- 13 Dawes PT, Fowler PD, Jackson R, Collins M, Shadworth MF, Stone R, *et al.* Prediction of progressive joint damage in patients with rheumatoid arthritis receiving gold or d-penicillamine therapy. *Ann Rheum Dis* 1986;45:945-9.
- 14 Mottonen TT. Prediction of erosiveness and rate of development of new erosions in early rheumatoid arthritis. *Ann Rheum Dis* 1988;47:648-53.
- 15 Westedt ML, Doha MR, Baldwin WH, Stijnen T, Cats A. Serum immune complexes containing IgA appear to predict erosive arthritis in a longitudinal study in rheumatoid arthritis. *Ann Rheum Dis* 1986;45:809-15.
- 16 Suarez-Almazor ME, Soskolne CL, Saunders D, Russel AS. Outcome in rheumatoid arthritis. A 1985 inception cohort. *J Rheumatol* 1994;21:1438-46.
- 17 Luukkainen R, Kaarela K, Isomaki H, Martio J, Kiviniemi P. The prediction of radiological destruction during the early stage of rheumatoid arthritis. *Clin Exp Rheum* 1983;1:295-8.
- 18 Eberhardt KB, Rydgren LC, Pettersson H, Woliheim FA. Early rheumatoid arthritis—onset, course and outcome over 2 years. *Rheumatol Int* 1990;10:135-42.
- 19 van Zeben D, Hazes JMW, Zwinderman AH, Vanderbroucke JP, Breedveld FC. Factors predicting outcome of rheumatoid arthritis: results of a follow up study. *J Rheumatol* 1993;20:1288-96.
- 20 Caruso I, Santandrea S, Sarzi Puttini P, Boccassini L, Montrone F, Cazzola M, *et al.* Clinical, laboratory and radiographic features in early rheumatoid arthritis. *J Rheumatol* 1990;17:1263-7.
- 21 Sjoblom G, Saxne T, Pettersson H, Woliheim FA. Factors related to the progression of joint destruction in rheumatoid arthritis. *Scand J Rheum* 1984;13:21-7.
- 22 Teitsson I, Withrington RH, Seifert MH, Valdimarsson H. Prognostic value of early rheumatoid arthritis. I. Prognostic value of IgA rheumatoid factor. *Ann Rheum Dis* 1984;43:673-8.
- 23 de Carvalho A, Graudal H. Radiographic progression of rheumatoid arthritis related to some clinical and laboratory parameters. *Acta Radiologica Diagnosis* 1980;21:551-5.
- 24 Kaarela K. Prognostic factors and diagnostic criteria in early rheumatoid arthritis. *Scand J Rheum* 1985;57(suppl):1-54.
- 25 van der Heide A, Remme CA, Hofman DM, Jacobs JWJ, Bijlsma JWJ. Prediction of progression of radiological damage in newly diagnosed rheumatoid arthritis. *Arthritis Rheum* 1995;38:1466-74.

(Accepted 16 May 1996)

Are community mental health teams providing an equitable service? Comparison of source of referrals with inpatient care

Richard Laugharne, Simon Fleminger

Some researchers have suggested that community mental health teams may have policies that result in those most in need not receiving priority for services and may thus not provide an equitable service.^{1,2} Referral practices of general practitioners have been suggested as a source of inequity.^{3,4} We investigated the factors affecting which patients are referred to a community mental health team by comparing the demographic characteristics of people referred to one community team with those of patients being admitted to hospital and also with the general population.

Method and results

The community mental health team serves a multiethnic population of 52 059 (of whom 32 783 are aged 15-64) in a deprived inner city area. It accepts referrals directly from general practitioners (many practice alone or in two-handed practices), psychiatric outpatient clinics, inpatient wards, social workers, health visitors, and elsewhere. We examined retrospectively consecutive referrals to the team over 18 months and also inpatient records. Information on the population was obtained from the 1991 census and records of the department of public health. The figures used were for adults aged 15-64 years. Over the 18 months 119 patients from the study area were admitted to the acute adult psychiatric wards and 513 were referred to the community mental health team. Patients referred to the team were significantly younger than those admitted as inpatients: 36.1 years (SD 12.0) *v* 39.1 (13.0) (*t* test 2.26, *P* = 0.024).

There was a large difference between referrals to the community mental health team, inpatient admissions, and the general population in terms of the size of general practice with whom subjects were registered. In the general population about a quarter were registered with practices with a single doctor, one half with practices with two, and one quarter with practices of three or more (table 1). The inpatient admissions showed no significant difference from this pattern, but there was a large overrepresentation of people referred to the community mental health team from large practices: the rate of referral from larger practices was four times that of the other two groups of practices. Of the patients referred to the team 310 were referred by their general practitioner and 195 from other sources. For those patients referred from primary care there was an even greater overrepresentation from larger practices (68.8% of referrals). For the referrals from other sources the distribution was closer to that of the general population, though larger practices were still overrepresented (31.1% of referrals).

Comment

Patients registered with general practices of three or more doctors are four times more likely to be referred to the community mental health team than are patients registered with smaller practices, contrasting with the findings of the inpatient population, where the distribution of patients is little different from that of the general population. If anything, patients from large practices are underrepresented among inpatients, though not significantly so.

Our interpretation of the findings is that the rates of inpatient admissions are a crude indicator of levels of psychiatric morbidity. Therefore the different rates of referral to the community team reflect inequalities in accessing this psychiatric service rather than different levels of need. General practitioners from larger practices might have a lower threshold for referral or detect more mental illness, or general practitioners from smaller practices might refer more to the outpatient department and the accident and emergency department.

Funding: None.

Conflict of interest: None.

Joint Academic
Department of
Psychological Medicine,
St Bartholomew's and the
London Medical College,
London E1 2AD

Richard Laugharne, clinical
training fellow
Simon Fleminger, senior
lecturer

BMJ 1996;313:476

Table 1—Percentages of the general population registered with different sizes of practices and of psychiatric inpatient admissions and referrals to the community mental health team

Size of practice	General population (n = 32 783)	Inpatients (n = 119)	Referrals to community mental health team (n = 513)
Single partner	25.9	23.6	14.7
Two partners	49.2	53.8	28.4
Three or more partners	24.9	21.7	55.8
No GP		0.9	0.5
Missing data (No)		13	38

Referrals to team *v* population: $\chi^2 = 244.1$, *df* = 2, *P* = 0.0001. Referrals to team *v* inpatients: $\chi^2 = 41.3$, *df* = 2, *P* = 0.0001. Inpatients *v* population: $\chi^2 = 1.1$, *df* = 2, *P* = 0.57.

- 1 Patmore C, Weaver T. Improving community services for serious mental disorders. *Journal of Mental Health* 1992; 1:107-5.
- 2 Sayce L, Craig TKJ, Boardman AP. The development of community mental health centres in the UK. *Soc Psychiatry Psychiatr Epidemiol* 1991; 26:14-22.
- 3 Thomas RV, Corney RH. A survey of links between mental health professionals and general practice in six district health authorities. *BJ Gen Pract* 1992; 42:358-61.
- 4 Robertson NC. Variations in referral pattern to the psychiatric services by general practitioners. *Psychol Med* 1979; 9:355-64.

(Accepted 11 April 1996)