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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KAREN BLAGDEN, *Queen's Medical Centre, Nottingham NG7 2UH*; JANET BRUCE, *Pastures Hospital, Mickleover, Derby DE3 5DQ*; STEFFAN DAVIES, *The Millbrook Centre, Kings Mill Hospital, Mansfield NG17 4JL*; and OLA JUNAID, *St Francis Unit, City Hospital NHS Trust, Nottingham NG5 1PB*

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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JON SPEAR, *York Clinic, Guy's Hospital, London SE1 9RT*

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

a way that it is clear to everybody concerned, particularly the patients.

A. M. P. KELLAM, *University Hospital of Wales, Cardiff CF4 4XW*

Psychotherapy training: brief therapies preferred

Sir: The College guidelines on what constitutes a good training in psychological treatments are soon to be updated. The current guidelines (1986) are ambitious and large regional rotations have made it harder to organise training in longer psychotherapies. We conducted a brief survey of the 82 senior house officers and registrars in the Oxford region asking what training in psychological treatments had been received and what trainees thought was important. The response rate was 63%.

We asked trainees to rank 'the importance for your psychiatric training' of training in various treatment modalities. (Higher scores mean greater perceived importance). Mean rankings were: cognitive behavioural therapy (CBT) 4.3, brief focal individual psychotherapy ('2–3 cases, <3 months/case') 4.0, counselling 2.4, marital therapy 2.3, individual dynamic psychotherapy ('>6 months/case') 2.0, cognitive analytical therapy 2.0, dynamic group therapy 1.1. The survey did not attempt further definition of these terms.

A trainee's ranking of CBT and individual dynamic psychotherapy did not significantly depend on whether he or she had had supervised training in these modalities, nor on total length of psychiatric training. Career psychiatrists were more likely to value highly training in brief focal individual psychotherapy than GP trainees, who preferred counselling. When the rankings from these two groups were combined, GP trainees and psychiatrists did not differ significantly (P=0.2) in the relative importance they attached to these brief therapies v. individual dynamic psychotherapy; both thought the briefer therapies more important for training.

It may be difficult for SHOs and registrars to appreciate the relevance of longer term therapies when, at this stage in training, they routinely see patients for no more than six months. Alternatively, they may be sensitive to the focused way consultants work. Whatever is the correct explanation, it does seem that the College may place more emphasis than trainees on the value of training in longer individual dynamic psychotherapy: it would be interesting to know how far trainees have been consulted in drawing up the new guidelines.

ROYAL COLLEGE OF PSYCHIATRISTS (1986) Guidelines for training of general psychiatrist in psychotherapy. *Psychiatric Bulletin*, **10**, 286–288.

R. H. MCSHANE and D. B. E. C. GILL, *The Warneford Hospital, Headington, Oxford OX3 7JX*

Sir: Drs McShane & Dr Gill are to be commended on conducting a survey of 82 senior house officers and registrars. Their results support the importance of psychotherapy training as perceived by the trainees. It would be interesting to know how other items of psychiatric training would rate in comparison with the ratings for different forms of psychotherapy training. It is difficult to interpret the significance of their results and it may be hard for people at the beginning of training to see the relevance of longer term therapies.

The aim of the new College guidelines for psychotherapy training as part of general professional psychiatric training (Grant *et al*, 1993), in suggesting experience of longer term therapy, is to enable the trainee to understand complex aspects of this work, rather than to prepare the trainee fully to practise it. Experience of longer term therapy allows complex issues in a transference/counter-transference relationship to be explored and this is an important learning experience. These principles are often of importance in clinical management in psychiatry. Of course such experience will often be more difficult and testing for a registrar or SHO than brief therapy, as it requires examination of personal feelings and attitudes in relation to the patient. It will be much more testing of the quality of teaching and supervision offered for psychotherapy which, if adequate, leaves the trainee with a difficult experience. The new guidelines are ambitious, but psychiatry should move towards a situation where all trainees are familiar with a wide range of psychotherapies, including more intensive approaches, and are able to apply psychotherapy principles to psychiatric practice. Otherwise we will be planning for a future psychiatric profession with a limited range of therapeutic skills. There is increasing demand from patient's organisations for psychiatrists to offer a wide range of talking treatments.

The guidelines were prepared in discussion with trainees who, on the whole, have welcomed these changes, as many wish to see the improvement in the quality of their training. Naturally they expressed anxiety about the additional demands made on their time and the requirement of the completion of a log book system.

Our present general professional training in psychotherapy compares unfavourably with other countries which have a much higher number of psychiatrists, such as the USA, Canada, Australia and New Zealand, each with roughly four times as many psychiatrists per 100,000 population. The demand for psychiatrists may be linked to their capacity to provide personal therapeutic work with patients. The psychiatrist in