child psychiatric field (CCPNs) in every district of the Region. We felt this matter might be of more general interest. After a great deal of discussion, we felt that the training, therapeutic role and case load of CPNs and their line management were particularly important.

We found that, because there is no widely available specialist training for community nurses in child psychiatry, different areas had approached the problems in different ways. Some areas had instituted their own in-service training, while others required CCPNs to have post-graduate training, such as the Course 603. Many CCPNs had long experience working in child and adolescent in-patient units, but even so, find the change to community work quite threatening and isolating. Because of this, it was felt particularly important that the CCPNs should operate as members of a strongly supportive multidisciplinary team. It is vital that CCPNs learn about available local facilities, and other workers in the community, and are able to liaise and co-operate with them. We became aware that there could be openings for workers from other fields, such as occupational therapy or education, to work in the community, and some experimental posts in one district were advertised as "requiring relevant qualification and experience in child and family work".

It was generally felt that "relevant experience" required skills in dealing with relationship problems between mothers and children, including attachment and bonding difficulties, as well as an ability to use a variety of therapies, including family therapy, behaviour therapy, social skills and group work. It is important that the case load remains small, say ten to twelve families, reflecting the expectation that community nurses will work intensively, and at times, use flexible hours.

Line management presented no problems with posts developed in an in-patient setting, but was more problematical in relation to a child guidance clinic, where we found discussion with local directors of nursing proved helpful. We felt it important to draw a well defined boundary between CPNs in adult psychiatry, and those in the child psychiatric field. We have sample job descriptions which might be helpful.

One issue that gave rise to a great deal of heated discussion was the question of autonomy. It is always important for CPNs to operate as part of a multidisciplinary team. At the same time, it seems clear that there is a move towards more professional independence on the part of nurses, with postgraduate specialisation and qualification. Where a particular nurse has wide experience and training, the team may not feel too threatened by the CCPNs having a good deal of autonomy, and even accepting direct referrals. At the present time, most clinics will continue to function with the child psychiatrist supervising, and accepting clinical responsibility for the CCPN's work.

DOREEN THORNBER
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Community based programmes for mental illness

DEAR SIRS

I have followed the discussions about the moves to community care with great interest; many of the arguments for and against have now been aired. These arguments revolve around the best arrangements for the care of the chronically ill patients with respect to their current needs. However, there are some areas which I feel have not been discussed adequately and, although they do not affect the immediate care of patients, they nevertheless have long-term consequences.

Firstly, I do not think that the manpower implications of the moves to community care have been fully thought through. Clearly, a psychiatrist covering several small units in the community is going to spend much more time travelling and much more time liaising with different teams than in a centralised service. Unless he or she is very careful there may also be far less contact with trainee psychiatrists than in the base hospital, and certainly there will be very much less time to 'rub shoulders' with colleagues and for discussion of day to day matters of interest or importance. Educational activities such as clinical meetings and journal clubs may also suffer. Even if these are organised, those senior and junior psychiatrists working in the community may have difficulty getting to them. Although these activities do not affect patient care short-term, they clearly have long-term implications for training and standards of care.

Secondly, while I acknowledge that much research is still needed into the social aetiologies and consequences of psychiatric disorders and that arguably this is best conducted from a community base, the biological aspects of psychiatric disorders may not be. The new investigative and imaging techniques which are being developed (for example NMR) are going to provide tools for the understanding of brain structure and function in a way which has not previously been possible. It seems ironic that, just at a time when these powerful tools are being developed, there is a danger that psychiatrists will move away from their medical and biological base and sequester themselves in the 'community'. Research into psychiatic disorder, I believe, should be an active process conducted at least in part by clinicians who are familiar with the problems of definition and classifi-

cation of the disorders which they are studying and who have access to a large data-base of patients. If psychiatrists isolate themselves in the community, progress in the understanding of the neurobiology of psychiatric illness will surely be delayed

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A career in psychiatry

DEAR SIRS

It is always flattering for an author to be mistaken for one of his characters but Dr Harrington (*Bulletin*, May 1988, **12**, 169–174), has given your readers the impression that their current President as early as 1973 had come to the "harsh conclusion that though psychiatry offers a fascinating and rewarding career, in the future it may be impossible to practise it properly because of lack of staff and resources".

He is quoting from a contribution which I made to a symposium on 'Planning a District Psychiatric Service'.[1] My topic was 'Manpower' and I discussed the possible roles and functions of the consultant – "the ghost in the machine". I contrasted various views of what was desirable as psychiatric manpower with what was actually available at that time. One particular Committee, to which the College contributed, asked for numbers of staff which seemed quite unobtainable. "My" gloomy conclusion was put into the mouth of someone who demanded this lavish staffing as essential. I went on to say "if we accept the harsh realities which I have outlined, what is a psychiatrist's job description and how do we train people for it?"

Interested readers can look this up for themselves. However, Dr Harrington is partly correct: I do believe that psychiatry offers a fascinating and rewarding career.

J. L. T. BIRLEY
President

Reference

[1] BIRLEY, J. L. T. (1973) The ghost in the machine. In *Policy for Action* (eds. R. Cawley & G. McLachlan). Nuffield Provincial Hospitals Trust, Oxford University Press.

Research as a registrar

DEAR SIRS

Competition for senior registrar posts is becoming increasingly intense in psychiatry, although not as tough as in other specialities such as general medicine and surgery. It seems that the MRCPsych is no longer a passport to a senior registrar post and, when competing for jobs, it is wise to have as many point-scoring attributes as possible. From my own experience, research experience and, better still, publications of some form, seems almost a necessity now and interviewers have realised that just "having a protocol" ready does not always mean that this will result in the work and effort needed to produce a publication.

Having worked in both a non-teaching, country-situated asylum and a teaching hospital, I have found that trying to get myself involved in some form of research can be quite easy in a teaching hospital where there are consultants who are already involved in projects and enthusiastic in giving advice and ideas to willing registrars. I think that as well as being in the right place, being lucky and working for the right person helps. Some seniors teach and give advice and help that proves to be invaluable in later years but I feel that there should be more emphasis on the teaching of research methodology in the preliminary exam and also the membership (now Part II) so that senior house officers and registrars in psychiatry can be "research minded" at an early stage in their careers and not when they are buying a new suit for an interview!

Finally, mammoth projects demand mammoth amounts of time and effort and a realistic project with clearly defined goals and limits would be wise for a busy registrar. Most of us realise that we will not be winning a Nobel Prize in the near future but some of us will progress from the necessity of undertaking research for job hunting to a more serious and demanding approach.

A. MARKANTONAKIS

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With regard to Dr Markantonakis' letter, research is important for a psychiatric trainee – both to evaluate research and to be involved with research. Research features within the MRCPsych Examination and research methods is recommended to come in MRCPsych courses. The College also organises, and advertises regularly, short courses in research methodology via the College's Research Committee.

Professor A.C.P. SIMS
Dean

Erosion of clinical autonomy of RMOs

DEAR SIRS

Over the last decade considerable changes in the practice of psychiatry have taken place. No more is the consultant accepted as head of the therapeutic programme by the non-medical professions. This has