experiments are happening and surely the evaluation of the effectiveness of these services is thus as proper an area for scientific study as any of the more common subjects at psychiatric scientific meetings.

The implication from the fact that individuals working in these services are interested parties seems to be that they are thus incapable of scientific rigour. This is fatuous, since all researchers are interested parties as far as their research is concerned. It is also inconsistent with the suggestion that the College "would be better to follow up its previous support for an improved NHS". This seems to argue for a partisan campaigning stance without serious consideration of the question of whether the vast majority of patients would be better served if psychiatric services were provided independently of the NHS, for example in a "contracted out" system. Such an attitude would seem unworthy of a Royal College.

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DEAR SIRS

Following the session on Psychiatry in the Private Sector, of the College's Meeting (26 October 1988), Dr Appleby and others wrote to the President of The College. "The point is whether or not this particular session should be given by implication academic status equivalent to the other session topics, such as psychiatric genetics or community care . . ." (*Psychiatric Bulletin,* December 1988 **12,** 554). Dr Appleby and the others who signed that letter to the President, who were conspicuous by their absence at the session, may be unaware that one of the most important papers delivered at the Quarterly Meeting 'A Locus on Chromosome 5 for Schizophrenia' by Robin Sherrington, Hugh Gurling *et al* (1988) was supported, among others, by The Priory Hospital. Dr Mark Potter, one of the co-authors, held a Priory Research Lectureship at University College and the Middlesex School of Medicine, at the time that this work was done. This very influential paper, which was recently published in *Nature,* must be regarded as one of the most important papers in the world psychiatric literature of 1988.

The Priory Hospitals Group supports research at two other medical schools – Charing Cross and St Bartholomew's Hospital. The Priory contributes £100,000 per annum to fundamental psychiatric research. It also provides an opportunity for three registrars to gain experience in research methodology in academic departments.

The Royal College of Psychiatrists was founded to improve the care of psychiatric patients, enhance teaching and support research. The Priory Hospital is accredited by the College for the training of registrars and is making its contribution to the NHS by this and by training nurses from teaching hospitals.

The President, in his reply to Dr Appleby, suggested that those who signed the letter to him might "ask questions and discuss their particular concerns". Surely the College is a proper place for open debate. After all, the College has been at the forefront of campaigning for scientific freedom in Russia.

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Reference

SHERRINGTON, R., BRYNJOLFSSON, J., PETURSSON, H., POTTER, M., DUDLESTON, K., BARRACLOUGH, B., WASMUTH, J., DOBBS, M. & GURLING, H. (1988) Location of a susceptibility locus for schizophrenia on chromosome 5. *Nature,* **336,** 164–167.

Discharge refusers

DEAR SIRS

We all know the trouble we often go through to bring some patients into hospital. In some cases, it might require the services of a hospital doctor, a GP, an Approved Social Worker, an ambulance crew, *and* the Police, not forgetting the tearful, pleading relatives.

It can be equally difficult to get a patient *out* of hospital, when the multidisciplinary team is satisfied that the patient no longer requires in-patient treatment, and that, in their view, he or she has been adequately prepared to cope with life in a residence outside hospital.

I have known patients who have refused to leave hospital for (a) their own homes; (b) hostels; (c) a residential care home; and (d) a group home. I would like to give brief case histories of three of these patients by way of illustration:

Miss J. A., aged 23, was admitted following several episodes of physical aggression at home. A shy, self-conscious, non-assertive young woman, her sudden violence was totally out of character, and was her reaction to the persistent hallucinatory voices tormenting her with discussions about her, and commenting on her every action. With medicinal treatment and occupational therapy, she rapidly settled down. Some three months into her admission she was considered for weekend leave, but her parents refused to have her, and have consistently maintained that they no longer wanted her home because she kicked her pregnant sister in the abdomen during the acute phase of her illness. Accordingly, we introduced her to a local hostel and she spent a few hours a day, two to three days a week, at

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'