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AUTHORS' REPLY: We thank Travers & Brabbins for their comments. We share their scepticism concerning the Penrose hypothesis but there is, undoubtedly, a small but important group of mentally disordered defendants who previously would have spent substantial periods in hospital but are now as likely to receive their psychiatric care in the remand prison as in hospital or in a community setting.

The process and ethical issues of obtaining informed consent was omitted from this paper, but has been covered in some detail by Joseph (MD thesis: available from the University of London and Institute of Psychiatry Libraries). Briefly, the independent and research role of the interviewing psychiatrist was stressed to the defendant and the courts, thereby avoiding adversarial implications. We disagree that there is an ethical dilemma in "interfering" in the due process of law. The discontinuance of a criminal case by the CPS is carried out under the due process of law, as set out in the Code for Crown Prosecutors issued pursuant to Section 10 of the Prosecution of Offences Act 1985. By focusing on the court, psychiatrists, in a similar way to the bail information and public interest case-assessment initiatives run by the Probation Service, can help to provide sufficient information to the CPS to enable them to carry out their proper function. A much more serious interference in the due process of law, in our view, is when psychiatrists take on a quasi-judicial role and insist on the prosecution of patients in their care, when there is sometimes a reluctance to proceed by police and prosecutors.

There will always be cases who slip through the 'filters', either at the police station, the court, or even the remand prison, and as the study of Gunn *et al* (1991) shows, appreciable numbers of psychotic individuals are found in the sentenced-prisoner population. The purpose of assessment at court is to provide an additional safety net while recognising that some will escape detection and others will have to continue in the criminal justice system because of the seriousness of the charge. The provision of a community psychiatric nurse at court on a daily basis has been described, but there are resource implications in trying to identify every case at court.

We had hoped it was clear from our papers that admission to hospital was still possible even if the CPS did not discontinue the case. However, it was necessary to suggest discontinuance, not for the benefit of the CPS or the legal process, but to placate the hospital to which admission was required. We found great difficulty in using Section 35 of the MHA, and it appears this difficulty is encountered across England and Wales (Gunn & Joseph, 1993). District hospitals also had a reluctance to admit patients while the criminal case was continuing. One example was a case where the hospital refused to admit a patient under Section 35 without a nursing assessment, but the same patient was accepted an hour later after the charge was dropped and a Civil Section 2 applied.

The criteria used in deciding on fitness to plead were the usual legal criteria which psychiatrists adopt in their psychiatric reports to court. Our high figure shows how the issue is fudged at the magistrates' court and rarely tested in practice. Those psychotic patients who were discharged precipitously remained psychotic but that was not the reason for discharge: rather it was their 'challenging' behaviour. The poor outcome for many of those diverted to hospital reinforces the statement in the Reed Report (Department of Health & Home Office, 1992) that diversion is the "end of the beginning". Without suitable hospital resources, namely readily accessible locked wards, and without adequate community facilities there is a danger that early diversion from custody, either at the police station or at the court, will simply speed up the revolving door.

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Integrated psychological therapy for schizophrenia

SIR: It is disappointing that Brenner *et al* (*Journal*, October 1992, **161** (suppl. 18), 154–163) could not report more encouraging results for their Integrated Psychological Therapy Programme for Schizophrenic Patients (IPT). This is especially disappointing given Brenner's pioneering work in attending to the cognitive deficits in schizophrenia in rehabilitation programmes.

While "favourable overall effects of IPT" are reported, the effects of Brenner's Cognitive Differentiation Module on both lower-order and higher-order functioning are questioned. Significantly, in our view, the Cognitive Module did not result in improvement in card sorting (a variant of the Wisconsin Card Sorting Test) or in attention (as measured by the D2-test).

It is possible that the IPT Cognitive Differentiation Module was not administered effectively. The training was brief, and given to groups of patients. Individual, one-to-one training may be necessary if cognitive strategies are to be imparted; strategies which could generalise to higher-order activities. Additionally, and as pointed out in the conclusion of the paper, programmes may need to be "more firmly based on comprehensive cognitive theories".

A variant of the IPT was introduced to Australia in 1988. Gains were achieved in measures of cognitive functions (such as certain subtests of the WAIS-R), and there were improvements in symptoms (as measured by the Expanded Brief Psychiatric Rating Scale) and in the skills of daily living (as measured by the Life Skills Profile). However, there were no gains in cognitive flexibility (as measured by the Wisconsin Card Sorting Test), nor in forward planning (as measured by the Tower of London).

This led us to abandon the IPT, and to concentrate on neurocognitive rehabilitation development as a 'front-end' to higher-order training, such as Communication Skills, Psycho-education, and Living Skills Modules. A computerised package, developed for patients with brain damage following head injury or stroke (Bracy, 1987), was administered to seven schizophrenic patients. Gains were recorded similar to those for the modified IPT, but again, there were no improvements in cognitive flexibility or forward planning.

A neurocognitive rehabilitation programme based on putative prefrontal/frontal executive functions, as subserved by distributed neural networks, was then developed, and called the Frontal/Executive Program. Improvements were recorded as for the ITP and for the Bracy computerised programs but, in addition, significant improvements in cognitive flexibility and forward planning were achieved (Morice & Delahunty, 1993).

Some 20 schizophrenic patients have now completed the Frontal/Executive Program, which comprises a two-week Cognitive Fexibility Module, and a six-week Planning Module, administered on a one-to-one basis. Results are encouraging, and suggest a generalisation to higher-order activities. Anecdotally, patients report clearer thinking and improved functioning, and their families quite often report marked changes in a range of behaviours.

We regard neurocognitive rehabilitation in schizophrenia as an important new adjunct to management, an innovation for which Brenner and colleagues are largely responsible. But possibly they have not been critical enough of their Cognitive Differentiation Module, have not developed it further on the basis of an adequate cognitive theory, and have not made sufficient modifications to it in the light of earlier results.

We encourage readers to remain more optimistic than the Bern originators of this approach to rehabilitation. While much more development and evaluation remains to be done, early results would seem to justify continuing optimism.

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AUTHORS' REPLY: Morice & Delahunty refer to the effects of IPT. IPT is a comprehensive group therapy consisting of five subprogrammes which proceed from functional cognitive skills to general behavioural

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