Prevalence of enduring and disabling mental illness in the inner city

JOE KAI

ANN CROSLAND

CHRIS DRINKWATER

SUMMARY

Previous research identifying the long-term mentally ill in primary care has been outside areas of deprivation. We used a case finding approach by a primary care group to identify the prevalence and characteristics of people with enduring and disabling mental ill health in a disadvantaged inner-city community. We found a high point prevalence (12.9 per 1000 patients) of enduring psychotic and non-psychotic illness (36.1% and 63.9% respectively). This contributed to considerable workload and disability, and included a significant proportion of older people (24.6% aged over 65 years). The approach may be useful for local needs assessment. It highlights a need to consider disability as well as diagnosis for service development.

Keywords: mental illness; disability; deprivation.

Introduction

THE new National Service Framework (NSF) for Mental Health[1] emphasises improving the care of those with chronic mental ill health as a priority for primary care groups (PCGs)[2] and mental health services. In identifying such patients in primary care, previous research has been outside areas of severe deprivation, involved research-oriented training practices, and excluded older people.[3] As a prelude to local needs assessment and service development, we report a case finding approach by a PCG of inner-city general practices in a severely disadvantaged community. We sought the prevalence and characteristics of people with enduring and disabling mental ill health and their frequency of contact with health services.

Methods

Practices were invited to develop patient case registers, where people with enduring mental illness were defined by disability (Box 1)[3] thus reflecting need for support.[4]

In contrast to previous research[3] we included people aged over 65 years (excluding chronic organic brain syndromes). Patients were identified from:

- computerised or manual search for patients receiving repeat prescriptions for psychotropic medication, either currently or in the past (defined as any treatment within the following sections of the British National Formulary: hypnotics and anxiolytics, drugs used in psychoses and related disorders, and antidepressant drugs).
- general practitioner/practice nurse memory; and
- searches by address of establishment (local hostels, supported care homes, voluntary sector accommodation).

GPs and practice nurses checked the generated list of patients for confirmation or exclusion against the defined criteria. Patient records were reviewed for demographic data, mental health problems, and recorded contacts with primary and other health services in the preceding two years. This was collated into a practice-held case register which was verified by GPs, and anonymised data were combined for the locality.

Results

Ten out of 13 practices in the PCG participated, with patient lists ranging from 1600 to 11 700 and a combined list of 64 200 patients (locality mean Townsend Deprivation Score = 7.75 [range = 6.06–9.35];[5] e.g. 60–80% without car, 22–39% unemployed). All practices received deprivation payments (Jarman UPA score[6] over 30 for between 26.3% and 59.2% of their patient lists). They included two single-handed and three training practices.

Diagnoses and prevalence of patients identified are shown in the Table 1. There was wide variation in patient prevalence between practices (4.5–26.8 per 1000 patients registered). The number of patients who had experienced disabling mental illness for over 10 years was 57.6%; 74.5% of those aged 16 to 64 years were not in employment and receiving long-term sickness certification; 50.8% of patients lived alone, 14.5% with a spouse/partner, 6.3% with another relative, and 13% lived in hostel accommodation (circumstances were unclear for 15.5% of patients).

Almost all patients (99%) had recorded contact with general practice in the preceding two years (practice attendance/home visits). Contact rates varied widely, with a mean of 8.55 contacts per year (mean = 17.1, median = 13.0, mode = 5.0, range = 0–98 contacts over two years). This contact was predominantly with GPs. The mean contact rate for those with chronic psychosis was 7.29 per year and for those with chronic non-psychotic illness 9.42 per year. The overall mean home visit rate was 1.8 per year (range = 0–37).

Overall, 430 patients (52.1%) had recorded contact with mental health services in the preceding two years (73% with psychotic illness, 42% with non-psychotic problems); 48.9% patients had seen a psychiatrist; 12.7% a community psychiatric nurse; 3% a psychologist and 12.3% a social worker/social services contact. A quarter of all patients (207 [25%]) had been admitted to hospital for mental ill health on one or more occasions in the past (102 with psychosis and 89 with non-psychotic illness).

Discussion

The study relied upon practitioners' perceptions of patients' disability and their interpretation of the definition provided. This may have contributed to variation in identified prevalence between practices that did not appear related to level of deprivation payment. Nevertheless, practitioners usually saw these patients frequently, were likely to know and recall them well,

J Kai, MRCGP, senior lecturer, Department of Primary Care and General Practice, University of Birmingham. A Crosland, MSc, RGN, research fellow; and C Drinkwater, CBE, FRCGP, senior lecturer, Department of Primary Health Care, University of Newcastle upon Tyne.
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Table 1. Prevalence and diagnoses of patients with enduring and disabling mental illness. (Denominator population: 64 000.)

	Number aged 16–64 years (%)	Number aged 65 years and over (%)	Total (%)
Patients identified	623 (75.4)	203 (24.6)	826 (100)
Men	317 (50.9)	69 (34.0)	386
Women	306 (49.1)	134 (66.0)	440
Prevalence (per 1000 patients registered)	9.7	3.2	12.9
Mean recorded consultation rate in primary care	9.15 per year	6.52 per year	8.55 per year
Diagnosis of psychosis			
Schizophrenia	159 (25.5)	36 (17.7)	195 (23.6)
Bipolar affective disorder	55 (8.8)	17 (8.0)	72 (8.7)
Other[a]	20 (3.2)	11 (5.4)	31 (3.8)
Total (psychosis)	234 (37.5)	64 (31.1)	298 (36.1)
Non-psychotic diagnosis			
Severe anxiety/depression	273 (43.8)	102 (50.3)	375 (45.4)
Alcohol/drug abuse	59 (9.5)	3 (1.5)	62 (7.5)
Personality disorder	21 (3.4)	4 (2.0)	25 (3.0)
Other[b]	36 (4.8)	30 (14.8)	66 (6.9)
Total (non-psychosis)	389 (61.5)	139 (68.6)	528 (63.9)

[a]For example, psychotic depression; [b]including agoraphobia, eating disorder, obsessive compulsive disorder, Munchausen's syndrome .

and rarely reported difficulty using the definition. Certain local factors were reflected; for example, three practices with highest prevalence rates provided care to particular hostels and supported accommodation.

At the time of the study, local mental health and social services could not systematically identify relevant clients, nor would we have included those who were not registered with practices, such as the homeless. However, case-finding in general practice appears to identify over 90% of long-term mentally ill patients in the community.[3] We attempted to increase comprehensive coverage by searching for service contacts over two years rather than one year by including those over 65 years of age and by engaging primary care teams serving a defined locality. Despite limitations, this pragmatic approach may offer a relevant step towards local needs assessment in the absence of better practical alternatives.

In considering service development we found that the process of contacts and social data recorded in notes were highly variable, and mental health service contact may have been underestimated through under-recording. Better coordination and exchange of information between primary, mental health, and social services will be needed if effective joint working is to be realised.[1]

The prevalence of enduring mental illness identified is over three times that found previously in general practice,[3] underlining the particular challenges of mental ill health in deprived localities. Other findings might form priorities for the forthcoming service framework for older people and social exclusion policy. A quarter of all patients were aged over 65 years and half of all patients lived by themselves with the possibility of social isolation compounding disability.

Only half of patients were in contact with mental health services and a quarter of those with psychosis were not in contact with mental health services at all, echoing national surveys.[7] However, almost all patients were being seen frequently in primary care, suggesting considerable workload and resource implications. Here, the focus of mental health policy upon those with chronic psychosis rather than non-psychotic problems remains a source of tension. Primary care teams identified patients in both groups as chronically and severely disabled. In the context of targeting limited resources to those most in need, our findings suggest current policy may neglect significant numbers of highly disabled non-psychotic groups.[8] As new standards for services are being implemented, better care might be achieved by local approaches to shared care[9] that focus upon disability as well as diagnosis.

A patient who for two years or more has been disabled by impaired social behaviour as a consequence of mental illness.

- Disability is the defining criterion; the patient is unable to fulfil any one of four roles: holding down a job, maintaining self-care and personal hygiene, performing necessary domestic chores, or participating in recreational activities.
- The disability must be due to any one of four types of impairment of social behaviour: withdrawal and inactivity, responses to hallucinations or delusions, bizarre or embarrassing behaviour or violence towards others or self.
- The diagnosis may be any one of the following: one of the psychoses; a severe and chronic non-psychotic disorder, including depression, anxiety and phobic disorders, obsessional neurosis, severe personality disorder, eating disorder, alcohol or drug misuse; or a mental illness which has not been given a specific label.
- Patients were excluded if they had dementia or other organic brain disorder, or a learning disability, or were aged under 16 years.

Box 1. Definition of enduring mental illness used.

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Address for correspondence

Dr Joe Kai, Department of Primary Care and General Practice, University of Birmingham Medical School, Edgbaston, Birmingham B15 2TT. E-mail: j.p.kai@bham.ac.uk