to develop flexible arrangements for availability of nursing staff. This, with its attendant problems in terms of forming a cohesive staff group, is the only way to avoid the dangers of on the one hand generally excessive levels and on the other occasional dangerous inadequacies.

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REFERENCE

[1]BALDWIN, J. A. (1963) A critique of the use of patient movement studies in the planning of mental health servces. *Scottish Medical Journal*, **8**, 227–233.

Community Treatment Orders

A Discussion Document of the Royal College of Psychiatrists

DEAR SIRS

It would appear that after an excellent description of the need for a compulsory Treatment Order in the Community, this document under paragraph 6, Procedures to Follow if Patients continue to Refuse Treatment, in the end concludes that compulsory treatment can only be given voluntarily; thus the order, with the back-up threat of rehospitalisation, becomes no more than blackmail to comply. This, however, seems to be because of poor use of words "... most patients will then agree to treatment. However, some will not and it is not proposed that the patient should be actually given medication compulsorily outside the hospital setting ... in the case of refusal ... admission to hospital is appropriate".

The issue in this paragraph would have been clearer if, instead of "not agree", the document had used "resist". What it is clearly trying to avoid is the inculcation of the use of what used to be called "a show of force" in the community: hence the suggestion that the patient, under such circumstances, be returned to hospital, where, presumably, the treatment would be forced if necessary.

This paragraph should then make it clearer that the Compulsory Treatment Order in the Community advocated in the rest of the document does mean compulsion and should be insisted on to the point at which resistance could only be met by force: at this point alone would readmission to hospital be considered.

As luck would have it, in my experience the schizophrenics who most need the compulsory treatment to avoid self-defeating relapse in the community not only refuse it if they possess the power, even against their own good estate, but, once they know compulsion exists and can lead to sanctions, comply readily, even to the point of regular visits to hospital for their depot injections.

I hope, then, the College will make clearer its position by strengthening the wording of paragraph 6 along the lines I have suggested.

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Judge Schreber's nervous illness

DEAR SIRS

In 1986 Dr Stanley[1] re-examined Judge Schreber's nervous illness in the *Bulletin*. His study was based on the English translation[2] of Schreber's autobiography, undoubtedly the most famous ever published. This is partly due to Freud using it as a starting point for his theory of paranoid psychosis. In addition though, as Baumeyer[3] wrote, "...the excellent presentation of his psychosis, the admirable objectivity of the description, and the even artistic imagination of his delusion make (it) ...a classical book which after 50 years (A. B.: and even after 85 years) has lost nothing of its attraction".

Stanley[1] ends his article by stating that the translators "...tried to discover the eventual outcome (of Schreber's illness) but were only able to establish that Schreber died in 1911 (and that) there is no mention of a post-mortem examination which Schreber said would provide 'stringent proof' that he suffered from a physical disease of the nervous system".

To provide that proof without a post-mortem is what Stanley[1] tries to accomplish. By an analysis of Schreber's writings, and by interpreting it against the background of relevant literature, the author suggests Schreber might have suffered from temporal lobe epilepsy and damages to other parts of his brain caused by encephalitis lethargica.

Having published the first autobiography of an African psychotic patient under the subtitle *A Schreber Case from Cameroon*,[4] I had come across more recently published literature on Judge Schreber's case and I feel Stanley's interesting article requires a supplementation.

Macalpine & Hunter[2] mention briefly a first paper by Baumeyer[5] in which he reports on "a further psychotic breakdown in 1907 which lasted to his death in 1911" but they had not been able to verify it. In the year of MacAlpine & Hunter's publication Baumeyer[3] reported in a second, detailed paper how he found Schreber's original case notes of the Mental Hospital Leipzig-Dösen where Schreber was treated as an in-patient from 27 November 1907 until his death on 14 April 1911. The case notes reprinted in the paper include excerpts, some very extensive or even copies, of the case notes of 11 previous periods of Schreber's hospitalisation. Most relevant in the present context is the fact that the case notes also include, as Baumeyer[3] states, "...a very detailed post-mortem protocol" of which the summary (pathologisch-anatomische Diagnose) is reprinted as follows (translation into English of German terms by A. B.): 'Pleuritis exsudativa chronica. Pyothorax sinister. Atrophy of the left lung. Atelektasis of the left upper pulmonary lobe. Pericarditis fibrinosa acuta—Myode-generatio.—Sclerosis of the coronary arteries. Multiple haemorrhages into the pons cerebri".

Considering the high standard of brain pathology in the mental hospitals of that period it is justified to assume the post-mortem would have discovered any relics of brain disease if they had existed, especially signs of chronic, subacute, or previous encephalitis of any type.

Taking into account further that Dr Baumeyer, whom I