

Sixty per cent of patients were deluded, and three patients were suicidal. During stay in hospital those with functional illnesses showed moderate to marked improvement, those with organic brain syndrome showed little cognitive but marked behavioural improvement. Ten patients were discharged into residential care, three to nursing homes, seven back home and three to long-stay wards. (Nine had no specified location).

Is the use of the Mental Health Act caring or coercive? The study suggests elderly patients admitted under the MHA suffered no harm. Of note the three patients with severe self-neglect settled well post-discharge (Clark *et al.*, 1975). Patients unable to comprehend the complexity of the situation may often simply be led into hospital. Perhaps demented patients who are at risk but able to protest are those requiring legal powers and raising ethical dilemmas (Cybulska & Rucinski, 1986).

Possibly they form a sub-type of dementia (frontal lobe type) in which character and social conduct are affected prior to overt cognitive decline (Orrell & Sahakian, 1991). This study shows fewer patients with affective disorders being admitted compulsorily, suggesting the difference in practice. A reliable explanation necessitates a detailed prospective study with larger samples and adequate follow-up, enabling a greater consensus as to good and ethical practice.

CLARK, A. N. G., MANIKAR, G. D. & GREY, I. (1975) Diogenes Syndrome. *Lancet*, **1**, 366-368.

CYBULSKA, E. & RUCINSKI, J. Gross self-neglect in old age. *British Journal of Hospital Medicine* (July 1986) 21-25.

ORRELL, M. & SAHAKIAN, B. (1991) Dementia of frontal lobe type. *Psychological Medicine*, **21**, 553-556.

JANE GLEESON, *Stone House Hospital, Thameslink NHS Trust, Dartford, Kent*

Primary care and the severely mentally ill

Sir: In recent months many of our patients have had difficulty registering with local general practitioners (GPs). This problem has frequently been compounded as patients have been removed from their GPs' lists as a result of their behaviour disturbance while acutely psychotic.

This problem was recently highlighted by a 51-year-old Afro-Caribbean man, with one previous admission for a schizophrenic illness, who had two years previously moved to our catchment area. He had tried, but had been unsuccessful in registering with a local GP, and had not been referred to our service. His prescription of 20 mg flupenthixol depot fortnightly was continued on FP10s by his previous GP. His hallucinatory experiences were not controlled on this regime and he eventually presented himself to our hospital. At this point, he had been self administering depot flupenthixol 20 mg fortnightly into his arm for two years.

This case raises a number of concerns:

- (a) the use of an adequate dose of medication via a potentially hazardous route (*Journal of the Medical Defence Union*, 1994)
- (b) the failure of a patient with a mental illness (even when highly motivated) to find a GP who would accept him/her onto his/her list
- (c) the difficulty of supervising mentally ill patients not registered with a GP.

While this difficulty may have been caused by local GP shortages in an inner city area, it may represent a reluctance of GPs to take on patients perceived as dangerous or time-consuming. If this were to represent a trend it would present a significant problem in providing 'community care' for our patients.

Journal of The Medical Defence Union (1994) **10**, 41.

R. DUFFETT, *East Ham Memorial Hospital, London, E7 8QR* and M. NATH, *Goodmayes Hospital, Ilford, IG3 8XJ*

Continuing professional development

Sir: I welcome the College's initiative on continuing professional development (CPD). However, I was concerned to receive recently notification of CPD workshops at the College later this year. The notice given for such meetings is quite inadequate to all but a handful of psychiatrists I suspect. I doubt very much that here in North Yorkshire my workload is more onerous than elsewhere in the country, yet my clinics are booked up

several months in advance. If I am going to attend CPD workshops, I would require a great deal more notice than three or four weeks. In the post reform NHS, cancelling clinics at short notice is likely to attract adverse comments at least, and may in the future be an activity that attracts a financial penalty under performance-related pay.

I would hope that, as the College gains experience in organising CPD, busy clinical psychiatrists can expect the sort of advance notification which accompanies annual College meetings.

G. E. P. VINCENTI, *Friarage Hospital, Northallerton, North Yorkshire DL6 1JG*

Sir: I agree entirely with Dr Vincenti that there should be as much notice as possible for CPD activities. I hope that eventually we will be able to give a programme of future courses and

workshops six months or even a year in advance and also that many activities will be repeated on a regular basis.

I think that Dr Vincenti is complaining about the notice he would have had of future meetings in the direct mailing to consultants. This, however, followed notice of workshops in the September 1994 issue of *Advances in Psychiatric Treatment* and a notice in the August 1994 issue of the *Psychiatric Bulletin* of the same events. This was two to three months before the workshop – still not long enough but we very much wanted to launch a series of courses during the Autumn and Winter.

We are very grateful for all comments on CPD activities, adverse as well as complimentary.

A. C. P. SIMS, *Chairman, Continuing Professional Committee, Royal College of Psychiatrists*

History of Psychiatry

An all-day symposium entitled **Hearing Voices from the Past – Sources in the History of Psychiatry** is being held on 10 February 1995 at the Wellcome Institute for the History of Medicine, 183 Euston Road,

London NW1 2BE. This has been jointly organised by the History Group of the College and the Wellcome Institute. Further information: Frieda Houser (Telephone 071-611 8619).