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 coersive? 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.

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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.

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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

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