [involvement of social workers] does exist for certain groups. I'm now thinking of older people, there, there are social workers and psychologists who go to their homes and who take care of a lot of things there and, and for other groups that will also exist, but maybe more specifically known for the support of those who are refugees. Maybe it already exists, but that, that is then even more known to us [GP working in CHC], that we know "Okay, we can send you there".*
>
> ***GP_2:*** *Mhm. I would also implant those in the neighbourhoods so that everyone knows "Okay, all those GPs refer people to that open house or you know", so that it is very low-key and they do not have to call first to make an appointment. Yes, that you could actually walk in (laughs).*

Action – "Designation of (primary care) psychologists and social workers"
The proposed action involves allocating resources to primary care psychologists in order to (1) enhance accessibility for vulnerable groups of patients, including those with a migration background, refugees and asylum seekers and, (2) consequently to relieve GPs who are frequently confronted with patients preferring the lower co-payments in general practices over the hourly wage charged by psychologist.

In addition, there is a crucial need for smoother integration of social workers to handle administrative aspects of consultations with patients with migration backgrounds, refugees, and asylum seekers. This action envisions an active role for social workers in the comprehensive care process for these patients, potentially serving as "case managers" to ensure comprehensive and coordinated care

Recommendation A.2.: Introducing a nomenclature number in case of a long consultation in general practices

During the focus groups, we discussed the integration of mental health care performance into primary care by introducing a specific nomenclature number for mental health care consultations within the context of primary health care. Given that the Belgian primary care system encompasses both the fee-for-service and flat-rate payment models, this action was tailored to each model during the focus groups addressing the accessibility of mental health care for newcomers. Concerning the flat-rate payment model, primarily employed by community health centres, we suggested including the number of newcomers (defined as 'refugees who have recently arrived in Belgium') registered as patients in these flat-rate practices as a determinant for calculating the monthly funding these practices receive. This approach aims to provide financial support to community health centers and similar flat-rate practices to assist newcomer patients. For the fee-for-service system, we proposed the introduction of a specific nomenclature number for newcomers.

During the focus groups, there was a critical examination of the legal foundation for introducing a nomenclature number regarding newcomers in the fee-for-service practices, as well as the utilization of the number of registered newcomers as a factor in determining the monthly forfeit of flat-rate practices. First, the comprehensiveness of the definition we applied to newcomers was deliberated. Several GPs indicated that the definition of "refugees who have recently arrived in Belgium" was inadequate and needed to be broadened up. Additionally, it was acknowledged that mental health problems do not necessarily diminish after obtaining a legal residence status, and it was suggested "a delay" (FG_LOK_1, FG_CHC_2) often exists in the manifestation of mental health issues among refugees or asylum seekers. GPs highlighted that asylum seekers might lack the mental capacity to address their mental health problems and that, in their practices, they often receive these patients seeking help after a longer period of integration they do have the mental space and peace to cope with mental health problems. In the focus group with French-speaking policymakers, a similar way of argumentation was present. In the sense that several policymakers argued that it is difficult for GPs to identify patients with a mental health diagnosis a priori, specifically in the group of refugees. This

discussion clearly illustrated the difference between flat-rate and fee-for-service practices and elucidated that the latter receive a significant lower amount of refugees and asylum seekers. An additional significant finding regarding the suggestion of introducing a dedicated nomenclature number of newcomers in fee-for-service practices emerged during the focus group involving GPs predominantly working in Brussels. These GPs alluded to their perception of this approach as a potential form of discrimination against other patients dealing with mental health problems:

> *No. No, yes, that's, we've had that discussion and I think that's discriminating against uh, anyway in that setting that you're introducing to, from other patients who have mental health needs; There is of course enormous underfunding and we, as GPs, of course feel that, so that would really discriminate against all other patients, so I don't think it's a good idea to specifically provide a nomenclature number for uh for that target group.* (FG_LOK_2)

Considering these discussed elements, we opted to shift our focus towards the integration of the performance of mental health care in primary care, through the provision of a specific nomenclature number. In various focus groups, GPs recognized the extended duration required for consultations centred around mental health problems should be taken into account. However, they do not explicitly mention a specific nomenclature number for longer consultations. Moreover, GPs clearly expressed their wish that substantial financial resources are first invested in mental health care. This allocation would serve a two-fold purpose according to them: (1) enhancing the overall accessibility of mental health care in Belgium and (2) subsequently, expanding the existing care provisions within mental health care. This again highlights the GPs' anticipation that "Action 1.A – Financial investment in mental health care services" first must be realized before this initiative can be fully effective. In the discussion with Dutch-speaking policymakers, an alternative proposal emerged for a nomenclature number designated for long consultations. Several policymakers argued that the critical aspect lies not in the specific category of patients but in the additional time required by GPs for certain types of consultations, such as for quitting smoking or consultations related to mental health problems). According to the policymakers, such a specific nomenclature number would safeguard loss of income by GPs while also affording them more time with these patients, consequently enhancing the quality of care for patients suffering from mental health problems. Nevertheless, the perspective of French-speaking policymakers contrasts with this viewpoint in the sense that they are less in favour of a nomenclature number. They also acknowledge the existing consultation time within general medicine does not allow GPs to address mental health problems, arising from the fact that somatic complaints often need to be untangled and interpreted first. However, these policymakers suggested to implement longer consultation times rather than an additional nomenclature number for these specific situations.

Action (Flanders) – "Nomenclature number in case of long consultations in general practices" This action involves integrating a specific nomenclature number for long consultations in general practices. The introduction of this nomenclature number is aimed at enabling GPs to receive compensation for longer consultations necessitated by the presence of mental health issues, which are notably more prevalent among individuals with a migration background.

Action (Wallonia and Brussels) – Longer consultation times

This action involves lengthening the consultation time. By increasing the allocated time for consultations, GPs can not only address somatic complaints effectively but also dedicate adequate time to discuss mental health concerns with their patients, which are especially prevalent among individuals with a migration background.

Recommendation A.3.: Introducing a pragmatic decision-tree

A third action initially included in our recommendations and deliberated within the focus groups focused on the development of an instrument encompassing a clear and pragmatic decision tree. This decision tree is intended to guide GPs during consultations with patients without a legal residence permit and in need of more specialized mental health care. The necessity for such a tool emerged during the in-depth interviews with GPs, during which several GPs expressed uncertainties about which organisations or authorities to approach, particularly in the case of patients without legal residence permits. Additionally, GPs often lack awareness of the available health professionals and services in close proximity to their practices. This proposed decision tree would offer a comprehensive overview of all health services and health professionals, including psychologists and psychiatrists, located nearby, along with their respective contact information.

In line with the in-depth interviews, the same viewpoint emerged during the focus groups with GPs and policymakers. The proposal for a decision-tree tool is generally appreciated, as respondents report a lack of knowledge of the existing structures in (mental) health care and a general lack of knowledge of the health care system among stakeholders.

> *What I really, really liked about this recommendation was the idea of a decision tree type of tool, especially as a young doctor. I don't yet have a great deal of experience, a great deal of experience of the network and of the initiatives that exist, and that's a shame because I think that there are a lot of initiatives that are under-exploited in fact, under-used by GPs quite simply because they don't know about them and so informing and helping doctors to work with all structures that exist, that already exist. That's a few, it's clearly something that I really like, that I think is really, really important.* (FG_Policy_French)

However, participants in the focus groups highlighted this need is not only of importance related to consultations with patients without a legal residence permit. GPs and policymakers agreed this decision-tree tool can also be of significant help in dealing with patients with a migration background

or asylum seekers in need for more expert mental health. Therefore, they offered to include both health professionals and the different actors in the field of (mental) health care and well-being (e.g. CAW or CPAS/OCMW) with expertise in dealing with patients with a migration background, asylum seekers and people without a legal residence permit. Moreover, several policymakers argued it would be of importance to map the various connections between these organisations, in order to support GPs in referring these patients to the right mental health care services.

> *But uhm, I think we, uhm certainly with scarcity- And indeed, it is due the shortage of GPs that we still have to think about who is best placed to do what for whom. And in that case, I think that it is certainly good that GPs have a basic competence of early detection. But my idea is that it becomes especially important to properly map "Who are the actors, both in health care and well-being, having the necessary expertise? Who are the actors with the necessary expertise in dealing with people with a migration background?". In this way, those connections between the actors can be mapped out much better and I think that can be really supportive for GPs to enable them to lead people to these services.* (FG_Policy_Dutch)

Finally, the discussion demonstrates a certain degree of alignment with the original proposal of the decision tree, which would encompass various mental health care services and practitioners. However, the discourse extends beyond the mere scope of a decision tree concerning patients without a legal residence permit in general practice settings.

Action – "Pragmatic decision-tree"
This action involves the development of a tool comprising a clear and practical decision tree for patients with a migration background, asylum seekers, and refugees in need of mental health care. The decision tree will encompass an overview of health care services and professionals in the surrounding area, including psychologists, along with their contact details. This could encourage GPs to consider social referrals and equip them with the knowledge and skills to make such referrals.

Recommendation B – 'Intercultural mediators and professional translators'

The second recommendation discussed during the focus groups centres on the role of intercultural mediators and professional translators in general practices. The primary objective of this recommendation is to promote collaboration with these professionals during consultations with patients who have a migration background and asylum seekers in general practices. This recommendation emerged from the insights obtained through in-depth interviews with GPs, highlighting that GPs frequently hesitate to engage professional translators due to various practical obstacles. Additionally, these interviews revealed that GPs are often unaware of the availability of intercultural mediators, especially in cases where GPs work outside of flat-rate services, as observed in interviews with GPs in Brussels and Flanders.

Recommendation B – Intercultural mediators and professional translators
Encouraging the utilization of intercultural mediators or professional translators in general practices when encountering language and/or cultural barriers.

Recommendation B.1.: Promoting the use of professional translators in the context of general practices

Both GPs affiliated within flat-rate practices and those working within the fee-for-service system disclosed that they make little or no use of professional translators due to various practical obstacles. To begin with, GPs within the fee-for-service system face specific logistical hurdles: (1) securing an appointment with a professional translator in advance, which leads to difficulties when patients arrive late or fail to show up, and (2) the expense of telephone-based professional translation being borne by the patient. Furthermore, a debate surrounding the distinction between cost-free video interpreters and paid telephone interpreters arose. While telephone professional translation was free in the past, nowadays this has become a paid service. Therefore, a part of the CHCs included in the focus groups preferred to mainly work with video interpreters, a choice that is generally endorsed by their GPs. However, they have noted that certain issues related to patient confidentiality and privacy persist among patients with a migration background when using video interpreters, rendering this option unsuitable in certain scenarios. In light of this, some of the surveyed GPs working in CHCs advocated to reconsider telephone-based interpreters as a paid service. This request was also endorsed in the focus groups with policymakers. Hence the revision of this action is twofold: (1) reinforcing accessibility to telephone interpreters and (2) ensuring GPs to be remunerated for consultations that extend beyond the initially allocated time of a consultation due to the involvement of a professional translator. The latter action can be fulfilled by the specific nomenclature number to remunerate GPs in case of longer consultations (see Recommendation A, action 2 "Nomenclature number in case of long consultations in general practices"), this was also endorsed by the policymakers. This nomenclature number would contribute to the attractiveness for GPs to work with professional translators since it allows them to have more time with a patient (with mental health problems) without harming their personal income.

Action – "Free of charge telephone-based professional translation"
This action involves improving access to professional translators in general practices by establishing a toll-free telephone interpreting service that GPs can utilize during consultations. This service needs to be tailored to accommodate the most prevalent languages spoken by foreign-speaking populations in Belgium.

Within the focus group discussions, GPs also indicated to have low levels of confidence towards professional translators, especially in the case of consultations related to mental health care problems. GPs often have the impression that professional translators do not feel comfortable

discussing matters related to mental health care or do not know how to act during these consultations. This was also critically discussed by the Dutch-speaking policymakers. However, one policymaker claimed that, although she did not want to undermine the important principle of accessibility of care, it was not realistic to expect every professional translator to be specifically trained for situations related to specialised mental health care. Moreover, GPs openly questioned the knowledge and training of professional translators in dealing with patients in their cultural context. One of the GPs stated: "I do not necessarily know whether professional translators are well-positioned, unless they are culturally competent. Therefore, several GPs and policymakers advocated for a specific training of professional translators working in the setting of (primary) care in order to (1) enable them to correctly deal with patients with a migration background and asylum seekers and, (2) to have the necessary skills to translate during consultations related to mental health problems.

Action – "Training of professional translators"

This action involves offering a specific training to professional translators working in the primary health care setting to make them more comfortable in discussing mental health problems (in a culturally sensitive way).

Action – "Investigate translation alternatives that do not involve a third party"

While this action was not explicitly discussed during the focus groups, participants indicated that involving a third party poses certain challenges. Therefore, it is recommended to explore the potential of incorporating AI translation systems within the primary care setting.

Recommendation B.2.: Scaling up the use of intercultural mediators in general practices

A second action related to the recommendation regarding professional translators and intercultural mediators focuses on the upscale of the use of intercultural mediators. A major finding of the in-depth interviews with GPs was that the majority of GPs working in fee-for-service system did not know about the availability of intercultural mediators. Therefore, this action was included in the focus groups.

Aligning with the findings of the in-depth interviews, the focus groups highlighted a similar lack of awareness about the availability of intercultural mediators in general practices among the participating GPs. This pattern is again particularly pronounced among GPs operating within the fee-for-service model in Flanders and Brussels. However, in the focus group with GPs working in Wallonia, this accounts for both GPs working in the fee-for-service system and the flat-rate system. Additionally, the focus groups reveal that this group of GPs harbour reservations towards intercultural mediators. They believe the mere presence of intercultural mediators can negatively influence the trust relationship between them and their patients. They emphasize that patients may not be acquainted with the intercultural mediator, and vice versa, thereby impeding the establishment and maintenance of a foundation of trust with the patient. Nevertheless, these arguments are always followed by the remark that the involvement of family or friends as translators is also "not ideal". Therefore, by enhancing the accessibility of intercultural mediators for GPs, especially in the fee-for-service system,

it may encourage these practitioners to more readily embrace the utilisation of intercultural mediators. Furthermore, GPs participating in the various focus groups express a more tentative reliance on professional translators compared to intercultural mediators. Their uncertainty stems from whether professional translators possess the necessary knowledge and training to effectively consider the patient's cultural background. In contrast, intercultural mediators are believed to be able to frame patients' complaints in their cultural context. This observation contributes to the formulation of this action that focuses on the use of intercultural mediators in general practices, with a specific focus on the fee-for-service system.

Action – "Enhance awareness and expand the utilization of intercultural mediators in general practices"

This action involves increasing awareness of and broadening the use of intercultural mediators, mainly among GPs who do not work in a community health centre or other flat-rate practices.

Action – "Investigate translation alternatives that do not involve a third party"

While this action was not explicitly discussed during the focus groups, participants indicated that involving a third party poses certain challenges (such as trust issues). Therefore, it is recommended to explore the potential of incorporating AI translation systems within the primary care setting.

Recommendation B.3.: Inclusion in the core curriculum of the education of general practitioners

Given that every GP may encounter patients with a migration background, refugees, or asylum seekers during and after their training, where the utilization of an intercultural mediator or professional translator is considered appropriate, it becomes nearly imperative to integrate this aspect into the core curriculum of GP training. It is noteworthy that we emphasize the inclusion of this content in the "core curriculum" of GPs in training, as a course on this subject is already offered at Flemish universities and the Dutch-speaking university in Brussels. However, it is crucial to underline that this course is not yet a mandatory component of GP training. Consequently, this action advocates for the inclusion of such a course as a compulsory element in the curricula of all Belgian universities that provide master's training for GPs. The importance of such a course is recognized in various focus groups. However, it is emphasized that the two preceding actions (which prioritize the accessibility, usability, and implementability of professional translators and intercultural mediators) are prerequisites before the incorporation of this course into the core curricula can yield meaningful results.

Action – Inclusion of a course on professional translators and intercultural mediators in core curriculum

This action involves incorporating a dedicated course focused on working with professional translators and intercultural mediators into the core curriculum of general practitioner training. This course would

become a mandatory component of the educational program in every Belgian university offering the master's program for general practitioners.

Recommendation B.4.: Including a training in the context of the required accreditation level of RIZIV-INAMI

In alignment with the proposal to introduce a course on working with professional translators and intercultural mediators into the core curriculum of GPs, we have also formulated the action of providing annual training on this subject. This training would be essential for obtaining and maintaining the required accreditation level from RIZIV-INAMI. Given that every Belgian GP may interact with patients from migration backgrounds, refugees, and asylum seekers, for whom consulting a professional translator or intercultural mediator is considered appropriate, this action holds significant priority.

Furthermore, RIZIV-INAMI plays a crucial role as they oversee the accreditation of general practitioners. However, despite the majority of focus group participants acknowledging the value of such training, both GPs and policymakers were not in favor of making it a mandatory requirement for obtaining or retaining the necessary accreditation from RIZIV-INAMI.

In the focus group with Dutch-speaking policymakers, they proposed an alternative approach, suggesting that GPs should have the option to attend webinars. This would allow GPs to complete the required training at their own convenience. Additionally, several policymakers pointed out that a similar webinar is already available and could be hosted on the websites of professional GP organizations (Domus Medica and SSMG) to enhance accessibility and visibility among GPs.

Furthermore, GPs emphasized the potential involvement of Domus Medica and SSMG as support structures for organizing training activities related to the use of professional translators and intercultural mediators in general practice settings.

Action – Inclusion of a webinar on working with professional translators and intercultural mediators on the website of RIZIV-INAMI

This action involves adding a webinar focused on working with professional translators and intercultural mediators in general practice settings to the RIZIV-INAMI website. This initiative aims to provide practicing GPs with an annual training opportunity.

Recommendation C – 'Intercultural competences in general practices'

The last recommendation that we discussed in the focus groups is related to intercultural competences in general practices. In order to have consultations with patients with a migration background and asylum seekers, it is essential to ensure that GPs are responsive to the specific cultural background of these patients to overcome possible barriers related to mental health. The in-depth

interviews demonstrated that GPs do not always feel capable of dealing with the specific cultural backgrounds of patients with a migration background and asylum seekers. Therefore, we formulated this broader recommendation.

Recommendation C – Intercultural competences in general practices

The (further) development of intercultural competences in general practice is crucial. It is essential to ensure that GPs are responsive to the specific needs of patients with a migrant background, refugees, and asylum seekers, and that they can effectively address mental health barriers.

Recommendation C.1.: Development of a missing statement regarding intercultural competences in the context of general practices

A first action we formulated to discuss within the focus group encompassed the development of a mission statement clearly stating what interculturally sensitive working in general practices entails and what intercultural competences GPs are expected to have. In this way, this mission statement can create a straightforward framework that can also be used as a basis for the accreditation and inclusion of a course in the core curricula of GPs.

This action was well received by most of the GPs participating in the focus groups. However, they had a critique in the sense that mission statements are mainly of benefit when also supported from bottom-up. Therefore, they did not agree upon the Ministry of Public Health being the only involved authority. Several GPs referred to the important role of Domus Medica and SSMG and the opportunity to include this kind of mission statement in the vision of the professional organisation.

However, we also need to acknowledge that some GPs (mainly working in Brussels) were not in favour of the proposed mission statement. They stated:

> ***GP_1:*** *Every practice must ensure that patients who do not master the language can also be taken care of? Must hey. […] Yes, I personally think that is far-reaching. That also reminds me of the next step is to introduce quotas, for example, that each practice must take in so many people. I think, I don't actually believe in that.*
> ***GP_2:*** *Someone else says: "That's a bit like opening Pandora's box I guess uh. In the sense that GPs are forced into a straitjacket, and I think GPs don't want that, most GPs don't."*
> ***GP_1:*** *And the first speaker again replies: "Well I would say, isn't that part of the job description, isn't it that we have an open unconditional conversation for anyone who applies to our practice? Point other line. I think that's the essence, but to pour it all into rules makes me shudder.* (FG_LOK_2)

Action – "Development of a mission statement regarding intercultural competences in general practices, in co-creation with GP umbrella organizations and migration-related organizations " This action involves creating a mission statement for intercultural competence in general practice. It will encompass the principles, rationale, and values that underpin the delivery of diversity-sensitive health services within the general practice setting.

Recommendation C.2.: Accreditation and recognition regarding intercultural competences

Given the increasing number of patients with a migration background in Belgium, it is crucial that GPs are better equipped to effectively interact with them. Therefore, we have included an action related to the accreditation of intercultural competences. This action was deemed important because it recognizes the significance of incorporating intercultural competences into the professional identity of GPs. As such, RIZIV-INAMI can play a crucial role in this initiative. While the majority of focus group participants acknowledged the value of offering this through webinars on the RIZIV-INAMI website, they were not in favour of making it a mandatory requirement for GP accreditation. Some GPs argued that mandatory accreditation could be too restrictive. Nevertheless, there was a consensus on the importance of providing incentives to encourage GPs to actively participate in workshops, seminars, or other events related to intercultural competences.

Action – "Promote participation in webinars on intercultural competences"

This action involves incentivizing GPs to participate in workshops, seminars and other events on intercultural competence, and ensuring professional recognition for GPs who demonstrate intercultural competence in their practice.

Recommendation C.3.: Inclusion in the core curriculum of the education of general practitioners

In line with the proposed action for the inclusion of a course related to professional translators and intercultural mediators in general practices as an obligatory element of the core curriculum of GPs, we proposed a similar action regarding intercultural competences in the focus groups. This emerged from the in-depth interviews with GPs indicating difficulties related to dealing with different cultural backgrounds of patients. Therefore, although a similar course is already present at the universities in Flanders and the Dutch-speaking university in Brussels, we propose to include this as a compulsory component in the curricula of all Belgian universities.

While all participating GPs concur on the necessity of incorporating an intercultural competence course into the core curriculum of the training program for GPs, they also provide several additional insights that are important to take into account. Primarily, the majority of the participating GPs are in agreement about the imperative to extend the same approach to the core curricula of other health-related disciplines. Given that GPs function within a multidisciplinary setting, the acquisition of identical competences by psychologists and social workers becomes essential for effective interaction

and communication with patients with a migration background, asylum seekers, and refugees. In tandem with this observation, it is notable that the majority of general practitioners specifically highlight the profession of psychologists, recognizing the absence of a dedicated course or emphasis on intercultural competences within their educational programs. Certain participants openly and critically questioned this gap, alluding to the increasingly diverse nature of society. Furthermore, a consensus exists among the participating GPs and policymakers to integrate this course into the core curriculum of the Bachelor of Science in medicine to encompass all medical students. As specialists are integral to the multidisciplinary health care context, they too require the same culturally sensitive proficiencies as GPs. This need is especially pronounced since they are the health professionals, such as psychiatrists, to whom GPs often make referrals. Moreover, both GPs and policymakers refer to the necessity of including similar courses in the core curricula of other health professionals in training. Here, they mainly refer to social workers and psychologists. In the core curriculum of social workers, this is already present. However, several policymakers urge the need of inclusion in the core curriculum of psychologists, since they argue "it is present to a very limited extent". This is necessary in order to create 'integrated care' among the different health professionals working in primary health care.

Action – "Inclusion of course on intercultural competences in core curriculum in bachelor of medicine"

This action involves integrating a dedicated course on intercultural competences into the core curriculum of the bachelor's program in medicine. This course would then become a mandatory component for all medical students.

Action – "Inclusion of course on intercultural competences in core curriculum in bachelor of psychology"

This action involves integrating a dedicated course on intercultural competences into the core curriculum of the bachelor's program in psychology. This initiative is intended to facilitate integrated care among different health professionals within primary care.

Recommendation C.4.: Developing a website on intercultural competences in general practice

This action emerged from the focus groups with GPs in which all participants mentioned the absence of practical tools on intercultural competences. Therefore, GPs urged the need for one central website providing practical tools they can use during consultations with people with a migration background. The development of this (scientific) website would have a twofold purpose. First, this website would offer several health brochures in different languages in order to enable GPs to refer patients to information on this website or print it for them during the consultation. Second, a core domain on "intercultural competences in general practice" should be included, providing general practitioners with an overview of the different tools and organizations in place that can support them with problems

they experience in the context of consultations with people with a migration background, refugees and asylum seekers. In the focus groups, the majority of GPs indicated that they already use this, but that they have to use the website of NHS (United Kingdom) or the Dutch website Pharos. Hence, the imperative for establishing a comparable website within the setting of Belgian (primary) health care becomes evident. The responsibility for this endeavour largely rests with the Ministry of Social Affairs and Health. Moreover, CEBAM, collaboratively with EvyKey, can explore the potential options for executing this initiative.

Action – "Development of a website including a core domain on intercultural competences in general practices"

This action involves creating a (scientific) website with a dual purpose:

(1) The inclusion of several health brochures in different languages in order to enable GPs to refer patients to information on this website or print it for them during the consultation. (2) The inclusion of a core domain on "intercultural competences in general practices" in order to provide GPs an overview of the existing tools and organisations in place to support them when encountering problems related to consultations with patients with a migration background, refugees and asylum seekers.

To enhance the website's interactivity and educational value, an e-learning module focused on intercultural competences can be included.

However, prior to creating the website, it is advisable to explore the possibility of integrating this information into existing platforms that GPs frequently consult, such as infosanté.be, for maximum accessibility and utilization.

6. DISSEMINATION AND VALORISATION

We have made several efforts to disseminate our findings to both academic and non-academic audiences. Furthermore, we have provided links to the dissemination activities below:

PODCASTS:

- Duveau C. REMEDI : diversité culturelle en médecine générale (1/2). RCF Radio; 2023. Podcast. Available from: https://www.rcf.fr/culture-et-societe/solidaides?episode=338119
- Duveau C. REMEDI : diversité culturelle en médecine générale (2/2). RCF Radio ; 2023. Podcast. Available from: https://www.rcf.fr/culture-et-societe/solidaides?episode=338219

NEWSPAPERS

- Duveau C. Santé mentale : Il vaut mieux s'appeler "Dubois" que "Alaoui" pour être pris en charge par son généraliste. RTBF. 20 janvier 2023. https://www.rtbf.be/article/sante-

mentale-il-vaut-mieux-sappeler-dubois-quealaoui-pour-etre-pris-en-charge-par-son-generaliste-11139521.

- Duveau C. et Durieux S. La santé mentale des personnes issues de l'immigration mal prise en charge. Le Soir. 14 avril 2023. https://www.lesoir.be/507391/article/2023-04-14/la-sante-mentale-des-personnes-issues-de-limmigration-mal-prise-en-charge#:~:text=Partager%20Accueil%20Soci%C3%A9t%C3%A9-,La%20sant%C3%A9%20mentale%20des%20personnes%20issues%20de%20l'immigration%20mal,prescrivent%20aussi%20moins%20de%20traitements.
- Duveau C. Santé : issus de l'immigration et sous-diagnostiqués. Newsletter Louvain Santé. 2023.

PROFESSIONAL JOURNAL:

- Duveau, C. (2023). "Inconsciemment, les médecins généralistes discriminent les patients migrants." Le Journal du Médecin (n°2755). 25 mai 2023. https://www.lejournaldumedecin.com/gestion/inconsciemment-les-medecins-generalistes-discriminent-les-patients-migrants/article-normal-68941.html?cookie_check=1687955100

Due to the delays caused by the COVID-19 pandemic, our dissemination activities primarily focused on the findings from the quantitative studies. However, in the near future, we plan to carry out similar efforts to disseminate the qualitative findings.

Please note that in addition to these one-time dissemination activities, we actively address the topic of provider bias in various courses that we engage with on an annual basis. During these courses, we incorporate recent findings obtained during the REMEDI project.

- Sociology of Health and Illness (Master in Sociology, UGent, and Master in Global Health, UGent).
- Interdisciplinary Perspectives on Work and Health (Master in Nursing and Midwifery, UGent).
- Health Sociology (Bachelor in Sociology, UGent, and VUB).
- Bachelor's in medicine (UCLouvain)

BELSPO SYMPOSIUM

On the 11th of September 2023, the REMEDI project team organized a symposium to communicate and share the results of the project. Here is the program of our symposium, including the various speakers and the titles of their presentations:

9:00 AM - 9:30 AM: Welcome and Registration

9:30 AM - 9:40 AM: Introduction by Prof. Vincent Lorant (UCLouvain)

9:40 AM - 9:55 AM: Presentation of the project's context by Dr. Katrijn Delaruelle (UGent)

9:55 AM - 10:25 AM: Presentation of quantitative results by Camille Duveau (UCLouvain)

10:25 AM - 10:55 AM: Presentation of qualitative results by Camille Wets (UGent)

11:15 AM - 11:45 AM: Conclusion and discussion of results by Dr. Stéphanie De Maesschalck and Dr. Hans Verrept

11:45 AM - 12:15 PM: Questions and Answers

The recording of the symposium can be accessed through this link: Symposium REMEDI-20230911_0922 37.mp4.

During the question-and-answer session, several comments and suggestions were raised. We also received questions for clarification of the results and for better understanding. It was recommended that our recommendations be validated using a Delphi panel method. The importance of training for general practitioners and psychologists was emphasized during the discussion, which supported our recommendations.

The idea of conducting future research on the implementation of the recommendations developed as part of the REMEDI project was discussed. This symposium also provided an opportunity for networking with healthcare professionals and journalists to more widely disseminate the results of the project.

7. PUBLICATIONS

We have prepared four manuscripts, two of which have been published:

- Duveau, C., Wets, C., Delaruelle, K., Demoulin, S., Dauvrin, M., Lepièce, B., ... & Lorant, V. (2023). Unintentional discrimination against patients with a migration background by general practitioners in mental health management: an experimental study. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-11.
- Duveau C., Wets, C., Delaruelle, K., Demoulin, S., Dauvrin, M., Lepièce, B., ... & Lorant, V. (2023). Individual, interpersonal and organisational factors associated with discrimination of medical decisions towards migrants with mental health problem: the case of general practice. *Ethnicity & Health*, 1-20.

One paper has been accepted and is undergoing the proofreading process at the moment of finalizing this report:

- Wets, C., Delaruelle, K., Bracke, P. & Ceuterick, M. (2023). A Foucauldian discourse analysis of Belgian policy regarding patients with a migration background and depression in general practices. *Health,* proofread.

One paper is being finalized (study 2, p. 39-53) and will be submitted to *Health Sociology Review.*

8. ACKNOWLEDGEMENTS

We would like to express our gratitude to several individuals and organizations who have played pivotal roles in the successful execution of our project:

First and foremost, our sincere thanks go to the members of our follow-up committee. Your active engagement and insightful feedback during our lively meetings were invaluable in shaping our research. Special appreciation is extended to Hans Verrept and Stéphanie De Maesschalck for their significant contributions and willingness to reflect on our findings during the concluding event.

Our sincere thanks also go to Gerwin and the two actors for their dedicated involvement in producing the video vignettes. Our collaboration with you has been a delightful experience.

We also want to express our gratitude to all the GPs (in training) and policymakers who participated in our study. Finding time for research participation is always a challenge, and during the COVID-19 pandemic, it was especially demanding. We greatly appreciated their willingness to be involved, as without their support, achieving our research objectives would not have been possible.

Furthermore, we extend our gratitude to the various organizations that assisted us in connecting with GPs.

Our heartfelt thanks also go to Aziz, Emmanuèle, Ria, Chloë and the dedicated team at BELSPO for their guidance and their prompt, helpful responses to the challenges we encountered.

Lastly, we extend our thanks to our administrative offices for their efficient support in managing the logistical aspects of our project.

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ANNEXES

Due to the extensive nature of this report, the following documents are not included in the annexes. These documents are available upon request from the authors.

In-depth interviews with general practitioners:

- Recruitment letter/e-mail
- Informed consent form
- Semi-structured questionnaire

Focus groups (general practitioners and policymakers):

- Informed consent form
- Topic guide
- Presentations