days when trained nursing staff in institutions for these patients are getting fewer, it is important that any recording method is reliable but not time-consuming. This scale is now seen to fulfil these criteria.

No claim is made by the authors that the scale could not be improved, nor that it could not be completed during more regular intervals during the 24 hours, giving a more complete record of a patient's behaviour. Clearly it could be so used, and this would answer one of the points in the letter criticising the trial's design (*Journal*, November 1987, **151**, 705–706). Any scale, no matter how unsophisticated it may appear and even be, is better than none and I, for one, am grateful for the efforts undertaken by Dr Craft and his colleagues in proving the validity of it despite its imperfections. Included in my gratitude are the unnamed nurse assessors who administered the scale during both its verification and use.

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DALE, P. G. (1980) Lithium therapy in aggressive mentally subnormal patients. *British Journal of Psychiatry*, **137**, 469–474.

Peer-Group Support for Patients in the Community

SIR: Ford *et al* (*Journal*, October 1987, **151**, 479–485) make a valuable statement when they claim that resettlement of "those (patients) currently remaining in hospital will require increasingly extensive provision". However, it is difficult to equate the variables they have measured with the resources and handicaps the patients actually have.

As an illustration of this criticism, the authors have determined how many patients go outside the hospital and how many have visitors. In my experience, patients with no contacts outside the hospital may still have valuable friendships within the hospital. For example, some patients, while not legally married, form stable heterosexual partnerships which are loving and supportive. In Sheffield, long-stay patients are being resettled in the community in social groups. This appears to be successful in that it makes the move less frightening and helps reduce post-discharge loneliness. Peer-group support gives the patients the confidence to become friendly with local people in the street, shop, and public house. Several patients for whom previous discharge plans broke down have been enabled to live outside this way.

Interested relatives and friends outside the hospital can provide valuable support; however, even patients without them should not necessarily be considered friendless. As patients left in hospital have fewer supports and resources it is important that we mobilise the ones they do have to best effect.

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P3 and CT Scan in Patients with Chronic Schizophrenia

SIR: We read with interest the paper by Romani *et al* (*Journal*, October 1987, **151**, 506–513). Using a similar auditory discrimination task in a group of 21 DSM-III diagnosed schizophrenic out-patients and short-term in-patients (Ebmeier *et al*, 1987), we also found reduced P3-amplitudes in patients compared with age-matched controls. Neither history of potential perinatal brain damage, nor – as found by Romani *et al* – psychiatric family history was correlated with P3-amplitude or P-latency within the schizophrenic group. For our patients, calculated means of P3-latencies were about 20 ms longer than for controls, although this difference did not reach significance if P3 was defined as the largest peak between 260 and 450 ms post-stimulus.

Increased latencies of P3 have been reported only by a small sub-group of investigators, most recently by Blackwood *et al* (1987). Baribeau-Braun *et al* (1983) incidentally do *not* report increased latencies, as suggested by Romani *et al*. Possible additional confounding factors will therefore have to be considered. The obvious one is that schizophrenic patients agreeing to ERP studies are a (self-)selected group which might differ from study to study. Romani *et al's* patients were receiving "monotherapy" with haloperidol. In the absence of a disclaimer it has to be assumed that anticholinergic drugs were prescribed to at least some of the patients. Callaway (1984) described an increase of P3-latency after scopolamine, and in our patient group P3-latency was correlated significantly with dose of anticholinergic medication (Kendall's $\tau = 0.48$, $P < 0.01$). We agree with Romani *et al* that neuroleptic medication is unlikely to account for P3 changes. Blackwood *et al* (1987) found no intra-subject differences before and after initiation of neuroleptic drug therapy, and for our patients there was no correlation between dose of neuroleptic (in chlorpromazine units) and P3-latency or amplitude. Pfefferbaum *et al* (1984) did *not* report an absence of a neuroleptic drug effect on ERPs as suggested by Romani *et al*.