Difficult behaviour in drug-misusing and non-drug-misusing patients in general practice — a comparison

Jez Thompson

SUMMARY
Some GPs may be unwilling to take on the management of drug misusers because of the risk of difficult behaviour. However, this study found that in a practice running a drug misuse treatment programme there was a relatively small difference in the rates of difficult behaviour from drug misusers and general patients.
Keywords: *drug misuse; drug misuser; aggressive behaviour; attitudes of health care staff.*

J Thompson, MRCGP, principal in general practice, Leeds.

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Address for correspondence
Dr J Thompson, St Martins Practice, 319 Chapeltown Road, Leeds LS7 3JT. E-mail: Jez.Thompson@gp-B86100.nhs.uk

Introduction

GENERAL practitioners (GPs) are encouraged to become involved in the management of drug misuse.[1] Many seem reluctant, perhaps fearing that disruptive behaviour from drug misusers may upset staff, doctors or other patients. Attitudes regarding problem drug users are seen in anecdotal reports[2] and in surveys in which drug misuse is characterised as a causative factor in aggressive behaviour.[3,4] At worst, GPs may refuse to accept drug-misusing patients onto their lists.[5]

There is, however, little evidence that drug misusers mean trouble in practice and the true incidence of behaviour-related problems is difficult to establish from the literature.[6] Indeed, some authors write positively about GP involvement in the management of problem drug use,[7] while others discuss the rewards to be gained from working with drug misusers.[8]

This study establishes data on the frequency of difficult behaviour from patients attending for treatment of drug misuse at St Martins Practice, Leeds and compares this with general patients.

Method

The practice team was involved in the reporting of difficult behaviour during July, August, and September 1999. We agreed a consensus definition of difficult behaviour beforehand while acknowledging the subjective nature of offence and the inevitability of individual interpretation. To facilitate data recording, difficult behaviour was divided into categories ranging from verbal aggression to physical violence. Staff added other categories as necessary, for example offensive smell, which became a problem during the study. Our method of recording difficult behaviour was built on existing health and safety policy on the confidential documentation of incidents.

The author reviewed the case notes of each patient listed to establish the reason for contact with the practice. A χ^2 test was used for statistical analysis.

Results

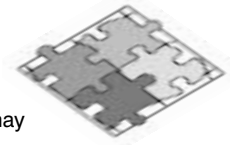
During the study period, 5223 appointments were attended. A further unspecified number of contacts were made with the practice, either in person or by telephone. Drug misusers attended 631 appointments (12% of the total). The practice list size was 4900, with 73 patients being treated for drug misuse.

In total 33 incidents were recorded, representing approximately one episode every second working day. Reception staff reported the majority (30 [91%]) of the incidents. Most

Table 1. Difficult behaviour, types, and frequencies.

Behaviour	Total episodes	Drug misuse patients	General patients	Status not known
Offensive smell	13 (39%)	8	4	1
Playing radio loudly	1 (3%)	1	0	0
Marked intoxication	1 (3%)	0	1	0
Verbal aggression	16 (48%)	4	9	3
Verbal threat	1 (3%)	0	1	0
Physical aggression	1 (3%)	0	1	0
Physical injury	0	0	0	0
Total	33	13 (39%)	16 (48%)	4 (12%)
Total (excluding offensive smell)	20	5 (25%)	12 (60%)	3 (15%)

HOW THIS FITS IN



What do we know?
GPs can be unwilling to treat drug misusers, fearing that their behaviour may be disruptive.

What does this paper add?
This paper quantifies the prevalence of disruptive behaviour from drug misusers and general patients. Excluding very minor problems, drug misusers were not significantly more likely to cause offence.

incidents were at the milder end of the scale, with only one example of direct physical contact with a staff member; this involved a baby being tossed towards a receptionist. No-one was injured during the study, and the baby was unhurt. Thirteen episodes (39%) involved drug misuse clients and 16 (48%) general patients. In a further four cases the person was not identified. Types and frequency of incidents are shown in Table 1.

The majority of episodes occurred with general patients, reflecting the larger number of contacts made by these patients. Overall, drug-misusing patients were six times more likely than general patients to show difficult behaviour per appointment attended (drug misusers: one episode in 62 appointments, general patients: one episode in 383 appointments, $P<0.001$). When offensive smell is excluded, drug misusers were approximately twice as likely to show difficult behaviour for each appointment, although the difference was not significant (drug misusers: one episode in 316 appointments, general patients: one episode in 656 appointments, $P = 0.15$).

Most incidents involved patients attending for appointments (22 [67%]), six (18%) involved attendance for other reasons, and five (15%) resulted from telephone calls. The average age of patients listed was 39 years (range = 18 to 80 years), with 21 (72%) being male. For a drug misuse client, the average age was 31 years (range = 22 to 46 years) and 12 (92%) were male.

Discussion

One incident occurring every second working day is enough to cause staff intermittent anxiety but has not resulted in loss of satisfaction at work. Reception workers reported the majority of episodes, lending weight to either of two commonly held beliefs; patients may behave aggressively towards reception staff and yet be polite with their doctor, and doctors may not be good at routine recording of information.

More serious aggression, involving verbal threats or physical contact, was uncommon during the study period. However, the one incident of physical contact was upsetting and took time to resolve the resulting distress.

Verbal aggression was the most common form of offensive behaviour and in response reception staff reported feelings of isolation and vulnerability. Offensive smell predominantly involved clients attending for drug misuse treatment. Our working environment became unpleasant from time to time and we received some complaints from other patients. The problem was successfully addressed through discussion and by encouraging those responsible, some homeless, to attend a local organisation providing showers and laundry facilities.

Drug-misusing patients were significantly more likely to show difficult behaviour per appointment than general patients, though by a factor lower than many would expect, particularly when offensive smell is excluded. Overall, drug misusers made a relatively small contribution to difficult behaviour experienced in the practice and there was no physical aggression involving a drug misuser during the study.

Training has been highlighted as crucial in preventing the escalation of threatening episodes and guidelines exist for the support and protection of staff in difficult situations.[1] At St Martins Practice, attention is given to training and all staff members participate regularly in workshops on the management of aggression in patients. We believe that this, a positive attitude to patients' needs, and unambiguous guidelines on the management of drug misuse, have contributed to the low rate of serious incidents.

General practitioners should feel able to become involved in the management of drug-misusing patients without fear of unacceptably high levels of difficult behaviour.

References

1. Department of Health. *Drug Misuse and Dependence — Guidelines on Clinical Management.* London: The Stationery Office, 1999.
2. Morris M. How we cope with violent attacks. *Medical Monitor* 24 March 1999; 67-68.
3. Hobbs FDR. Violence in general practice: a survey of general practitioners' views. *BMJ* 1991; **302:** 329-332.
4. Deehan A, Taylor C, Strang J. The general practitioner, the drug misuser, and the alcohol misuser: major differences in general practitioner activity, therapeutic commitment, and 'shared care' proposals. *Br J Gen Pract* 1997; **47:** 705-709.

5. King MB. Psychosocial and social problems in HIV infection: interviews with general practitioners in London. *BMJ* 1989; **299:** 713-717.
6. Hobbs FD, Keane KM. Aggression against doctors: a review. *J R Soc Med* 1996; **89(2):** 69-72.
7. Wilson P, Watson R, Ralston GE. Supporting problem drug users: improving methadone maintenance in general practice. *Br J Gen Pract* 1995; **45:** 454-445.
8. Cohen J. Problem drug users: a problem for the GP? *Practitioner* 1994; **238:** 715-718.

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