I can sympathise with Dr Double's point about protecting less experienced trainees from inappropriate service responsibilities and trust that we will be even better at doing so when postgraduate medical training is more protected within the NHS, and the service staffed with appropriately trained people in order that this can occur, as *Achieving a Balance* and 'Calman' require.

Is recruitment to psychiatry falling, or are we being affected by the devastating drop in recruitment to general practice?

Finally, I find Dr Double's labelling of me as "conservative" ironic.

F. CALDICOTT, *President, Royal College of Psychiatrists*

Sir: It is unfortunate that the debate about improving psychiatric training in response to Calman has cencentrated on where exactly the split between basic and higher specialist training should occur and when exactly to award the CCST. This had obscured discussion about how to improve the quality of psychiatric training, which is far more important than what we call trainees for how long. Debate at the latest CTC meeting attempted to address issues such as content of training; setting training goals; educational contracts; methods of assessment; feedback and progress reviews; the role of research; flexible training. Calman's proposals for structured training were intended to address much more than just the structure of the training grades – a fact we would all do well to remember.

STEFFAN DAVIES, *Chairman, Collegiate Trainees Committee, Royal College of Psychiatrists*

Sir: Evans & Johnson (*Psychiatric Bulletin*, July 1994, **18**, 405–407) cite two possible models for the delivery of medical care: an elite body of consultants with a small group of trainees (most of the clinical work being undertaken by non-consultant career grades), and a large body of consultants with increased clinical care. The Calman Report seems to aim towards the second model. However, while its recommendations have been accepted by the government, no extra funding has been set aside to implement them. This, coupled with the Health Minister's intention to ease restrictions on numbers of SHOs and staff grade doctors, suggests that we are in reality moving towards the first model.

The paper reports that 69% of the senior registrars were not in favour of a new NHS sub-consultant grade. Presumably they see themselves being promoted to the first model's "elite body of consultants", rather than filling the non-consultant career grades. However, in all probability a significant proportion will become caught in the post-CCST (Certificate of Completion of Specialist Training) gap, exposed to the potential for exploitation as cheap labour by NHS trusts.

Rather than resign ourselves to the inevitability of a sub-consultant grade introduced through the back door, we might do better to embrace the opportunity to develop a new specialist grade. This could meet many of the needs created by the complex changes occurring within health care. A period of independent clinical practice post-membership would meet some of the increased service needs created by reducing juniors' hours while addressing the expectation that an increasing proportion of patients will be treated by trained specialists. If such posts allowed progression to consultant status they would not be seen as 'dead end' jobs but as a period where further experience and skills could be developed. This period could have fewer of the management and non-clinical responsibilities of consultants, and be of variable length to give greater security while allowing the necessary flexibility to meet the needs of individuals. Surely it is better to negotiate suitable terms and conditions for a specialist post now, rather than let ourselves be shunted into an inferior sub-consultant post by default.

DAVID ROBERTSON, *Department of Psychiatry, University of Leicester, Leicester General Hospital, Leicester LE5 4PW*

Care programme approach

Sir: Nigel Fisher's (*Psychiatric Bulletin*, August 1994, **18**, 453–456) valuable editorial on community care may have been too charitable about the confusion of the political and clinical in policy. The imposition of the care programme approach (CPA) without a clear understanding of its impact has been wasteful for mental health services. I think trusts and districts are likely to remain confused despite the recent guidance on discharge and continuing care.

The essential problem has been in deciding to whom the CPA applies. There are also questions about the value of bureaucratising the care planning process. I am not convinced the Department of Health (DH) has fully considered these issues. The DH seems to have believed that it has exercised its responsibility by merely requiring the implementation of the CPA. Mental health services have not been blameless in this respect as they have not been very forthcoming in reporting difficulties in implementing the approach.

In my view, the CPA should apply to all people in contact with mental health services, whether mentally ill or not. An advantage of this approach is that it avoids philosophical problems about the nature of mental illness! I am not saying it does not make sense to concentrate on those with longer term, more severe disabilities and particularly those known to have a potential for dangerous or risk-taking behaviour. But current guidance does not explain how to concentrate on this group. True, those most at risk will be on the supervision register, but the category of those who present special risks is wider. The CPA applies to all mentally ill people and should be applied if relevant to other mentally disordered people.

Nor is there complete guidance about what should be recorded under the CPA. When are formal review meetings necessary and how valuable are they? Would it not be better to introduce a system of community ward rounds?

These clinical issues have become entangled with the political. Mental health services should resist this intrusion and develop systems that provide good care in the community.

D. B. DOUBLE, *South East Sheffield Mental Health Services, East Glade Centre, Sheffield S12 4QN*

Community psychiatry: under-remuneration for challenging outreach work

Sir: Community psychiatry is not a job for those who expect their work to be orderly and to present to them at their desk. It is important to be able to respond to need in the community in a varied and innovative way. Sometimes this is time-consuming and extremely challenging. In the 'new NHS' it is of concern that this work may go financially unrewarded.

Case example. Section on the number 12 omnibus. When patients are ill they do not always report to hospital or sit at home. Many leave home and roam the streets by day and night. Following extensive efforts to contact a very ill patient both in the High Street and at home (five visits in total) it was decided to convene two doctors and a social worker outside 'Macdonalds' in an attempt to engage the patient. Relatives, and even shoppers in the street, had by now voiced their grave concern at the health of the patient. The police had felt unable to act on their own by using a section 136 of the Mental Health Act. With a bed organised, police and ambulance requested and everybody assembled we waited, and we waited. At a second attempt the patient again failed to arrive. A few days later a relative phoned to say that the patient was very disturbed and in the High Street. Racing to the scene on a number 12 bus (parking takes forever in Camberwell) it was clear that old type London buses which have no doors are a great asset to community psychiatrists as you can hop off as soon as you see your patient. The patient was seen outside 'Curry's' and was very disturbed. The police were called on the mobile phone from the porch of 'Dixons' opposite and the patient was at last brought to hospital under section 136, and then placed on section 3.

A brand-new mobile phone backed up by a good old London bus and huge effort was followed by excellent response to treatment and the patient thanked us for our efforts. I am delighted to say that the patient remains well, compliant with treatment and is now better than for several years.

The effort and innovation needed to enable this person to receive treatment was enormous. There were eight community visits by between one and three professionals at any one time. This entailed somewhere between 15 and 30 hours of clinical time. The monitoring of clinical activity by our local health authority is based on face to face contacts with patients. Vast efforts resulted in a single effective meeting by one clinician with a patient. The standard charge for such a contact is £70. Nothing else could be charged for according to our present arrangements. Our efforts were thus effectively financial suicide for the service.

I report this case not for its uniqueness or unusual clinical significance but because it is an example of the importance of ensuring that contracts between providers and purchasers reflect good psychiatric practice. I believe that as services become increasingly driven by cost considerations there is a risk that the most difficult outreach work may be financially unrewarded and therefore neglected by services that are stretched both financially and in terms in manpower. I hope that contracts and clinical activity monitoring systems will continue to allow occasional substantial outreach work.

ADRIAN TRELOAR, *Peckham Community Mental Health Services, Maudsley Hospital, Denmark Hill, London SE5 8AZ*

Making community care work

Sir: I am a parent whose mentally disordered son died partly because of a lack of community care. Grieving parents and loved ones need to know that lessons from the past are learnt, so that future tragedies might be best avoided. This I have found frustrating. I would like to share with your readers some ideas about future research.

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