SIR: The article by Lawrence *et al* (*Journal*, September 1991, **159**, 334–340) has prompted us to share some of our results concerning hospital admissions in the psychiatry of mental handicap.

Our uncontrolled retrospective survey has shown that with the changes in admission policies in the mental handicap hospitals, the rate and number of people coming to those hospitals has dropped. At the Cell Barnes Hospital, the number of new admissions for 1979 ($n=156$) and 1980 ($n=198$) were quite different from the number of new admissions for 1989 ($n=64$) and 1990 ($n=33$), showing a significant fall to between one-third and one-fifth in the past decade.

There have been several factors influencing the fall in the number of admissions in the large mental handicap hospitals. An awareness of reasons for hospital admissions and its consequences, the benefits versus drawbacks of admissions, cessations of easy availability of beds, and the decrease of social and indiscriminate admissions have affected the number of people coming to hospital.

An awareness of benefits of community care, the increases in community resources, rehabilitation, respite care, day-time facilities, and adult training centres, and the increase in the number of other professionals have eased the follow-up of people with dual diagnosis and multiple problems who had been candidates for admissions in the past.

In the psychiatry of mental handicap, we now believe that community alternatives to hospital admissions have crystallised the needs for the real admissions of people with psychiatric and behavioural disorders. We are also aware that although alternatives to in-patient care have a valid place in the psychiatry of mental handicap, those alternatives cannot fully replace the assessment, treatment aspects, and security of the hospital.

We now have a better understanding and clearer definition of the mentally handicapped people who can live in a highly supported environment in the community as compared with the few whose intractable challenging behaviour and dual diagnosis make them candidates to become new long-stay hospital patients.

The issue now is to increase the community facilities at district level provided by health and social services to accommodate all the patients who can live in the community and to resettle all the hospital residents who can cope in the community environment.

Our results have shown that in mental handicap, community care has reduced the need for psychiatric beds and has brought more insight into new admissions; these results will be sustained if the community provides the necessary resources for people to live independently.

Contrary to the information coming from adult services, when it comes to admissions of mentally handicapped people, the bed-rock of illness will reach stability and clarification after community care has been fully implemented. At today's pace this may take many years.

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Family psychiatric histories in general practice referrals

SIR: The role of heredity in many psychiatric disorders is now acknowledged. With the advent of new biological techniques, molecular genetics will offer a range of approaches to psychiatric science (Baron & Rainer, 1988). Hence there is renewed interest in the genetics of psychiatric illness. General practitioners have traditionally been viewed as family doctors, and they are in a unique position to report the occurrence of psychiatric illnesses within the family. Family psychiatric history has been identified as one of the key items to be included in a referral letter from a general practitioner to a psychiatrist (Pullen & Yellowlees, 1985).

In this context, we report one finding from an audit of referrals to a small psychiatric team in an inner city area of Nottingham. During a six-month period beginning in October 1990, 41 referrals were received from general practitioners. Forty of these referrals failed to mention the presence or absence of a family psychiatric history.

There could be many reasons for such a high rate of omission of the details of family psychiatric history. Perhaps general practitioners did not consider family histories to be relevant. Perhaps they assumed that psychiatrists were already aware of seriously affected family members. Many of the referral letters received were computerised, and we wondered whether the fixed format of these led to the family history not being included.

We would welcome comments from psychiatrists on their experiences of practice elsewhere, and also as to how they perceive this finding.

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Role of general practitioners in the care of long-term mentally ill patients

SIR: As the institutional care of psychiatric patients is replaced by community care, the role of GPs in the management of such patients is becoming increasingly prominent. Poynton & Higgins (*Journal*, November 1991, **159**, 703–706) correctly remark that it is timely to look at this role. It is salutary to note that Kendrick *et al* (1991) found among GPs an almost complete lack of specific practice policies for the care of long-term mentally ill patients.

A particular challenge to GPs is the care of schizophrenic patients, many of whom still have active symptomatology and profound social disabilities one year after discharge from mental hospital (Melzer *et al*, 1991). Recent literature concerning the community management of schizophrenia stresses the importance of integrating both pharmacological and psychosocial interventions through close co-operation between patients, carers, primary care professionals, and mental health specialists (e.g. Falloon *et al*, 1990).

In a recent (unpublished) study, I examined the part played by the GPs in one inner city practice in Sheffield in the care of the schizophrenic patients on their list. A sample of 47 patients was selected from a population of 72 known schizophrenics. Data were collected from computer records and practice notes, including details of antipsychotic medication, and a summary of correspondence and note entries for the two years between November 1989 and October 1991.

Of the 47 patients, 45 were receiving antipsychotic drugs from their GP. Of these, 28 were receiving a dose within the defined maintenance range specified by the British National Formulary (1991), and nine were receiving a higher dose. The latter figure may represent appropriate treatment of acute schizophrenic illness, or it may indicate over-prescription. Holloway (1988) found that the drug management of chronic mentally ill patients was frequently in the hands of GPs, and that over-prescription was common. He suggested local treatment protocols to improve prescribing practices.

GP liaison with other parties involved in patient care was assessed by analysing letters and phone calls filed or recorded in the notes during the two-year period. Correspondence was entered into regarding 28 of the 47 patients. For these 28, a mean of 5.5 letters were written or received (s.d. = 0.72), of which over 90% were to or from psychiatrists. Telephone calls were recorded in the notes of 25 patients: a mean of 3.2 calls per patient (s.d. = 0.68), which were distributed fairly evenly between psychiatrists, hostel staff, and other primary care professionals. A picture thus emerged of well developed communication with local psychiatrists, which was further enhanced by a fortnightly liaison-attachment scheme. Liaison with other involved parties was, however, haphazard and rare, furnishing little evidence of the teamwork favoured in the literature.

To assess the extent of GP involvement in patient care, all note entries made during the two-year period were analysed. A mean of 43.4 (s.d. = 3.16) entries were made per patient: approximately one entry for each patient every 17 days. More than half of these recorded the prescription of drugs or the administration of a depot injection – further evidence that the GPs were highly involved in managing patients' medication. Nearly 30% of entries referred to surgery attendances or home visits, showing the GPs to be in regular personal contact with their schizophrenic patients. Melzer *et al* (1991) similarly found high GP contact rates for schizophrenic patients, and suggest further work to examine the quality of that contact.

In summary, the GPs studied were highly involved in the care of their schizophrenic patients, playing a major role in the supervision of medication, and making regular personal contact through consultations. It is important to ensure the quality of both these aspects of involvement. Liaison with local psychiatrists was well developed, to the probable benefit of patient management, whereas liaison with other involved parties was poor. If the contribution of GPs is to be effectively integrated into a comprehensive community-based service, then a well developed system of liaison is of paramount importance.

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