criticisms that I have heard. The first, inevitably, is financial. I have heard our College criticized because of the frequency of our Approval Visits relative to the other colleges, which have been approving their training schemes over a very much longer period. So there is pressure on Conveners to manage with one consultant colleague. Adding a senior registrar, however desirable that is, increases the expense significantly, but I agree that they are likely to make the Approval Visit more effective. The other criticism I have heard, Dr Frost mentions himself. In my article I pointed out that feelings can run high during Approval Visits and there may be much frank and even aggressive discussion. Consultants have said to me that they would rather that senior registrars were not present on these occasions. I do not comment on this, which Dr Frost very reasonably describes as 'not in front of the juniors'.

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Damage to medical training through rapid change in health services

DEAR SIRS

Medical training entails learning about illness and treatment in the context of a society and health service. Rapid changes in the health service are making present training irrelevant. Resources that are essential components of therapy are being attacked by rigid financial policies. For example, many hospital Social Work departments have been unable to replace staff when funds are frozen. At least one nurse training school cancelled a term's intake of pupils without regard to the service implications for the future. According to Professor John Wing, Director of the Medical Research Council Social Psychiatry Unit: 'In a period of recession, it is well known that services develop unequally and there may be serious gaps in provision which particularly affect people with long-term disability.'

Although the Government has encouraged Regional Health Authorities to give priority to services for patients who are elderly, mentally handicapped, or mentally ill, these specialties are labour-intensive and costs continue to outstrip funding. Consequently, staff levels have fallen, dangerously in some districts, particularly in night nursing.

At the same time, changes in society, such as mass unemployment, involve an increased risk of illness, both physical and mental. This is producing a rising demand on medical and social services. Inevitably the less articulate chronically handicapped are put at a further disadvantage in the competition for dwindling services. Resettlement becomes impossible.

As psychiatrists in training from all parts of the British Isles we are opposed to public policies which lead to ill-health and impoverish services. We wish to draw attention to the consequences of such policies for our training. Unless the changes in progress are halted, little will remain but an emergency service, lean and competitive, but one for which our present training is inappropriate.

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Planning in child and family psychiatry

DEAR SIRS

The good physician makes sure that his treatment does not make the patient worse; we wonder if this is true of administrators.

During the further reorganization of the NHS, child and adolescent psychiatrists have had to take difficult planning decisions at short notice and without opportunity for consultation.

The Child and Family Psychiatric Service (CFPS) in Bedfordshire consists of three small clinics, and by the end of 1981 we were represented on both area and district planning teams. A CFPS area planning group consisting of practitioners, Community Physicians and Social Services adminstrators met regularly and had access to the Joint Consultative Committee (JCC) via the Joint Care Planning Team (JCPT). The consultant psychiatrists were also represented on district planning teams both for children's services and the mentally ill.

Because the area level of organization was to be abolished in the forthcoming NHS reorganization, administrators wished to disband the CFPS group. In future there would be two district health authorities within Bedfordshire, cutting off administratively one clinic in the north from two in the south. The practitioners in the CFPS group realized its importance as a base for overall planning of the service and decided to keep it in being even if its former link with the JCPT did not exist during reorganization.

The consultative documents issued by the new district health authorities did not mention CFPS Services, so all three clinics wrote pointing out that we were a *psychiatric* service and should be planned as such. This was accepted in the southern district, but was ignored by the northern district management team, which, without consultation, placed the CFPS in the Community Services unit. If these arrangements are confirmed, our service, split between two different planning units, may be worse off than before. We have, for instance, to plan jointly the training of junior psychiatrists studying for the Membership Examination, and this may be hindered by administrative separation.

At the moment our only united base is the CFPS group

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