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.

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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.

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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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