arguments with Department of Health Officials that Dr MacKeith was party to, but left the rest of us wondering whether we were not followers of the Grand Old Duke who was not so much passive as hasty in retreat.

ROBIN PINTO, *South Beds Community Health Care Trust, Calnwood Road, Luton LU4 0FB*

Sir: Dr Robin Pinto expresses anger at the care programme approach and the way it was introduced. I share completely with him dissatisfaction over the manner of its introduction. It was not properly discussed with the profession before being foisted on us; the documentation was abstruse to the extent of being misleading; we were never told how we would obtain resources to make it work; it was not specified who appoints the key-worker nor who that key-worker should be; and it was not clear who among the total of psychiatric discharges would be subject to the CPA. For all these reasons the manner of introduction of the CPA was little short of disastrous.

On the other hand, the principles which underline the care programme approach are simply those that psychiatrists have tried to practise for many years. When a patient is discharged from in-patient care it is reasonable that one individual should be identified to give adequate level of follow-up; if after-care involves social services and the health service, then reasonable liaison between the two authorities needs to be arranged; before discharge takes place there should be a plan agreed and accepted by all those involved to maintain the patient at the optimum level outside hospital.

These principles of care are reasonable. However, to be implemented, psychiatric services must have adequate resources; there must be enough consultant psychiatrists to look after the patients in the community who still require treatment and follow-up; the consultant needs to be able to identify the appropriate key-worker for each patient discharged into the community; it must be possible to agree with other authorities who takes responsibility for what parts of care, and who pays for it.

It is my opinion that rather than attacking the underlying principles of the care programme approach, Dr Pinto would more profitably spend his time working with us to achieve what is needed to implement it, both locally and nationally. We want to provide an improved level of psychiatric care to our patients but it cannot be done without additional resources and adequate control by consultants of the facilities we already have.

A. C. P. SIMS, *Chairman, Steering Committee, Confidential Inquiry into Homicides & Suicides by Mentally Ill People, PO Box 1515, London SW1X 8PL*

Fund-holding practices and follow-up clinics

Sir: Armond (*Psychiatric Bulletin*, February 1995, **19**, 177) highlighted potential problems in respect of fund-holding practices taking over the supervision of lithium prophylaxis of patients.

I was shocked last year to receive a letter from the fund-holding practice manager terminating further appointments and saying that follow-up would occur in the general practitioner's surgery. This patient, who I had been seeing for 12 months, suffered from a mild depressive disorder, largely related to his chaotic personal life. Management had involved supportive psychotherapy with problem-solving techniques and cognitive strategies to reframe pessimistic thinking. Matters had improved to the point where the patient anticipated returning to work. I wrote outlining his progress and planned one more appointment to confirm the improvement and then discharge.

I wrote to the GP expressing my disappointment and asking for clarification, including knowledge of whether the patient had been informed. I received another letter from the practice manager (not the GP) telling me that the practice had been arranging their own follow-up clinics for some time and that "as a matter of courtesy we inform the provider in good time so that they could reallocate the appointment to someone else". The writer trusted that I found the explanation satisfactory. I found the response of the local purchasing authorities more bland but equally unsatisfactory in that there seemed little more to be done about the matter *vis-à-vis* local management although the response was more positive from the Chair of the Regional Mental Health Services Committee.

The final icing on the cake was when, on the day and time of the appointment, the patient arrived with no knowledge of what had been happening but considerable surprise and anger when informed of it.

I wonder whether I was alone in having such an experience but suspect not and would be grateful to hear of others' experiences and any successful strategies that may be enacted.

N. S. BROWN, *Solihull Healthcare NHS Trust, Lyndon Resource Centre, Hobs Meadow, Solihull, West Midlands B92 8PW*

Trainees' understanding of services

Sir: It is encouraging to learn of trainees' interest in learning about the past and future pressures that shape our service (Gaughran & Davies, *Psychiatric Bulletin*, February 1995, **19**, 121–122).

Sub-specialisation has occurred extensively in many medical specialities, and concern about the inadequate support of general services has been voiced often. It is essential that the right balance is struck between sub-specialisation and the general service provision, and the driving principle based on outcomes rather than rhetoric; for example, following guidance on the differing morbidity and mortality rates for vascular surgery. Resources should follow outcomes but there are many examples in psychiatry where there is pitiably poor support for a locality's service provision.

Like old age psychiatry, adolescent psychiatry developed as a body of knowledge and practice in response to poorly met needs. It might be broadly defined as 'the general psychiatry of adolescence', and, where in-patient provision exists, the assessment and treatment of psychotic illness of adolescent-onset should be a primary task. The contemporary literature clearly supports that stance and, instead of internecine quarrelling in the profession, hard decisions on resource allocation made on the basis of what can be afforded and where the best outcomes can be ensured, so that the needs of patients and their clinical services are supported to the maximum that NHS funding permits.

R. M. WRATE, *Edinburgh Healthcare NHS Trust, Royal Edinburgh Hospital, Edinburgh EH10 5HF*

Out of Darkness video

Sir: Jacqueline Atkinson writes (*Psychiatric Bulletin*, January 1995, **19**, 43) about the video *Out of Darkness* starring Diana Ross which describes the recovery of a schizophrenic patient on clozapine. The criticisms which she levels "stress mentioned only in passing" and the presence of stereotypes and the fact that "we learn little of the chronic negative symptoms" and many similar remarks sound like she is refereeing an academic paper.

This is a simple video made for the viewing lay public with accurate technical input from one of the world's major experts on schizophrenia in general and clozapine in particular. Of course the film offers hope, and as a clinician with nearly 25 years of experience I welcome anything that offers hope in contrast with the dreadful legacy that schizophrenic patients and their families have endured in so-called civilised countries this century.

I have shown the video to many of the families of my clozapine patients and they love it. The best of luck to them, God knows they deserve it and let us not try to denigrate simple entertainment using pseudo-academia.

MICHAEL LAUNER, *Burnley Health Care NHS Trust, Burnley General Hospital, Burnley BB10 2PQ*

Sir: *Out of Darkness* (certificate 15), whatever else it does, promotes clozapine. That it also entertains means that it reaches a wider public than would a television documentary. In the month of its release (August 1994) my local video shop's two copies were borrowed 26 times (2-day hire), showing its popularity.

People are susceptible to messages about mental illness portrayed in the media (e.g. *Brookside*, *Eastenders*) (University of Glasgow Media Group 1993a, b). There is also a suggestion that, in this area, media messages may outweigh personal experience for some people. To pretend that films such as *Out of Darkness* elicit no response other than 'entertainment' is naive. It might be unrealistic to expect any media message/entertainment to be unbiased but to point out bias can be merely to refer to ones' own experience and reality, not 'pseudo-academia'. Surely by showing the film to patients' families Dr Launer is treating it as something other than 'simple entertainment' (education?, to promote discussion? to confirm the use of