inhabitants). The hospital population has steadily declined since 1960, when the census indicated 5621 in-patients. Our survey was conducted on a random sample of 300 of the 831 in-patients aged 18–60 with a primary functional psychiatric diagnosis. A short questionnaire was sent to the consultants. We provided a choice of operationally-defined residential facilities, and asked the consultants to indicate the most appropriate setting for the patient. Response rate was near 99%.

The consultants estimated that 51% were not suitable for community placement, 19% would need nursing home facilities, and 29% could be discharged to community settings. Out of this latter 29%, 13% were for group homes supervised by trained staff, and 12% for hostels or group residences staffed by private owners or a warden; only 3% were envisaged in cluster flats, and less than 1% in independent accommodation.

Our consultants estimated a greater need for facilities staffed by professionals than was found in the Glasgow survey. The discrepancy may stem from at least two sources. Firstly, our consultants' perception may be more conservative in terms of the amount of supervision required by the discharged patients. However, the estimates of potential discharge rates were very similar. Secondly, the residential services practices may differ. For example, one of us (AL) trained in London and saw some "residence staffed by non-professional personnel" actually staffed by trained psychiatric nurses (paid as non-professional).

It will be interesting to compare our experience with the Scottish one in the years to come. Attention should be paid to carefully describing the type of accommodation and the level of staffing. In the end, only actual trial of discharge and follow-up to assess outcome will indicate how many sheltered housing places with professional staff are required and what resources need to be committed to this end.

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Affective 'switch mechanisms'

SIR: We fear Mobayed (*Journal*, June 1989, **154**, 884) has got hold of the wrong end of the stick. In our paper (*Journal*, January 1989, **154**, 48–51) we referred to our previous results which showed that SAM enters the CSF, is linked with CSF 5HIAA and folate metabolism, and influences prolactin. We not unreasonably thought that anything which influences prolactin and CSF HVA might have an effect on the dopamine system. Nowhere have we excluded an effect on serotonin also.

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The opiate prescribing debate continued

SIR: Hill (*Journal*, June 1989, **154**, 888–889) may well consider prescribing a tot of best Scotch whisky to an alcoholic, if it would stop his patients robbing someone and paying a gangster for adulterated meths.

It is important to realise that any response, including continuing as before, is a policy which must be evaluated, otherwise clinging to it is purely emotive, especially if continuing as before sees a relentless increase in the drug problem. This is just what has happened in America since the 1920s and in western Europe since the 1960s.

Our own appraisal found that, paradoxically, making drugs available in a controlled fashion *reduced* the problem (Marks, 1987; *Lancet*, 1987). It therefore seems reasonable to conduct a further experiment on the lines of the Mersey Clinics' experiments in Widnes and Warrington to see if our findings can be repeated or refuted.

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Case conference correction

SIR: I wish to dissociate myself from some of the remarks attributed to me in the case conference report by Howells & Beats (*Journal*, June 1989, **154**, 872–876). The second sentence of what I am alleged to have said is ungrammatical, inaccurate and offensive in tone. As the conference was not tape recorded I cannot quote my exact words, but I do recall commenting

https://doi.org/10.1192/S0007125000016688 Published online by Cambridge University Press

on the problem of alcoholism in the USSR and on media reports of Soviet airforce personnel consuming aircraft de-icing fluid (N.B. *not* engine fluid). However, I did not and should not have intended to put my points in such terms as were published. I sincerely hope they will not have caused offence.

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Distress caused by miscarriage

SIR: Milner (*Journal*, July 1989, **155**, 127) raises the issue of the amount of distress caused by miscarriage. Research shortly to be published in this *Journal* (Friedman & Gath, 1989) indicates high levels of distress in a group of women one month after miscarriage. In a series of 67 women, 48% PSE cases and two cases of self-harm not known to the medical profession were found. Another paper (Friedman, 1989) discusses the dissatisfaction of patients with their management and the problems of caring for this group of patients.

I agree with Dr Milner on the need for doctors and nurses to be more aware of this distressing condition, and that quite simple intervention may be effective in alleviating the considerable emotional turmoil caused.

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CPK levels and neuroleptic malignant syndrome

SIR: I was interested to read Maharajh's letter (*Journal*, June 1989, **154**, 885–886), as our District Biochemist, Mr G. Trevis, and I have recently started looking at the interpretation of CPK levels (including isoforms of MM isoenzymes) in the face of many variables. For example, elevated levels have been found in acute cerebral disorders, head injury, alcohol excess, muscle diseases, after oral neuroleptics, and in renal, cardiac, or thyroid dysfunction.

Some years ago there was considerable interest in elevated levels of CPK in patients with acute psychosis, and now more recently in raised CPK in neuroleptic malignant syndrome (NMS). I would suggest that a diagnosis of NMS should depend far more on clinical examination than finding a raised CPK. It has been suggested that the raised levels in acute psychotic patients may well be due to increased motor activity (Goode *et al*, 1979) or even intramuscular injections, but a study by Kumar (1984) looking at levels of CPK in schizophrenics and their first-degree relatives compared with normal controls found not only significantly raised CPK levels in the patient population but also in the first-degree relatives compared with normal subjects. The phenomenon of malignant hyperthermia has much in common with NMS, and again has been associated with increased CPK levels, and at one time it was thought that a raised level may predict a susceptibility to malignant hyperthermia, although this was subsequently refuted (Paasuke & Brownell, 1986).

Finally, I note that Dr Maharajh questions what the levels of CPK may be in black psychotic patients without NMS. Earlier work (Meltzer & Holy, 1974) has suggested that there are sex–race differences in serum CPK activity, levels being highest among black males and lowest among white females, and more recently a study by Gledhill *et al* (1988) confirmed that black males had higher CPK levels than white males.

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Paradoxical intervention

SIR: Macdonald's letter (*Journal*, June 1989, **154**, 883) has prompted me to read the case report of use of paradoxical intervention in a ritualist woman

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