duration to be made by a Section 12 approved doctor on the prison medical staff. This would enable treatment to begin, for the patient to be housed under more acceptable conditions and allow time to seek help from the catchment psychiatric hospital or the regional secure unit. Often these patients are young and suffering from acute drug induced psychoses, and three days' treatment is all that is necessary for them to be able to be handled under normal prison hospital conditions.

I am well aware that this is a "hot potato" politically, but I do feel that the degree of degradation and indeed physical danger which these patients suffer during their acute psychotic phases needs to be specifically legislated for. I wonder whether the Mental Health Act Sub-committee would be interested in exploring this problem.

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Community Treatment Orders

DEAR SIRS

The debate about Community Treatment Orders rumbles on, possibly indefinitely, without appearing to come to any satisfactory conclusion. Meanwhile patients and their relatives continue to suffer.

I may have missed something but it seems to me that the situation is quite simple if we assume that everyone who is subject to compulsory treatment has had a period of in-patient observation and treatment at some stage in the episode/illness for which compulsory treatment is being applied – usually at the outset. This assumption is justified on the following grounds:

(a) Long-term compulsory treatment – particularly with depot neuroleptics – is probably never justified without an adequate period of intensive observation to allow a proper diagnosis. Even with today's community style of management it seems most unlikely that adequate diagnosis can be made without at least some period of in-patient observation. This is supported by the continuing discussions concerning the differentiation between schizophrenia and affective psychosis. No doubt, also, every psychiatrist has seen cases which have in the past been diagnosed as schizophrenia which he himself would diagnose as affective disorder, with consequent implications for long-term treatment.

(b) It is difficult to imagine the need for compulsion unless an illness was of sufficient severity to require a period of in-patient care at some stage during its course.

If we accept this assumption then surely all that is required is a minor amendment which would allow us to renew an existing Section 3 while the patient was still in the community without the patient necessarily having to be in hospital at the time of renewal. This would obviously have the benefits of insuring that a patient remained under the care of a Responsible Medical Officer who would have the obligation to be kept informed about the patient's mental state and would then have the power of recall to hospital at any time, if necessary, when signs of relapse developed.

Given the same kind of safeguards of appeal and review which are at present incorporated into the Act, I wish someone would please explain to me what the loopholes are that I have missed in the above proposal which I find it difficult to believe has not already been suggested.

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Training in psychiatry for GPs

DEAR SIRS

The College has a right to be proud of the enormous improvement achieved in the training of career psychiatrists. It is the only College to approve schemes rather than posts and over a number of years virtually all training posts have been incorporated in rotational schemes associated with academic courses. Since the beginning of the 'approval exercise' standards have gradually evolved and although many schemes may not yet have achieved optimal standards, most career psychiatrists are offered training experiences that are highly satisfactory.

In my view, the College was correct in placing a high priority on the training of career specialist psychiatrists. However, it must not be overlooked that most psychiatric patients first present to their family doctor, and that some 90% of such problems are dealt with exclusively by the GP. The spectrum of psychiatric disorder and the skills required to treat patients within the setting of general practice are generally quite different from those of a specialist psychiatrist, even when working in the community.

Most general practitioner trainees gain their psychiatric experience in hospital based posts. Some posts are tied to vocational training schemes, but most are not. Often general practitioner trainees are appointed to posts which are supernumary to the requirements of schemes or have failed to attract a suitable career trainee. Sometimes the posts are in hospitals with only limited approval and general practitioner trainees are attracted to meet the service requirements of the district. It is true that many consultants make special arrangements to meet the needs of the general practitioner trainees, but even in these posts the only academic training available is frequently more appropriate to the MRCPsych student than the RCGP trainee. It is agreed that

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