ORIGINAL ARTICLE

Mental Health of Ethnic Minority Elders in West London : Pathways into secondary care

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ABSTRACT

The understanding of pathways into care is necessary to plan services and identify health care needs of patients. We set out to study these pathways into care in south Asian and white elderly patients coming into contact with secondary care psychiatric services. All inpatients, day patients and community assessments of patients over 65 being referred for the first time or after a gap of one year were invited to take part in the study over a 6 month period and those willing were interviewed. Pathways to care encounter, GP satisfaction, Past Psychiatric History Schedule and mental illness beliefs were studied. Only the pathways and GP satisfaction are presented here. Of 117 patients, 71 were white and 46 south Asians. South Asians were more likely to ask for help but had longer delays in contacting psychiatric services. They were also more dissatisfied with their GPs. A complex interaction of interpersonal and intrapersonal factors influences pathways into help-seeking.

Key words: Ethnic minority; Elders; Pathways into care

INTRODUCTION

Goldberg and Huxley (1980) pioneered the model of pathways into care suggesting that not all cases with psychiatric morbidity in the community came into contact with secondary psychiatric services. They argue rightly that in order to do so the individuals or their carers have to recognise the symptoms as abnormal, then seek help from their GPs who have to be able to identify those symptoms in order for treatment at the primary care level or referring them on to psychiatric services. The main theme of this model is that patients have to go through a range of filters prior to reaching specialist care. Although each filter is selectively permeable, the patients and carers may use alternative pathways which are influenced by various models of explanations they may have. Interestingly, these filters apply to the UK models, though, these have been used elsewhere as well.

Literature Review : Elderly migrants may suffer mental disorders associated with old age, but may also be related to stresses related to migration, culture shock, alienation and feelings of displacement. Most of the migration to the U.K. by ethnic minority groups occurred over 30 years ago and these are the groups who are now nearing retirement or have retired. In addition, a sense of isolation may contribute to increased rates if elders feel ignored because either their children have moved on and they may still be holding on to traditional views of their own role and importance within the family hierarchy. There is a relative paucity of literature on ethnic minority elders mental health and pathways they take into seeking help from the secondary case services.

Pathways into care are determined by several factors. As Goldberg and Huxley (1980) suggest at each stage, filter is overcome by a number of reasons. For example, individuals and their carers have to recognise the symptoms as abnormal and then be able to identify potential sources of help and then depending upon availability, accessibility and recognition of services they may get to the professional sector for help.

Although studies have reported rates of various psychiatric disorders in the over-65 also called elderly (Bhatnagar and Frank 1997. Some argue that higher rates of reported chronic health problems and disability among Bengali elders, and their correlation with mental health problems were not correlated. It has been suggested that features like communication, cognitive impairment and language barriers will also affect help-seeking and pathways into care. The caution that awareness of issues like idioms of distress are crucial to undertaking any research into these populations. Bhui and Bhugra (2002) suggest that as Asians frequent primary care in the U.K. (Gillam et al 1989) but do not have high rates of mental illness it is possible that their contact with primary care may also reflect varieties in their explanatory models. In this paper we present the findings on pathways into care of ethnic minority elders in West London.

METHOD

Over a six month period all patients over the age of 65 who had presented to secondary services in Ealing were approached. For those who refused to be interviewed, data into pathways was collected from the case notes. Pathways into care schedule (Gater et al 1991), Psychiatric and Personal History Schedule (PPHS, Jablensky et al 1992), and beliefs about mental health were used. In this paper only the data on pathways and GP satisfaction are being presented. Using the criteria patients' were asked to describe their ethnicity.

In total 117 patients entered the study and of these 71 were whites and 46 were Asians. Of the whites 64 came in through primary care and 7 did not and among the Asians 39 came in through primary care and 7 did not. Basic socio-demographic details are shown in Table I.

Looking at pathways Asians (9 out of 47) were more likely than whites to suggest to

TABLE I. Socio-demographic details of two groups

	White Pry care	White Not Prycare	Asian Pry care	Asian Not Prycare
Total	64 (%)	7 (%)	39 (%)	7 (%)
Male	19 (30)	3 (43)	14 (36)	1 (14)
Female	45 (70)	4 (57)	25 (64)	6 (86)
Marital status				
Single	3 (5)	0	0	0
Married	32 (50)	3 (43)	16 (41)	2 (28)
Widowed	24 (37)	4 (57)	19 (49)	3 (43)
Sep/Divorced	5 (8)	0	4 (10)	2 (28)
Accommodation				
Owner	40 (62)	6 (86(	23 (59)	3 (43)
Council	6 (9)	1 (14)	1 (3)	0
Others	18 (29)	0	15 (38)	4 (57)
Retired	60 (94)	7 (100)	6 (92)	
Benefits	64 (100)	7 (100)	30 (79)	7 (100)

their carers that they needed help whereas for whites (2 out of 71) their carers did. (chi-square 9.193, df = 1, p = 0.002.). There was no significant differences between the two groups in previous care by psychiatric services.

The first contact with services are shown in Table II.

An analysis of pathways into first contact shows that 95% of whites approached their

TABLE II. First Contact

	Psychiatric	Mental Health	GP	Nurse	Priest	Other
White P N = 64	1 (1.6)		61 (95)	2 (3)	0	0
White N N = 7	3 (43)		2 (28)	2 (28)	0	0
Asian P N= 39	2 (5)		33 (84)	2 (5)	2 (5)	0
Asian N N=7	0		4 (57)	0	3 (43)	0

P = Primary Care N = Non Primary Care

GP compared with 8.7 % of Asians and among those Asians not using the primary care pathway, one third had approached a priest or another religious person.

By second contact no patient had approached a priest or other religious person. One third Asians approached a nurse or other health workers at this stage.

By third contact all those whites who had come through non primary care route had established contact with psychiatrists or other mental health specialists whereas the Asians still were in contact with others (in 67% cases)

GP Satisfaction : Seven aspects of GP consultation and satisfaction with this process were analysed. These included general satisfaction, satisfaction with premises, accessibility and availability of the GP, satisfaction with the depth of their relationship.

When compared according to ethnicity whites were reported to be more satisfied than their Asian counterparts with the depth of relationship with their GP, medical care received and overall satisfaction.

Asian patients demonstrated a delay in seeking help when compared to their white counterparts. Mann Whitney U test revealed a mean rank of 79.76 days before seeking help for Asians compared with a mean rank of 44.51 days for whites (p = 0.000).

DISCUSSION

Two caveats are essential prior to any interpretation of this data. Firstly the numbers are small and collected over a short period. Secondly both the groups are heterogeneous and should be seen as such.

Referrals to secondary care: Pathways which patients take are likely to be influenced by conventions governing referral, by relationships which exist between mental health services and other sources of help and by availability and accessibility of mental health and other helping agencies.

In a study by Gater and Goldberg (1991), they examined relative intervals or delays in the pathways to care. From 250 patients newly referred to mental illness services of South Manchester almost 2/3 were referred directly by their GP, a further third were referred by hospital doctors. Non – medical sources of referral accounted for only 2% of new cases . Patients with somatic problems had longest interval between seeking care and referral to Psychiatric services.

These findings were further supported in another study investigating cross cultural referral pathways. The investigation conducted by Gater et al, (1991) highlighted factors related to delays in referral. The pathways to Psychiatric services of 1554 newly referred patients in 1 1 countries showed that within centres which were reasonably well supplied with Psychiatric staff, the pathways within the centres were dominated by GP's and to a lesser extent hospital doctors. The relatively less well resourced centres demonstrated differing pathways. Native healers often played an important role. Delays were short in all centres despite level of Psychiatric resources but in the pathways taken using native healers longer delays were observed.

TABLE III. GP satisfaction by route

	Primary/Not primary care	N	Mean Rank	Sum of Ranks
Reldepth	**Primary care**	**78**	**46.43**	**3621.50**
	Not Primary Care	10	29.45	294.50
	Total	**88**		
Contin	**Primary Care**	**78**	**46.04**	**3591.50**
	Not Primary Care	10	32.45	324.50
	Total	**88**		
Medical	**Primary Care**	**78**	**46.21**	**3604.50**
	Not Primary Care	10	31.15	311.50
	Total	**88**		
Avail	**Primary Care**	**78**	**46.18**	**3602.00**
	Not Primary Care	10	31.40	314.00
Access	**Primary Care**	**78**	**45.46**	**6545.50**
	Not Primary Care	10	37.05	370.50
	Total	**88**		
Premises	**Primary Care**	**78**	**46.12**	**3597.00**
	Not Primary Care	10	31.90	319.00
	Total	**88**		
Gpsat	**Primary Care**	**78**	**46.22**	**3605.50**
	Not Primary Care	10	31.05	310.50
	Total	**88**		

Test Statistics[3]

	Reldepth	Contin	Medical	Avail	Access	Premises	Gpsat
Mann-Whitney U	39.00	269.500	256.500	259.000	315.500	264.000	255.500
Wilcoxon W	294.00	324.500	311.500	314.000	370.500	319.000	310.500
Z	-2.429	-1.993	-2.209	-2.168	-1.062	-2.032	- 2.294
Asymp.Sig (2-tailed)	.015	.046	.027	.030	.288	.042	.022

Grouping Variable: Primary Care / Not Primary Care

Pathways into care: Although a majority of patients in both groups (irrespective of ethnicity) take primary care route as defined by Goldberg and Huxley model it appears that a significant number of south Asians do not do so. Even among those who do, there appears to be a significant delay in help seeking. There could be two explanations for this delay. First and foremost is a non- medical model seeing symptoms as part of the normal ageing process, hence there being no need to seek medical intervention.

A similar model and explanation were put forward by Punjabi women who saw depression as part of life's ups and downs and therefore not a medical problem and these women who use non medical sources such as religious persons and healers. It is likely that a similar model may be in existence for the elder group. Secondly it is possible that even if they get to the GP there may be a delay in identification of symptoms if right words are not used. We are in the process of conducting a series of qualitative studies to address these findings. There is also a possibility albeit small that GPs miss the diagnoses. This is less likely in this group because all the surgeries had GPs from Asian backgrounds who would have been aware of cultural and social factors at play among the Asian group.

GP Satisfaction : Not surprisingly those who came through non-primary care routes were more dissatisfied with their GPs which may well explain why they chose alternative routes, Interestingly enough, there were clear ethnic differences in levels and degree of satisfaction with the GPs where Asians were generally less satisfied. This needs to be investigated further. Their lack of satisfaction is not likely to do with ethnicity of their GP's. As mentioned above the majority of surgeries have doctors from Asian backgrounds who are aware of the cultural nuances and expressions of illness, and yet Asians were less satisfied with relationships with their doctors and the medical care they receive. It may be that Asian patients approach their doctors expecting them to have similar models of care and if there is a disagreement this may be seen as significant factor in low satisfaction. If the doctors are holding western views of mental or physical illness that too may cause conflict. This needs to be investigated further by interviewing doctors and getting their views as well as by observing doctor-patients interactions.

In view of the Primary Care Trusts coming into existence in the UK, satisfaction with their GPs becomes much more important and relevant for studying pathways into care.

CONCLUSIONS

Pathways into care are linked with models of illness which may not be medical and level of satisfaction with general practitioners and their surgeries. It is likely that a complex interaction of factors – both interpersonal and intrapersonal is at play to influence pathways into help-seeking.

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