1977). Thus, in our analysis, (a) any variance in marital status that is correlated with gender (and, by proxy, any gender-related differences in age at marriage) is removed, to produce a 'gender-adjusted marital status'; (b) any variance in age at onset that is correlated with gender (and, by proxy, with gender differences in age at marriage) is removed, to produce a 'gender-adjusted age at onset'; and (c) the adjusted relationship between marital status and age at onset is estimated by the correlation between the gender-adjusted marital status and gender-adjusted age at onset described above. As a result, no portion of the association between age at onset and marital status in the models from which we draw our conclusions reflects those two variables' common association with gender differences in age at marriage.

While Jennen-Steinmetz *et al* are correct in arguing that age differentials would induce a simple correlation between marital status and age at onset when gender differences in age at onset and age at marriage exist, our analyses adjust for this effect and continue to identify a significant relationship between marital status and age at onset in schizophrenia.

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Working on the interface between primary and secondary care

Sir: Gask *et al* (1997) reviewed models of working at the interface between primary and secondary care and concluded that the consultation–liaison model had several theoretical advantages. They commented that factors affecting referral remain poorly understood.

We examined the reasons why eight general practitioners (GPs) based in a deprived area of Liverpool referred patients to a shifted out-patient clinic over a 10-month period. The GPs were contacted as soon as possible after receipt of a referral letter and a semi-structured questionnaire was completed, either by telephone or face-to-face. Data were available on 44 out of 47 of the referrals.

Three-quarters of referrals were initiated by the GP (33 out of 44), while the remainder were made at the request of the patient, their family or other professionals. Around half of the referrals (23 out of 44) were due to a failure to respond to the GP's treatment. Severe mental illness was given as the main reason for referral in only eight cases. The GPs wanted the psychiatric services to take over the management of two-thirds (30 out of 44) of the patients and not to refer them straight back. The GPs usually did this by requesting treatment for their patients but sometimes made it clear that they felt burdened by the patient. Expectations in the 13 cases that the GPs wished to keep on managing were more concrete and included advice on diagnosis, changing the antidepressant and the patient's fitness to work.

The GPs thought that referral was helpful to 73% (22 out of 30) of the patients, 23% (seven out of 30) of the patients' families and 93% (28 out of 30) of the GP practices. GPs rated their overall satisfaction with the referral as 'mostly satisfied' or 'excellent' for 68% (26 out of 38) and 'mixed' in 32% (12 out of 38). The GPs were not asked directly about their reason for satisfaction but in several cases they spontaneously attributed satisfaction to not seeing the patient again.

Our study suggests that an important role of referral may be to reduce the stress or burden on GPs by passing on the responsibility to the psychiatric services. GPs are often more concerned with the minor disorders they see frequently than with the more severe disorders that current policy is directing psychiatrists towards (Department of Health, 1994). There is little evidence that the widespread development of consultation–liaison links with GPs will lead to a reduction in the referral rate or a shift in the case-mix of referrals. It may be more realistic to expect liaison with GPs to facilitate the shared care of patients with severe mental illness and the early discharge of patients with less severe disorders.

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One hundred years ago

Temporary insanity

Recently the Brighton coroner referred to the automatic way in which the verdict of "suicide during temporary insanity" is given, and though we agree with him that this kindly verdict is too frequently given if the interests of truth only are to be served, yet it is not clear that any moral or social harm follows this sympathetic untruth. In the case under consideration a man who had attempted suicide had been brought up and tried before the assizes, and acquitted. Two doctors seem to have seen him, and to have decided that at that time he was not of unsound mind, yet the poor fellow, after being at home and being depressed for a fortnight, killed himself. The earlier stages of melancholia are generally free from delusions, and therefore would be considered by some medical men as uncertifiable. It will never be possible to stop all melancholiacs from self-destruction, and for their cure some risk must often be run, and generally the verdict of temporary insanity is justifiable in such cases.

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Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

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