NEW LONG-STAY PATIENTS IN A HOSPITAL FOR MENTAL HANDICAP

DEAR SIR,

In relation to this paper (*Journal*, May 1976, **128**, pp 467–70) and the letter from Dr Kushlick and his colleagues (*Journal*, September 1976, **129**, pp 287–8), the following additional facts are relevant.

In the five years 1970–74, 536 patients, 301 male and 235 female, were admitted to Meanwood Park Hospital, Leeds. Of these patients 50 (9·4 per cent) remained as long-stay and were the subject of the paper referred to above. Hence over 90 per cent of the mentally handicapped patients admitted to this hospital were returned to the community, many within a period of a few weeks. Those who stayed in hospital presented behaviour disorders or physical infirmity and helplessness of a degree which made them unmanageable outside the hospital in present circumstances. For these patients the hospital was the only place with the staff and resources to receive and help them. The White Paper *Better Services for the Mentally Handicapped* (1971) presents figures for the planned future hospital provision and in doing so acknowledges that a hospital will continue to be the only instrument that can cope with a certain minority of mentally handicapped people. Hospitals for the mentally handicapped in this country are far from ideal in many instances, but no comparable countries have been able to eliminate completely hospital-type establishments for the care of a certain proportion of their mentally handicapped population.

'Long-stay' in hospital is not synonymous with 'permanent stay'. Today no patient should be regarded as a permanent resident in hospital, as the aim of every progressive and enlightened hospital is to secure the improvement of these patients' conditions to such an extent that they can achieve the chance of discharge—and this necessarily involves work which will include the criteria listed in Dr Kushlick's letter.

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HALLUCINATIONS CAUSED BY BROMOCRIPTINE

DEAR SIR,

Parkes, *et al* (1976) using bromocriptine, a dopamine agonist, in the treatment of Parkinsonism found that four out of thirty one patients experienced hallucinations. In this connection we wish to report the following case.

F.W., a single 28-year-old technician was being treated for acomagaly. He had been in the habit of surveying nearby flats with binoculars, and occasionally he saw a young girl undressing. Soon after starting bromocriptine he 'realized' that she was undressing for him when he masturbated. He believed neighbours began banging on his door to show their disapproval, and that another woman in the flat was seen masturbating for him. When he visited her flat, which he now believed to be in a brothel, he explained her rejection of him by saying 'prostitutes can tell when you're a virgin'. By this time he was seeing sex orgies in each flat in the block.

He subsequently witnessed 'hundreds of police converging on the block' and awaited his own arrest 'because they knew I had been watching'. He is certain these events occurred but says he did have 'visual hallucinations' of 'white forms, distorted table lamp and flowers and an aura around his mother's face'. On cessation of bromocriptine the above symptoms stopped.

This case report is of a schizophrenia-like state produced by a dopamine agonist in a patient with no past psychiatric history and perhaps gives some support to the dopamine theory of the causation of schizophrenia (Thorner 1975).

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A CORRECTION

DEAR SIR,

In the article 'Dyskinesias Associated with Tricyclic Anti-depressants' by William E. Fann, John L. Sullivan and Bruce W. Richman, (*Journal*, May, 1976, **128**, 490), it was erroneously reported that patients received from 100 to 200 mg of amitriptyline at four hour intervals, totalling 400 to 800 mg daily. The actual doses were 100 or 200 mg once daily at bedtime.

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