el are compared with the observed outcomes, 81 percent of the patients who were not early readmissions were correctly classified. Fifty-three percent of the patients readmitted within 30 days were correctly classified. Overall, the correct classification rate was 68 percent.

Discussion and conclusions

Like a number of other studies (3–5), our study found previous hospital admission to be the strongest predictor of readmission. We also found that having any of several manifestations of instability before discharge predicted early readmission. This finding is similar to that of Swett (6) in a study of readmissions. His study found that elevated scores on subsections of the Brief Psychiatric Rating Scale were nonredundant predictors of readmission after the number of previous hospitalizations were controlled.

Swett's study and the one reported here suggest that patients at greater risk for readmission may be identified before discharge through careful assessment. Early readmission may be prevented by ensuring that patients with past hospitalizations are stabilized before discharge. An advantage of the measures we used as clinical indicators of instability is that they are readily available in the medical record. ♦

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Care of Long-Term Mentally Ill Patients by British General Practitioners

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In the United Kingdom, patients gain access to psychiatric care through general practitioners (GPs). The first of three studies conducted to assess the role of GPs in managing patients with long-term mental illness found that such patients were unevenly distributed in general practices and that GPs preferred to care for them in collaboration with psychiatric specialists. A more detailed study of 16 general practices yielded information on characteristics and care of long-term mentally ill patients, including a high rate of GP consultations for them. A third, controlled study examined the impact of teaching GPs to provide a structured assessment of long-term mentally ill patients every six months; after the intervention, only a small number of patients actually received such assessments. (*Psychiatric Services* 48:1586–1588, 1997)

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Health care in the United Kingdom is divided between primary care, provided mainly by general practitioners (GPs), and secondary care, provided by specialists. GPs are contracted to offer comprehensive, 24-hour medical care for about 2,000 patients each, and more than 95 percent of the population are registered with a GP.

General practitioners are the first point of contact for virtually all mental health problems in the United Kingdom, and indeed the only health professionals involved for the vast majority of people with such problems (1). The last 20 years have witnessed a growing interest in improving and evaluating GPs' mental health skills and practices (2), but most work has focused on the detection and management of so-called "minor morbidity" —depression, anxiety, and adjustment disorders.

It is known that general practitioners, who are perceived as easily accessible and nonstigmatizing (3), are the

professionals most likely to be in contact with schizophrenia patients a year after hospital discharge (4). However, little research has been conducted into the GP's role in managing schizophrenia or other long-term mental illnesses. The three studies summarized here were conducted between 1990 and 1995 to assess GPs' involvement in and attitude toward care of people suffering from long-term mental illness, to determine the patients' clinical characteristics and the care provided to them, and to evaluate the impact of teaching GPs to make periodic structured assessments of these patients.

The patients studied had psychiatric illnesses disabling enough to stop them from working or to significantly restrict their normal social roles for at least two years. Patients younger than 16 or older than 65 and those with primary diagnoses of organic brain disease or learning disability were excluded from the studies (5).

The three GP studies

The questionnaire study

To assess general practitioners' involvement in and attitudes toward care of long-term mentally ill patients, a postal questionnaire was sent in 1994 to every third GP in the South West Thames Health Region, which stretches from the center of London to the south coast (6). The region's population of three million closely reflects the national demography.

GPs were asked whether they had recently noticed any effect on their practice of the discharge of long-term mentally ill patients from hospitals to the community and the number of such patients in their practice. They were also asked about characteristics of their practice, their mental health experience, and their direct access to mental health staff.

GPs' attitudes were assessed by a series of statements they rated as strongly agree, agree, disagree, or strongly disagree. Eight statements concerned who should have clinical responsibility for the long-term mentally ill patient in the community, three were about who should be the key worker or principal caregiver for long-term mentally ill patients, and six were about potential difficulties in caring for such patients. Associations were assessed using chi square or unpaired t tests.

Of 507 active GPs surveyed, 369 (73 percent) replied. Almost a third (110, or 30 percent) had noticed an effect of the discharge of long-term mentally ill patients on their practices. The majority of respondents (225, or 61 percent) had ten or fewer such patients, but those practicing in Greater London or within three miles of a large mental hospital had more, as did those who had a psychiatrist visiting their practice.

Targeted training for general practioners in the management of long-term mental illness is urgently needed.

Most general practitioners (333, or 90 percent) thought care should be shared by the psychiatrist and general practitioner. Only 59 GPs (16 percent) were willing to take full responsibility for care. Only nine had specific practice policies for this patient group, and 287 (78 percent) agreed that such patients came to their attention only at times of crisis.

This survey confirmed that long-term mentally ill patients were unevenly distributed in general practices and that GPs were willing to care for them but preferably in collaboration with secondary, or mental health, specialists. The absence of practice policies for reviewing the care of these patients meant that GPs' care of them was concentrated on crisis management.

Provision of care: a 16-practice survey

Because the questionnaire study provided little specific information on the nature of patients' problems or patterns of care, 16 group practices in the study area were recruited for an in-depth study (7). Although the practice locations ranged from deprived inner-city areas to affluent semirural areas, the practices were not a representative sample; they comprised generally higher-quality, motivated practitioners involved in medical student teaching.

A total of 440 long-term mentally ill patients in these practices were identified through repeat prescriptions, diagnostic information where it was computerized, a review of appointments over two months, and psychiatric records (5). Patient details, the number and content of GP consultations with the patients within the preceding 12 months, and patients' contact with community mental health team members for this period were extracted from the practice records. Study patients were compared with an age- and sex-matched control group of patients not suffering from long-term mental illness, through unpaired t tests.

The sample comprised 262 women (60 percent) and 178 men, with a mean age of 47.4 years. They had been ill from two to 46 years, with a mean of 18.2 years. Of the primary diagnoses recorded, 253 (58 percent) were psychoses. The overall rate of long-term mentally ill patients was 3 per 1,000 patients registered in the practices. Social deprivation among the long-term patients correlated positively with a psychotic diagnosis but not with a nonpsychotic diagnosis nor with the overall rate.

The mean rate of GPs' consultations per year with long-term mentally ill patients was 8.1 (range, 0 to 88), significantly higher than the mean of 2.8 consultations (range, 0 to 26) with the control patients. The total number of consultations recorded with the sample patients was 3,564. The most common reasons for consultation included minor physical disorders (334 patients), repeat prescriptions for physical and mental disorders (339 patients), and requests for certificates verifying illness (211 patients). As for

elements of mental health care provided, psychotropic medication adjustments were recorded in 20 percent of the patients' records, elements of a formal mental state examination in 32 percent, and nonspecific indications of well-being (for example, "doing fine" or "well") in 29 percent.

More than a third of the long-term mentally ill patients (175, or 40 percent) had no contact with psychiatric secondary services during the preceding 12 months, and 29 (7 percent) had no record of such a contact ever. Those who were in contact with psychiatric services were more likely than those with no contact with psychiatric services during the study period to be psychotic (75 percent versus 47 percent), younger (45.4 years versus 50.4 years), and ill for a shorter time (16.7 years versus 19.6 years).

Other differences between long-term mentally ill patients in contact with psychiatric services and those in contact only with GPs were small. Overall, the study showed that patients with long-term mental illness make substantial demands on GPs; their rate of consultation with GPs is unaffected by their contacts with psychiatric services. However, the high rate of GP consultations gives general practitioners the opportunity for a greater role in monitoring patients' mental state and drug treatment.

Controlled trial of a structured assessment

In the third study, the high rate of GPs' consultations with long-term mentally ill patients was targeted as a way to increase GPs' involvement with those patients and encourage GPs to be more proactive (5). GPs do not review the care of these patients as often as they do the care of patients with chronic physical illness (7,8). Prescriptions for psychotropic drugs are often renewed without consultation and may not be reviewed for years (9).

The 16 practices in the previous study were randomly allocated to an experimental or a control group, stratified by number of partners, size of the list of registered patients, and number of long-term mentally ill patients. For practitioners in the experimental group, the authors provided two sessions of teaching on long-term mental illness and the principles of a structured assessment. Of the 35 GPs in the experimental group, 34 attended the first teaching session and 29 the second. They were asked to complete a structured assessment for each patient every six months for two years. The control group received no teaching but were encouraged to review their long-term mentally ill patients every six months.

The outcome was assessed by examining practice records for changes in the process of care between the two years preceding the teaching intervention and the two years after. The primary outcome measures were adjustments in psychotropic drugs, referrals to psychiatric care, rates of GP consultations, and data indicating provision of preventive health care.

Postintervention data were available for 373 of the 440 patients (85 percent). At least one assessment was recorded for 127 of the 184 experimental patients (69 percent), but only 29 patients (16 percent) received all four assessments. Participating GPs considered the assessments to be too time consuming, rarely leading to treatment changes.

Despite the GPs' view, an overall increase in activity was found for the intervention group; adjustments of neuroleptic medications had increased significantly (up 14 percent), as had referrals to secondary care (up 13 percent). No significant differences were found between the two patient groups in psychiatric admissions, incidents of self-harm, referrals or admissions for physical problems, consultation rates, continuity of care, or recording of data indicating preventive mental health care.

This study demonstrated that teaching GPs about long-term mental illness may increase their involvement in psychiatric care, although their conducting structured assessments in routine appointments seems problematic. Nazareth and King (10) propose scheduling specific sessions for similar reviews. We are investigating the impact both of involving general practice nurses in conducting assessments and of paying GPs to conduct them.

Conclusions

General practice remains the cornerstone of British health care, playing a major role in mental health. Several training initiatives for GPs for depression, anxiety, and somatization have been reported, but the role of GPs in community care of the severely mentally ill has generally been overlooked.

As long-term mentally ill patients are reintegrated into society, they will probably want to obtain health care the same way other people do. In the United Kingdom, this means consulting their GP who, at present, is unlikely to have extensive postgraduate experience in mental health. Although the number of general practitioners with such experience is increasing, targeted training for GPs in the management of long-term mentally ill individuals is urgently needed.

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