Psychiatric Bulletin (1991), **15**, 503–512

Correspondence

GPs and mental handicap

DEAR SIRS

Mathews (*Psychiatric Bulletin*, May 1991, **15**, 268–270) has prompted us to report our evaluation of the general practitioners' involvement in the community mental handicap team of the Royal Borough of Kensington and Chelsea. With the changes in the NHS and the implementation of community care, more and more mentally handicapped people are being discharged from long stay hospitals into the community.

The consultant psychiatrist, who has had overall clinical responsibility to the mentally handicapped population (MHP) in hospital and who has cared for them, together with the team of junior and staff grade doctors and other professionals, is now passing this responsibility to the general practitioner who is becoming more involved in the care of the MHP.

In the community, it is the community mental handicap team (CMHT) consisting of one community nurse, psychologist, occupational therapist and physiotherapist who, together with the psychiatrist, will assist and support the GP in caring for the MHP. It is the CMHT who is expected to help the GP in the prevention of crises and improvement of quality of care.

With the ever increasing numbers of MHP in the community, the question is whether the GPs have the necessary information about the appropriate services on offer, the functions of the CMHT and its members, and how to make use of them. We have therefore assessed the GPs' amount of information on and involvement with the MHP in their lists, and with the CMHT in the Royal Borough of Kensington and Chelsea.

A questionnaire was designed to discover how much GPs knew about the number of MHP on their lists; the functions of the CMHT; the specific functions of the professionals in the team; the number of referrals to the team and the areas where they thought they needed help and more information. This was sent to 102 GPs and 45 valid responses were received which showed a response rate of 44%; of the GPs, 51% who had responded had adult MHP on the lists, 33% did not have any adult MHP and 16% did not know if they had any MHP or not. Of the GPs who had MHP on their lists, one had 50 patients, one had eight MHP, two had 6, one had 5, and 16 had four or less on their lists.

The information on the different professions within the team was: 69% of the GPs were aware of speech and occupational therapists, 62% were aware of community nurses, and 60% knew of psychologists in the team. Four per cent of GPs knew of one professional, 2% knew of two professionals, 18% knew of three professionals and 47% knew of five professionals in the team.

When GPs were asked about areas where help would be most useful, replies showed that speech therapists would get 23% of all requests for help; occupational therapists 22%, psychologists 20%, community nurses 18% and physiotherapists 17%. This showed a fairly evenly spread demand for help. Fifty-six per cent of the GPs asked for more information and/or referral forms, and leaflets about the team.

The 44% response rate is an acceptable number for the GP questionnaire returns. Half of the responding GPs knew of the MHP on their lists and 65% of them could give the exact number of MHP. This showed a considerable degree of interest and involvement on the GPs' side. Except for one GP who had 50 MHP and is involved with the mentally handicapped, the rest of the GPs had an evenly spread small number of clients. The GPs' knowledge of the different professionals in the team varied from two-thirds to one half. This is fairly uniform information. Half of the GPs knew of all five professions functioning in the team and half knew four or less. GPs' replies about 'requests' from the team showed one-fifth of requests going evenly to every profession involved.

Out of the 151 referrals directly made to the Royal Borough of Kensington and Chelsea CMHT in the last year, only two had come by way of the GPs (1.3%). In contrast, out of the 102 referrals made to the consultant psychiatrist 42, or over 40%, came from GPs. The referral system which may be looked on as the basis of interaction between the GP and the team is obviously not working satisfactorily and needs improvement.

This survey has been successful in gathering information from a reasonable proportion of GPs in the Royal Borough of Kensington and Chelsea and raising the questions about their relationship and involvement with the CMHT. There is clearly room for improvement in publicising the team and letting GPs know exactly how the team functions, what kind of service the team members provide, and their day to day work with individual patients. GP training programmes should include the problems of MHP in the community and GP oriented open days should be part of the postgraduate training (Royal College of General Practitioners, 1990).

Practice and communication policies which include GPs will improve the relationship with the CMHT, the mentally handicapped people and the GPs.

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"Cannabis psychosis"

DEAR SIRS

I read with interest the letter by Dr Cembrowicz (*Psychiatric Bulletin*, May 1991, **15**, 303) which reported on the popularity of "cannabis psychosis" as a diagnosis used by health workers in Tobago, West Indies. The study of psychiatrists in Birmingham which Dr Cembrowicz referred to (Littlewood, 1988) reported that although most did not find "cannabis psychosis" a useful diagnosis, a significant minority (40 out of 104 respondents) did. In view of the lack of evidence to support the separate clinical entity of "cannabis psychosis", and the lack of agreement among psychiatrists as to what this label represents, it has been suggested that clinicians discard the term (Thornicroft, 1990) and instead employ the appropriate diagnosis from ICD-9 or DSM–III–R. Cases where there is clouding of consciousness would be coded as "transient organic psychotic conditions" (293.0) in ICD-9 and as "cannabis delirium" (292.81) in DSM–III–R. Those occurring in clear consciousness would be coded as "paranoid and/or hallucinatory states induced by drugs" (292.1) in ICD-9 and as "cannabis delusional disorder" (292.11) in DSM–III–R.

Littlewood commented on the readiness of the psychiatrists he studied to prescribe major tranquillisers for cases of "cannabis psychosis", despite their perception of this as a self-limiting condition. Improvement in our knowledge of how to treat such cases is likely to be hampered if clinicians fail to distinguish between those showing features of an acute organic reaction and those resembling a functional psychosis.

The diagnosis of "cannabis psychosis" may survive in clinical practice, like the "amotivational syndrome" did for many years, not because of its validity but because it fits popular assumptions about the effects of illicit drug use. Or could it just be that it is easier to remember than the appropriate ICD or DSM code?

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Ode to the Code

DEAR SIRS

I read Dr Travers's article on the new Code of Practice (*Psychiatric Bulletin*, May 1991, **15**, 274–275) with some interest. My interest was abruptly interrupted in the paragraph dealing with guardianship, by two intrusive pieces of obfuscation. Being a psychiatrist and therefore in the know with respect to the private, and often stigmatising, language which we seem to develop, I was able to understand it on second or third reading. I am fairly sure though that those who are not in the know would be completely puzzled. May I therefore make yet another plea for dropping curious neologisms and new definitions of commonplace words which add nothing to comprehension.

The passage that gave me a problem is "guardianship is to be considered as an alternative to sectioning". The aggressive word "sectioning" here does not of course refer to some frightful fate which befalls the patient, but simply compulsory admission. Furthermore, guardianship has its own sections of the Mental Health Act 1983. In the next sentence we are told that it is sad that those mentally disordered individuals under guardianship are referred to as patients? This puzzle is illuminated by an implied new definition that an individual has to be in hospital before they can qualify for the term patient. What on earth am I supposed to call my out-patients? I treat "patients" on guardianship orders and I expect many other psychiatrists do also.

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Psychiatry in war

DEAR SIRS

There are a couple of ambiguities in Jacqueline Atkinson's two informative articles (*Psychiatric*