I saw him recently in DSM–IV but younger psychologist colleagues who were entrusted with his care seem to have forgotten about him and have little desire to ensure his whereabouts or condition. I am informed that most cannot recognise him, having been led astray by more alluring upstarts.

If he is found but is too ill to recover it might be that those of us who valued him greatly could ensure a worthy memorial.

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Depot clinics

Sir: Singh *et al*'s (*Psychiatric Bulletin*, December 1995, **19**, 728–730) conclusive findings showed that consumers preferred to receive their depot medication at the traditional psychiatric depot clinic setting. I studied an inner city sector (population 100 000) in Nottingham where there is a well developed community mental health service. We looked at the prescribing pattern to the population receiving depot medication.

We had 106 patients receiving their depot medication at this clinic. The diagnosis of our patient group was very similar: diagnostic breakdown (90%); schizophrenia (6%); bipolar disorder and schizoaffective disorder (4%). We also issued a questionnaire to the sector's 58 general practitioners (GPs) to see whether they were prescribing and administering a depot to any patient not attending the clinic: 75% replied and none was prescribing or administering a depot at a GP surgery.

It is essential that the future of the depot clinic survives within the mental health setting, be it hospital or community psychiatric base. These patients have a serious mental illness diagnosis. To ensure care and contact with this vulnerable group who usually relapse without medication the depot clinic remains a valuable resource.

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Audit and psychiatry of learning disability

Sir: Successful audit depends on active participation by a peer group working in the same speciality. As psychiatrists specialising in learning disability, we find that some clinical topics can be audited locally with the multidisciplinary team of the learning disability service, or with other psychiatric specialities, but there are some topics that can be usefully audited only with specialist peers.

Psychiatry of learning disability is a small speciality with very low staffing levels in the former North Western region. There are only nine whole-time equivalent consultants, whereas the minimum number recommended by the College is 21 (for a population of around 4.2 million). Very few Trusts employ more than one consultant in the speciality. With the progress towards closure of the mental handicap hospitals and development of local services, doctors in the speciality have little daily contact with each other, and it is difficult to establish a peer group.

An organisational framework is required for audit, including a person to coordinate audit and administrative support, access to case notes, and information technology. It is not feasible to have an audit coordinator dedicated to the speciality in each district. If other psychiatric specialities have an audit coordinator, that person could provide some time, but it is difficult to secure a fair share of time, and the person is unlikely to be familiar with the speciality. Another option is for one service to take responsibility for coordinating audit in the speciality for several services.

There are also significant problems of gaining access to case notes. We have considered three options: case notes could be moved temporarily to a central place for audit, they could be scrutinised at their base by a person employed by the service which produced them, or they could be scrutinised by a person employed by another service.

The first of these is undesirable because of the risk of losing records, or needing them for clinical purposes during the period of the audit. The second is undesirable because of the need to validate the data. The third might be regarded by some Trusts as intrusion into their business by competitors.

There is a need to devise improved systems for enabling audit in psychiatry of learning disability in areas where consultants are single-handed in a service. We would welcome the views and suggestions of colleagues who have similar difficulties.

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Imbalance in the purchasing of drug services

Sir: Another tranche of grants was recently issued by the National Lottery Charity Commissions and Merseyside received £1.5 million to help good causes in the area. One voluntary drug

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agency in Liverpool received £300 000 (Hunt, 1995).

We have no doubt that this money was thoroughly deserved and will be spent wisely on improving and delivering services to those with drug problems. However, we are concerned that such large grants may cause an imbalance in the provision of services when not part of an overall local strategy. The position of agencies which do not receive such sums may be undermined by not having these resources available to them.

Most areas will expect agencies to adhere to any strategy negotiated locally (Liverpool Health Authority, 1995), but funds that bypass the normal funding mechanisms can undermine this strategy. Applications for funding would normally have to submit bids to health purchasers (or joint commissioning consortia if social services are involved) and these would have to satisfy criteria on effectiveness, outcomes and quality.

Self-interest groups with no need to comply with these regulations can proselytise their service, justifying their own agenda to win funds, whereas statutory services will be committed to the public health agenda. Lottery Commissions may be unaware of the wider implications and are unwittingly encouraging perverse incentives. They will never be allowed to fund mainstream statutory health services, possibly to the detriment of professional care and to those who are committed to the public health agenda.

The new Drug Action Teams (1995) will have to be aware that any decisions they make on the way services should be formed or purchased may be contrary to the initiatives supported by the Lottery Commission. Other health disciplines should be aware they may face similar problems.

DRUG ACTION TEAMS (1995) *Tackling Drugs Together: A Strategy for England 1995*. CM 2846. London: HMSO.

HUNT, A. (1995) Charity numbers come up. *Liverpool Echo*, 20 November, 15.

LIVERPOOL HEALTH AUTHORITY (1995) *Strategy: Substance Misuse*. Liverpool: Annual Public Health Report.

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Certificate of Completion of Specialist Training (CCST): implications for higher training in psychiatry

Sir: There are a number of concerns regarding the implementation of the recommendations of the Calman Report which are germane to psychiatry. The Royal College of Psychiatrists proposes to award CCSTs after a total of three years of higher professional training, with a minimum of two years in a chosen speciality. Our understanding is that individuals training in specialities (old age, forensic, etc) will only be granted a CCST in that speciality. For a trainee to be awarded a CCST in both general adult psychiatry and a speciality will require a minimum of four years' training (two years in general adult psychiatry and two years in a speciality). Dual accreditation is highly desirable. The approach to provision of psychiatric services by Trusts is liable to change, and clinicians in specialities may be required to undertake work in general adult psychiatry in the future. Furthermore, participation in 'on call' rotas which cover general adult psychiatry may also require accreditation as a general psychiatrist. The consequence of this is that the length of training for disciplines other than general adult psychiatry has been increased, contrary to one of the principles underpinning the Calman Report. This is ironic given the dearth of suitably qualified applicants in some psychiatric specialities, for example old age psychiatry. In addition, any doctors training in the UK wishing to practise elsewhere in the EU may not be able to do so without CCST in general psychiatry as many EU counties may not recognise accreditation in some specialities.

The situation in the rest of Europe is very different. The Calman exercise took place in order to bring the length of specialist training in the UK into line with the rest of Europe. Despite this, considerable inequality remains. According to the College (Collegiate Trainees' Committee, 1995), the award of a CCST, whether granted in the UK or other countries in the European economic area will bring automatic inclusion in the new Specialist List. In many EU countries individuals will obtain CCST or its equivalent after just four years' postgraduate training. Under these circumstances they will be included in the Specialist List held by the General Medical Council (GMC) and hence be eligible for consultant posts in the UK.

COLLEGIATE TRAINEES' COMMITTEE (1995) Collegiate Trainees' Committee position on structural training. *Psychiatric Bulletin*, **19**, 455–458.

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Sir: Unfortunately Drs Cervilla and Warner have not portrayed the College's proposals concerning the award of the CCST in the psychiatric specialities accurately.

In each of the recognised specialities (child and adolescent psychiatry, forensic psychiatry, general psychiatry, the psychiatry of learning disability, psychiatry of old age and psychotherapy),

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