Original Articles

Problems in psychiatric care of 'difficult patients': a Delphi-study*

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SUMMARY. **Aims** – 'difficult patients' may evoke strong feelings in health professionals. The ambivalent attitude of, especially, non-psychotic chronic patients towards psychiatric care may be frustrating and burdensome to professionals. Many of these patients are cared for in non-specialized services, where professionals are often more used to working with psychotic patients. Specific problems with 'difficult' non-psychotic patients may occur, and hamper the quality of care offered. The aim of this research is to determine precisely what problems psychiatric professionals perceive in contact with non-psychotic chronic patients in order to identify starting points for alternative or improved care in non-specialized services. **Methods** – a modified five-phase Delphi study with three groups of eight participants from was used to identify and prioritize experts' judgments. **Results** – 46 problems were identified of which some were relevant to one or two subgroups and some were relevant to the entire group. **Conclusions** – a program that combines a coherent view at services level, with support and increased communication at the interprofessional level (e.g. through regular supervision, sharing of case-loads) may be highly beneficial to non-specialized services.

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INTRODUCTION

'Difficult' patients may evoke strong feelings in health care professionals: frustration, helplessness dislike, anger and even hatred (e.g. Hinshelwood, 1999; Groves, 1978). The noun 'difficult' is debated though: some find the term displaying a current lack of knowledge (Kendell, 2001), in need of differentiation (Dewan & Pies, 2001), stigmatizing (Corrigan, 2006), or just plain unsatisfactory (Tyrer, 2008). In a recent review, we distinguished three 'prototypes' of 'difficult patients': paranoid psychotic patients ('difficult-to-treat patients'), antisocial and abusive patients ('difficult people') and non-psychotic chronic patients ('difficult patients'). Especially the latter patients puzzle psychiatric professionals by their often ambivalent way of help-seeking. It does not comply with what professionals expect from 'good' patients, namely to ask for help and accept it, get better and gradually become autonomous again (Koekkoek *et al*., 2006). These patients may find or engage themselves in risky

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circumstances or behaviours, be high and ad-hoc users of psychiatric services yet without establishing an effective alliance but meanwhile being highly dependent on the institution at large (Kent *et al*., 1995; Kent & Yellowlees, 1995; Roick *et al*., 2002).

There is evidence that a substantial number of these non-psychotic chronic patients receive care in non-specialized psychiatric services such as community mental health teams (Greenwood *et al*., 2000; Keown *et al*., 2002). These services are often more tailored to the needs of chronic patients with psychotic disorders than to those with non-psychotic disorders. Evidence-based practices are less available and professionals may experience the care for these patients as burdening. This burden, just as the 'difficult'-qualification, may easily result in substandard care or treatment.

To identify starting points for alternative or improved care in non-specialized services, the aim of this study is to precisely determine the difficulties mental health professionals perceive in contact with non-psychotic chronic patients. The following three research questions were stated:

1) which problems occur in the care for 'difficult' non-psychotic chronic patients?
2) which differences exist in these problems between subgroups of 'difficult' non-psychotic chronic patients?
3) which similarities exist in these problems between subgroups of 'difficult' non-psychotic chronic patients?

METHODS

Design

To elicit and prioritise experts' views on the problems occurring in the care of 'difficult' non-psychotic chronic patients, we used a modified five-phase Delphi design with three groups of eight participants. The Delphi-procedure is well-known and often used to explicate tacit knowledge and reach consensus on a little-researched subject (Fiander & Burns, 1998; Jones & Hunter, 1995; Hasson *et al*., 2000). We modified the regular procedure by the use of a focus group (Knudsen *et al*., 2000) in the 1st round instead of anonymous generation of items, followed by thematic analysis of the group interview and a 2nd round in which participants validated the items derived from this analysis. The 3rd and 4th rounds were used to score the items with regard to urgency and changeability. The 5th and final round again was a face-to-face group meeting with representatives of each of the three subgroups. Rounds 2 through 4 took place by e-mail communication, rounds 1 and 5 were face-to-face meetings.

Definitions

The target group of our research into 'difficult patients' is substantially narrowed by only including non-psychotic chronic patients, as highlighted before. However, defining chronicity (and severity and duration of mental illness in general) has proven to be a complicated subject and many definitions have been presented throughout the years (Schinnar *et al*., 1990). Here, we limit the group of non-psychotic chronic patients to those with a severe mental illness (SMI), using the broad definition of Ruggeri *et al*. (2000). This includes all patients that have been in psychiatric care longer than two years and that have a GAF-score at or below 50. Further diagnostic specification was based on our review (Koekkoek *et al*., 2006) and resulted in three major 'difficult' subgroups of non-psychotic chronic patients. First, patients with chronic depression (CD), defined as (1) major depression with a duration longer than two years, or (2) dysthymia or (3) recurrent major depression with incomplete remission, all according to DSM-IV criteria. Second, patients with borderline personality disorder (BPD), defined according to DSM-IV criteria. Third, patients with an unclear diagnosis (often deferred 799.9), multiple diagnoses or diagnoses shifting within or across Axis I and II (further defined according to criteria based on a review and relevant national literature sources on such patients; details available from the first author). We will refer to this latter group as not otherwise specified non-psychotic chronic patients (NOS).

Participants

National experts in non-psychotic chronic disorders were purposively approached for this study, specifically for each subgroup. The three panels each consisted of eight mental health experts from different disciplines, treatment settings and educational backgrounds (see Table I). To be considered an expert, participants had to meet two criteria:

1) having at least three years of working experience with the patient group and
2) being employed in a nationally-recognized centre of expertise or being a nationally-recognized expert through publications, lectures or academic excellence.

We selected experts by searching recent literature for authors on the three distinct patient groups and through consultation of key figures in nationally recognized centres of expertise.

Data collection and analysis

Data collection and analysis took place between June 2006 and June 2007 in an iterative process, typical to the Delphi-procedure. In round 1 we used a focus group interview in each subgroup, to elicit data about the problems in the care for non-psychotic chronic patients. Focus groups allow interaction between participants, which we considered useful and necessary in this sparsely illuminated subject. We expected more diverse results from this exercise than through an anonymous generation of items or individual questionnaires (see also Kitzinger, 1995). The focus group interviews were facilitated by the 1st and 2nd author in a neutral space (unrelated to a psychiatric facility) and lasted 90-100 minutes. Discussion items were partly generated by the researchers using a literature review (Koekkoek *et al.*, 2006) and partly introduced by the experts (in response to the initial question 'what are the problems in the psychiatric care for this patient group?'). We audio taped and fully transcribed the focus group interviews, and coded all text manually through thematic analysis (Joffe & Yardley, 2003), using qualitative data analysis software (MaXQDA). Three preliminary lists of short items (problems) were constructed.

In round 2, the three item-lists were sent to the participants for validation of the accuracy of the descriptions. All participants returned the list and comments were discussed in the research team, resulting in one final list per group.

In round 3, these items were scored by all participants of each subgroup. They were asked to rate the *urgency* ('to what extent you rate this an urgent problem in the daily psychiatric care for this patient group?') and the estimated *changeability* ('to what extent you rate this problem to be amenable for positive change through professional intervention') of the identified problems. Ratings were given on a 7-point Likert scale, with 1 being a very low and 7 a very high rating. Results were analyzed using SPSS, considering the data to be on an interval level of measurement. We fed back the group mean scores of all items to the participants. Participants whose scores differed substantially from the group mean were, according to Delphi-procedure, asked to elucidate these. We summarized their statements for each item.

In round 4, all participants again received the item list for their respective subgroup, together with the summarised statements from round 3. We asked them to reconsider their own scores in the light of these clarifications. After round 4, mean scores and standard deviations of each item were calculated. Since the literature on the Delphi-procedure is inconsistent about the establishment of consensus, we choose to use the standard deviation to establish variation in the scores. The smaller the standard deviation, the more consensus there was on that item. The cut-off point was set at 1.5: items with a higher standard deviation were interpreted as items about which there was dissension.

In the 5th and final round three experts from each subgroup were invited to discuss and interpret the results of the Delphi-procedure. Selection of these 5th round participants was guided by the level of participation in the 1st round focus group: clear and outspoken participants were invited from each subgroup. This meeting again was chaired by the 1st and 2nd authors in the same facility and lasted 100 minutes. We made audio-recordings and summarized these in a report of the meeting which we sent out to the eight participants for validation.

Analysis of the final quantitative results was performed using analysis of variance (ANOVA) with Bonferroni-corrected post-hoc testing of observed differences.

Table I - Characteristics of Delphi-participants (n=24).

		CD	BPD	NOS	Total
Age	<30	–	–	2	2
	30-39	3	–	2	5
	40-49	4	6	2	12
	50-59	1	2	1	4
	59>	–	–	1	1
Sex	male	5	4	6	15
	female	3	4	2	9
Profession	psychiatric nurse	4	4	4	12
	psychiatrist	2	2	2	6
	psychologist	2	2	2	6
Experts criteria	criterion 1	8	8	8	24
	criterion 2	6	7	5	18
Treatment setting	outpatient	4	4	5	13
	inpatient	2	2	2	6
	day treatment	2	2	1	5
Educational setting	general	5	6	7	18
	academic	3	2	1	6

CD: Chronic Depression, BPD: Bordeline Personality Disorder, NOS: Not Otherwise Specified Non-psychotic Chronic Disorder.
Criterion 1: having al least three years of working experience with the patient group.
Criterion 2: being employed in a nationally-recognized centre of expertise or being a nationally-recognized expert through publications, lectures or academic excellence.

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Table II - Urgency scores and ranking orders of identified problems in the care for three subgroups of 'difficult' non-psychotic chronic patients.

Description of Problem	CD		BPD		NOS	
	Mean (SD)	rank	Mean (SD)	rank	Mean (SD)	rank
Undertreatment	6.38 (0.74)	1	4.75 (1.39)	28	4.38 (1.41)	29
No view on problems and treatment	5.88 (1.13)	2	5.25 (0.89)	12	4.50 (1.60)	24
Relapses	5.75 (1.28)	3	5.38 (0.92)	9	–	
No clear distinction between cure and care	5.75 (1.16)	4	–		4.63 (1.41)	20
No treatment offered at all	5.50 (1.20)	5	–		–	
Demoralization (in patient and professional)	5.50 (1.20)	6	4.63 (1.60)	31	4.75 (0.89)	18
Pessimistic attitude	5.38 (1.06)	7	5.50 (1.07)	6	4.88 (1.25)	16
Lack of structured treatment	5.38 (1.85)	8	5.50 (1.07)	5	5.00 (1.51)	15
Negative view of patients/stigma	5.25 (1.28)	9	–		4.63 (1.69)	22
Only 'pampering and dithering'	5.13 (1.46)	10	5.13 (1.36)	15	5.00 (1.20)	13
Lack of long-term treatment	5.13 (1.73)	11	4.88 (1.55)	25	4.75 (1.28)	19
Lack of organisational support	5.00 (1.51)	12	5.63 (1.06)	4	6.13 (0.83)	1
High expectations (in patients)	5.00 (1.31)	13	–		–	
Dependency	4.88 (1.36)	14	5.75 (0.71)	2	4.38 (1.85)	30
Poor alliance of family carers and professionals	4.88 (1.36)	15	4.88 (1.46)	22	5.13 (0.92)	9
Poor social functioning	4.88 (1.36)	16	4.38 (1.06)	32	5.13 (0.64)	8
Lack of clear diagnosis	4.88 (1.64)	17	–		4.13 (0.99)	32
Personality problems	4.88 (1.64)	18	3.88 (1.46)	35	5.38 (0.74)	4
Lack of congruence in expectations	4.88 (1.55)	19	3.75 (1.04)	36	3.38 (1.41)	39
Fearful attitude with suicidality	4.75 (1.58)	20	5.38 (0.92)	10	–	
Lack of family support	4.63 (1.06)	21	4.88 (1.46)	23	4.38 (0.92)	27
Lack of gratefulness/success (by patient)	4.50 (1.69)	22	4.38 (1.19)	33	4.25 (0.71)	31
Complex problems	4.50 (1.31)	23	5.13 (1.36)	16	5.00 (1.31)	14
Patients limited role in the family	4.50 (1.41)	24	4.38 (1.30)	34	4.38 (0.74)	26
Patients poor parental functioning	4.50 (1.69)	25	4.88 (1.36)	21	4.38 (1.30)	28
Limited cooperation professionals	4.50 (1.41)	26	5.13 (1.13)	14	5.38 (1.19)	5
Lack of intensive treatment	4.50 (1.70)	27	4.88 (1.96)	26	5.50 (1.20)	2
Lack of treatment contracts	4.25 (1.67)	28	5.00 (1.41)	18	3.75 (1.49)	36
Limited skills with suicidality	4.25 (1.49)	29	–		–	
Suicidality	4.25 (1.28)	30	4.88 (1.13)	20	–	
Urgent problems	4.00 (0.76)	31	5.38 (1.06)	11	5.25 (1.28)	7
Lack of diagnostics	4.00 (1.51)	32	–		5.13 (1.46)	11
Feeling pressured (in professional)	3.88 (1.13)	33	4.88 (1.46)	24	4.50 (1.77)	25
Considering patient as being able but unwilling (in professional)	3.50 (1.60)	34	5.75 (1.04)	3	5.50 (1.20)	3
Interference with time/agenda	3.38 (1.30)	35	5.38 (0.74)	8	5.13 (1.55)	12
Attachment disorders	–		6.13 (0.64)	1	3.75 (1.49)	37
Lack of reflection	–		5.50 (1.20)	7	–	
Limited general therapeutic skills	–		5.25 (1.04)	13	5.13 (0.99)	10
Powerlessness (in patient and professional)	–		5.00 (0.93)	17	4.86 (0.69)	17
Lack of consistent treatment	–		4.88 (0.99)	19	4.50 (1.31)	23
High but inefficient use of services	–		4.75 (1.28)	27	3.75 (1.39)	35
Diffusion of responsibility	–		4.75 (1.39)	30	4.63 (1.41)	21
Large amount of problems	–		4.75 (1.28)	28	4.13 (1.46)	33
Lack of accumulation of knowledge	–		–		5.25 (1.16)	6
Limited professional ambitions	-		–		4.00 (0.93)	34
Low professional status	–		–		3.63 (1.19)	38

CD, Chronic Depression; BPD, Borderline Personality Disorder; NOS, Not Otherwise Specified, Non-psychotic chronic patients.

RESULTS

Problems in the care of non-psychotic chronic patients

Response rates were optimal throughout the entire procedure, with all participants responding in all rounds. Combining the lists for the three groups, a total number of 46 problems was identified. The problems and their urgency scores are displayed in Table II, including a ranking order that differs between groups. Of these 46 problems 26 appeared in all three groups, 14 in two groups and 6 in only one group. Problems in the care for BPD-patients scored the highest on urgency (mean 4.99, sd 0.52), followed by those in the care for CD-patients (mean 4.81, sd 0.65) and NOS-patients (mean 4.68, sd 0.59). None of these differences were statistically significant.

Specific problems: subgroup profiles

Based on the ranking of the five most urgent problems per subgroup (Table II, bold print) the specific difficulties in the care for each subgroup of patients can be clarified. The Delphi-procedure showed that problems in the care for patients with chronic depression (CD) primarily have to do with the form and content of the treatment offered. Undertreatment is the single most important problem, largely caused by demoralization of both patient and professional: both parties simply lose faith in further treatment due to frequent relapses and limited progress. The lack of a coherent view on both problems and treatment may be detrimental in such cases. The experts state that there is no generally accepted model that explains the treatment resistance of some depressive patients. This may result in ascribing the lack of effect and patient's dependency on mental health care to his or her unwillingness to get better, or to underlying personality characteristics. All problems have one thing in common: the notion that it is very difficult to stay motivated in working with chronic depressive patients. As a consequence it is hard to assess when treatment should become long-term care, or should be terminated at all. In the latter case, the question is if this is an objective decision based on the patient's situation or if it is based on the professional's subjective state of demoralization.

For patients with borderline personality disorder (BPD), other problems are scored the most urgent. The problems these patients have with attachment and dependency place a heavy burden on the professional. It is very difficult for borderline patients to become attached to a professional, yet once this has happened it is just as hard to reclaim independence. Experts describe the charged therapeutic relationship, which is often the consequence, as burdening. This burden is increased and complicated by professionals' tendency to consider patients as able but unwilling to behave differently, thus suggesting that the patient is purposively sabotaging help. Two other problems consider the organisation of mental health care. Professionals experience little support in working with these patients, neither from management nor from colleagues. Structured treatments may exist but are often inaccessible due to their limited capacity or implementation. Other than with chronic depressive patients, for whom treatments are more available but are underused because of mutual demoralization, professionals are eager to try these treatments. Another difference between CD and BPD patients is the stronger emphasis on interpersonal problems with borderline patients, which makes professional more inclined to consider them unwilling instead of unable. As a result, borderline patients are blamed more for their lack of improvement than chronic depressive patients.

The third group, that of not otherwise specified non-psychotic chronic patients (NOS), often defies diagnosis or classification and combines multiple psychiatric problems into an undistinguishable amalgam of misery. Many problems with this group are, according to experts, related to the mental health system itself. The most urgent item is the lack of organisational support: facilities to work properly with these patients are lacking, (intensive) treatments are unavailable and cooperation with co-workers is poor since most are unwilling to accept or be responsible for these patients. Although it may well be very difficult to design proper services for these multi-problem patients, it currently are the patients that are blamed for this mismatch. The second most urgent problem in this group is the professional qualification of patients as able but unwilling to change their behaviour. The urgency of personality problems is illustrative in this matter, exemplifying that not so much the possible Axis I-disorder or practical problems are considered explanatory but that merely the patient's personality is. Certainly more that in chronic depressive and somewhat more that in borderline patients, lack of treatment success and interpersonal difficulties are attributed to the patient. The lack of a clear and stable diagnosis apparently makes professionals and organisations powerless towards the care needs of these patients that often are so clearly present or vividly articulated. Unlike for the other groups, there simply is no treatment available for this NOS group. Concluding, their presentation and help-seeking behaviour does not fit the current diagnostic and therapeutic structure of mental health care.

Table III - Aggregated urgency and changeability scores of problems in the care for 'difficult' non-psychotic chronic patients.

Rank	Problem	Urgency	Changeability
		Means (SD)	**Means (SD)**
1	Lack of organisational support	5.58 (1.21)	5.63 (1.06)
2	Lack of structured treatment	5.29 (1.46)	5.75 (1.26)
3	Pessimistic attitude	5.25 (1.11)	5.21 (1.32)
4 t	No view on problems and treatment	5.21 (1.32)	5.46 (1.22)
5	Undertreatment	5.17 (1.47)	5.58 (1.35)
6	Only 'pampering and dithering'	5.08 (1.28)	5.38 (1.31)
7	Limited cooperation professionals	5.00 (1.25)	5.33 (1.13)
8	Dependency	5.00 (1.45)	4.58 (1.53)
9	Poor alliance of family carers with professionals	4.96 (1.12)	4.46 (1.06)
10	Demoralization (in patient and professional)	4.96 (1.27)	4.96 (1.49)

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Generic problems

Since all three groups together were earlier described as one, we also analysed the most urgent problems across all groups. We selected the 10 most urgent overall problems (Table III). Here, most of the items are related to an overall lack of knowledge about the necessary content of treatment, the evidence of 'what works' and the organisational embedding within the total mental health care system. As such, professionals, regardless of the specific non-psychotic patient group they work with, experience problems that are not directly related to the patient's specific psychopathology or disorder. Describing the central dilemma as briefly as possible, it comes down to: psychiatric professionals lack a view on how to understand and structurally treat non-psychotic chronic patients, with whom dependency (on part of the patient) and pessimism (on part of the professional) are particularly problematic, resulting in demoralization and limited therapeutic ambitions within an organisation that does not support the work with these patients very well, while professionals experience limited cooperation with each other and a limited alliance with family carers.

Considering many problems not to be related to patient characteristics but to the functioning of mental health care itself, we expected experts to be quite optimistic about the changeability of these problems. Indeed, organisational problems attract the highest changeability scores, while professionals' pessimism and demoralization score lower and problems related to the patient (dependency) and his or her social system (poor alliance with family carers) clearly score lowest. Although present in all groups, the perceived changeability of problems differed between groups. The chronic depression group evoked most optimism, shown through a high mean changeability-score over these ten most urgent items (mean 5.70, sd 0.67). The NOS-group evoked least optimism (mean 4.94, sd 0.47), while the borderline group scored somewhat higher (mean 5.02, sd 0.41). The difference between the CD-group and the other two groups was significant (ANOVA F=6.384, df=2, 27, p=0.005). The same pattern was found when the mean changeability scores of all problems, not just the 10 most urgent, were compared: CD scored highest (mean 5.25, sd 0.74), NOS lowest (mean 4.71, sd 0.59) and BPD in between (mean 4.86, sd 0.39) (ANOVA F=7.998, df=2,107, p=0.001) (raw data may be obtained from the first author). In terms of clinical significance it may be stated that the CD-group evokes up to three-quarts of one point, on a 7-point Likert- scale, more belief in possible change that the BPD and NOS-groups do.

The 5th Delphi-round supported this outcome. In the final group discussion the changeability of the identified problems was thoroughly discussed, regarding the experts' observation that most patients with severe and persistent mental illness receive care in non-specialized services. Many were critical of such services: CD-experts strongly favoured more therapeutic options, while NOS-experts were somewhat sceptical of therapeutic endeavours and stronger supported needs-focussed care arrangements. All agreed that if non-specialized psychiatric care was better structured and more focussed on problems like chronicity and dependency, care could be improved. However, all experts also agreed that evidence-based treatments (if existent and available) should be tried first.

DISCUSSION

Regarding our research questions, we have identified 46 problems in the care for three groups of non-psychotic chronic patients. The largest differences between groups were found in patient-related problems. Descriptions of the particular problems in these groups have given insight in how these variables contribute to perceived difficulty by professionals, and possible effects on subsequent care. The most important generic problems across all three groups considered the organisation and provision of mental health care, professional's pessimism and demoralization of both patient and professional.

The use of aggregated scores of the larger group of non-psychotic chronic patients, is somewhat at odds with the present scientific focus on disorder-oriented treatments and dedicated services. It did, however, show that some problems are more generic than estimated beforehand. Although generic, differences between diagnostic groups were present: problems in patients with an Axis I-diagnosis (CD) were perceived much more changeable than problems in patients with an Axis II-disorder (BPD) or no clear diagnosis at all (NOS). This suggests that the better patients fit into the (diagnostic) mental health system, the less pessimistic professionals become. An alternative explanation is that the larger number of effective treatments for depressive disorders, compared to BPD and NOS, evokes more optimism in professionals. Experts are truly optimistic about changes in the mental health system to reduce problems in the care of 'difficult' patients. The patient-professional interaction remains largely out of sight, which is surprising since substantial research is directed towards the therapeutic alliance and a large part of treat-

ment effectiveness is ascribed to its quality. As such it appears that, additional to blaming the patient, experts blame mental health care for systemic failure with these patients.

Our list of most urgent items (Table III) points to such systemic failure at three different levels. First, the scientific level at which there exist relatively few treatments for many of these patients. Second, the services level at which the existent treatments may not be available to patients, either because of scarcity of means or because of poor fit (as a result of e.g. diagnostic uncertainty, co-morbidity, repeated no-show, recurrent crises). In such cases, patients are often referred to services with few treatment options for patients, little appeal to professionals and limited resources in general. Within such services, a coherent view on the care for these patients is often lacking. It is unclear how intensive professionals may follow patients, how long care may continue, how problems in treatment should be understood or from which therapeutic framework care should take place at all (Koekkoek *et al*., in press). The third systemic level is the interprofessional level, at which cooperation and support are hard to find, leaving professionals relatively isolated with their 'difficult' patients. All aforementioned elements of systemic difficulties may find their way into the patient-professional interaction and result in professionals' insecurity, pessimism and demoralization.

While the search for more refined diagnoses and specialized treatments continues, it appears useful to also develop strategies for practical problems regardless of diagnosis (e.g. frequent no-show, chronic suicidality, dependency, demoralization). A program that combines a coherent view at services level, with support and increased communication at the interprofessional level (e.g. through regular supervision, sharing of case-loads) may be highly beneficial to non-specialized services (e.g. Tyrer, 2007; Tylee & Haddad, 2007). It goes beyond doubt that an evidence-based treatment that fits the patient's problems and needs, should be provided first if available. However, the non-specialized services that patients are referred to in the case that this is not an option, need support to offer proper care. More so, they may even need to become specialized services for non-psychotic chronic patients, analogous to specialized services for 'difficult' psychotic chronic patients (e.g. Assertive Community Treatment). Then, they can incorporate evidence-based strategies for specific problems without requiring patients to fit an entire treatment program or a specific diagnostic category.

Strengths and limitations of the study

The Delphi-procedure was beneficial in increasing our understanding of difficulties in the care for non-psychotic chronic patients. The focus groups in the 1st round were useful because of their interactive nature, helping experts to explore their explanations beyond what is commonly said about 'difficult' patients. Furthermore, the validation of summarized items in the 2nd round improved both the reliability and validity of the statements used in the following rounds. The diverse sample in terms of professional background and working setting may have further improved the validity of the results. However, participants came form only one country and all were experts. Even though the Dutch mental health system resembles that of most highly developed countries, we cannot rule out that 'regular' professionals would have come to other conclusions than our experts did. Bias in the selection of experts may have occurred, yet we have put in maximal effort to ensure that participants met the preset objective expertise-criteria. Last, generalization of the three subgroups of 'difficult' non-psychotic chronic patients researched here to all non-psychotic chronic patients is not readily possible.

Dividing a Delphi-panel into three smaller groups is not a regular procedure. In this case, it resulted in small numbers per subgroup and the absence of some items in one or two groups, making it impossible to calculate aggregated scores of all problems across three groups. This procedure may have introduced a bias towards more general and less specific items. However, the selected items do represent a large part of the urgent problems in each of the three groups.

CONCLUSIONS

To state that mental health care produces its own 'difficult' non-psychotic chronic patients may be too strong. Yet it is clear that 'turfing' patients to under-resourced services is more likely to reinforce than to diminish professional's pessimistic attitudes towards these patients. This and other problems have been exemplified through this research. The results may be helpful in developing increasingly tailored strategies to deal with these problems in non-specialized services.

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