The role of ethnicity in access to care and treatment of outpatients with depression and/or anxiety disorders in specialised care in Amsterdam, the Netherlands

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Chapter 2

Ethnic disparities in missed initial appointment rates after referral to secondary care for depressive and/or anxiety disorders: a comparative study

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ABSTRACT

Objective: To study determinants of missed initial appointments in specialized mental health care for affective disorders. Specific attention will be paid to the role of ethnicity and possible cues to improve access to care.

Method: The medical files of 110 patients with a Moroccan or Turkish ethnic background, and 110 matched patients with a Dutch ethnic background were selected from a referral list of a specialized clinic for depression and anxiety treatment. Data were analyzed using logistic regression.

Results: In total 44 (20%) patients missed the first initial appointment. Ethnicity was found to be the only significant determinant: 31% patients with a Moroccan or Turkish ethnic background missed the first appointment, compared with 9% in the indigenous Dutch patient group. After repeated invitations these percentages were reduced to 13% for the Moroccan and Turkish patients and 3% for the indigenous Dutch patients.

Conclusion: The first step in the referral process from primary to secondary care for affective disorders, leads especially among migrant patients to a substantial dropout. Repeated invitations can be effective, although an ethnic gap remains. This study underscores that efforts should be made to support the referral process for patients with a non-Western ethnic background in Western countries.

INTRODUCTION

Ethnic minorities or non-Western migrants in Western countries run a higher risk for developing anxiety and depressive disorders than indigenous Western citizens (Breslau et al., 2011; De Wit et al., 2008; Missinne et al., 2012; Weich et al., 2004). As a result in Western countries mental health needs of individuals with non-Western ethnic backgrounds are becoming a major concern and priority as their groups are growing. These concerns are underscored by evidence of less favorable subjective experiences and treatment outcomes for ethnic minorities. Pathways to specialized mental health treatment are considered to be more complex in ethnic minority groups (Bhui et al., 2003).

In the Netherlands, non-Western ethnic minority populations have been growing from 1% of the total Dutch population in 1972 to 12% in 2011 (http://www.cbs.nl/nl-NL/menu/themas/dossiers/allochtonen.htm). At this moment two of the largest non-Western ethnic minority populations are Turkish and Moroccan people, who mostly live in urban areas. As was found in international studies and several Dutch studies, anxiety and depressive problems are more prevalent among the non-Western migrants compared to indigenous Dutch people (De Graaf et al., 2011; De Wit et al., 2008; Van der Wurff et al., 2004). In contrast with findings in international literature help-seeking pathways and behaviour (preference for help from family, general practitioner or traditional healer) among Mediterranean migrants in the Netherlands seemed relatively similar to that of the indigenous Dutch (Knipscheer et al., 2005a). Also, Turkish and Moroccan migrants with depressive and anxiety problems were well presented in general practice and the quality of care in primary care was comparable to that of the indigenous Dutch population (Fassaert et al., 2009b; Fassaert et al., 2010). Nevertheless, especially when the patient's proficiency in Dutch was poor and acculturation low, quality of care and satisfaction with the general practice were found to be at stake (Harmsen et al., 2008).

In the Netherlands patients are referred to specialized mental health care by their general practitioner when depression and anxiety care within general practice is not sufficient or effective. Several studies focused on the role of ethnicity in access to specialized depression and anxiety mental health care in the Netherlands. Some did not find ethnic differences (Fassaert et al., 2009b; Schrier et al., 2005) while others did in terms of use, intensity and dropout (Fassaert et al., 2009c; Fassaert et al., 2010; Uiters et al., 2006). A recent international review study on treating depression in Muslim patients found some indications for reluctance concerning Western therapy: for example self disclosure is not

always acceptable and a woman does not always wish to be treated by a male therapist (15). Additional studies are needed that explore in more detail the process of access to specialized mental health care for non-Western migrants.

In the current chapter we will focus on one aspect of the access to care, the referral process, and more specifically: the attendance to the initial appointment. Missed initial appointments impair access to care, and may lead to prolonged suffering and disability (Ruggeri et al., 2007) of the patient and are economically undesirable (Carpenter et al., 1981; Otero et al., 2001). Therefore it is important to study the initial appointments and try to find cues to improve this step in the access to mental health care. In the literature we found only few studies about this topic in mental health care focused on the role of ethnicity. In a USA study on impoverished ethnic minority patients 44% of the referred patients with depressive disorders could not be contacted (Miranda et al., 2003). A Danish study found 32% missed initial appointments among outpatients, non-Western background and longer waiting time were no determinants. Offering new appointments reduced the rate of missed initial appointment to 16% (Glyngdal et al., 2002). A study in the Netherlands showed that non-Western outpatients were significantly more likely to miss their initial appointment in secondary mental health care (18% versus 9%). There was no relation found with age, gender and waiting time. Patients mentioned practical problems and no trust in mental health care as reasons for no-show. Several other studies explored determinants of missed initial appointments in mental health, but did not focus on ethnicity. In a USA study 31% missed initial appointments were found in a community mental health center for adult or child and adolescent outpatient programs. Delay in scheduling appointments, being male and adult had a significant impact on missed appointments (Gallucci et al., 2005). Another USA study showed a comparable percentage of missed initial appointments among adult outpatients of 31.3%; determinants were aged between 18 and 24, vague reasons for seeking help and longer waiting time (Carpenter et al., 1981). In a Spanish study, having a previous history in mental health care was negatively correlated with missing the first visit to mental health centers; patients with a previous contact in the center failed less than those who never attended (Otero et al., 2001). Finally, in a Dutch study (Peeters et al., 1999) a relatively low rate of 9.6% missed initial appointments was found, and no determinants could be identified. Prevalent reasons of missed initial appointment were waiting time, lack of motivation and resolution of mental health problems.

In summary, migrants in Western countries such as the Netherlands run a higher risk for depressive and/or anxiety disorders. As their number is growing there are concerns about access to mental health care. This study focuses on the question whether ethnic differences exist in access to care and aims to disentangle other possible determinants of initial appointments. Beside ethnicity also gender, age, marital status, language problems, waiting time and former referral, gender of the inviting intake therapist are mentioned in former studies as possible determinants of missed initial appointments, but do so in an inconsistent way. In this study we aim to find more consistency in these former findings.

In this study we focus on the following questions:

1. What are the percentages of missed first appointments (psychiatric intakes) in a Dutch outpatient clinic for depressive and anxiety disorders?
2. Are ethnic background (Moroccan or Turkish), age, gender, partnership, having children, waiting time, former referral, language problems and gender of inviting therapist determinants of missed initial appointments?
3. What are the reasons for missed initial appointments?
4. Does the identification of determinants lead to cues for improvement of the access to mental health care?

MATERIALS AND METHODS

Data source

For this study administrative data of 110 first or second generation Turkish or Moroccan patients and 110 indigenous Dutch patients were selected. They were all referred to a specialized anxiety and depression outpatient clinic of GGZ inGeest in the Western part of Amsterdam (an area with a relatively large population of Turkish and Moroccan residents) between January 2010 and July 2011. All data were gathered anonymously. The study was approved by the Medical Ethics Committee of the VU University Medical Center.

Being Turkish or Moroccan was defined as having at least one of the parents born in Turkey or Morocco. The registration assistant selected these patients based on names and referral data. Subsequently a comparable amount of ethnic-Dutch patients were selected. They were matched on sex, age and clinical problem. The definition we used for

an ethnic-Dutch person was: the person and the parents were born in the Netherlands. The administrator invited the patients by means of a written invitation or a telephone call for the first appointment (including date, location and name of the therapist). If the patient did not show up for the first appointment, the therapist tried to contact the patient to check the reason of no-show, and to offer a new appointment for a maximum of two times.

Outcome

Medical files were used to extract data of the initial appointments, waiting time for the first appointment offered, total number of appointments offered and reasons of missed initial appointment. The first initial appointment was defined as: the patient received the first invitation for the initial appointment but did not show up. Missed all initial appointments was defined as: the patient received one up to three invitations for a psychiatric intake but did never show up. Referral data were used to extract possible deteminants of outcome. We were able to study socio-demographic data as ethnic background (Turkish, Moroccan, indigenous Dutch), age, gender, marital status, having children, language problems (interpreter asked) and the gender of the inviting intake therapist. Also waiting time between referral and intake, former referral to the same clinic, and gender of the therapist was extracted from the medical files.

Statistical analysis

Difference in ethnic groups and other patient characteristics were analysed with chi square tests for proportions and t-tests and ANOVA for means. Post-hoc analyses were conducted with Tukey's method to compare significant differences between the ethnic groups. Ethnic differences concerning the initial appointments were analyzed with the same methods. To assess the determinants for the missed initial appointment we tested covariates with bivariate and multivariate logistic regression. We first evaluated the contribution of the separate covariates in the bivariate model. In a multivariate model we included all relevant demographic characteristics to evaluate the associations with missed appointments and we did the same for all psychiatric intake related characteristics. In the third multivariate model a logistic regression test was analyzed for all characteristics. Variables with more than 10% missing data were not included in the regression analyses.

RESULTS

Patient characteristics

Table 2.1 gives an overview of the patients characteristics of in total 220 patients categorized by ethnicity. 33% of the total selected group is of Moroccan, 17% Turkish and 50% indigenous Dutch background. Regarding the un-matched characteristics: employment was significantly lower, social security use (missing data for employment and social security use was higher than 10%), marital status and having children were significantly higher for Moroccan and Turkish patients compared to indigenous Dutch patients. Also, former referral between one and ten years in the same clinic was significantly higher for both migrant groups. There were no significant differences found between the Turkish and Moroccan patients on any of the above characteristics.

Table 2.1 Characteristics of enrolled patients by ethnic background

	Moroccan (N=72)		Turkish (N=38)		Indigenous Dutch (N=110)	
	N	%	N	%	N	%
Age, Mean ± SD	42.25 ± 9.50		41.03 ± 8.23		42.03 ± 12.12	
Female	42	58.3	27	71.1	67	60.6
Married or living together [a]	46	63.9	24	63.2	41	37.6
Having children [b]	54	75.0	28	73.7	39	35.8
Economic status						
Employment [c]	14	19.4	9	23.7	59	54.2
Social Security use [d]	30	41.7	10	26.3	23	21.1
Former referral						
<1 yr	5	6.9	5	9.8	14	12.8
<1 yr-10yr> [d]	23	31.9	13	35.0	10	9.2
Referral problem						
Depression	48	66.7	24	63.2	67	60.6
Anxiety [e]	13	18.1	5	13.5	7	6.4
Depression and Anxiety	7	9.7	7	18.8	13	11.9
Other symptoms / not specified	4	4.3	2	5.4	23	21.1

[a] Moroccan versus indigenous Dutch p<.001 and Turkish versus indigenous Dutch, p<.001
[b] Moroccan versus indigenous Dutch p<.001 and Turkish versus indigenous Dutch, p<.001
[c] Moroccan versus indigenous Dutch p<.001 and Turkish versus indigenous Dutch, p<.01
[d] Moroccan versus indigenous Dutch p<.05 and Turkish versus indigenous Dutch, p<.05
[e] Moroccan versus indigenous Dutch p<.05

Percentages of missed initial appointments

Overall the percentage of missed first initial appointments was 20% (44 of in total 220 patients) and 7.7% (17 of in total 220 patients) after repeated invitation for an initial appointment.

Ethnicity and missed initial appointments

Table 2.2 shows that cultural background or ethnicity is a determinant for missing initial appointments. Turkish and Moroccan patients together missed the first appointment significantly more often than indigenous Dutch patients (31% versus 9%). Waiting time for the first initial appointment was about a week longer for migrant patients, a significant difference compared to indigenous Dutch patients. After repeated invitations the percentages of missed appointments were reduced to 13% for Moroccan and Turkish patients versus 3% for Dutch patients, a still significant difference. The time from the enrollment to the psychiatric intake was significantly longer for the migrant groups. This was due to the amount of appointments offered which was also significantly higher for the migrant groups.

Other determinants for missed initial appointments

In Table 2.3 possible determinants for missed initial appointments were analysed. In a bivariate model having children was significantly related in a positive direction and resulted in more missed initial appointments but this relation disappeared when ethnicity was entered in the multivariate model. This can be explained by the fact that the Turkish and Moroccan patients most often had children. We also analysed the impact of the diagnoses (depression, anxiety, depression and anxiety) but found no significant association. The number and diversity of referrers (most of them general practitioners) was too high to find any relation with missed initial appointments.

Reasons for missed appointments

Of the 44 missed first initial appointments we could identify 21 reasons for missing the appointments categorized by ethnicity. As shown in Table 2.4 the reasons given are diverse, and no clear pattern can be identified.

Table 2.2 Missed initial appointments and waiting time of enrolled patients by ethnicity

	Moroccan (N=72)		Turkish (N=38)		Indigenous Dutch (N=110)	
	N	%	N	%	N	%
Missed first initial appointment [a]	22	30.55	12	31.57	10	9.1
Missed all initial appointments [b]	8	11.11	6	15.78	3	2.7
Waiting time referral-first initial appointment, Mean weeks ± SD [c]	5.41 ± 2.73		5.79 ± 3.46		4.41 ± 2.86	
Waiting time referral-final initial appointment, Mean weeks ± SD [d]	6.47± 3.71		7.67± 4.49		4.81± 3.91	
Number of initial appointments offered, Mean weeks ± SD [e]	1.35 ± 0.58		1.42 ± 0.85		1.08 ± 0.31	

[a] Moroccan versus indigenous Dutch p<.001 and Turkish versus indigenous Dutch, p<.01
[b] Moroccan versus indigenous Dutch p<.05 and Turkish versus indigenous Dutch, p<.01
[c] Moroccan versus indigenous Dutch p<.05 and Turkish versus indigenous Dutch, p<.05
[d] Moroccan versus indigenous Dutch p<.05 and Turkish versus indigenous Dutch, p<.01
[e] Moroccan versus indigenous Dutch p<.05 and Turkish versus indigenous Dutch, p<.01

DISCUSSION

This study focused on the percentages and determinants of missed initial appointments with specific attention to ethnic differences in access to an outpatient clinic for depressive and anxiety disorders in the Netherlands.

We found that overall, 20% of the initial appointments were missed and 7.7% after repeated invitations. Having a Moroccan or Turkish ethnic background was a determinant of missed initial appointments: 31% patients with a Moroccan or Turkish ethnic background missed the first appointment, compared to 9% in the Dutch patient group. After repeated invitations these percentages were reduced to 13% for the Moroccan and Turkish patients and to 3% for the indigenous Dutch outpatients. The percentage of missed appointments found in this study for the total group was lower than found in the USA studies of Miranda et al., Gallucci et al. and Carpenter et al. (Carpenter et al. 1981; Gallucci et al., 2005). Also the rates for the ethnic minority groups with depressive disorders found by Miranda et al. were higher than the rates found for the ethnic minority groups in this study. This can partly be explained by the health care insurance or the referral system in the USA. Also in the Danish study, with the more comparable insurance and health care system, the found rate was higher than in our study but this could be explained by the different mental health problems (psychoses, substance

Table 2.3 Determinants of missed initial appointments (n=44) versus never missed appointments (n=176) using logistic regression

	Bivariate model			Multivariate model Socio-Demographics		Multivariate model Treatment variables		Multivariate model Full model	
	OR	95% CI	n	OR	95% CI	OR	95% CI	OR	95% CI
Socio-demographic patient characteristics									
Turkish or Moroccan	4.47***	(0.10, 9.68)	220	4.44**	(1.56, 12.66)			4.25*	(1.35, 13.35)
Age > 40 years	0.57	(0.94, 1.13)	220	0.70	(0.29, 1.71)			0.69	(0.27, 1.73)
Female	1.00	(0.51, 1.97)	220	1.13	(0.48, 2.64)			1.31	(0.49, 3.42)
Married or living together	2.09	(0.96, 4.56)	202	0.82	(0.49, 3.03)			1.24	(0.39, 3.91)
Having children	3.49**	(1.37, 8.91)	200	1.39	(0.43, 4.43)			0.89	(0.22, 3.67)
Clinical characteristics									
Former referral <1 yr-10yr>	1.75	(0.84, 3.64)	220			1.61	(0.74, 3.49)	1.92	(0.72, 4.69)
Interpreter asked	1.77	(0.78, 4.04)	220			1.79	(0.75, 4.24)	0.95	(0.11, 2.75)
Male intake therapists	1.16	(0.57, 2.34)	217			1.20	(0.57, 2.56)	1.10	(0.46, 2.67)
Waiting time < 3 weeks	0.97	(0.34, 1.53)	219			0.97	(0.86, 1.11)	1.19	(0.46, 3.13)
n				194		217		194	
R^2 (Nagelkerke)				0.18		0.08		0.25	

* p<.05, ** p<.01, *** p<.001

Table 2.4 Reasons for missed first initial appointments given by patients

	Missed first initial appointment	
	Turkish or Moroccan	Ethnic-Dutch
Unclear	19	4
Illness of patient	4	
Forgot appointment	3	3
Preferred other organization	3	1
Did not receive appointment	2	1
Not motivated	1	
Remission of symptoms	1	
Afraid or shame	1	
Did not open mail		1
Total n	34	10

abuse), our study confirms their finding that repeated invitation is worthwhile (Glyngdal et al., 2002). The findings were also partially consistent with those of the Dutch study of Korrelboom et al. (2007): ethnic minority patients missed significantly more often the initial appointment than the ethnic majority group did.

Ethnicity beside, having children seemed to be a determinant for missed initial appointments. Corrected for ethnicity, the relation disappeared. Also, the need for an interpreter or gender of the inviting therapist was not related to missed appointments. Determinants found in other studies (age, sex, waiting time and former attendance) did not in this study explain the missed initial appointments. Reasons for the no show diverse, and specific cues for improving access to care could not be identified. Yet, it is remarkable that shame was only mentioned once as a reason for no show as this factor is mentioned in the literature (Fassaert et al., 2009a; Knipscheer et al., 2005b) as an explanation for difficulties within treatments of non-Western ethnic minority patients. Also lack of motivation and remission of symptoms was only mentioned once. However, it seems important for general practitioners to pay more attention to the referral process of migrant patients as an ethnic gap seems to exist. For example more attention should be given to the migrant patients perceived needs for care, motivation and expectations of treatment. Also more information should be given about treatment options and benefit in advance of the process of referral to specialized care. Another option is more intensive or collaborative care which can possibly give a positive incentive to the transition from general practice

to specialized mental health care. In a review study on interventions to increase initial appointment attendance also were mentioned: asking clients to formulate plans to deal with obstacles to attendance and giving clients a choice in therapist style (Schauman et al., 2013) Nevertheless more research is needed to disentangle the determinants and reasons for missed initial appointment in non-western migrants in specialized depression and/or anxiety care.

The strength of this study is the minute scrutiny of the variables from the medical files of each patient, which variables were categorized afterwards. This made it possible to analyze data from a group of ethnic minority patients mostly excluded in research. A limitation of the study is the lack of detailed information concerning social and economic characteristics especially from those who missed all appointments (n=17) and were unreachable by phone. In those cases we only had the referral information (gender, birth date, clinical problem, need for an interpreter and cultural background) as well as in some cases information from a former treatment episode. However this was too small a percentage of the total population to have a substantial impact on our findings. Also, the information regarding the reasons for no show was limited. We had some information of half of the patients who missed the first appointment. The reasons given were too diverse to draw conclusions from.

In our study we found that the first step in the referral process from primary to secondary care for affective disorders leads to a substantial dropout, especially among migrants. Repeated invitations can be effective, although an ethnic gap remains. This study underscores the consideration that efforts should be made as to overcome culturally determined problems in the referral process of an obviously hard to reach but vulnerable group of ethnic minority patients.

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