there is great pressure put on trainees to supplement the inadequate consultant numbers. This is understandable and acceptable to a point, but it has been the view that it is not acceptable when it impinges on academic activities. There is also pressure put on senior registrars in some places to substitute regularly for consultants acting on committees or when doing private practice, but I am sure these things never happen at the Joint Hospitals.

We would all join in the aspiration to provide the best training and service. I think that 'supernumerary' is not the ideal word for describing the way the Joint Committee views a senior registrar post. A better term might be sought. It is used to imply that the trainees are not permanent members of the team. While they must be integrally involved with the work of the service to which they are attached, they preserve the flexibility to move to other posts as their training needs require. Because the service is not dependent on them its quality is not impaired when they move. The Maudsley group ought perhaps to travel a little more outside London where most of the schemes in the country now accept and work well with the system of more training slots than salaries, enabling senior registrars to choose their posts. My own service will be without a senior registrar from October because none of our trainees needs to do liaison psychiatry at this time. The service I hope will not be impaired, although the consultants will have to take back some of the work load they shared with the senior registrar in exchange for his teaching time. A senior registrar must play as full a part in the service as is reasonably possible, substituting from time to time for the consultant and taking over from the consultant responsibility for a reasonable proportion of the work. The consultant gains time to teach the trainee. If senior registrars did not share in the full responsibility for the service, how else could they learn their job?

Regarding "acting down", it is regular and expected acting down which is objected to. It happened particularly in the old mental hospitals when difficult to fill registrar posts were converted to senior registrar posts to make them more attractive. In those days the job description did not change, only the money. Such traditions still linger in some places.

The JCHPT has set rules and guidelines but has rarely been rigid about their application when they judged that the spirit behind the training was right. I hope they have been determined when it was judged the spirit was not right.

The final paragraph of the letter seems more by way of an advertisement and I think I have dealt with the only point it makes

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Clinical independence

I submit that Dr T. D. Scannell's letter (*Psychiatric Bulletin* August 1992, **16**, 509) merits placement under the vision of those holding power in the College. His final sentence "a doctor nowadays who questions, who tackles the system, who says "what of my patient though" is told he is shroud waving or that he is awkward, and he can now be threatened with dismissal" is as true as it is damning of the pass we are now in. This is a pass that is mortally threatening to proper standards for patients. It is a pass that those with power and preferment should be exploring for a juster future for those who dare speak unpopular thoughts, displeasing to the politics of mental health. If our leaders can honourably get the profession out of the morass, they will deserve recognition like those at Thermopylae!

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DEAR SIRS

Thank you for letting me see Dr Jacobs' letter. It is quite clear from the Supplemental Charter and Bye-Laws of the Royal College of Psychiatrists that Fellows and Members have a duty "the achievement and maintenance of the highest possible standards of professional competence and practice ... to give consideration to improve methods of hospital and other medical administration ... to consider, pronounce and make representations upon all questions affecting ... the promotion of improvements in the principles and administration of the law relating to mental disorder and to the treatment of persons suffering from mental and connected illnesses". Pointing out what is detrimental to the care of our patients is not only sanctioned, it is obligatory.

I know of no Fellow or Member of this College practising in the United Kingdom or Ireland who in carrying out this duty has been threatened with dismissal.

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Psychotherapy in the reorganised NHS

DEAR SIRS

I practised as a psychotherapist in the NHS for nearly 25 years. My new patient waiting list was similar in length to those of my colleagues; medical students' attendance was good, and, so far as clinical

results are assessable, one-third of the patients seemed to gain considerable benefit, one-third some benefit, and the remainder dropped out or were not helped – similar proportions to the rest of psychiatry. In addition psychiatrists, psychologists and MSWs were supervised in ongoing therapy and medical students too if they opted to 'have a go'.

In the new era of purchasers and providers, will psychotherapy be seen as a worthwhile option? Perhaps the more robust therapies (behavioral, cognitive, M & J sex therapy), but what about the exploratory-interpretive therapies?

From the point of view of a general practice purchasing services, particularly in an inner-city area, it is likely to be more cost- and time-effective to underpin the assessment and management of two units of schizophrenia rather than one identity crisis in an anxious young adult and one couple whose marital relationship is deteriorating. But, if psychoneurotic, psychosomatic and psychosexual problems are not referred for consideration of psychotherapy, doctors in training will not learn about conditions which affect over 10% of general practice patients.

The only good blown by this ill-wind is that psychotherapists of all allegiances are, at long-last, getting together, even if only in the pursuit of mutual survival. Sadly, it is difficult to see that psychotherapists, at the 'soft' end of psychiatric practice, will have the muscle to be an effective pressure group once the financial chips are down.

It would be an immense loss to patients if psychotherapy ceased to be practised in the public sector and returned, as years ago, to being solely private.

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Day care

DEAR SIRS

Drs Orrell & Johnson (*Psychiatric Bulletin*, September 1992, **16**, 540–542) have helpfully drawn attention to the problem of the ageing cohort of long-term psychiatric day patients and the lack of appropriate day care facilities for elderly people with a functional mental illness. However, their implication that research into day centres is lacking is surely false. Studies have repeatedly shown that the populations served by day hospitals and day centres are often very similar, calling into question the value of the distinction (Holloway, 1988). It may not be possible to generalise the finding of Brewin *et al* quoted by Orrell & Johnson that day hospitals are more effective than day centres at meeting the needs of long-term attenders: what is important in meeting need is the quality of the liaison between the day unit and the rest of the mental health service system (Holloway, 1991). Day centres that are "client-oriented" in their management practices have been shown to be characterised by a more personal approach to clients' problems and a warmer quality of interaction between staff and client when compared with "institutionally-oriented" centres. In a study of "under-attendance", it was the more chronically disabled referrals who terminated contact prematurely with a day centre that emphasised talking therapies.

An important multi-centre study has been carried out of the role of psychotropic medication and 'day treatment centres' (long-term day care facilities) run by the Veterans' Administration in the USA in the aftercare of recently-discharged schizophrenic patients (Linn *et al*, 1979). All centres improved social functioning compared to the drug-only condition. In addition, centres that delayed relapse and reduced symptoms were characterised by lower patient turnover, an emphasis on occupational and recreational therapy as opposed to talking therapies and a "sustained non-threatening environment".

Despite Government policy that has, since the publication of *Better Services for the Mentally Ill in 1976*, stressed the role of day hospitals in acute psychiatric care and the day centre as the source of long-term social support, the bulk of long-term day care is still provided by the National Health Service. In an era of increasingly scarce resources, the future funding by the NHS of what is quite clearly 'social care' (albeit of demonstrable value to patients' clinical state) must be very vulnerable. In the light of the health/social care dichotomy, purchasing health authorities may well seek to reduce spending on psychiatric day care and transfer responsibility for long-term day care to Social Services Departments and the voluntary sector. Unless appropriate mechanisms are developed for coordination between the psychiatric and social services and monies are ring-fenced, services for patients with chronic psychiatric disabilities may well deteriorate following implementation of the Government's community care reforms.

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