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

many of the basic skills are common to both trainees and some skills are most appropriately gained in a specialist hospital setting, but this is not to deny the special requirements of the general practitioner trainee.

I would like to suggest that the College should now direct its attention to the improvement of training in psychiatry for general practitioners. This is not something that should be done in isolation but in conjunction with the Royal College of General Practitioners. Given that psychiatric morbidity is among the most common of conditions in the community, the ultimate goal must be that all GPs gain some post-graduate experience in psychiatry. It is important that this training should be appropriate. The available posts should be jointly approved by the two Colleges and associated with academic courses specifically designed for their needs, although selected experiences existing on current MRCPsych courses may also be appropriate. The achievement of these goals will, of necessity, be a fairly slow evolutionary process over some years. However, not only are these changes desirable but the changes that will arise from the process of 'achieving a balance' present an opportunity that should be grasped without delay.

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## *Writer in residence in psychiatry*

DEAR SIRS

We were very interested in your interview with the poet Selima Hill (*Psychiatric Bulletin,* November 1988, **12,** 491–493), and in particular her comment that there had been no serious consideration in the UK of appointing a writer in residence in a psychiatric setting.

In late 1988 the Literary Arts Board of the Australia Council awarded Fiona Place a grant to work as a writer in residence in the Psychiatry Unit of the Prince Henry Hospital in Sydney (a teaching hospital of the University of New South Wales). Although there have been previous grants to writers to work in hospitals in Australia, this is the first such appointment in a psychiatric setting in this country. Fiona commenced this five month appointment in February 1989.

Fiona has published both poetry and prose in highly regarded Australian literary journals in recent years. Her novel *Cardboard,* concerning the experience of a young woman with anorexia nervosa, will be published by Local Consumption Press in April 1989. She is uniquely suited for the position as, in addition to her highly regarded writing skills, she herself suffered from anorexia nervosa for eight years.

The main aim of the residency is to act as a catalyst or stimulus for patients, relatives and staff to express their experiences of psychiatric illness in their own words, either in poetry or prose form. In addition to working with individuals, Fiona will hold workshops on 'Writing yourself out of illness'.

We will be evaluating the response and attitudes of both patients and staff to this residency.

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FIONA PLACE

*Writer in Residence, Psychiatry Unit*
*Prince Henry Hospital, Little Bay*
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## *Multiple personality disorder – appeal for help*

DEAR SIRS

I am trying to find a psychiatrist in England who is familiar with the phenomenon of multiple personality disorder. I am currently involved in a situation with a British subject who may manifest this profile. Although your ICD-9 does not recognise this condition, the DSM-III has provisions for it and there is an international society dedicated to its study (International Society for the Study of Multiple Personality and Dissociation, 2506 Gross Point Road, Evanston, Illinois 60201 USA).

The British subject in question was the victim of physical abuse, emotional neglect and probably sexual abuse any time from infancy to age eight when he left the orphanage and was reunited with a family he never knew existed. The natural mother was not nurturing (in fact, was abusive) and the British gentleman left home at age 16. My concern for his welfare and the wish to avoid further complications has led me to do considerable research and thus uncover the possibility of multiple personality disorder to explain the adult behaviour I have witnessed as well as have experienced at his hands. Knowing full well the inaccuracy of diagnostic methods, I am trying to cull enough data and expert opinions so that whatever therapeutic route is taken will have a fine chance of success rather than be one that is merely taken for the sake of expedience.

Since I myself utilise homeopathic medical treatment, it would be an even greater find to discover a homeopathic psychiatrist with this multiple personality disorder expertise. Although I have already been cautioned that such a person is rare as hen's teeth, I pass along this wish anyway since you may be able to find someone like this for me.

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