

A survey of the management of psychosocial illness in general practice in Manchester

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SUMMARY. As part of a larger study 201 urban general practitioners from five health districts provided information on 6870 consultations with patients recorded as having psychosocial disorders, 5610 of which were concerned solely with psychosocial problems. The results showed a lower percentage of consultations for such conditions than other studies, although the age and sex distribution of the patients was similar. There was a wide variation in the proportion of such disorders in the case-mix of the 201 general practitioners, a higher proportion being associated with longer consultation times. The pattern of prescribing and referral is described and discussed. Referral to non-medical agencies played a small part in the overall care of patients with psychosocial disorders. Questions are raised as to the extent of team care in this wide cross-section of practices.

Introduction

A PREVIOUS paper¹ described a study of the management of a group of common self-limiting illnesses by 201 urban general practitioners which was part of a larger study of five health districts in the Manchester area. The parent study showed wide variation between doctors in the process of care,² and subsequent analyses have shown that these differences were largely independent of patient variables such as age and social class. However, the overall figures could hide variations among individual groups of conditions, as was found to be the case for minor illness.

Psychosocial problems contribute considerably to the general practice workload — in the second national morbidity study³ 17% of patients consulted for mental disorder (10% of consultations). The third national study⁴ showed a fall in the proportion of consultations for these conditions but even so over 10% of patients consulted for mental disorder.

There have been a number of detailed studies on the recognition and management of this group of conditions.⁵⁻⁷ In particular the use of the general health questionnaire has enabled investigators to compare the identification skills of the general practitioner with indicators of psychiatric morbidity in the community, although often on small numbers of practices.

Previous investigators^{5,7} have expressed concern about the wide variation between general practitioners in their recognition of psychological illness generally, and of particular conditions such as depression.⁸ In a large study, if such variations were confirmed, it might be possible to relate the differences to particular characteristics of doctors.

A range of alternative management strategies are available to general practitioners. Psychotropic drugs remain an option, although there is increasing concern about their extensive use.⁹ Many alternatives have been suggested including increased use of social work support,¹⁰ psychologists,¹¹ counsellors¹² and community psychiatric nurses.¹³ There have been no reports so far of the extent to which these alternatives are used and for

some, such as the use of nursing services, there may be differences in accessibility.

The study reported here used a large range of practices, 40% of those in the study area, and therefore gives a general indication of the perception of general practitioners and their management actions.

Method

Forty per cent of the general practitioners in five health districts participated in the study, and family practitioner committee data showed that these doctors were similar in most respects to non-participating practitioners and were therefore likely to be representative. The information from the 201 doctors who completed data collection was adjusted to give a set of data balanced for seasons and days of the week. This structured data base contained details of over 85 000 consultations.

As previously reported¹⁴ the recorded diagnoses were coded according to the classification of the Royal College of General Practitioners used for the third national morbidity study, and then clustered into homogeneous groups. The following clusters were selected for this study: schizophrenia, dementia, other psychoses, anxiety, depression, alcohol and drug problems, minor psychogenic illnesses and other neuroses (all from International classification of diseases V). In view of the close association between social and mental stress those patients with marital and social problems (from ICD XVIII) were also included. These nine clusters are referred to as the psychosocial clusters. Although some analyses reported here are based on the full data for 6870 consultations which included a psychosocial diagnoses, in most instances details of the 5610 consultations with diagnoses solely in the psychosocial clusters are reported.

As doctors were asked to record diagnoses, in certain instances a period of mental or social stress for the patient may not have appeared to merit a clearly defined label, thus leading to under-reporting of psychological and social problems. Failure to include dual diagnoses, even though many psychological and social problems may be associated with physical illness, may also result in underreporting. To assess whether differences between doctors affected recording, participating doctors were divided into quintiles based on the proportion of their diagnoses which were in the psychosocial clusters. The quintiles were analysed by the sex, age, possession of MRCGP/FRCGP, prescribing rate and average consultation time of the doctors.

The study was cross-sectional and did not follow the management of individual patients over a period. Thus the involvement of other professionals in the care of an individual was underestimated. However, with such a large data base it was possible to gauge the overall frequency with which general practitioners formally refer patients to consultants, nurses, social services or other agencies.

Tests of significance of group differences are included but as the sample was not random these statistical analyses should be treated with some caution. Generalizations may be made about the consultations of these general practitioners but not necessarily extended to the total population of all doctors in the area.

Results

Overall 6870 of all 85 115 consultations (8.1%) included a diagnosis in the psychosocial clusters — 7.6% included ICD V

diagnoses, which is a lower proportion than recorded in both the second national morbidity study³ and in Harris's more recent study of five inner London practices (Table 1).¹⁵ This was largely accounted for by a lower recording of depression in this study, especially for doctors with practices within the inner city area.

Nearly half the consultations for anxiety (48%) and 60% of those for marital and social problems were recorded as new cases, that is the doctor saw them as patient-initiated, although the category includes new crises in a long-standing problem.

Patient characteristics

Table 1 shows the distribution of patients suffering psychosocial disorders by social class, sex and age. The sex distribution was similar to that found in other studies (including both the second³ and third⁴ national morbidity studies), a higher proportion of consultations for women being within the psychosocial clusters than for men. As women account for well over half of all consultations, twice as many women as men are labelled with these conditions.

Social problems are felt by many to contribute disproportionately to the workload of general practice especially in inner city areas,¹⁶ but in this study the separate recording of marital and social problems accounted for less than one in 200 cases. Marital and social problems were noted more frequently in non-manual classes and almost half were family problems. Only three housing and 15 occupational problems were recorded, although the study took place during a period of high and increasing unemployment, reaching 50% for men in some areas. These problems were overrepresented in the 15–39 years age group, but particularly underrepresented in social classes 4 and 5.

Less than 1% of patients with a physical illnesses also had a psychosocial diagnosis recorded.

Doctor characteristics

Individual doctors showed a wide variation in the proportion of cases they recorded within the psychosocial clusters. The range was from 1.9% to 24.0% of all diagnoses with one-fifth of doctors recording less than 5.1% and one-fifth more than 10.4%.

Table 2 shows that there was no significant difference between doctors in different quintiles with respect to sex, age or possession of MRCGP/FRCGP. There was also no difference with respect to training or to practice in inner or outer areas of Manchester. However, there were significant differences with respect to overall prescribing rate and average consultation time (Table 2). A high proportion of psychological diagnoses was associated with a high average consultation time. The trend with prescribing rate is less clear, although a lower prescribing rate (particularly under 70%) was associated with a higher proportion of diagnoses in psychosocial clusters.

Prescriptions, referrals and fixed return dates

Table 3 shows the percentage of patients leaving the surgery with fixed return dates by age, sex and social class of the patients. The results confirm the higher rate of prescribing for women and for those in older age groups found by previous workers.⁹ Men and younger patients were more likely to be referred to consultants and this also applied to those in social class 1/2 for depression only. No other significant variation was found with social class.

In 3405 consultations for anxiety, minor psychogenic and other neuroses and for marital and social problems, 93 referrals to counsellors, social workers, clinical psychologists and community psychiatric nurses were recorded. Nearly three-quarters (74.7%) of the 1728 consultations for anxiety resulted in a prescription and only 35 (2.0%) in referral to another agency. In the 306 consultations for marital and social problems 25 referrals to another agency were recorded and 122 patients left with a prescription.

District variations in referral patterns

Referral to other agencies is a management option that varies between health districts. District 4 has a well established community psychiatric nursing service with direct access from general practitioners to nurses. Table 4 shows that the presence of this

Table 1. The proportion of consultations for psychosocial disorders found in this study with figures from the second national morbidity study³ and Harris's study¹⁵ for comparison.

Study and patient characteristics	Percentage of all consultations		Number of solely ICD V consultations ^a	Percentage of ICD V consultations for:			
	Mental (ICD V)	Marital/social (ICD XVIII)		Anxiety	Depression	Schizophrenia	Alcohol/drug problems
Manchester study							
<i>Social class</i>							
1/2	7.2	0.44	913	34.7	30.8	3.2	3.8
3N	7.5	0.43	719	33.3	31.7	4.8	1.3
3M	6.8	0.44	1378	35.0	28.8	2.8	4.7
4/5	7.9	0.35	1208	34.2	27.3	5.7	4.6
<i>Sex</i>							
Male	5.9	0.27	1683	31.4	22.1	8.4	8.6
Female	8.8	0.56	3588	33.0	31.1	3.9	1.7
<i>Age (years)</i>							
<15	—	—	135	27.0	6.7	3.0	2.2
15–39	—	—	1916	34.2	26.7	6.4	4.0
40–64	—	—	2229	33.0	31.2	6.1	5.2
65+	—	—	1024	29.3	27.0	2.0	1.3
<i>Overall</i>	7.6	0.43	5304	32.6	28.1	5.4	3.9
Second national morbidity study	10.0	—	—	25.0	35.0	1.5	0.7
Harris's study	10.0	—	—	25.0	40.0	6.9	7.5

^a In a few cases patient's sex was not recorded or insufficient data was available for determining social class.

Table 2. Doctor characteristics by proportion of diagnoses in psychosocial clusters (percentages of doctors in each quintile are given).

Doctor characteristic	Number of doctors	Proportion of diagnoses in psychosocial clusters (quintile)				
		0-5.1%	5.2-6.3%	6.4-7.8%	7.9-10.3%	Over 10.3%
Sex						
Male	172	18.0	19.8	22.7	18.0	21.5
Female	29	27.6	17.2	6.9	34.5	13.8
$\chi^2 = 8.31, 4 \text{ df, NS}$						
Age (years)						
<35	35	20.0	0.0	22.8	28.6	28.6
35-44	66	19.7	24.2	16.7	19.7	19.7
45-54	68	19.1	25.0	22.1	16.2	17.6
55+	32	18.8	18.8	21.9	21.9	18.8
$\chi^2 = 12.67, 12 \text{ df, NS}$						
Qualification						
MRCGP/FRCGP	53	11.3	15.1	20.8	20.8	32.0
No MRCGP/FRCGP	148	22.3	20.9	20.3	20.3	16.2
$\chi^2 = 7.98, 4 \text{ df, NS}$						
Prescribing rate (per 100 consultations)						
46-64	41	17.1	12.2	29.3	19.5	21.9
65-70	39	12.8	7.7	41.0	12.8	25.6
71-75	44	22.7	20.5	11.4	25.0	20.5
76-80	39	25.6	25.6	7.8	15.4	25.6
81-95	38	18.4	31.6	13.2	28.9	7.9
$\chi^2 = 32.60, 16 \text{ df, } P < 0.01$						
Average consultation time (minutes)^a						
<6.00	30	20.0	40.0	13.3	20.0	6.7
6.00-6.99	50	20.0	14.0	28.0	20.0	18.0
7.00-7.99	58	22.4	19.0	27.6	15.5	15.5
8.00+	61	14.8	14.8	11.4	24.6	34.4
$\chi^2 = 25.41, 12 \text{ df, } P < 0.05$						

NS = Not significant. df = degrees of freedom. ^a Results for two doctors missing.

Table 3. Percentage of consultations with patients suffering solely from psychosocial problems where patients leave the surgery with prescriptions, consultant referrals and fixed return dates by age, sex and social class of the patients.

Patient characteristic	Number of consultations	Percentage of consultations		
		Prescriptions	Consultant referral	Fixed return dates
Sex^a				
Male	1759	64.2	6.9	46.8
Female	3817	74.5	3.7	48.1
$\chi^2 = 62.30, P < 0.001$ $\chi^2 = 27.30, P < 0.001$ $\chi^2 = 1.80, NS$				
Age (years)				
<15	157	51.0	7.0	31.2
15-39	2058	66.9	5.7	46.5
40-64	2330	72.9	3.8	48.9
65+	1065	79.4	4.6	49.7
$\chi^2 = 87.0, P < 0.001$ $\chi^2 = 9.01, P < 0.05$ $\chi^2 = 21.20, P < 0.001$				
Social class				
1/2	974	70.1	3.4	50.5
3N	759	69.7	5.1	49.9
3M	1471	72.5	5.3	46.6
4/5	1256	72.1	5.3	45.8
$\chi^2 = 2.78, NS$ $\chi^2 = 5.92, NS$ $\chi^2 = 7.23, NS$				

NS = not significant.

^a Patient's sex was not recorded in a few cases.

service significantly increased referrals to the district health authority nursing service without any effect on referrals to consultants or social services.

Discussion

Psychosocial problems, recorded in one in 12 of all consultations in this study, form a major part of general practice workload. As only one in 20 contacts for these problems ended in a consultant referral and even fewer were referred to other agencies, general practitioners clearly play an important role in the management of these conditions.

The doctors studied, however, demonstrated a 12-fold difference in the extent to which they recorded psychosocial illness as a separate problem and this is not associated with populations differing markedly in anticipated need. A preference for recording clear diagnoses rather than vague statements of psychosocial stress, or a failure to record a psychological problem where there was associated physical illness may explain some of the difference and the effect of such factors needs further investigation. However, 20 years ago Shepherd and colleagues⁵ noted that some doctors had a particular mental attitude that made them look for psychological problems even in physical illness, while others stated that the physical needs of patients were too great to devote time to such aspects. Such variation in mental attitude is likely to be a major determinant of the wide variations found in this study, and of the low recording (1%) of dual physical and psychological diagnoses.

Failure to record a psychological problem cannot be equated with failure to take psychological and social factors into account in the overall management of patients, or even with failure to recognize psychiatric disturbance. However, there are indications in the study that mental illness may be receiving less attention than it deserves. The recorded rates of psychological problems, especially depression, are lower than those in other surveys. This shortfall is most notable in the manual social classes because

Table 4. Referrals of patients suffering from psychosocial problems by health district (percentages of consultations are given).

Health district	Number of consultations ^a	Referral to:			
		Consultant	DHA nursing service	Social services	Other services
1	996	4.6	0.4	1.3	1.5
2	1518	3.8	0.2	0.9	1.4
3	896	5.7	0.1	0.9	0.6
4	1858	5.8	1.3	0.9	1.5
5	1081	5.2	0.2	0.3	1.0
6	704	4.8	0.6	0.3	1.4
		$\chi^2=8.06$ NS	$\chi^2=28.9$ $P<0.001$	$\chi^2=9.82$ NS	$\chi^2=5.59$ NS

^a Based on an unstructured data base including information from six high-status wards in a sixth district. NS = not significant.

the study area was one of severe social deprivation where one might expect a higher rate.¹⁷ It may be that anxiety, depression and social stress are seen as a norm rather than a deviation to be noted; part of the context rather than a specific condition to manage.

The high proportion of consultations for anxiety and marital and social problems recorded as new cases, and the low numbers of fixed return dates suggest that these problems are perceived as isolated episodes rather than situations requiring continuing care. Many patients with marital and social problems had no recorded management option although the psychotherapy, advice and reassurance that Shepherd⁵ found to be the preferred approach of most general practitioners were not recordable. In some cases the doctor may be used to give temporary support while patients await help from other overloaded agencies such as the social services or marriage guidance counsellors, to which they have already referred themselves.

A higher recording of psychosocial problems was associated with a longer average consultation time. Morrell and colleagues^{18,19} also showed recently that longer planned consultation times were associated with a higher recording of psychological problems, as well as a higher proportion of psychosocial questions put to patients and a higher rate of prescribing psychotropic drugs. A willingness to spend longer listening to patients in the consultation may be necessary to draw out such problems. On the other hand doctors with a leaning towards psychosocial explanations may define such problems with increased frequency and this may necessitate spending longer in management. Non-pharmacological treatments such as counselling are time-consuming, yet may be preferred by this group of doctors.

In view of the interest in the use of counsellors, social workers, clinical psychologists and community psychiatric nurses, it is of note that in this study direct referral to such agencies was only half as frequent as that to consultants. This may well be a result of the availability of services. The situation in the one health district where community psychiatric nurses are available for direct primary care referral suggests that they bring an additional management option, an interpretation supported by the lack of effect on consultant referrals.

Extension of such services may however prove expensive. Trepka and colleagues²⁰ found there was no close correspondence between reduction of anxiety and reduction of service costs in their investigation of various psychological treatments of anxiety. Currently the major management option for psychosocial disorders in primary care still appears to be pharmacological even though this, too, is expensive, of uncertain value and, as recent reviews²¹ have shown, may bring problems in its wake.

These results from a broad range of practices suggest little change over 20 years in terms of rates of recognition, use of medication and use of alternative managements. The majority of practitioners still seem to depend on pharmacological treatments even for minor psychosocial stress, and there is little evidence of team support. It is possible that much of the distress recorded in these psychosocial clusters is due to shortlived emotional crises which can be well managed by listening, support and brief courses of medication. In such cases neither the doctor nor the patient would have the time or inclination for referral, but should alternative support be offered, with open access, within practices? Is it possible that the decline in patients consulting for mental stress is a reflection of the development of alternative support and counselling services? Further discussion of the role of general practice in the management of psychosocial illness is required.

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Acknowledgements

The data on which this study is based was collected by the DHSS Urban Primary Care Research Unit (now known as the Centre for Primary Care Research). Thanks are due to all the doctors who participated, and to Drs David Wilkin and Clare Ronalds for advice on the analyses.

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