the hostel for several weeks. When the hostel offered her a placement she turned it down. The only reason she gave was that she had lost one home, the hospital had become home to her, and she did not wish to leave. In fact, she had become emotionally involved with another (male) patient and feared she would lose him if discharged. However, the O T assessment had established that she would not be able to live on her own, was not sufficiently disabled to require formal rehabilitation, and would survive in a hostel setting. On two occasions, she was given her discharge to the hostel and staged a sit-in in the hospital reception area. She has now lost the hostel placement.

Mr R. S., aged 42, is a chronic schizophrenic patient with a serious alcohol problem. His current admission dates from January 1985. Whenever he has been sufficiently rehabilitated to return to the community, the placement breaks down in a matter of hours: he simply drinks until he's out cold or out of control and is returned to the hospital. Although he refuses to be discharged, from time to time, when he feels "well", he disappears from the hospital for days on end and reappears exhibiting florid symptoms.

Finally, Mr G. C., aged 75, with chronic schizophrenia, was admitted from a residential care home after several episodes of disturbed behaviour. He has since settled down, and is now in his third year in hospital. He refuses to do any occupational therapy, or to return to the residential care home whence he came here in the first place. He would be quite happy to go back to the house he claims is his (it was, until 20 years ago); otherwise, he's here to stay and "there's nothing you can do about it".

The reasons given by patients for refusing to leave hospital include delusional ideas about their "rightful" place of residence, unwillingness to have yet another move, total satisfaction with the room and board at the hosptial, and the conviction that they are "too ill" to cope outside hospital. Sometimes, there is an unstated motive, as in the case of Miss J. A. above, and this may only become apparent over a period of further observation.

When a patient refuses to leave hospital, and demonstrates this refusal by acting-out, expressing psychotic-like symptoms, or even camping out on the grounds in the cold (to give everyone concerned a conscience), it is often difficult to decide what action to take. To give in and re-admit the patient might encourage others to do likewise when it is their turn to be discharged. Some units have responded by calling in the hospital porters, security staff or the police, to remove the patient from the premises. Where alcoholics are concerned, such drastic action may not see the staff losing too much sleep over it, as this group of patients are generally not seen as particularly vulnerable. There are also those who see alcoholism as a self-inflicted problem, or as the expression of untreatable personality traits.

It is when patients who are perceived as vulnerable are concerned that it becomes somewhat more complex. In my experience, discharge refusers of this kind generally get their way: they are allowed to stay on in hospital, the situation to be reviewed at a later date. The act of refusal of discharge may even prompt a reappraisal of the patient's mental condition, as doubt is then cast on the patient's initial readiness for discharge.

Some units, convinced that a show of force might get the right response, arrange for the discharge refuser either to be shown around a dreadful long-stay ward (and told that he would be sent there) or actually transferred to such a ward. There is something a little punitive about this and I don't think it produces the desired results. In my observation, this approach tends to be used for inadequate personalities who just hang on, being "ill", especially on ward round days.

Having on my hands at present a discharge refuser who provokes more sympathy than any other feeling, I would be glad to hear from other psychiatrists how they have responded to discharge refusers, and with what results.

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Treatment of psychotic patients in prison

DEAR SIRS

For the last two years I have been visiting consultant psychiatrist for two sessions a week at Brixton Prison Hospital. I have become increasingly concerned at the treatment of very disturbed and psychotic patients who have to be contained in the so-called "Special Medical Rooms" (SMRs). These rooms are bare apart from a mattress, extremely dirty and often faeces-smeared as a result of the patient's mental state, and stiflingly hot in summer and cold in winter. Patients often are naked because of their mental condition and have only a canvas blanket with which to keep warm. They may remain in this condition for some considerable time.

Medical and prison hospital officer staff are most reluctant to give medication compulsorily to these very disturbed patients for obvious reasons, although it is occasionally given under common law. While I am well aware of the extreme views which may exist from people who do not see the human degradation caused by non-treatment of these psychotic patients, and talk about "chemical truncheons", I believe that consideration should be given to an amendment in the Mental Health Act to allow an emergency treatment order of, say, three days'

duration to be made by a Section 12 approved doctor on the prison medical staff. This would enable treatment to begin, for the patient to be housed under more acceptable conditions and allow time to seek help from the catchment psychiatric hospital or the regional secure unit. Often these patients are young and suffering from acute drug induced psychoses, and three days' treatment is all that is necessary for them to be able to be handled under normal prison hospital conditions.

I am well aware that this is a "hot potato" politically, but I do feel that the degree of degradation and indeed physical danger which these patients suffer during their acute psychotic phases needs to be specifically legislated for. I wonder whether the Mental Health Act Sub-committee would be interested in exploring this problem.

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Community Treatment Orders

DEAR SIRS

The debate about Community Treatment Orders rumbles on, possibly indefinitely, without appearing to come to any satisfactory conclusion. Meanwhile patients and their relatives continue to suffer.

I may have missed something but it seems to me that the situation is quite simple if we assume that everyone who is subject to compulsory treatment has had a period of in-patient observation and treatment at some stage in the episode/illness for which compulsory treatment is being applied – usually at the outset. This assumption is justified on the following grounds:

(a) Long-term compulsory treatment – particularly with depot neuroleptics – is probably never justified without an adequate period of intensive observation to allow a proper diagnosis. Even with today's community style of management it seems most unlikely that adequate diagnosis can be made without at least some period of in-patient observation. This is supported by the continuing discussions concerning the differentiation between schizophrenia and affective psychosis. No doubt, also, every psychiatrist has seen cases which have in the past been diagnosed as schizophrenia which he himself would diagnose as affective disorder, with consequent implications for long-term treatment.

(b) It is difficult to imagine the need for compulsion unless an illness was of sufficient severity to require a period of in-patient care at some stage during its course.

If we accept this assumption then surely all that is required is a minor amendment which would allow us to renew an existing Section 3 while the patient was still in the community without the patient necessarily having to be in hospital at the time of renewal. This would obviously have the benefits of insuring that a patient remained under the care of a Responsible Medical Officer who would have the obligation to be kept informed about the patient's mental state and would then have the power of recall to hospital at any time, if necessary, when signs of relapse developed.

Given the same kind of safeguards of appeal and review which are at present incorporated into the Act, I wish someone would please explain to me what the loopholes are that I have missed in the above proposal which I find it difficult to believe has not already been suggested.

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Training in psychiatry for GPs

DEAR SIRS

The College has a right to be proud of the enormous improvement achieved in the training of career psychiatrists. It is the only College to approve schemes rather than posts and over a number of years virtually all training posts have been incorporated in rotational schemes associated with academic courses. Since the beginning of the 'approval exercise' standards have gradually evolved and although many schemes may not yet have achieved optimal standards, most career psychiatrists are offered training experiences that are highly satisfactory.

In my view, the College was correct in placing a high priority on the training of career specialist psychiatrists. However, it must not be overlooked that most psychiatric patients first present to their family doctor, and that some 90% of such problems are dealt with exclusively by the GP. The spectrum of psychiatric disorder and the skills required to treat patients within the setting of general practice are generally quite different from those of a specialist psychiatrist, even when working in the community.

Most general practitioner trainees gain their psychiatric experience in hospital based posts. Some posts are tied to vocational training schemes, but most are not. Often general practitioner trainees are appointed to posts which are supernumary to the requirements of schemes or have failed to attract a suitable career trainee. Sometimes the posts are in hospitals with only limited approval and general practitioner trainees are attracted to meet the service requirements of the district. It is true that many consultants make special arrangements to meet the needs of the general practitioner trainees, but even in these posts the only academic training available is frequently more appropriate to the MRCPsych student than the RCGP trainee. It is agreed that