effectiveness and "recommendations should be explicitly linked to that evidence".

The College CPGs steering group intends to produce guidelines at a rate of two per year. In the interim, clinicians may wish to look at guidelines which are already in existence for a specific area of clinical practice. Criteria have recently been published (Hayward *et al*, 1995) which allow the clinician to critically evaluate the validity and utility of guidelines (including those which will be produced by the College) before adopting them in local clinical practice.

In the preparation of practice guidelines, I anticipate that many areas will be identified where the research evidence for the effectiveness of interventions is not available. It is hoped that this will demonstrate the need for further well designed and funded research.

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Diversion of mentally disordered offenders: a step too far?

Sir: There is reluctance on the part of the police and the Crown Prosecution Service to prosecute mentally disordered individuals who have committed offences. This is frequent when the offender is living in the community but most marked when the offender is in hospital and particularly when detained under the Mental Health Act.

Where there is a causal relationship between mental illness and an offence, diversion into psychiatric treatment is more just and humane than imprisonment. Regretfully, the overwhelming majority of offences committed by mentally ill persons are not causally related to the illness; they instead represent an epiphenomenon related to the offender's perception that diagnosis of mental illness indemnifies him or her against punitive judicial action.

The Clunis report highlighted the failure of the Metropolitan Police to charge Clunis with repeated offences that he committed; as a result, his record of convictions bore no entries for offences of violence despite a very long track record of violent behaviour. He was instead diverted into the psychiatric system without any record of his dangerousness.

Supervision registers will not solve this problem since they blur the distinction between danger to others and to self, and without a centralised online system available to every police station and psychiatrist, information forewarning of dangerous behaviour is generally unavailable until too late.

Effective rehabilitation strategies must make use of rewards and punishments: if mentally ill patients know that they can offend in a way that their 'healthy' counterparts cannot, without attracting punitive measures, then they will continue to offend, particularly when significant degrees of personality disorder are present.

Care in the community is all very well for the majority of those with severe and enduring mental illness but it must be backed up by facilities for those who repeatedly offend. A particular problem is posed by those who offend while in mental states which are self-induced – patients with mental illness who abuse illicit drugs or who fail to take their prescribed treatment, and it may be appropriate for long-term institutional care to be provided for such individuals.

Mentally disordered offenders are still offenders and should be charged and convicted. Diversion should take place with regard to the penal rather than the legal system.

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Care programme approach in the community

Sir: Chris Gilleard gave a comprehensive description of the intertwined processes of care programme implementation and audit in two London Boroughs (*Psychiatric Bulletin*, December 1995, **19**, 750–752). The audit looked at both percentages of psychiatric patients who had care programmes and various quality standards to do with the care programme process itself. In Bristol we performed a retrospective case notes audit focusing on in-patients from units in two Health Care Trusts. This showed a similar trend of increasing rates of care programming for patients discharged in May 1995 compared to the two previous years. Results from the third Health Care Trust in Bristol were also available for May 1995 and with the combined data we were able to address the question 'which patients are not getting care programming?'

In all three Trusts, patients admitted for longer periods were more likely to have a care programme and those in hospital for less than one month, the least likely. With respect to age there was no clear relationship other than that the over 65 years of age group fared best. Those patients with organic diagnosis (F00–F09) were most likely

to have care programmes and those with neurotic and stress-related disorders (F40–42) least likely. If a patient was psychotic during admission they were more likely than average to have a care programme.

An explanation for the higher rates in the elderly and those with dementia may be that these patients are generally hospitalised for longer periods and so there is more opportunity to arrange meetings, as well as the fact that elderly teams are generally more used to routinely working in a multidisciplinary setting. However, for those younger patients whose hospital stay lasts less than one month, there are the very real difficulties of trying to arrange care programming meetings with multi-agency involvement at short notice or sometimes after a patient is discharged. These problems are amplified if the patient is homeless or disengaged from the treatment process and in these cases, a limited care programme may have to be accepted with little or no patient cooperation.

The finding that younger patients who have a neurotic or stress-related illness are less likely to have care programmes may be because they are considered less ill than psychotic or demented patients or less in need of coordinated care and so the whole process may seem too cumbersome or bureaucratic. This underlies the need for a flexible, tiered approach to care programming where the philosophy of needs assessment, user involvement, clear definition of professional roles and good communication are tailored to the requirements of each patient in a pragmatic way.

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European psychiatry: a force for the future

Sir: The European Forum for all Psychiatric Trainees (EFPT) can be likened to the Association of European Psychiatrists (AEP) as described by Murray (*Psychiatric Bulletin*, December 1995, **19**, 721–722). It too is following trends of European cooperation, has grown rapidly in the number of member countries and is an important, if not the only, forum of exchange of ideas between trainees in psychiatry across Western Europe.

Unlike the AEP, Britain was not a latecomer to the EFPT but a founder member. The forum was set up in June 1992 at a European Trainees Conference organised by the Collegiate Trainees Committee at the Royal College. Subsequently, meetings have been held annually in Utrecht (1993), Cork (1994) and Copenhagen (1995). The forum has now established representation from every country in Western Europe and Scandinavia and has been effective in promoting the development of national organisations of psychiatric trainees in member countries. The annual meetings have discussed issues relevant to training, such as international exchange, the role of psychotherapy in training and access to resources for research (Van Beinum *et al*, 1993; Sheldon & Cornwall, 1996). The forum has also represented trainees at the European Board for Psychiatry in its discussions on the proposed EU-wide minimum requirements for specialist training in psychiatry. In our opinion, through the EFPT, trainees are another force for the future in European psychiatry.

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Reassessment of anatomical preparations

Sir: Until the outbreak of World War II, post-mortems on patients dying in mental hospitals were the rule rather than the exception. The causes of death varied but the low rate of cancers, even allowing for age, was striking when compared with today. There is also a real possibility that mental illness of the type we now call schizophrenia increased in the 19th Century.

There may exist in our remaining mental hospitals anatomical preparations including microscopic slides going back to those times. With the advances in molecular biology it might well be possible to use such techniques to re-examine these specimens and tease out differences between those days and the present. This might cast light on the nature and causes of conditions as diverse as cancers and mental illnesses.

I would be delighted to hear from anyone who has knowledge of such preparations and I would volunteer to set up a preliminary register of such artefacts so they can be assessed and studied at some future date.

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