hospitals for years. On leaving these institutions they had resorted to a life of petty crime and had also drifted to the shelters.

With the College highlighting the need for discharge and after-care plans, and the Department of Health's Care Programme approach, there will perhaps be better recording of discharge plans in notes. The responsibility for coordinating and delivering the service to those discharged from hospital and from psychiatric care will also be clearer. While this may improve the care given to future referrals to the psychiatric services, there remains a reservoir of people who have 'fallen through the net' and their needs have yet to be addressed. However, delivering a service to this group of mentally ill people remains difficult as these individuals seem to have other major difficulties apart from their severe mental illnesses. Perhaps for many it is the combination of a severe mental illness, with personality difficulties or low intelligence, that leads to social isolation, lack of support, rejection of services provided, and a drift into substandard accommodation and criminality.

References

BERRY, C. & ORWIN, A. (1966) No fixed abode. A survey of mental hospital admissions. *British Journal of Psychiatry*, **12**, 1019–1025.

HAMID, W. A. & MCCARTHY, M. (1989) Community psychiatric care for homeless people in inner London. *Health Trends*, **21**, 67–69.

HERZBERG, J. L. (1987) No fixed abode: a comparison of men and women admitted to an East London psychiatric hospital. *British Journal of Psychiatry*, **150**, 621–627.

MARSHALL, M. (1989) Collected and neglected: Are Oxford hostels for the homeless filling up with disabled psychiatric patients? *British Medical Journal*, **299**, 706–709.

PRIEST, R. G. (1976) The homeless person and the psychiatric services: an Edinburgh survey. *British Journal of Psychiatry*, **128**, 128–136.

Psychiatric Bulletin (1992), **16**, 687–688

The relationship between hospital hostels in the community and the general practitioners who look after them

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As long-stay patients move into the community, the relationship with the psychiatrist gets diluted. One reason is the logistical problem of visiting widely spaced residences, but another is that patients are primarily under the care of general practitioners (GPs) who provide physical care in the majority of cases. The way in which psychiatric care is delivered is variable (Horder, 1991). For the system to function a *modus vivendi* has to develop between GPs, psychiatrists and care staff. This study looks at current practice in Gloucester.

The study

The Gloucester model of community care has been written about elsewhere (Anstee, 1985; 1991). The study looked at the core of the system: four 'hospital-hostels' and a rehabilitation hostel with a total population of 34. Questionnaires were sent to all hostel staff asking for their views about GPs' practices and psychiatrists and about the number of contacts GPs had had with residents, and to GPs asking for their views of the hostels.

Findings

Staff

The five GPs qualified between 1960 and 1979. There were three clinical assistants, one in psychiatry and two in mental handicap. They had looked after homes/hostels for between one and ten years. Sixty-five questionnaires were given out to hostel staff and 37 (57%) were returned. Staff had been working in hostels between 3 weeks and $7\frac{1}{2}$ years. There were 13 registered mental nurses, 13 nursing auxiliaries, 7 state enrolled nurses and 4 students.

General practitioners' views

All five GPs approved of hostels as a way of looking after this particular group of people. They said that carers almost always accompanied residents to the surgery and they thought it useful that they did

so. Only some patients were able to give their own accounts of their problems but when they could not, the carers did so effectively for them.

There were mixed feelings about the value of a clinical examination to screen for medical illness. In its favour GPs cited poor reporting of symptoms and a high incidence of asymptomatic peptic ulcers. Against it they suggested that it was an ineffective technique.

They felt that the hostels could improve their service by providing long-life drug charts, regular communication with GPs, supplying depot injections (they are expensive) and ordering treatment regularly (as opposed to *ad hoc*).

The improvements which GPs felt surgeries could make included constituting regular patient protocols for follow-up and having a social worker attached to the surgery. In addition, one GP felt that having a weekend drop-in centre and an urgent 'hot-line' would be helpful.

Hostel carers' views

Of the staff, 31 (84%) had taken a resident to see a GP and of these, 28 (90%) thought that residents had been given a chance to talk for themselves (only one was considered unable to); 27 (87%) felt the residents received good service from the GP. Fifteen (41%) staff had called GPs to the home and they all said that the response was satisfactory on at least one occasion, although two staff felt that there were occasions when this had not been the case.

Eleven (30%) staff felt they had a relationship with the practice nurse. Of these, 6 (55%) consultations were for depot injections, 11 (100%) for blood tests and 4 (36%) concerned liaison with the GP.

Fifteen (41%) staff felt they had a relationship with the psychiatrist. Of these, 13 (87%) consultations were for medication, 6 (40%) for blood tests and 11 (73%) for behavioural problems.

Twenty-two (59%) staff were involved with dispensing drugs. The practice followed varied between the homes with three predominantly using a record kept by the nurse on a hospital card with the GP also prescribing what the psychiatrist wrote on the drug chart. At one home the main method involved the GP prescribing what the psychiatrist wrote with the psychiatrist signing drug and self-medication charts. At the short-stay rehabilitation hostel the psychiatrist signed the drug and self-medication charts and the GP prescribed what the psychiatrist wrote up as well.

Staff felt that there were a number of improvements GPs could make including more accurate prescribing, being more welcoming, and receptionists being more sensitive and speaking to the resident rather than to the carer. Some staff felt that better liaison was needed, involving meetings with GP and nurses and discussing roles and expectations. One carer felt that residents needed somewhere other than the waiting room to wait.

Improvements hostel staff felt they could make included regular reviews, use of the care programme approach, increased liaison and full use of the multidisciplinary team. Some carers felt the need for more communication and input from psychiatrists while others felt regular meetings with patients would be beneficial.

Contacts

In the survey month there were 13 patient GP contacts: one visit for a prescription, 11 surgery consultations and two home visits (to the same patient).

Comments

There was a general level of satisfaction with the hostel system among GPs and carers. The symbiosis between GPs and psychiatrists has developed differently in each hostel but has broadly followed one of the three patterns of care described by Horder (1991), i.e. GPs looking after the physical care of residents with a psychiatrist visiting.

Proportionately three times as many GPs had postgraduate experience in psychiatry compared with Stansfeld's (1991) findings. Comments about the value of clinical screening reflect the uncertainty about its value in this group of people (Honig *et al*, 1989).

GPs and carers agree on several possible improvements. Better communication and liaison between GPs and hostels is akin to Stansfeld's (1991) findings with regard to GPs and out-patients. The desire on both sides for joint care planning and co-ordination on drug dispensing mirror Honig *et al*'s (1989) finding which suggests that much untreated physical morbidity could be picked up by a combined approach of carers and GPs.

These suggestions are fairly simple to implement and could lead to fruitful discussion and change.

References

ANSTEE, B. H. (1985) An alternative form of community care for the mentally ill: supported lodging schemes . . . a personal view. *Health Trends*, **17**, 39–40.

— (1991) The residuum of a traditional psychiatric hospital. *Psychiatric Bulletin*, **15**, 666–667.

HONIG, A., POP, P., TAN, E. S., PHILIPSEN, H. & ROMME, A. J. (1989) Physical illness in chronic psychiatric patients from a community psychiatric unit. The implications for daily practice. *British Journal of Psychiatry*, **155**, 58–64.

HORDER, E. (1991) Care for patients discharged from psychiatric hospital. *British Journal of General Practice*, **4**, 399–400.

STANSFELD, S. (1991) Attitudes to developments in community psychiatry among general practitioners. *Psychiatric Bulletin*, **15**, 542–543.