Routes to psychiatric inpatient care in an Inner London Borough

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Summary. A study is reported in which pathways to psychiatric inpatient care were investigated in an Inner London Borough. Data were collected on a series of 52 consecutive admissions of adults to the psychiatric wards serving the area. The most striking feature of the results was the variety of routes taken to inpatient care, combined with a high level of police involvement (23.1% of admissions) and a low level of referral from General Practitioners (15.4% of admissions). Significant age differences in routes to care were found: those under 30 years were usually brought to hospital by the police or presented directly to psychiatric emergency services; those over 30 typically came via medical/surgical hospital services, domiciliary psychiatric services or psychiatric outpatients. There were no differences in the routes taken by Afro-Caribbean and white people or by men and women. Higher proportions of Afro-Caribbeans received a diagnosis of schizophrenia, considered themselves to have nothing wrong with them and were compulsorily detained. Higher proportions of whites were diagnosed as depressed and considered themselves to have physical problems rather than psychiatric ones. However, results clearly indicated that it was ethnic status rather than diagnostic category that accounted for the higher rates of compulsory detention of Afro-Caribbean people. The implications of the findings for service development and delivery are considered.

There has been considerable recent interest in the pathways which people take to psychiatric care. In particular, Goldberg and Huxley (1980), on the basis of their work in General Practice proposed their now well recognised ‘filter model’ indicating the ways in which people experiencing psychological problems get help. This work has now been extended in a large multi-centre study by the World Health Organisation (Gater et al. in press) indicating considerable international variation in pathways to care. However, the results from Manchester, U.K. broadly support Goldberg and Huxley’s (1980) original formulation.

This study considered all new referrals to psychiatric services within one calendar month. Every patient referred who had not received psychiatric care in the last year was included. In the majority of centres that were relatively well provided with psychiatric staff, General Practitioners dominated the pathway taken to psychiatric services, with about two-thirds of people using this route.

However, these studies have been concerned with referrals to psychiatric services in general, rather than with inpatient admissions in particular. Clearly, there are many factors determining admissions, all of which are important in the present climate of attempts to reduce the number of psychiatric beds. If efforts are to be made to reorganise services and provide alternatives to inpatient care wherever possible, one critical piece of information is a knowledge of the routes that people are taking to care. Without such information it is not possible to ascertain where efforts should be directed to provide the necessary help before admission becomes inevitable. For example, additional resources and services at the General Practitioner level might be considered, but these would only be relevant if this is an important port of call on the route to inpatient care.

There have been a few studies that suggest, for example, that at least some groups within inner cities to not reach inpatient care via their General Practitioner (G.P.). In particular, Rogers and Faulkener (1987) demonstrated a high level of police involvement particularly in London. Similarly, Harrison et al. (1984, 1988, 1989), Ineichen et al. (1984) and Rwegellera (1980) found a high level of police involvement and a low level of G.P. involvement in admissions of Afro-Caribbean patients. Again these studies were predominantly concerned with inner city areas. A framework for considering the diversity of routes that such studies imply has already been proposed by the present authors (Moodley and Perkins 1990).

The purpose of the present study was to consider not pathways to psychiatric care in general, but instead to examine in particular routes taken to psychiatric inpatient care in an Inner London Borough. In this context it was considered important to investigate routes taken by all
those admitted to inpatient facilities serving a geographically defined catchment area with a population of 90000. As a whole, the area is the sixth most deprived in the country in terms of the Jarman 8 Index (Royal College of Psychiatrists 1988), and on the basis of 1981 census estimates some 23% of the population were from racial minorities, predominantly Afro-Caribbean.

Psychiatric inpatient facilities were provided by two wards, admissions to which were the subject of the present study. Other psychiatric services in the area comprised a psychiatric outpatient service seeing people both by appointment and as emergencies; a domiciliary psychiatric service; a liaison psychiatry service operating in a large teaching hospital; a psychiatric day hospital; and access to a 24 hr walk-in psychiatric emergency clinic in a neighbouring district (the designated place of safety for assessment of people detained under Section 136 of the Mental Health Act).

Method

Subjects

The subjects in this study were 60 consecutive psychiatric admissions, of people aged between 18 and 65 years, to the wards serving the catchment area. It was not possible to collect data on eight of these people (they were either unavailable at the time of interview or were unable/refused to complete the interview). Of the 52 on whom data was collected, there were 19 males and 33 females whose ages ranged from 18 to 64 years (mean age 39.0, s. d. 13.5).

Materials

Data were collected on each admission using the ‘Encounter Form’ developed for the W.H.O. study of pathways to psychiatric care (Gater et al. in press). This is an interview schedule taking about 10 minutes to complete which asks the person to relate details of timing and type of help sought or received since the start of their current difficulties (W.H.O. 1988). Although designed to investigate routes to all types of psychiatric care, it was considered that this schedule would provide the information necessary in investigating the specific routes to inpatient psychiatric care.

Procedure

All subjects were interviewed within one week of admission to hospital by the researchers. Basic demographic data (age, address, etc.), and information on psychiatric history (previous admissions, date of last discharge, etc.) and diagnosis were obtained from the case notes. All interviews were conducted in private interview rooms on the wards. Interviewees were assured that any information they gave would be confidential, and that the purpose of the study was to investigate how people get help when they have problems.

Results

Characteristics of the people admitted

The majority of the patients were young (55.8% under 40 years). Most were single (80.8% single, divorced, separated or widowed), living in council accommodation (63.5%) and unemployed (75%). In terms of their current or most recent occupation most fell into Registrar General’s Social Classes 3–5 (71.2%). The majority had experienced previous psychiatric admissions (84.6%) and on the current admission received a variety of diagnoses: manic depressive illness (25.5%), depression (27.7%), schizophrenia or schizoaffective disorder (40.4%). There were no significant sex differences on any diagnostic or demographic variables.

In terms of ethnicity, 48% were White and 42% were Afro-Caribbean. The Afro-Caribbeans and Whites did not differ on any demographic variables other than age, the Afro-Caribbeans being younger ($\chi^2 = 12.5, P < 0.005$). The Afro-Caribbeans more often received a diagnosis of some form of psychosis ($\chi^2 = 8.7, P < 0.05; 62\%$ of Afro-Caribbeans and 26.1% of Whites). However, these differences in diagnosis were found only in older subjects: amongst those over 30 years, more Afro-Caribbeans received a diagnosis of schizophrenia ($\chi^2 = 8.9, P < 0.05: 70\%$ of Afro-Caribbeans, 21% of Whites). A higher proportion of older Whites received a diagnosis of depression (47% of Whites, 0% of Afro-Caribbeans). There were no differences in the proportions of Afro-Caribbeans and Whites diagnosed as suffering from manic depressive illness.

Initial problem reported

The main problem that each person reported at the start of their quest for help was categorised (physical, social, psychiatric, behaviour problem, overdose, or no problem at all – denial that anything was wrong). There was a significant difference in the frequency with which different problems were reported by White and Afro-Caribbeans people ($\chi^2 = 12.9, P < 0.05$). Similar proportions reported social and psychiatric difficulties (social problems reported by 24% of Whites and 22.7% of Afro-Caribbeans; psychiatric problems reported by 28% of Whites and 32% of Afro-Caribbeans), but a higher proportion of Whites reported physical problems (24% of Whites, 9% of Afro-Caribbeans) or took overdoses (12% of Whites, 0% of Afro-Caribbeans), and a higher proportion of Afro-Caribbeans thought that they had no problems at all (0% of Whites, 32% of Afro-Caribbeans). There were no significant age or sex differences in problem reported.

Routes to inpatient care

There was a marked variety in the routes that people took to arrive at inpatient care. The number of people taking different routes can be seen diagrammatically represented in Fig. 1. The largest proportion (38.4% –