and standards of postgraduate training and methods of accrediting schemes are already well developed in the College. We need to concentrate on improving the translation of these policies into high quality psychiatric training throughout the country. The other vitally important factor in ensuring the College's compliance with the requirements of the CMO's Report, particularly with regard to the length of training, is the funding of the latest allocation of senior registrar posts. This will allow us to address our own bottleneck which occurs between registrar and senior registrar grades and fill the large numbers of vacant consultant posts in some areas. This is in contrast to the excess of senior registrars to consultants in many other specialities.

On behalf of the CTC I would also like to correct the impression which may have been gained from Dr Kisely's article that we have not been active or responsive to the issues raised by Calman. The statement that the CTC recommends only minimal changes to the present system is true in as much as we only see a need for continuing the progress made in psychiatry over recent years. This view is not intended to apply to the other Royal colleges where more radical changes may be needed. The CTC is an integral part of the Royal College of Psychiatrists and as such has been working to ensure that the standards of psychiatric training are high and continue to improve, since our foundation in 1979. We do not feel that radical change is necessary and are proud of the College's record of setting standards for training and involvement of trainees at all levels. As far as comments about reducing the length of postgraduate training to five or six years, we do not find a great deal of support for this among trainees themselves, as long as the time is spent in useful postgraduate training and not repeating previous experience while waiting for an SR (or to a lesser extent registrar) post. There is so much material in the psychiatric curriculum that trainees feel the need to expand the length of time spent in educational activities during the current training period.

The future for psychiatric training is to build on the progress made and to address the shortage of posts at SR level to allow a smoother transition through the training grades. We do not need radical changes, designed to address the problems of other specialities, imposed on us again. Trainees can be assured that the CTC will continue to be vociferous in its support of trainees and training standards within the College.

STEFFAN DAVIES, *Chair, Collegiate Trainees Committee (CTC), The Royal College of Psychiatrists*

Sir: I am sorry that Dr Steffan Davies, Chairman of the Collegiate Training Committee (CTC), should take such exception to the suggestion that his committee should carefully consider whether psychiatric training could be further improved in the light of the Calman Report (Kisely, 1993).

I am well aware of the views of the CTC, given that I was one of the representatives on the committee for North Western Region until six months ago. Unless the committee has changed radically since, I found that many representatives were more open-minded about possible changes to training following Calman. In my experience, trainees in general certainly are. While training in psychiatry has many advantages over many other specialties, this does not mean that there is no room for improvement. Psychiatric trainees may wonder why training to be a psychiatrist in the UK should take so long; the Colleges of other medical specialities in Britain may soon require only five to six years of training, while the Royal Australian and New Zealand College of Psychiatrists stipulate only five years. Is the answer to an expanding psychiatric curriculum simply to increase the time spent in education activities within the current framework, or to critically examine the relevance of some of the training?

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CT scans in the elderly

Sir: We read with interest the article by Jon Spear (*Psychiatric Bulletin*, 1993, **17**, 536–537) which compares the quality of the use of computerised tomography (CT) scans in two psychogeriatric services. The author does not define the term 'quality' and it is assumed that this is measured in terms of identifying potentially treatable structural lesions (PTLs).

If diagnosing these PTLs is the only aim, as seems implied, then there is evidence supporting the finding that the most useful predictor is the presence on examination of focal neurological signs although further clinical prediction rules for the use of CT scans in the elderly are required (Martin *et al*, 1987; Wasson *et al*, 1985; Deitch, 1983).

In Spears study, patients of Service X, which only had access to CT scans through neurosurgical referral, suffered proportionately more 'risk factors' and had a greater rate of PTLs diagnosed. This implies that the application of neurosurgical criteria leads to more efficient use of CT scans. Discovering PTLs is obviously important but psychogeriatricians need to adopt

broader criteria in evaluating the use of an investigation. These criteria should include the making of more confident diagnoses, and thus formulating management plans and prognostic expectations.

There is increasing public expectation that the investigation of dementia will include neuroradiological techniques. With the prospect of more overt rationing of limited resources, we urgently need to address the quality of health care provision particularly in terms of efficiency and effectiveness.

We are currently undertaking a large prospective study in the use of CT scans in the elderly, which we hope will address some of these issues.

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Sir: Blagden and colleagues raise some points regarding my article (Spear, *Psychiatric Bulletin*, 1993, **17**, 536–537). I used a multidimensional definition of 'quality' (Maxwell, 1992). The dimensions of quality assessed were accessibility, efficiency and effectiveness.

Computerised tomography is useful in the diagnosis of dementia because it may detect other disorders such as subdural haematoma, brain tumour, normal pressure hydrocephalus and multi-infarct dementia (McKhann *et al*, 1984). Although I did not suggest that diagnosing potentially treatable structural lesions (PTL) is the only aim of computerised tomography (CT), by defining efficiency in terms of identification of PTL it was possible to compare the services with earlier research (Roberts & Caird, 1990).

My study confirmed earlier research (Riisoen & Fossan, 1986) that the presence of focal neurological signs is the most useful predictor of PTLs, although a thorough medical history and further investigations are also important.

I welcome Blagden and colleagues' research which may offer further insights into the most appropriate use of CT scans in the elderly.

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Care of patients discharged from hospital

Sir: I have recently read the government's consultative paper about extending compulsory care to patients who have been discharged from hospital. While accepting that as professionals we have the luxury of being able to give the advice we believe to be correct without considering its public acceptability, a luxury not enjoyed by politicians, I fear from the tone of the paper that the proposed legislation is attempting to please everybody and deliberately vague.

Certainly neuroleptics have disadvantages and where practicable other methods of preventing relapse, and overwhelmingly we are talking of schizophrenia, are to be preferred. However, only two interventions reliably reduce relapse in schizophrenia, the administration of neuroleptics on a long-term basis and the manipulation of the environment with a reduction in high expressed emotion (HEE).

The reduction of HEE is clearly to be preferred but its delivery cannot be guaranteed and depends upon the ability and co-operation of many individuals, whereas administration of a depot neuroleptic is certain even if side effects have to be tolerated.

It is important that the College makes sure our advice to the government is unequivocal; if they wish to reduce unfortunate incidents involving discharged schizophrenic patients, the only legislative channel likely to achieve this is a power which will enable psychiatrists and multidisciplinary teams to insist that patients continue taking medication after discharge.

On the whole this is not difficult in practice and most patients will comply if the psychiatrist and the multidisciplinary team can tell them they must. Many are well versed in the technicalities of the Mental Health Act and know exactly when they are permitted to stop against medical advice.

I think the vast majority of the College, however, would agree that it is essential that the amendment to the Act says that patients in appropriate circumstances can be required to continue taking their medication after discharge from hospital and that this is written in such