Provision of care to general practice patients with disabling long-term mental illness: a survey in 16 practices

TONY KENDRICK

TOM BURNS

PAUL FREELING

BONNIE SIBBALD

SUMMARY

Background. *Increasing numbers of long-term mentally ill people now live in the community, many of whom lose contact with psychiatric services and come to depend on general practitioners for medical care. However, it has been suggested that general practitioners may be unaware of some of these patients and their needs.*

Aim. *This study set out to investigate the care received by this group of patients.*

Method. *Case registers of adults disabled by long-term mental illness were set up in 16 of 110 group general practices asked to participate. A search of each practice's record systems was combined with a survey of local psychiatric and social service teams, to seek practice patients who might not be identified from the general practice data.*

Results. *Of the 440 patients found, 90% were identified from information within the practices, mainly computerized repeat prescription and diagnostic data. The other 10% were identified only by psychiatric services. Over one third of the patients had no current contact with psychiatric services. Patients in contact with psychiatric services had been ill for a shorter time than those not in contact. More patients suffering from psychotic illnesses were in current contact than those with non-psychotic diagnoses. Over 90% of the patients had been seen by their general practitioners within 12 months, on average eight times. Most consultations were for minor physical disorders, repeat prescriptions and sickness certificates. Elements of the formal mental state examination were recorded in one third of cases and adjustments of psychotropic medication in one fifth.*

Conclusion. *These findings suggest that patients in long-term contact with specialist services cannot be taken as representative of the whole population with long-term mental illness. General practitioners could use their frequent contacts with long-term mentally ill people to play a greater role in monitoring the mental state and drug treatment of this group.*

Keywords: psychiatric disorders; long term care; continuity of patient care; GP services; psychiatric services.

T Kendrick, BSc, MRCGP, Mental Health Foundation research fellow; P Freeling, FRCGP, professor; and B Sibbald, PhD, senior research fellow, Division of General Practice and Primary Care, St George's Hospital Medical School, London. T Burns, MD, MRCPsych, professor of community psychiatry, Department of Mental Health Sciences, St George's Hospital Medical School, London.

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Introduction

MORE than 100 000 people disabled by long-term mental illnesses were estimated to be living in the community in England in 1986,[1] and the number is likely to have increased since then with hospital closures. There is serious concern that such patients may not receive the continuing care they need.[2]

Although mental health teams have been asked to target long-term mentally ill patients for continuing support,[3] many patients lose contact with specialist services, and depend on general practitioners for medical care.[4,5] However, some of these patients may not be seen by their general practitioners either. Goldberg pointed out that the number of patients with chronic schizophrenia seen in a year by general practitioners in the third national morbidity survey fell short of the known prevalence of such patients.[6] Practice activity analysis data revealed that around half of all prescriptions for phenothiazines were repeat prescriptions where the patient was not seen, and only one third were given in follow-up consultations.[7] The majority of general practitioners surveyed in South West Thames Regional Health Authority, England agreed that some patients with long-term mental illness came to their attention only at times of crisis; very few had specific practice policies for the care of these patients.[8]

The aim of this study was to investigate the care received by those with long-term mental illness, by setting up case registers of such patients in a number of practices and exploring patients' contacts with general practitioners and specialist services. It was decided to combine a search within each practice with a survey of local psychiatric and social service teams, to seek patients who might be unknown to their general practitioners.

Previous studies of patients with long-term mental illness have usually included only those in contact with psychiatric services,[9-11] who may be an unrepresentative sample, or specific diagnostic groups, such as those with schizophrenia,[4,5] not all of whom remain disabled in the long term.[12] The need for support is related more to disability than to diagnosis.[13,14] Therefore, in this study patients with long-term mental illness were defined as those with enduring disability owing to impaired social behaviour associated with mental illness.

Method

Recruitment of practices

In order to recruit practices in a range of locations, from inner city London to semi-rural areas, 110 group practices involved in teaching medical students from St George's Hospital Medical School, London were contacted in August 1991. All of the partners in the practice had to be willing to help identify their long-term mentally ill patients, and to participate in a planned controlled trial of regular structured assessments of such patients by their general practitioners.

Information about the number of partners, patient list size, training status, records systems and general practitioners' qualifications, psychiatric experience and interest in psychiatry was obtained. As a measure of socioeconomic disadvantage the mean of the Jarman eight-item underprivileged area (UPA-8) scores[15] for the local authority wards covering the bulk of each practice area was calculated.

Identification of patients

Three sources of information within each practice were used to identify patients who might have long-term mental illness. Repeat prescription data were used to search for patients receiving psychotropic drugs. This search was made by computer or by monitoring patient requests for repeat prescriptions for three months. Diagnostic information was used to identify patients where this was recorded on computer. Appointment books and home visit records of patients seen in a two-month period were also used to remind the general practitioners of any additional patients.

In addition to searching practice data, local consultant psychiatrists, community psychiatric nurses, psychiatric day hospital staff and social service managers were asked to examine their caseloads and to identify any long-term mentally ill people known to them who were registered as patients of the participating practices.

The names of patients identified from all these sources were checked with their general practitioners, to confirm that each matched the study definition of a long-term mentally ill patient (Appendix 1), using both the general practitioner's knowledge of the patients and information in practice records.

Spearman's rho was calculated to assess whether the prevalence of patients identified correlated significantly with practices' UPA-8 scores.

Data extracted from patients' general practice records

The practice records of the long-term mentally ill patients identified were examined. Details of age, sex and psychiatric diagnoses were noted, together with the length of the primary illness. For patients given several diagnoses over a long history, psychotic diagnoses were considered to be the primary diagnoses. Diagnoses were classified using the categories of the *International classification of diseases* (ICD-9).[16] Personality disorders were noted as both primary and secondary diagnoses. The number and content of general practitioner consultations within the preceding 12 months were recorded. Entries were not included which were made by practice nurses or other staff, or which simply recorded the issue of repeat prescriptions. Indications of contacts with psychiatrists, community psychiatric nurses or social workers in correspondence received were also recorded. Where there was no documented contact during the preceding 12 months, or a clear indication of continuing appointments, the patient was recorded as no longer in contact.

Analysis

Patients in current contact with psychiatric services were compared with those not in contact, in terms of age, sex, diagnosis (psychotic versus non-psychotic), length of illness, frequency of consultation with their general practitioners, and their general practitioners' experience and interest in psychiatry. The unpaired *t*-test was used to assess the significance of differences found.

In each practice an age and sex matched control sample of patients who were not suffering from a long-term mental illness was selected at random, in order to determine their consultation rate, for comparison with those with a long-term mental illness. The paired *t*-test was used to assess the significance of the difference found.

Results

Participating practices

Of the 110 practices contacted 16 agreed to participate; their main characteristics are shown in Table 1. Twelve of the 16 practices were training practices. All 16 operated a repeat prescription system, which was computerized in 14 practices. Six practices recorded diagnostic information on computer. The mean list size of the 70 general practitioners in the 16 practices was 2075.

Nineteen of the 70 participating general practitioners (27%) had six months' experience as a psychiatric senior house officer. None was working part-time in a hospital psychiatry department or had any psychiatric qualifications. Thirteen doctors declared themselves very interested in psychiatry, 45 fairly interested, 11 not very interested and one not at all interested.

Long-term mentally ill patients

Overall, 440 long-term mentally ill patients were identified in the 16 practices; 262 women (59.5%) and 178 men (40.5%), with a mean age of 47.4 years. The length of illness ranged from two to 46 years (mean 18.2 years), with no record of onset in 21 cases.

The primary diagnoses recorded in the records are shown in Table 2. Overall 253 patients (57.5%) had received a psychotic diagnosis and 187 (42.5%) a non-psychotic diagnosis. Forty six patients (10.5%) had a diagnosis of personality disorder; this was the primary diagnosis for 16 patients and the secondary diagnosis for 30. The four patients with an 'other' non-psychotic diagnosis comprised two with transsexualism, one with Tourette's syn-

Table 1. Characteristics of the 16 practices and prevalence of patients with long-term mental illness.

Practice	Number of partners	Number of practice patients[a]	Jarman UPA-8 score	No. of patients (no. per 1000 registered patients)		
				With psychotic diagnoses	With non-psychotic diagnoses	Total with long-term mental illness
1	5	10 100	−14	9 (0.9)	17 (1.7)	26 (2.6)
2	4	8800	3	13 (1.5)	16 (1.8)	29 (3.3)
3	4	7800	0	9 (1.2)	9 (1.2)	18 (2.3)
4	4	8500	−8	12 (1.4)	8 (0.9)	20 (2.4)
5	5	10 000	−10	7 (0.7)	14 (1.4)	21 (2.1)
6	4	8500	−10	12 (1.4)	8 (0.9)	20 (2.4)
7	3	5600	12	13 (2.3)	3 (0.5)	16 (2.9)
8	4	7200	15	25 (3.5)	7 (1.0)	32 (4.4)
9	6	12 400	3	38 (3.1)	18 (1.5)	56 (4.5)
10	4	11 000	10	16 (1.5)	17 (1.5)	33 (3.0)
11	5	10 000	−18	17 (1.7)	16 (1.6)	33 (3.3)
12	4	7500	26	15 (2.0)	1 (0.1)	16 (2.1)
13	3	3400	−10	4 (1.2)	6 (1.8)	10 (2.9)
14	5	10 000	12	27 (2.7)	21 (2.1)	48 (4.8)
15	4	8500	8	13 (1.5)	12 (1.4)	25 (2.9)
16	6	16 000	−21	23 (1.4)	14 (0.9)	37 (2.3)

[a]To nearest 100.

drome, and one undiagnosed, who presented quasi-religious ideas.

The overall prevalence of patients with a long-term mental illness in the 16 practices was 3.0 per 1000 patients registered. The prevalence of patients with psychotic diagnoses was found to correlate with the practice UPA-8 scores (Spearman's $r = 0.64$, 95% confidence interval 0.21 to 0.86) (Table 1). There were no significant correlations between practice UPA-8 scores and the prevalence of those with non-psychotic diagnoses and the prevalence of long-term mentally ill patients overall.

Search methods

Overall, 395 of the 440 long-term mentally ill patients (89.8%) were identified from practice information. Of these, 65 were also identified by psychiatric services, together with the remaining 45 (10.2%) who had not been identified within the practices. Only 24 patients (5.5%) were identified by social service managers, for nine of the practices. For the other seven practices, social service managers were unable to help with the study, citing pressure on their time and the lack of any centralized record of individual social workers' caseloads.

Patients' contact with professionals

Twenty nine long-term mentally ill patients (6.6%) had no record of a general practitioner consultation within the preceding 12 months (Table 2). Of these 29, 11 were also no longer in contact with psychiatric services. The mean consultation rate of the long-term mentally ill patients was 8.1 consultations per year (range 0–88). This was significantly greater than the mean of 2.8 per year (range 0–26) for the control patients (paired t-test; $P<0.001$).

In the preceding 12 months 75.9% of the 440 long-term mentally ill patients had consulted for minor physical disorders, 12.0% for serious (potentially life-shortening) physical disorders, 77.0% for repeat psychotropic prescriptions and 48.0% for sickness certificates (65.7% of the 178 men consulted for sickness certificates and 35.9% of the 262 women). Changes in psychotropic drug regimens made in the preceding 12 months were recorded in 20.0% of the 440 records. While elements of the formal mental state examination carried out in the preceding 12 months were recorded in 32.0% of cases, in a further 29.1% the records included non-specific indications of well being, such as 'doing fine', 'well' and 'no change'.

Overall, 62.3% of patients were in current contact with psychiatrists or community psychiatric nurses (Table 2). A greater proportion of those with psychotic diagnoses were in current contact with these professionals than of those with non-psychotic diagnoses (unpaired t-test, $P<0.001$). Virtually all the patients had seen a psychiatrist at some time (Table 2). The 274 patients in contact with psychiatric services were younger than the 166 patients no longer in contact (mean age 45.4 years versus 50.4 years, $P<0.001$), and had been ill for a shorter time (mean of 16.7 years versus 19.6 years, $P<0.05$). There were no significant differences between those in and out of contact with psychiatric services in terms of sex, frequency of consultation with general practitioners, or their general practitioner's experience or interest in psychiatry.

Discussion

When extrapolating the findings presented here to other practices

Table 2. The primary diagnoses recorded in the practice notes for patients with long-term mental illness and the patients' contacts with professionals.

Primary diagnosis	No. of patients	In preceding 12 months: % of patients seen by GP	In preceding 12 months: Mean no. of GP consultations	% of patients currently in contact with: Psychiatrist	CPN	Psychiatrist or CPN	Social worker	% of patients ever in contact with psychiatrist
Psychotic								
Schizophrenia/ schizo-affective disorder	204	*88.7*	6.3	*56.9*	*43.1*	*70.6*	*7.4*	*100*
Manic-depressive psychosis	38	*97.4*	9.1	*84.2*	*21.1*	*86.8*	*2.6*	*100*
Psychotic depression	11	*90.9*	5.3	*72.7*	*36.4*	*72.7*	*0*	*100*
Total	253	*90.1*	6.6	*61.7*	*39.5*	*73.1*	*6.3*	*100*
Non-psychotic								
Anxiety/depression	103	*98.1*	9.0	*39.8*	*17.5*	*48.5*	*2.9*	*90.3*
Agoraphobia	27	*100*	10.0	*29.6*	*14.8*	*40.7*	*7.4*	*81.5*
Personality disorder	16	*93.8*	10.6	*50.0*	*25.0*	*50.0*	*12.5*	*100*
Alcohol abuse	15	*100*	18.3	*60.0*	*33.3*	*60.0*	*6.7*	*93.3*
Anorexia nervos[a]	7	*100*	9.6	*57.1*	*14.3*	*57.1*	*0*	*100*
Chronic atypical (psychogenic) pain	6	*100*	14.7	*0*	*0*	*0*	*16.7*	*66.7*
Obsessive-compulsive disorder	5	*80.0*	5.4	*60.0*	*20.0*	*60.0*	*0*	*100*
Drug abuse	4	*100*	5.5	*25.0*	*0*	*25.0*	*25.0*	*100*
Other	4	*100*	7.5	*75.0*	*25.0*	*75.0*	*0*	*75.0*
Total	187	*97.9*	10.0	*41.2*	*18.2*	*47.6*	*5.3*	*89.8*
Overall	440	*93.4*	8.1	*52.7*	*30.5*	*62.3*	*5.9*	*95.7*

CPN = community psychiatric nurse.

it should be remembered that the study group was not a random sample. The general practitioners had to be prepared to do extra work to identify their long-term mentally ill patients and to explore ways of improving their care; only 16 practices out of 110 approached were prepared to participate.

Although the mean list size of the doctors taking part (2075) was close to the regional mean of 2005 patients, the 38% of general practitioners who work in single-handed or two-partner practices in South West Thames Regional Health Authority[17] were not represented in this sample. However, the practice areas covered did range from affluent parts of Surrey to disadvantaged districts of south west London, with UPA-8 scores ranging from −21 to 26, respectively (compared with an overall range from −37 to 57 in the region[15]). The practices were generally well organized, with partners interested in psychiatry.

In such practices 90% of the long-term mentally ill patients included in the study were identified through readily available practice data. The other 10% were identified through psychiatric services, with diminishing returns for the time and effort expended. However, setting up case registers may be more difficult in less well organized and motivated practices.

The overall prevalence of patients identified as suffering a long-term mental illness was three per 1000 patients registered, but rates varied widely between practices, in part due to a higher prevalence of patients with psychotic disorders in the more disadvantaged areas, which was not unexpected.[18] This may partly explain why the prevalence found here is lower than the 13 per 1000 patients with high levels of social disability found in a community survey in the very deprived inner city area of Camberwell.[19] In addition, the methods used here would not have identified long-term mentally ill patients in the community who had not been in touch with any health or social services for some time, such as the homeless.

The high mean general practitioner consultation rate of 8.1 consultations per year may be compared with the rate of 6.5 per year found for patients on a district psychiatric case register in Worcester.[9] Though few in number, most long-term mentally ill patients are demanding of general practitioners' time. However, 29 patients (7% of the total) had had no recorded contact with their general practitioners for a year. This confirms suspicions that some disabled long-term mentally ill patients are not seen regularly by their general practitioners,[6] although they seem to be few in number in these practices.

According to practice records, most contacts with general practitioners were for minor physical problems, repeat prescriptions and sickness certificates. A similar pattern was found in a study of general practitioner involvement with schizophrenic patients carried out over 30 years ago.[20] In only a minority of cases were elements of mental state examinations and changes of psychotropic medication recorded. It is possible, however, that mental state review occurred more often and was not specifically recorded in the notes.

While virtually all the patients in this study had been assessed by psychiatrists at some time, patients with a psychotic illness were more likely to be in current contact with psychiatric services than patients with non-psychotic diagnoses. A survey of psychiatric day patients found that only 10% had chronic neuroses and 10% personality disorders.[11] The findings presented here suggest that patients in long-term contact with specialist services cannot be taken as representative of the whole population with long-term mental illness.

Who should look after patients with long-term mental illness? If mental health teams were to take on regular supervision of all the patients identified in this study then their caseloads of patients with chronic illness from these practices would increase considerably. Apart from the cost implications this might be quite inappropriate for many long-term mentally ill patients, once they are in relative remission and their condition is stable.

An alternative would be to ensure adequate general practitioner monitoring of the majority of patients with long-term mental illness, with specialist back up only when required, as with most long-term physical illnesses. This would require a change to more proactive care. Long-term mentally ill patients who have a relapse commonly fail to seek help.[21] Even when they do present, general practitioners may not detect changes in their mental state because of communication difficulties and a lack of training in the assessment of mental state.[8]

This study has demonstrated that long-term mentally ill patients can be readily identified in general practice. General practitioners could perhaps use their contacts with these patients to play a greater role in monitoring their mental state and psychotropic medication. The next phase of this study is a controlled evaluation of regular recall of patients for structured assessments by their general practitioners, to determine whether such an approach is feasible and improves the care of this vulnerable group.

Appendix 1. Definition of a long-term mentally ill patient.

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 of the following: one of the psychoses; or 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 (mental handicap), or were aged under 16 years or over 65 years.

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Address for correspondence

Dr T Kendrick, Division of General Practice and Primary Care, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE.