Family-doctor support for patients on a psychiatric case register

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SUMMARY. The family-doctor consultations of 76 patients on a psychiatric case register and 76 matched controls were examined. During a two-year period the psychiatric patients consulted just over twice as often as the controls ($p < 0{\cdot}001$). Contact with the psychiatric services did not reduce the psychiatric patients' demand for general-practitioner time.

Introduction

THE Worcester Development Project (Hassall, 1976) is a Department of Health and Social Security project. It replaces an old isolated mental hospital (Powick Hospital, near Worcester) and some of the services based on that hospital, with a community psychiatric service. Under the new service, beds will be sited at two general hospital inpatient units at Worcester and Kidderminster, which are the two main population centres in the catchment area, and day hospital care, at present available only at Powick Hospital, will be provided at each of these units and also at Malvern and Evesham. Day centres, group homes, and psychiatric hostels will also be developed in the catchment area. Besides these physical components of the project, the DHSS is paying for a psychiatric case register for the area and has set up a small team (the authors) to monitor and evaluate the new and changing services.

The function of a psychiatric case register is to provide a computerized record of every patient within the psychiatric services. There is some variation between registers but most record the usual personal data, diagnosis, and the patient's contacts with each branch of the psychiatric services. Thus, in time, a long-term history of the patient's contact with the psychiatric services is built up. The first step in starting a register is to define a 'case'. In the Worcester psychiatric register a case is anyone within the psychiatric services and, for social workers, any client who has seen a psychiatrist in the preceding six months.

Using such a definition, essential for the register, leads first to the exclusion of patients whom some workers see as 'psychiatric cases' (Hassall and Stilwell, 1976), and secondly of the services of some professionals who look after patients on the register. This study looks at an example in the second category—an agency giving support to official psychiatric cases but not recorded on the register—the family doctors.

As a group, the family doctors in the Powick catchment area have taken a keen interest in the Development Project. Representatives from practices in the urban and rural areas sit on both the Worcester Development Project co-ordinating committee and the advisory committee to the Worcester psychiatric case register. Data from general practice have never been planned for the register, and it is doubtful whether the cost of collection would be worthwhile as it seems unlikely that doctors could find time to supply data on a regular basis. Nevertheless, at informal meetings with the research team they have often said that they play a considerable part in the care of the mentally ill.

With the co-operation of a group practice in the centre of Worcester we decided to try to measure the demands made on a group of family doctors by patients on the psychiatric case register. In the future we hope to estimate the number of other patients who are attending general practitioners with psychological problems but who are not on our register.

Method

The practice

The practice has a list of just over 14,000 patients, more than three quarters of whom live in the city itself. At the

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Table 1. Sex and age group of patients on the psychiatric register.

Age group	Male	Female	Both sexes
Under 25 years	4	2	6 *(8)*
25 < 44 years	15	27	42 *(55)*
45 < 64 years	6	22	28 *(37)*
Total	25	51	76 *(100)*

time of the study there were seven doctors in the group, one of whom was part-time.

Patients in the care of the practice were drawn from the psychiatric case register and those under the age of 65 years whose first contact with the psychiatric services was before the beginning of the survey period (1 January 1974 to 31 December 1975) made up the study population. Each patient was paired with a control by taking the first suitable person in the file with a different surname. Controls were matched for sex, age (within five years either side of the patient's age), and in the case of females, for single or 'ever married' state.

Results

The number of patients in the practice under 65 years who had been in contact with the psychiatric services and were therefore on the psychiatric case register before 1 January 1974 was 96. Of these, five were found to have moved away, eight were not registered with the survey practice, and a further seven could not be traced in the family practice records for the area. Thus, 76 patients remained from the original sample.

Sex and age group

Table 1 gives the sex and age group of the psychiatric patients. A third of the psychiatric patients were males and just under two thirds (63 per cent) were under 45 years of age. A larger proportion of the males (76 per cent) fell into this age group than females (57 per cent).

Diagnostic group

The diagnostic grouping of the psychiatric patients is shown in Table 2. The largest diagnostic group (46 per cent) was formed by patients suffering from neurosis, personality disorder, and alcohol addiction. Those with schizophrenia or other psychoses made up just under a third of the patients from the psychiatric case register. There were more males than females in the neurosis group, while the position was reversed in the 'schizophrenia' category; numerically, however, there were substantially more females than males in both these groups.

Number of days in the psychiatric service during the survey period

Table 3 illustrates the amount of contact between the

Table 2. Diagnostic groups by sex of patients on the psychiatric register.

Diagnostic group	Male	Female	Both sexes
Schizophrenia and other psychosis, including dementia	6 *(24)*	17 *(35)*	23 *(30)*
All neuroses, personality disorder, alcohol addiction	14 *(56)*	21 *(40)*	35 *(46)*
Depression	4	11	15 *(20)*
Other*	1	2	3 *(4)*
Total	25	51	76 *(100)*

*Includes attempted suicide, not yet diagnosed, social reasons and no psychiatric diagnosis.

case register group and the psychiatric services during the two-year study period. The most common service received by the psychiatric patients was an outpatient appointment (received by 43 per cent of the group). Nearly half the patients on the psychiatric register (47 per cent) had no contact with the psychiatric services at all during this time. If each separate inpatient and day-patient day is regarded as a contact and added to the other contacts, such as outpatients or social worker visits, then the mean number of contact days is highest for the schizophrenia group at 26, followed by the neurosis group with a mean of 21 days. The mean for the neurosis group is, however, inflated by one patient who had 529 contact days (more than 400 days more than any other psychiatric patient in the study). If this patient is removed, the neurosis group mean becomes, more realistically, six days, and the depression group moves into second place with a mean of 15 contact days.

If the patients who were in contact with the psychiatric services during the study period are compared with those who were not, then the mean number of general-practitioner consultations is highest for the former at 15, as against nine for the latter.

Total number of family-doctor consultations

The number of consultations during the two years (either at the surgery or in the patient's home) is shown in Table 4. The difference between the matched pairs is highly significant ($p = < 0{\cdot}0001$ using the Wilcoxon matched-pairs test). The range of contacts was from 0 to 40 for the psychiatric patients and 0 to 26 for the controls. The mean number of consultations per patient for the two years was 13 for each patient in the case register group and six for the controls. If the consultations are examined for the two years separately then the total group of psychiatric patients had a mean of 46 consultations a month during the first year, and 36

Table 3. Contact with the psychiatric services during the survey period.

	Number of days or contacts						
	None	1<10	10<20	20<50	50<100	100 and over	Total
Patients in hospital beds	64 *(84)*	2	—	7	1	2	76
Patients in day care	69 *(91)*	1	2	1	3	—	76
Patients having outpatient visits	43 *(57)*	28	4	1	—	—	76
Patients having other contacts*	59 *(78)*	11	2	4	—	—	76

*Social worker visit, community psychiatric nurse visit, domiciliary visit by psychiatrist.

Table 4. Total number of family-doctor consultations for psychiatric patients and controls: 1 January 1974 to 31 December 1975.

Number of patients	*Number of consultations*								
	None	1<5	5<10	10<20	20<40	40 and over	Total	Total no. of consultations	Mean for each patient
Psychiatric patients	3 *(4)*	14 *(18)*	16 *(21)*	26 *(34)*	16 *(21)*	1 *(2)*	76 *(100)*	973	13
Controls	4 *(5)*	37 *(49)*	18 *(24)*	14 *(18)*	3 *(4)*	—	76 *(100)*	466	6
Total	7	51	34	40	19	1	152	1,439	9

for the second. The controls had a mean of 20 doctor contacts per month for both years.

Number of family doctor consultations by diagnostic group

If the number of consultations is examined by diagnostic group (Table 5) the mean for both the schizophrenia and depression groups is 14, while for those in the neurosis group it is 12. Dividing the total consultations by diagnostic group, those in the neurosis group accounted for 42 per cent of the consultations during the two years, followed by the schizophrenia group who made up a further 34 per cent.

Different types of prescription recorded

The consultations were divided into those where no prescription was recorded, those which resulted in prescriptions for hypnotic, sedative, antidepressant, tranquillizing, or other psychotropic drugs (termed 'psychiatric' prescription for convenience), and those where drugs for physical complaints were entered.

Table 6 gives the distribution of these consultations for the psychiatric patients and the controls. The proportion of consultations at which no prescription was recorded (30 per cent) was the same for both groups, though numerically the patients on the psychiatric register had more than twice as many such consultations as the controls. The psychiatric patients had proportionately fewer consultations with prescriptions for physical ailments (35 per cent compared with 64 per cent) though again, numerically, they had slightly more visits. Case register patients who were in touch with the psychiatric services had an average of five psychiatric prescriptions each as opposed to three prescriptions for the no-contact group.

Discussion

The *Morbidity Statistics from General Practice* (OPCS, RCGP and DHSS, 1974) give consulting rates by sex and age group. If these rates are applied to the age-sex grouping of the control patients, then the expected number of consultations in one year is 3·1, which is very similar to 3·2 found in this study. The psychiatric register patients made far heavier demands on practice time, consulting just over twice as often.

In his study of the use of psychotropic drugs in general practice, Wilks (1975) found that patients receiving these drugs consulted 1·7 times more than the rest of the practice, but points out that it would be necessary to add consultations with psychiatric patients whose problems were treated by discussion alone to obtain a true picture of the workload.

In addition, he points out that "the number of consultations is a poor indicator of the time spent with these patients". This is certainly borne out by the Worcester health centre practice: not only were the consulting rates of psychiatric patients much higher than those of the controls but when, in another study in the same practice (Stilwell and Hassall, 1977), almost

Table 5. Psychiatric patients: number of family-doctor consultations by diagnostic group.

	Consultations						
Diagnostic group	None	1<5	5<10	10<20	20<40	40 and over	Total
Schizophrenia and other psychosis including dementia	—	5	6	5	7	—	23
All neuroses, personality disorder, alcohol addiction	1	7	6	15	5	1	35
Depression	1	1	4	5	4	—	15
Other*	1	1	—	1	—	—	3
Total	3	14	16	26	16	1	76

*Includes attempted suicide, not yet diagnosed, social reasons and no psychiatric diagnosis.

Table 6. Types of consultation of psychiatric patients and controls.

	Type of consultation					
Number of patients	No prescription	Psychotropic prescriptions	All other types of prescription	Mixed prescription	Referred to psychiatrist	Total
Psychiatric patients	300 *(31)*	326 *(33)*	280 *(29)*	63 *(6)*	4 *(1)*	973
Controls	146 *(31)*	25 *(5)*	292 *(63)*	3 *(<1)*	—	466
Total	446	351	572	66	4	1,439

3,000 consultations were monitored, the mean time for psychiatric patients was nine minutes, while for the controls it was 6·5 minutes. The effect of the raised consulting rate and the longer interview is highlighted if these figures are applied to both groups of patients over the two years. During this period the 76 control patients would have accounted for 52 hours of practice time and the psychiatric patients, 149 hours.

In general practice in Bristol, Whitfield (1973) found that the incidence of non-prescribing consultations was highest particularly in the under 40s. If, using his figures, the proportion of such consultations is calculated for Bristol patients between the ages of 20 and 59 years, it is 32 per cent. This is similar to our study, where the figure for both groups of patients was 30 per cent, though numerically the psychiatric patients had just over twice as many such consultations.

It is clear that the patients who were on the psychiatric register, whether or not they were in contact with the psychiatric services, made more demands on general-practitioner time than the control group, and that being in touch with the psychiatric services appeared to increase their consultation rate, possibly because they had more 'psychiatric' prescriptions. Thus, although the contribution of the family doctor to the care of those in the mental health services is not formally recorded on the psychiatric case register, in this practice it is substantial. Unless there is a corresponding expansion in other community support services, or perhaps even if there is, the growing tendency to treat psychiatric patients in the community may increase the family-doctor consultations made by this group of patients.

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