Barriers and facilitators to diagnosing dementia in migrant populations

A systematic review of European health professionals' perspectives

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REVIEW ARTICLE

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Barriers and facilitators to diagnosing dementia in migrant populations: A systematic review of European health professionals' perspectives

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Abstract

Background: Rates of dementia are increasing in migrant populations, however, there is evidence that they remain underrepresented in older adult healthcare services. Barriers and facilitators to accessing dementia care have been explored from the viewpoint of migrants and caregivers, however, no review has synthesised the literature pertaining to clinicians' viewpoints. This review aimed to explore clinician perspectives as to the barriers and facilitators in assessing and diagnosing dementia in migrant populations.

Methods: A systematic review of the literature was conducted. Databases included EMBASE, CINAHL, PsycINFO, MEDLINE and ProQuest. Qualitative studies from the perspective of European clinicians were included. The methodological quality of each study was assessed using the Critical Appraisals Programme Tool (CASP). The analysis adopted a thematic synthesis approach.

Results: The review included 11 qualitative studies relating to the diagnosis of dementia in migrants. The quality of the studies was generally high, although few studies reported on the relationship between the researcher and the participants. The data related more to the barriers in diagnosing dementia, and few facilitators were found. Four themes were constructed: (1) service access (2) perceptions of migrant beliefs (3) relationships and (4) quality of the diagnostic process.

Conclusions: The review is limited by the small number of studies available. The findings highlight significant clinical concerns in the diagnosis of migrants, in particular the underrepresentation of migrants within services and the barriers to access they may face. The quality of the diagnostic process was often thought to be undermined by a lack of culturally sensitive assessment tools. Further research on the use of an interpreter in diagnosing dementia is needed.

KEYWORDS
communication, dementia, diagnosis, europe, health professionals, migrant

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Key Points

- **Increasing Rates of Dementia in Migrant Populations:** The background highlights a rising trend of dementia in migrant populations, emphasising the need to comprehend current barriers and facilitators in diagnosing this group from the perspective of clinicians.
- **Systematic Review Methodology:** A systematic review was conducted, involving databases such as EMBASE, CINAHL, PsycINFO, MEDLINE, and ProQuest. Qualitative studies from the viewpoint of European clinicians were included, with the methodological quality assessed using the CASP tool. Thematic synthesis, was employed for analysis.
- **Focus on Barriers in Diagnosing Dementia:** The results of the review, based on 11 qualitative studies, predominantly addressed barriers in diagnosing dementia among migrants, with few facilitators identified. Four themes emerged: service access, perceptions of migrant beliefs, relationships, and the quality of the diagnostic process.
- **Clinical Concerns and Need for Further Research:** Significant clinical concerns were highlighted, particularly the underrepresentation of migrants in services and the barriers they may encounter. The quality of the diagnostic process was perceived to be compromised by a deficiency in culturally sensitive assessment tools. The review emphasised the necessity for additional research, especially regarding the role of interpreters in diagnosing dementia in migrant populations.

1 | BACKGROUND

By 2030, dementia diagnoses in Europe are expected to rise to 13.95 million.[1] Although European migrant populations face increased dementia risks due to factors like social isolation,[2] lower education,[3] and dietary patterns,[4] they are underrepresented in healthcare services [5, 6] and memory clinics.[7] There is, therefore, a recognised need to improve care for migrants due to their vulnerable socioeconomic status.[8] The core structure of memory clinics throughout Europe is remarkably similar, with multidisciplinary teams including medical specialists, psychologists, other specialist therapists, and MRI imaging.[9, 10] The similarity of diagnostic procedure, and memory clinic structure in Europe, provides a rationale for the focus of this systematic review on European settings.

Research has indicated multiple impediments to timely and accurate diagnoses of dementia in migrants including: a lack of culturally sensitive services and diagnostic tools; challenges in providing language-matched interpreters; and cultural beliefs relating to dementia.[11]Additionally, when migrants do reach services, they may feel invisible in these settings due to time-constrained interactions, and a perception that symptoms are dismissed by clinicians as normal ageing. These factors may lead to avoidance or complete disengagement with services.[12]

Clinicians' perspectives are crucial, but studies are limited. Two surveys suggest primary care physicians have lower confidence in assessing dementia in migrants, linked to perceived lack of knowledge and acceptance [13] and lack of confidence in assessing and communicating the diagnosis to migrants.[14] In addition, language barriers and a lack of cultural competence contributed to low confidence in diagnostic ability.

Lack of clinicians' skill in navigating diagnostic consultations involving patients, family members and interpreters is reported in qualitative literature.[15] The language barrier could lead to clinicians' hesitation and insecurity,potentially hindering the ability to develop congruence and alliance.[15] Understanding reports of clinicians'a low confidence, which may arise from a lack of cultural competence and training, may provide better insight into a barrier to quality care.[16]

A further barrier to quality care for migrants is the dearth of culturally sensitive assessment tools and norms available,[17] as well asinadequate culturally-sensitive assessment tools, leading to under and over-diagnosis of dementia in migrants.[18, 19] Additionally, family members may be used in the absence of available professional interpreters, potentially distorting diagnoses.[17, 20] Even when a professional interpreter is used, the accuracy and validity of cognitive assessments may be compromised, owing to subtle changes in the phrasing of questions and interpretation of answers.[21]

Clinicians' perspectives on barriers and facilitators are essential for improving service provision.[22] In synthesising the evidence base relating to clinicians' perspectives on barriers and facilitators, this review aims to generate a deeper account of the current challenges and issues inherent to this process.

2 | METHODS

A thematic synthesis of clinicians' perspectives in assessing and diagnosing dementia was conducted adopting the thematic synthesis approach by Thomas and Harden.[23] A qualitative coding strategy was adopted, in which inductive line-by-line codes were ascribed to any part of a paper that was presented as results or findings. These codes were then arranged into descriptive themes followed by overarching analytical themes to identify barriers and facilitators to dementia diagnosis.[24] The review protocol is registered on PROSPERO (CRD42022373480).

2.1 | Search strategy

The search included the following words using AND/OR techniques: alzheimer* OR cognitive impairment OR dement* OR cogni* disor* OR cogni* func* AND identif* OR access* OR evaluat* OR assess* or consult* OR disclos* OR communicat* OR diagnos* OR 'break* bad news' OR difficult* OR facilitat* OR inequal* OR view* OR opinion* OR insight* OR experience* OR attitude* OR facilitator* OR barrier* OR challenge* OR belief* OR understand* AND 'ethnic*' OR 'minorit*' OR migrant* OR immigrant* OR 'immigration' or ethnic minorit* OR 'CALD' OR 'culturally and linguistically diverse' OR 'overseas born' AND GP* OR 'general practitioner' OR nurse* OR psychologist* or psychiatrist* OR neurologist* OR clinician* OR professional* OR interpret* OR translator* OR primary care OR secondary care OR memory clinic OR memory centre OR memory centre.

Five databases were searched:Embase, CINAHL, PsycINFO, MEDLINE and ProQuest. Including ProQuest in the search, and therefore grey literature, was intended to capture unpublished literature on the present topic, and to minimise publication bias. The search strategy included combined search terms related to (1) dementia and (2) the diagnostic process and (3) migrants and (4) clinicians. The SPIDER tool (Sample, Phenomenon of Interest, Design, Evaluation, Research type) [25] was used to develop and guide the search strategy.

2.2 | Inclusion and exclusion criteria

Studies were included if they considered perspectives of clinicians involved in the diagnosis of dementia in migrant populations (Table 1). For the purposes of this review, migrants were defined as 'people who move from their country of nationality to live in a foreign country that becomes their new place of residence'.[26] There was no restriction on the reason for migration or the amount of time that a migrant had settled in a country within this definition. The term migrant was viewed as distinct from ethnic minority, with ethnic minority encompassing wider criteria such as race, nationality, and ethnic origin.[27] Migrant was also viewed as distinct from refugee, since migrants are generally considered to have choice regarding their global movement, whereas refugees are considered those who migrate specifically for international protection.[28] Relevant clinicians involved in the diagnosis of dementia are wide-ranging in Europe; a variety of healthcare professionals were therefore considered in the inclusion criteria including general practitioners (GPs), psychologists, psychiatrists, neurologists, nurses, and occupational therapists.

All subtypes of dementia were considered for the purpose of this review; however, the diagnosis of other neurological conditions such as stroke or traumatic brain injury were excluded. The review was restricted to European settings due to the similarity in diagnostic services across countries. As the research question aimed to include the experiences of clinicians, the review was restricted to qualitative research.[29]

2.3 | Study screening and data extraction

Titles and abstracts of the identified studies were screened, and a second reviewer (DM) conducted a 10% independent inter-rater reliability check. There were no discrepancies. Identified full texts were then assessed according to the inclusion criteria by two reviewers.

2.4 | Quality appraisal

The CASP (2018) has been used in qualitative systematic reviews and is thought to successfully review the quality of qualitative research, owing to its ten-question checklist covering aspects of quality and rigour. To enhance the rigour of this review and reduce error, the methodological quality of papers was assessed by two reviewers independently with discrepancies resolved through discussion.

2.5 | Methods of thematic synthesis

Within this review, 'data' was often readily identifiable in the form of quotations from participants. The findings from studies were entered verbatim into Nvivo 20's software and coded in alphabetical order. One researcher coded the findings from each study line-by-line, to mitigate unconscious selectivity that may arise from initial interactions with the data.[30] Codes were created inductively by the researcher to condense meaning and were not organised within a hierarchical structure.[31] A 'bank' of codes was developed within Nvivo with new codes generated as necessary after the coding of each paper. Codes were then organised and refined into descriptive themes. Analytic themes were then developed in relation to the research aim to identify perceived barriers and facilitators.

3 | FINDINGS

3.1 | Search results

A total of 995 records were identified from the database searches completed in January 2023. The breakdown of papers found within each database are as follows: PsycInfo (262), Embase (157), Medline (108), CINAHL (400) and ProQuest (68). After the removal of duplicates, abstract and title screening, 57 texts were assessed for inclusion and exclusion criteria. A total of 11 papers met the criteria (Figure 1).

3.2 | Characteristics of studies included

Of 11 studies, two studies collected data through individual interviews only and two collected data solely through focus groups. Three studies used observational data. The remaining five studies

TABLE 1 Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Diagnosis of dementia	Other types of cognitive impairment such as traumatic brain injury and stroke
Studies conducted in EU/EFTA countries	Studies conducted outside of EU[a]/EFTA[b] countries
Qualitative research, including observational studies	Quantitative, surveys, questionnaires, systematic reviews, editorials, commentaries, conference abstracts
Focus on the facilitators and barriers in assessment and diagnosis	Focused on residential care, day-centre care, hospital care
Perspectives of clinicians (may be embedded within research containing patient/carer views)	Solely patient or carer-focused
Migrant populations	Studies exclusively concerned with ethnic minorities, refugees or indigenous populations

[a] EU refers to the European Union.

[b] EFTA refers to the European Free Trade Association.

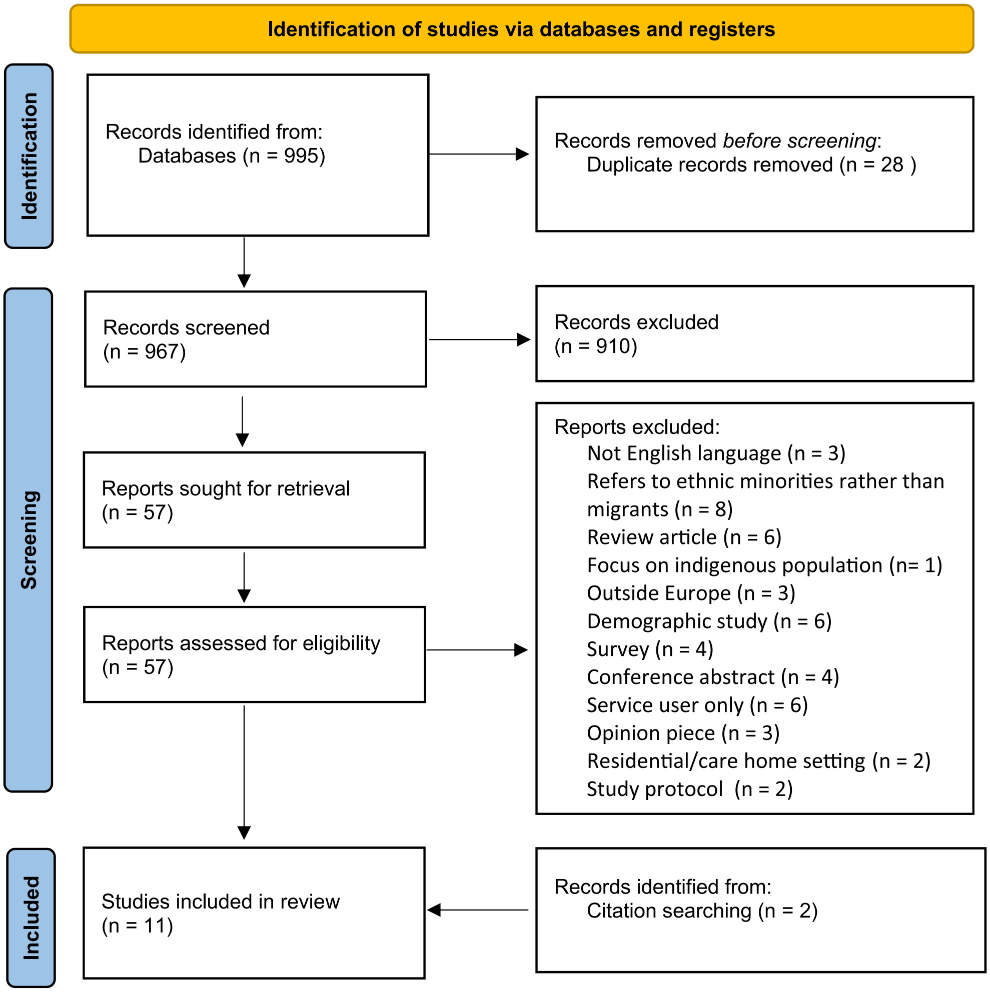

FIGURE 1 PRISMA flow diagram [32] of search and screening process. PRISMA, preferred reporting items for systematic reviews and meta-analyses.

blended data collection methods including individual interviews, dyadic interviews, and focus groups. The most used data analysis was thematic analysis, followed by analysis methods drawn from phenomenology. Within 11 studies, there were a total of 166 clinicians. The clinicians interviewed included GPs, psychiatrists, neurologists, clinical psychologists, nurses, occupational therapists, and dementia coordinators. Table 2 includes a full list of the characteristics of the studies.

TABLE 2 Characteristics of included studies.

Author and country	Topic	Definition of migrant	Participants	Data collection and analysis	Summary of findings
Plejert et al.,[21] Sweden	Interpreter-mediated cognitive assessment	Foreign-born and first-degree descendants	1 patient, 1 clinician, 1 interpreter	Observational study Conversation analysis	The cognitive assessment was considered culturally invalid, as well as inappropriate for the participant's educational background. Participants were observed to engage in a process of 'repair' that is, a joint problem-solving effort to resolve communication difficulties.
Sagbakken et al.,[33,15] Norway	Challenges in diagnosing dementia	Foreign-born, or first degree descendants of foreign-born	27 clinicians	Individual interviews, dyadic interviews, and focus group discussions Phenomenological analysis	Clinicians perceived migrants to attribute symptoms of dementia to normal ageing processes, and to hold culturally-specific beliefs about dementia as a shameful condition. Language barriers and the involvement of an interpreter complicated and undermined the diagnostic process. Clinicians lacked knowledge regarding culturally valid assessment tools.
Atcha et al.,[34] United Kingdom	Barriers to service engagement and dementia diagnosis	Foreign-born whose first language may not be that of the research country	34 participants, including 9 clinicians and 24 patients	3 focus groups Thematic analysis	South Asian migrants are under-represented in dementia diagnostic services. Health professionals consider migrants to reach diagnostic services in the later stages of dementia, relating to perceptions of cultural beliefs and stigma.
Vissenberg et al.,[35] Netherlands	Barriers to providing primary dementia care	Non-Western foreign-born individuals (Moroccan, Turkish, Surinamese)	17 clinicians	3 focus groups Thematic analysis	GPs reported barriers to diagnosing dementia in migrants as a lack of culturally competent services and lack of culturally valid screening tools. The language barrier was seen to impact the ability to understand care needs.
Berdai Chaouni & Donder,[19] Belgium	Providing of dementia services for Moroccan migrants in Belgium	Foreign-born Moroccan individuals	31 participants, including 12 informal caregivers and 19 professional caregivers	One focus group and 25 one-to-one interviews Grounded theory	Dementia care services were perceived as inaccessible due to their limited cultural sensitivity. The paper reported that clinicians could overlook the lack of culturally sensitivity and specificity within services. Clinical disregard for cultural sensitivity was thought to constitute a barrier to the diagnosis of dementia.

(Continues)

TABLE 2 (Continued)

Author and country	Topic	Definition of migrant	Participants	Data collection and analysis	Summary of findings
Majlesi and Plejert,[36] Sweden	Interpreter-mediated cognitive assessment	Foreign-born whose first language is not that of research country	3 clinicians including 1 occupational therapist, 1 patient and 1 professional interpreter	Observational study of one cognitive assessment Conversation analysis	Interpreter-mediated cognitive assessment results were considered the product of three individuals working collaboratively. Concerns regarding the reliability of testing were raised, relating to interpreter alterations in meaning and clinician understanding.
Sagbakken et al.,[33] Norway	Perceptions of dementia and access to care	Foreign-born and first degree descendants	81 participants including 51 migrants, 12 family members and 18 clinicians	Focus groups, individual interviews, dyadic interviews Phenomenological analysis	Clinicians perceived migrants to hold culturally-specific and/or spiritual beliefs about dementia. Some clinicians believed migrants saw dementia because of 'karma'. Clinicians believed socioeconomic factors could explain the underrepresentation of migrants within services.
Czapka and Sagbakken,[37] Norway	Barriers and facilitators in accessing dementia care	Foreign-born and first degree descendants	8 families migrant backgrounds families, 6 migrant community representatives, 5 clinicians	19 individual semi-structured interviews Thematic analysis	Clinicians perceived migrants to lack knowledge and understanding of dementia, serving as a barrier to the diagnosis. Service barriers were identified including linguistically competent services, as well as a lack of medically-trained interpreters.
Nielsen et al.,[38] Denmark	Barriers in access to dementia care	Foreign-born or first degree descendants	35 participants including 23 clinicians and 12 caregivers	19 individual interviews and 6 focus groups Phenomenological analysis	Clinicians perceived migrants as possessing a lack of knowledge about dementia and inaccurate beliefs relating to the condition. The paper called for greater outreach and awareness raising within migrant communities.
Wirz,[39] Switzerland	Obstacles to dementia care	Foreign born or first degree descendants	16 clinicians	16 individual interviews Thematic analysis	Four themes relating to obstacles to a dementia diagnosis were found: (1) delayed diagnosis and lack of diagnostic tools (2) obstacles to seeking help (3) lack of migration sensitivity in services and (4) administrative and financial obstacles. Clinicians reported an under-representation of migrants within services and the need to educate clinicians further on cultural competence.

TABLE 2 (Continued)

Author and country	Topic	Definition of migrant	Participants	Data collection and analysis	Summary of findings
Torkpoor et al.,[40] Sweden	Challenges in interpreter-mediated dementia assessment	Foreign-born with heterogenous educational, linguistic and cultural backgrounds	57 participants, including 19 patients, 19 clinicians and 19 interpreters	Audio and video recordings of 19 dementia assessments Constant comparative method	Interpreters may change the meaning and content of cognitive assessments. Alterations of meaning could impact judgement of patients' cognitive abilities, resulting in changes to treatment and support.

3.3 | Quality appraisal findings

The ratings according to the CASP tool indicated that all studies included a clear statement of research aims, selecting a research methodology and design appropriate to the intended research question(s) and reported on their recruitment strategy. Taken as a whole, each of the studies were found to meet most, if not all, of the CASP criteria for quality appraisal (Table S1).

3.4 | Results of the synthesis

A total of 11 qualitative studies examined the views of clinicians involved in the diagnosis of dementia in migrant populations. The nuanced approach to the data coding resulted in 153 codes from which four superordinate (service access, perceptions of migrant beliefs, relationships, and quality of diagnostic process) and 12 subordinate themes were constructed. Tables 3 and 4. The themes are described and illustrated with examples from across relevant studies.

3.5 | Service access

In addressing the challenges of assessing and diagnosing dementia, the notable absence of migrants in services emerged as a recurring theme across multiple papers. Clinicians attributed this underrepresentation to various factors, including socioeconomic position, family arrangements, service-related issues, and the necessity for enhanced outreach efforts.

Socioeconomic factors. Clinicians, even those in migrant-dense areas, reported limited contact with migrants, emphasising socioeconomic factors such as occupation, education, and financial status as key contributors to their underrepresentation.[15, 39] Some papers highlighted that socioeconomic status explained underrepresentation more than migrant status, culture, or language ([15, 33, 39]).

Family arrangements. Perceptions varied concerning the degree of migrants' social support when accessing services. While some clinicians suggested that migrants rely more on family members for support in accessing appointments, contradicting views suggested that migrants, aware of not wanting to burden their families, might not expect accompaniment.[39] Social isolation, stemming from disrupted family care patterns, was considered an access barrier.[15] There was speculation that families may want to avoid accessing dementia services and therefore discussing 'intimate and exposing' issues with their family member ([38], p. 1428).

Service factors. Clinicians recognised the lack of culturally sensitive services as a significant barrier, emphasising the need for linguistically competent services, including professional interpreters and multilingual information resources.[37] Establishing trust and connections with patients, community representatives, and other professionals was viewed as crucial for facilitating access.[39]

Improving access. Suggestions to enhance access for migrants included active engagement and outreach efforts by services, for example, multicultural link workers were proposed as intermediaries to disseminate information about dementia services and encourage their normalisation.[37]

3.6 | Perceptions of migrant beliefs

Across studies, clinicians speculated that migrant beliefs about dementia, its symptoms, and the role of the family served as significant barriers to diagnosis. Migrant families were perceived to view dementia as a shameful condition with potential consequences for family reputation and marriage prospects. Beliefs about the hereditary nature of dementia and its impact on family responsibilities were reported as potential barriers to timely diagnosis.

Views on the nature of dementia. Migrants' beliefs about the cause, prognosis, and treatment of dementia were seen to influence the acceptance of a diagnosis. Divergent perceptions of dementia as a Western construct or a form of madness created barriers to diagnosis ([15, 33]). Several papers reported that migrants could view dementia as a form of madness or insanity, resulting in a reluctance to accept the diagnosis. Beliefs that dementia may be transient or curable were reportedly held by several patients with a migrant background.[33] There was variability in perceptions of migrants' beliefs regarding the cause of dementia. Most papers reported a sense that migrants viewed symptoms of dementia as normal ageing.

Beliefs delaying diagnosis. Stigmatising beliefs about dementia were linked to delayed diagnosis, with families managing symptoms at home due to cultural norms around caring responsibilities. Some clinicians believed that families would deliberately deny symptoms of dementia and attempt to 'maintain the façade that the patient is

TABLE 3 Analytical themes and corresponding subthemes, with study contributions.

Study	Service access				Perceptions of migrant beliefs				Relationships		Quality of diagnostic process		
	Socio-economic factors	Family arrange-ments	Service factors	Improv-ing access	Views on nature of dementia	Beliefs delaying diagnosis	Beliefs about conse-quences	Beliefs about role of family	Clinician relation-ships	Interpreter relation-ships	Assess-ment accuracy	Interpretation quality	Clinician confidence
Plejert et al.[21]				✓					✓	✓	✓	✓	
Sagbakken et al.[15]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Atcha et al.[34]		✓	✓	✓	✓	✓	✓	✓	✓		✓		✓
Vissenberg et al.[35]			✓	✓		✓			✓		✓		✓
[19]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Majlesi and Plejert[36]				✓					✓	✓	✓	✓	
[33]	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Czapka and Sagbakken[37]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nielsen et al.[38]		✓	✓	✓					✓		✓		✓
Wirz[39]	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Torkpoor et al.[40]									✓	✓	✓	✓	✓
Plejert et al.[21]				✓					✓	✓	✓	✓	

TABLE 4 Summary of analytic themes and subthemes.

Analytic theme	Subtheme	Description
Service access	Socioeconomic factors	Occupational, educational, and financial factors explain barriers to service access
	Family arrangements	Patterns of caregiving result in migrants not accessing services, or advanced presentations when they do
	Service factors	Culturally insensitive services, including lack of tailored resources, prevent engagement
	Improving access	Outreach efforts may reduce barriers to access and increase diagnosis
Perceptions of migrant beliefs	Views on the nature of dementia	Clinicians perceive migrants to hold inaccurate beliefs about dementia regarding aetiology and curability
	Beliefs delaying diagnosis	Dementia regarded as a shameful condition or denoting madness, resulting in concealment of symptoms
	Beliefs about the consequences of diagnosis	Clinicians perceive migrants to hold beliefs that a diagnosis may result in being removed from their family, or that a diagnosis may damage a family's reputation
	Beliefs about the role of family	Clinicians believe families to assume responsibility for declining cognitive ability, and to take on higher degrees of caring
Relationships	Clinician relationships	Clinicians viewed trust-building with patients and caregivers as important, and to maintain awareness of caregiver burden
	Interpreter relationships	Interpreters may have pre-existing links to migrant communities and compromise privacy. Interpreter competence may negatively impact the patient experience.
Quality of diagnostic process	Assessment accuracy	Culturally insensitive tests and lack of appropriate testing norms may result in misdiagnosis
	Interpretation quality	The availability of interpreters is not always guaranteed, and interpreters may change the content and meaning of assessments
	Clinician confidence	Clinicians reported low confidence in their diagnostic abilities, resulting in aversion to assessment or hesitation in communication

functioning normally in daily life' ([35], p. 6). Attempts to conceal symptoms of dementia were reported, with families 'keeping people with dementia in their homes and hiding them away when cognitive or behavioural symptoms became apparent' ([38], p. 1428).

Attempts to conceal symptoms and scepticism about reported daily functioning further impeded timely diagnosis.

Beliefs about the consequences of diagnosis. Fear of consequences, such as being taken away or damaging the family's reputation,[39] was reported as a barrier to effective communication of a dementia diagnosis. Clinicians reported that migrants may believe that dementia is hereditary and therefore that 'insanity is running in the family' ([38], p. 1428), affecting potential marriage prospects for children and grandchildren. Social shame was also presented a potential consequence of a dementia diagnosis.[34]

Beliefs about the role of family. The perception that declining memory is a shared familial responsibility acted as both a barrier and facilitator, with clinicians sometimes viewing family obligations as problematic for diagnosis. This could be perceived as a facilitator to communicating the diagnosis, in that it meant families believed they could compensate for memory loss and saw this as their responsibility. There was a general perception that a barrier to diagnosing dementia was the strongly rooted sense of obligation and duty families felt to care for relatives themselves.[37] Although clinicians often commented on families' sense of obligation to care for their family member, there was a sense that clinicians saw this as a problem and barrier, even if family members did not.[33]

3.7 | Relationships

The quality of relationships between clinicians, patients, and family members played a crucial role in the assessment and diagnosis process. Trust, familiarity, and rapport were identified as essential elements. Privacy concerns were reported to threaten the integrity of the diagnostic process, for example, where an interpreter may have pre-existing links to a migrant community.

Clinician Relationships. Building positive relationships with patients and families was considered foundational for good diagnostic practice. The language barrier was acknowledged as an obstacle, but sensitivity to migrants' needs could facilitate better communication.[39] Non-verbal cues, such as gaze, were seen as potential facilitators to the clinician-patient relationship.[36]

Collaborating with families, including instigating family meetings and involving multiple family members in consultations, was viewed as beneficial for diagnostic communication (Czapka and Sagbakken). Intuition and careful attention to potential mismatches between caregiver reports and observed reality were emphasised.[35]

Maintaining an awareness of caregiver stress in the diagnostic process was often viewed a facilitator.

Professional relationships beyond the consultation room, for example, establishing connections with third sectors, welfare facilities, and public campaigns was seen as important for raising awareness of dementia in migrant communities.

Interpreter relationships. Concerns were raised about the impact of interpreter-patient relationships on communication. Issues included interpreters' personal links to patients' communities, potential breaches of privacy, and concerns about the quality of interpretation.[40] Although clinicians more commonly reported concerns regarding the interpreter-patient relationship, some facilitators to relationship were also observed, including the use of non-verbal gestures to build alliance.[36] Non-verbal gestures, particularly those that mirrored clinicians, were viewed in several papers as attempts to put the patient at ease and facilitate the smooth assessment of dementia, as well as enhance the accuracy of questions.

3.8 | Quality of diagnostic process

Several barriers to the integrity and validity of the diagnostic process were identified, including concerns about communication accuracy, assessment tools, and interpretation quality. Clinicians frequently reported a lack of personal confidence in communicating the diagnosis due to perceived cultural gaps.

Assessment accuracy. One of the worst outcomes of culturally insensitive tests was reported as the misdiagnosis of dementia [15] findings implied that this was a frequent occurrence in their sample of clinicians, with inappropriate assessment tools 'used improperly' to inform clinical opinion. The reliability of assessments was questioned, with reports of culturally insensitive tests leading to misdiagnosis. Culturally appropriate assessment tools were suggested to improve the accuracy of dementia diagnoses.

Interpretation quality. Challenges in obtaining professional interpreters and concerns about the quality of interpretation were reported.[35, 41] Issues included interpreters modifying or omitting instructions, potential mismatches in dialects,[40] and the impact of using family members for interpretation.[21] Clinicians also expressed their concerns about the quality of interpretation provided by an interpreter.[15] An inability to know the exact exchanges between interpreters and patients was viewed as a source of frustration and worry, impacting confidence in the assessment and diagnostic process.

In many studies, where professional interpreters were not available, interpretation often fell to clinicians or family members. Where family members provided interpretation, 'emotional and personal involvement were seen as pitfalls for conscious and unconscious alterations of content' ([39], p. 15). Using family members for interpreting was seen to threaten the quality of content, where medical terminology may not be understood, and outcomes of the diagnosis could be altered.[37]

Clinician confidence. Clinician confidence in the ability to convey a diagnosis directly influenced the diagnostic process. Insecurity and hesitation in conveying diagnoses were reported, driven by perceived cultural gaps, stereotypes, and assumptions about diverse populations.[41] Lack of confidence appeared to drive either a referral to a specialist service to promote further investigation, or conversely an underestimation of symptoms and therefore a reluctance to refer to specialist services.[37]

Despite these challenges, the literature highlighted potential facilitators, including the use of non-verbal gestures, sensitivity to cultural nuances, and active collaboration with families and communities. Ongoing efforts to address these issues and to enhance cultural competence in dementia assessment and diagnosis are crucial for ensuring equitable access and accurate diagnoses for migrant populations.

4 | DISCUSSION

This synthesis examined clinicians' reported barriers and facilitators to the assessment and diagnosis of dementia in migrant populations. The aim was to uncover the perceived barriers and facilitators to inform clinical practice and service provision. Analytic themes represented core issues in the assessment and diagnosis of dementia in migrants related to service access, perceptions of migrants' beliefs about dementia, clinician-patient-interpreter relationships, and the quality of the diagnostic process.

The first theme, 'service access', suggested that in asking about the challenges of assessing and diagnosing dementia in migrants, clinicians report that migrants are simply not represented in their services. This underrepresentation is verified in European demographic studies.[42–44] Some clinicians attributed underrepresentation to socioeconomic factors, such as low education levels. This belief itself may serve as a barrier to migrant representation in services. Migration is a major life event affecting lifestyle and health, and may therefore affect service access.[45] Acknowledging migration as a major life event with consequences for service access may improve impetus for service change, such as outreach initiatives.

Occasionally, clinicians viewed migrant families as gatekeepers to a diagnosis of dementia. It was hypothesised that families could prevent help-seeking, related to an unwillingness to discuss uncomfortable topics. Avoidance of diagnosis-seeking has been reported in general populations,[46] related to a discomfort in acknowledging the symptoms of dementia. It may be that the views expressed by clinicians in this synthesis apply more generally to familial avoidance of diagnosis seeking, regardless of culture. Service access was thought to be impacted by linguistically insensitive services that could be off-putting for migrant families, as well as unavailability of resources catering for different languages. Some clinicians saw it as the service's responsibility to develop outreach strategies, for example, deploying community link workers and approaching community leaders to promote services.

The second theme concerning perceptions of migrants' beliefs about dementia was reported more often as a barrier to the diagnostic procedure. The findings here suggest clinicians often believe migrants view symptoms of dementia as normal ageing. It is noteworthy, however, that in Arora et al.'s [12] synthesis of migrant perspectives on access to healthcare, migrants considered *clinicians* to dismiss their symptoms as normal ageing. Clinicians often viewed migrants and families as holding inaccurate beliefs regarding the cause and treatment of dementia, leading to diagnostic delay. Inaccurate beliefs regarding dementia and its consequences for a timely diagnosis have been reported in larger ethnic minority communities.[47, 48] Beliefs about the role of family in this synthesis are also viewed as a barrier to timely diagnosis. Family care practices have been previously reported as impediments to timely diagnosis from patient perspectives.[38, 49]

Relationships between the clinician, patient and caregiver were viewed as integral to the diagnostic process, as were relationships between the interpreter and patient. Several clinicians reported the belief that it was their duty to gain trust with patients and families to assess and diagnose dementia.[50] A concerning finding was evidence of poor relationships between professional interpreters and patients. Occasionally, clinicians reported that pre-existing links between an interpreter and the migrant community could compromise the privacy of the diagnostic process.[51]

Diagnostic tools were viewed as a consistent barrier to the valid assessment of migrants. The cultural validity of assessment tools is an extensive research area, with many Western tools considered inappropriate for those with low education levels or where the host-country language is not a first language.[52, 53] However, while this synthesis suggests while culturally sensitive tools may not be readily available in services, an additional barrier may be a lack of interest in obtaining them, or a belief that Western tools are sufficient.

A surprising finding of this synthesis was that interpreters could often be viewed as a barrier to quality assessment and diagnosis of dementia.[54] Interpreters may alter the content of clinician's communication in ways that compromise the accuracy and validity of the diagnostic process. The fluency, dialect-match, and conduct of the interpreter may need further consideration for services to be suitably culturally sensitive. This reflects issues highlighted by Gilbert et al.[55] that interpreters may miss subtle indications of cognitive decline such as distorted speech or word-finding difficulties. Additionally, Gilbert et al. highlight that interpreters may fail to render all of a patient's speech, or may have difficulties in understanding and conveying instructions specific to the assessment.

Clinicians may perceive migrants to be those from non-Western countries and may therefore consider migrants and their families to hold collectivistic notions of caregiving. Qualitative research has shown before that families generally assume responsibility for a relative's cognitive decline, and that this responsibility is rooted in duty and obligation.[50, 56] Clinicians also highlighted that migrants possess non-Western beliefs about dementia as a form of insanity or as a transient condition, and this is reflected in the literature examining migrants' own attitudes towards dementia.[57, 58] While migrant attitudes towards caregiving and the nature of dementia may serve as a barrier to engagement, an additional barrier may be clinicians' difficulties in addressing these with patients.

4.1 | Strengths and limitations

A major limitation of this synthesis is the lack of clarity and shared understanding regarding the term migrant, as well as the individual meaning of this term to the clinicians participating in each study. The small number of studies included in this review may also reflect the fact that various migrant populations within Europe are still relatively young, and not yet seeking diagnostic services. This may partly explain why several clinicians within these studies reported a lack of contact with migrant populations, even within migrant-dense areas of European countries. Additionally, given the breadth and heterogeneity of migrant populations in Europe, the themes constructed here may over-simplify barriers and facilitators for a population with disparate and divergent beliefs about dementia.

Additionally, a limitation of this synthesis is that several studies included a combination of clinicians, patients, and caregivers. The data collection methods used, for example, focus groups and dyadic interviews, may have influenced self-reports from clinicians regarding the barriers and facilitators to diagnosing dementia in migrants. Clinicians' perceptions of barriers to service access may be inaccurate, and the self-reported views here are not necessarily accurate.

5 | CONCLUSIONS

The analytic themes constructed from the data imply that the diagnosis of dementia in migrants is seated within issues of service access, perceptions of migrant beliefs, clinician-interpreter-patient relationships, and variable assessment quality. The findings suggest that it is not possible to discuss the diagnosis of dementia in migrants without discussing their underrepresentation in services. Many of the countries included in this study have public health care systems that migrants will have free access to. It may not be direct financial costs that impede service access, but other socioeconomic factors such as education levels. Clinicians perceived migrants to hold self-stigmatising and inaccurate beliefs about dementia that prevented service access and diagnostic acceptance. A prevailing view was the notion that clinicians are directly responsible for building trust and alliance with patients and caregivers to communicate the diagnosis. There was evidence of clinicians requesting training in cultural competence, as well as valid cognitive tests, to facilitate the accurate diagnosis of dementia.

Potentially, the results highlight the need for services to turn their attention to the provision of culturally sensitive tools, and to provide clinicians with education and training surrounding the importance of these. In particular, this synthesis highlights the need for greater attention to the provision of quality interpreters within services to facilitate positive patient experiences and valid dementia assessments. Considerations regarding interpreters' personal links to migrant communities, as well as ensuring dialect-matched professionals, may further facilitate the diagnostic process. Although services may intend to provide culturally sensitive care, it is evident in this review that service-level constraints can impact the provision of quality interpreters and adequate assessment tools. Clinicians routinely reported low confidence as another significant obstacle to assessing and diagnosing dementia in migrants. Barriers range from individual confidence and competence to service-level provision, and addressing this spectrum may support more accurate and timely diagnoses in this population.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in Edinburgh Research Archive at https://era.ed.ac.uk/handle/1842/41019.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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