Would more mental illness services help general practitioners manage their difficult patients?

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SUMMARY. It is argued that the type of local specialist services and the extent of their use are largely the outcome of negotiations between general practitioners and their patients. A study was carried out on behalf of a health care planning team for the mentally ill to discover whether more mental illness services would help general practitioners manage their difficult patients. The findings led to some developments in problem-oriented services but not mental illness services in general.

Introduction

HEALTH care planning teams were set up to help identify gaps in district services and ways of improving existing services by better use of resources (DHSS, 1972, para. 2.46). The study reported here was undertaken in 1978 on behalf of the Northumberland Area Health Authority's Health Care Planning Team for the Mentally Ill.

As psychologists who had been involved in primary care for several years, we had observed that patient problems are defined through a process of negotiation and discussion between the patient and his or her general practitioner. The negotiations often extend over several consultations and are determined not only by the patient's demands but also by what local services are available. In short, doctors and patients appear to try to define problems in such a way that something can be done about them, rather than reach definitions which, although correct, would not be useful because lack of local provision would lead to frustration on both sides.

This observation was pertinent to the work of the health care planning team because, whatever judgements may be made about the population's need for specialist mental illness services, the demand for them is largely the consequence of referral decisions by local general practitioners. In planning specialist services, it may therefore be more useful to consider them in relation to the network of services of which they are an element, rather than attempt to relate them to population need as such, and to recognize that the existence of the proposed services may in turn affect the way general practitioners and patients see their problem.

Aim

In this study we asked local general practitioners about patients whose management they found 'difficult'. We also asked them whether there were any gaps or shortfalls in the existing provision of services which might be relevant to the care of these patients. We hoped that, as a result, we could identify ways in which local mental illness services could be improved.

Method

A circular was sent to all the 285 general medical practitioners on the Northumberland Family Practitioner Committee list, inviting them to take part in the investigation. From among the respondents, 10 doctors (all male) with practices in different kinds of communities agreed to take part in the final study. Northumberland has both urban and rural areas; two doctors were from rural areas, two from urban areas and the rest had practices combining both kinds of population. At that time the average list size in Northumberland was

2,160 and the list size of all the doctors taking part in the study was within three hundred of that figure.

The study doctors were asked to identify 10 to 15 patients whom they found difficult to manage. Apart from indicating that the study was being undertaken on behalf of the Health Care Planning Team for the Mentally Ill, we gave no direction about what kind of difficulty should be chosen. The doctors then put a specially printed orange record card in each patient's record envelope, and for a period of three months each contact made by the patient was recorded on these cards under the headings "reasons for contact" and "constraints on management". At the end of the three-month period the doctors reviewed the cards they had been keeping and filled in two sections, one headed "case summary: main problem or diagnosis", the other headed "service deficiencies noted".

Results

The doctors returned a total of 100 cases. No information was collected about 50 unreturned cards. Nearly one third of the cases returned referred to patients aged 60 and over. Compared to the general population, women aged 15 to 59 were over-represented (Table 1). Only three people aged 14 and under were recorded, possibly because it was assumed that the planning team which originated the project was not concerned with services for children.

The median number of contacts made by the selected patients in the course of the study was 4·6 (Table 2), which is equivalent to 18·4 contacts per year. This is very high compared to estimates of the national average (Fry, 1979).

Patient problems

The kinds of problem recorded were diverse, but their character is conveyed by the following case summaries.

Table 1. Age-sex distribution of cases (in brackets, age/sex distribution of population of Britain (1971 census)).

	Age			
	0-14	15-59	60+	Total
Male	2 *(12%)*	11 *(29%)*	9 *(8%)*	22 *(49%)*
Female	1 *(11%)*	55 *(28%)*	22 *(12%)*	78 *(51%)*
Total	3 *(33%)*	66 *(57%)*	31 *(20%)*	100 *(100%)*

Up to and including 14 years (three patients)

1. A 14-year-old boy who presented having been charged by the police with stealing bikes, tools, etc., which he sold to buy presents for his mother and sibs. The general practitioner noted a need for an urgent referral to a child psychiatrist.

2. A 14-year-old girl who resented her step-father's attempts at discipline and had accused him of indecent assault. Lack of suitable alternative accommodation was noted.

3. A two-year-old illegitimate boy who lived with his maternal grandmother because his mother refused to have him adopted at birth. This lady having died, he was in the care of his maternal grandfather and aunt. The general practitioner said: "I think his chances of normal development are nil."

Males, aged 15 to 59 (11 patients)

1. Three cases of alcoholism. There were no special facilities for problem drinkers in Northumberland.

2. A 24-year-old, suffering from epilepsy following head injury in childhood, low IQ, belligerent behaviour and depression. No suitable day care available.

3. "A case where no diagnosis has ever been offered, yet the man is already a chronic invalid."

4. A difficult terminal-care case.

5. Two chronic schizophrenics for whom no suitable day care facilities existed; multiple social problems.

Females, aged 15 to 59 (55 patients)

Although this was the largest group, there was more uniformity about the problems recorded and perceived service deficiencies than in any other. This was also the only group with reference to whom doctors noted their own lack of time (five cases).

1. Anxiety/depression was mentioned in 14 cases.
2. Sexual and marital problems in 10 cases.
3. Family problems in eight cases.
4. Alcoholism in five cases.
5. Personality disorder/overdependence/manipulative behaviour in 12 cases.
6. Need for psychotherapy/counselling service in 11 cases.
7. Need for family support services in five cases.
8. Physical handicap in three cases.

Table 2. The number of contacts made by the patients (median number 4.6).

Number of contacts	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Number of patients making this number of contacts	1	9	16	18	13	12	12	2	3	3	3	1	1	2	3	0	0	0	0	1

One case summary included most of the common factors:

Emotional immaturity. Came from a broken home. First marriage ended in divorce. Second husband died of cancer. Often suicidal. May be alcoholic. Lived in sheltered housing but, despite constant visiting by social worker and myself, failed to integrate into the community owing to patient's inability to feel wanted. Resorted to drink. Very lonely. Does best in a controlled and secure environment and appears to settle well into hospital system. An impossible problem.

Males, aged 60 and over (nine patients)

1. Four case notes referred to heavy demands made by patients suffering from brain failure.

2. Three patients were physically disabled; two were refusing supportive services, one was very demanding and wearing his wife out.

3. Widower, chronic depression.

4. One case showing the problems of providing adequate care for house-bound diabetics living deep in the country.

Females, aged 60 and over (22 patients)

1. Senile dementia was mentioned in seven cases; in four of these there was reference to someone requiring help but refusing it.

2. Major physical disabilities were mentioned in six cases. For example:

Age 83. Colostomy. Indwelling catheter. Obesity++ Arthritis++. Difficult personality. Required two district nurses, one to get her out of bed in the morning and one to put her to bed at night. Completely alone otherwise and immobile in chair except for visiting home help and handyman. Repeated problems with staff but refused to live elsewhere.

3. Loneliness and social isolation was mentioned in six cases.

4. Hypochondria was mentioned in three cases.

Service deficiencies

These were summarized under nine descriptive headings.

Lack of skill

In two cases the general practitioner felt that a patient's difficulty had continued because of inexperience. In one case the general practitioner failed to see that the patient's problem was exacerbated by her daughter's difficulties. In the other, the doctor felt unable to help with a psychosexual problem.

Lack of time

The five cases where the doctors felt that more time was needed than they could give seemed similar. Having already given considerable time, the doctors seemed to recognize that they were unable to tackle the intensive work needed and withdrew because of "lack of time". The time spent with patients before this decision was taken varied between two and 14 consultations.

The time spent with each patient is not as absolutely limited as might be thought (Howie, 1979), and appears to become an issue only at a critical moment in the doctor/patient relationship, perhaps when the doctor begins to understand the magnitude of a case and the demands that it might make. He or she then has to decide either to make a lasting commitment or to refer the patient to someone else. Because there were few local counselling and support services, the study cases often could not be referred and became a problem to the general practitioner.

Social service deficiencies

Declared problems with social services included: direct criticism of social workers for failing to keep up an established contact after a crisis had passed (six cases); problems with inappropriate provision (two cases); delay in obtaining aids (one case); disagreements about the patient's social needs (two cases); and the rules governing payment for local authority services (three cases). One case was cited where a patient could not be admitted to a surgical ward because the social services had failed to make child care arrangements.

It was mainly social service provision that was refused by patients. However, one rejected a psychiatric referral and some (mainly the elderly) refused all services. In three cases, Part III accommodation was refused because the husband was still working and was not willing to help pay for it. As a result, one of these people was admitted to a hospital bed without a pressing medical reason. In another case an elderly man fell in the ambulance taking him to a day unit; he was slightly injured and as a result his wife refused to allow him to use the ambulance service.

There was some indirect evidence of liaison difficulties, and occasionally doctors felt that, because the social services did not agree about the most appropriate types of care, the doctor and family were left to cope with the results.

It was noted that a battered wives' hostel and more sheltered accommodation for the elderly would be valuable.

Psychiatric service deficiencies

General practitioner comments on psychiatric services included the following: "Difficulty obtaining opinion, since registrar was from a different culture" and "The well-meaning psychiatrist was no help."

In the latter case, the doctor felt that he had uncovered many relevant and disturbing facts about his patient. He referred the case hoping the psychiatrist would follow through with the intensive work for which he "did not have the time". Having taken the trouble to find out about the development of his patient's problems, he felt the psychiatrist ignored this information and only dealt with the patient's symptoms.

One old man was removed from hospital by his wife

because she was not satisfied with the care he was receiving: "Wife very unhappy with treatment and policies of sedation on the ward and nursing care—did not make formal complaint."

One general practitioner complained about the lack of liaison after one of his patients used a walk-in clinic for the treatment of addictions.

Psychiatric facilities which the general practitioners said they would like available were quicker access to child psychiatry, an assessment unit for family problems and an adolescent unit.

Rural areas

The main problems were difficulties in getting accurate laboratory results and conducting rigorous, regular checks when the general practitioner/patient contacts were mainly in the patient's home:

> His diabetes should be checked annually. I try to do this at home because there is no way he can get to the surgery. Bus services infrequent and inconvenient, he has no car and mine is not insured to bring him to the surgery. Therefore, diabetic care is deficient in that visual testing is not adequate at home, his weight can't be checked and blood tests have to get to the lab within two or three hours and this is difficult to arrange.

Shortage of counselling services

Counselling, for all kinds of problems, including sexual difficulties, was the service deficiency most often noted (14 cases). The patients concerned mainly had marital problems, or were bereaved or lonely. Since no clear distinction was made by doctors between counselling and psychotherapy, this category and the next overlap.

Shortage of psychotherapy services

The second most noted deficiency (12 cases) was the lack of some form of psychotherapy. These patients either presented with long-standing, deep-rooted problems with which the general practitioner was reluctant to get involved, or were categorized by their general practitioner as having a "personality disorder", an "inadequate personality" or being a "psychopath". It is probable that these labels, which were used frequently, but by only three doctors, referred to people with very similar problems; they may reflect the general practitioners' desperation over the depth of the problem or reflect their training in psychiatric terminology.

In general, psychotherapeutic services were thought necessary for alcoholism, family therapy and pre-crisis intervention.

Self-help groups

Seven patients were thought to need local self-help groups—for weight loss, support, trips out and visits. It was felt that such groups could replace the general practitioner as the main social contact for both patients and the relatives of severely disabled people.

Domiciliary services

Deficiencies in these services were mentioned mainly in relation to the elderly and the physically handicapped. Although their needs varied and would need to be the subject of special study, a common issue worthy of special attention appeared to be how to care for elderly people who reject all kinds of help.

Discussion

The study was regarded as a practical success. The doctors who participated were willing to identify problems in terms of specific needs, to keep detailed records and to return them. The results were used in planning several service developments: a working party studying the mental health needs of the rural area of Tyneside proposed that mental health services should be based in primary and community care and that hospital-based services should support these; a working party was also set up to look into problem drinking in Northumberland and has led to support for self-help groups; a clinic for psychosexual and relationship counselling has been organized and is becoming well used; and the issue of liaison between social workers and general practitioners has been considered and in time may lead either to an attachment scheme or to more formal liaison procedures between the health and social services. Hence, although it was non-epidemiological, this study made a useful contribution to service planning.

A local investigation such as this was not intended to provide general conclusions, but two findings are worth further comment. Firstly, general practitioners did not ask for more of the mental illness services that already existed. The remit and membership of the Psychiatric Services Management Teams proposed by the Working Group on Organisational and Management Problems of Mental Illness Hospitals (DHSS, 1980) may result in needs being defined in a way which invites the provision of further conventional psychiatric services. However, our investigation might suggest this is not necessarily appropriate. One reason why more of the same might be inappropriate is that many general practitioners are aware how complex their difficult patients' problems are, and do not see these patients as suffering from a psychiatric disorder, however broadly defined. It is perhaps worth recalling that the policy document *Better Services For The Mentally Ill* (DHSS, 1975) opens with a discussion about whether problems of human relationships and behaviour should be regarded as instances of mental illness. It is possible that by focussing on individual cases our study prompted responses phrased in terms of specific problem-oriented services rather than a comprehensive specialty-based service, and that by not raising epidemiological issues we obtained information which is unrepresentative of the population served. However, we have already suggested that there may only be a demand for a specialist service in so far as it is seen as relevant in an individual case, and that this partly reflects the general practitioner's own way of perceiving problems.

Secondly, our study (of 10 male doctors) suggests some of the factors which lead to a difficult relationship between doctor and patient. For instance, women were disproportionately represented in the group of patients recorded. This recalls the comment made by Shepherd and colleagues (1966) that "it would be a justifiable exaggeration to say that, in the eyes of the general practitioners, psychiatry in general practice consists largely of the psychosocial problems of women". Possible reasons for this imbalance could be that there is a higher prevalence of social and emotional disorders in women than in men, that women could be the presenting symptom of a disordered or stressful family, that general practitioners may condition women to attend more frequently than men by the way they manage them, that women may have more time and opportunity to attend or that women are more readily perceived as difficult by their general practitioners.

General practitioners appear to use the word 'difficult' to summarize many things: lack of support or of specialist services, the inappropriateness of existing services, limitations in their own skills or failure to reach a mutually acceptable agreement on the definition of the patient's problem. This paper would suggest that there are ways of developing appropriate local facilities without relying on epidemiological studies, which might be insensitive to local variation.

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