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other than commenting on the rise in total number of referrals made no comment on the underlying referral rate.

We agree with Dr Willis that the MMSE, assuming that it measures an actual underlying 'cognitive ability' where the intervals between adjacent scale values are indeterminate, is an ordinal rather than an interval or ratio scale and corresponding tests should be used. We are pleased to note that our data still show a significant move towards earlier referral in dementia.

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the college

What will one CCT mean for us?

On 3 July 2006 we emailed members and fellows to inform them of Council's decision that the College should apply to change from six certificates of completion of training (CCTs) to one CCT. We have been asked some questions about this change and here are the answers to the most frequently asked questions.

Why the changes and why now?

Several sub-specialties in psychiatry (e.g. addictions, liaison, rehabilitation and neuropsychiatry) have been trying to obtain specialty status, but the Department of Health has not approved these because of difficulties in getting these changes through the UK Parliament. We have also been told that no new applications for CCTs would receive support from the Postgraduate Medical Education and Training Board (PMETB).

If a single CCT is approved by Parliament then the initiative will be with the College to ask PMETB to approve new sub-specialty curricula as they evolve or change. This gives the responsibility back to the College to determine what is good for patients and the profession.

The time is right now so that trainees entering the unified training grade will know what CCT they will receive on completion of training. However, it is likely to take a long time to go through the UK and European parliaments and the final decision will not be made by August 2007.

How many specialist curricula have been approved by PMETB (the new regulatory body for medical education)?

The PMETB has approved the six specialist curricula that currently have a CCT. There are currently some non-CCT specialties recognised for article 14.

How long will it take for a trainee to obtain one CCT? Will it be longer or shorter than it currently takes?

It will take about 6 years, as now. It might take some trainees longer and some trainees less time to obtain one CCT.

When will trainees complete core training and specialist training?

'Core' training will normally take 3 years and will end once the MRCPsych has been passed. 'Optional training in accredited specialties' generally will start at ST4. However, the whole period in the unified training grade will be called specialist training.

When will trainees be selected for specialist training, for example in forensic psychiatry or psychotherapy?

Allocation into specialty training will take place after the MRCPsych has been passed, as now. Every trainee will be expected to pursue specialist training following one of the approved curricula.

If there is only one CCT, what will my entry on the specialist register say?

Your entry should reflect the specialist curriculum you have completed, i.e. if you have followed the learning disability programme your entry will read psychiatry (learning disability psychiatry), and if you have followed the child and adolescent training programme your entry will say psychiatry (child and adolescent psychiatry). In the future the specialist register is expected to include much more information about an individual specialist's qualifications and competencies.

When will the change take place?

At this stage, the move to one CCT is a recommendation and may not be approved by the UK and European parliaments. There will be extensive consultations by the Department of Health. It may be 6 years before the changes are implemented. These changes should hopefully be in place by the time trainees entering the unified training grade in August 2007 will be finishing their training, i.e. around 2013.

Will psychiatric specialties be dumbed down?

Absolutely not! The Royal College of Psychiatrists is committed to developing the best specialist expertise, as our patients and carers expect. Faculties and their educational committees will submit their curricula and ensure that specialist competencies are clearly identified.

Professor Sheila Hollins President,
Professor Dinesh Bhugra Dean,
Royal College of Psychiatrists

Medical Director Initiative

The College Strategic Plan 2005–2010 includes a proposal to harness in a more systematic way the considerable influence of medical directors, and through them to work more effectively with healthcare managers. Peter Kennedy, a former medical manager, chief executive and co-director of the prototype for the National Institute of Mental Health for England (NIMHE) regional development centres was elected Vice-President by Council in January 2006 to lead this initiative.

The founding meeting of the Medical Directors' Executive (MDE) took place on 6 April and defined terms of reference. Each Division will have two medical director nominations to the MDE, one as main member and one as deputy. The MDE will advise the President and College on key issues that need to be taken forward at College level. The College will be more influential working in partnership

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with other interested bodies where collaboration can be mutually beneficial. Links have already been formed with the National Mental Health Partnership of Chief Executives, NIMHE, British Association of Medical Managers, and the NHS Institute for Innovation and Improvement.

Important issues were highlighted at this first meeting of the MDE. These included the need for development of medical directors and their supporting medical management structures in order to better support consultants in handling the impact on service delivery of the reforms (foundation trusts, choice, practice-based commissioning, and payment by results). Since national guidance on New Ways of Working makes it clear that leadership of multidisciplinary teams is not the exclusive right of any one profession, another concern was how to ensure adequate training in team leadership for specialist registrars and consultants. It was proposed that further work may be needed to define the indispensable, non-transferable contributions of psychiatrists to mental health services in order to encourage members of the College to hone their skills in these areas.

The Vice-President and MDE will draw on the intelligence and work of a much-wider network of medical managers in mental health services. Steve Choong, Chairman of the College Management Special Interest Group, will be an ex officio member of the MDE. He will coordinate and transmit advice of the special interest group's wider membership of medical managers through the MDE to the central College Executive Committee (which has replaced the College Council). Anyone interested in joining the special interest group or learning more about its work should contact Ian Davidson, Honorary Secretary (email: ian.davidson@cwpnt.nhs.uk). Membership is not restricted to those holding management positions but is open to anyone interested in leadership and management issues in mental health and learning disability services.

In addition, there are flourishing local networks of medical managers working in some College Divisions on how to implement new ways of working. Peter Kennedy would welcome discussion with medical directors/managers who are interested in developing similar local networks where none yet exists (email: peter@kennedy89.freeserve.co.uk).

To launch and shape how this College-wide network will develop, an overnight stay and day workshop for medical directors is planned for 12 December in York. A larger event for all medical managers and clinical leaders in mental health services is a possibility for next year.

We are currently trying to establish an accurate database of contact addresses for medical directors. We are particularly concerned to include 'heads of psychiatry' in mental health services that do not have a medical director who is a psychiatrist. This is especially likely in Northern Ireland, Scotland, Wales and Ireland. Any medical director or equivalent who has not been contacted directly with details about the workshop in December please send your details to Eva Davison (email: edavison@nyorkdiv.rcpsych.ac.uk).

Building and Sustaining Specialist Child and Adolescent Mental Health Services

Council Report CR137, June 2006, Royal College of Psychiatrists, £7.50, 52 pp

This document provides guidance to practitioners, managers and commissioners on the capacity and provision of specialist child and adolescent mental health services (CAMHS) in England, Ireland, Northern Ireland, Scotland and Wales. Evidence is collated from a number of sources, including published and unpublished literature and examples of best practice. During consultation the document was shared with practitioners, non-statutory organisations, policy makers and commissioners from the agencies of health, social care, education and justice across the five jurisdictions.

The guidance is designed to be a support for service development that is based on assessment of need. It emphasises that local factors should be taken into account, including deprivation indices, the numbers of Black children and those from minority ethnic groups, and whether the area is rural or urban.

For Tier 2/3 CAMHS, an epidemiologically needs-based service for 0- to 16-year-olds requires a minimum of 20 whole-time equivalent (wte) clinicians per 100 000 total population. Teams must have a range of clinical professionals with cognitive, behavioural, psychodynamic, systemic and medical psychiatric skills. Team capacity should be set at 40 new referrals per wte per year. Clinician keyworker case-load should average at 40 cases per wte across the service, varying according to the type of cases held and the other responsibilities of the clinician. Specialist CAMHS work with Tier 1 professionals is best provided by dedicated primary mental health workers working as a team and closely linked to Tier 2/3 CAMHS. Matching demand and capacity is essential to ensure effective service provision.

Recommendations for the remit and staffing of Tier 4 services are given, including specialist community intensive treatment services, day services and in-patient services. It is recommended that 20–40 in-patient CAMHS beds per 1 million total population are required to provide for children and adolescents up to the age of 18 years with severe mental health problems, and that bed occupancy should be 85% to ensure availability of emergency beds.

The authors did not find sufficient evidence to provide recommendations for staffing levels for CAMHS for 16- to 18-year-olds, but argue that significant extra resources are needed to extend services to include this age-group. There was a paucity of evidence on infant mental health services and mental health services for children and adolescents with learning disability, substance misuse and forensic problems. However, the mental health needs of these groups must be met and should be provided by specialist CAMHS.

This document is recommended to anyone who is struggling to answer the questions, 'what should specialist CAMHS be doing and how many people do they need to do it?'

Role of the consultant psychiatrist in psychotherapy

Council Report CR139, May 2006, Royal College of Psychiatrists, £5.00, 15 pp

This report reviews the range of roles and responsibilities that are undertaken by consultant psychiatrists in psychotherapy. It sets out three core principles.

- Consultant psychiatrists in psychotherapy have a range of roles.
- Consultant psychiatrists in psychotherapy bring to multidisciplinary teams the knowledge, responsibility and ethos associated with the medical profession.
- Consultant psychiatrists in psychotherapy bring specific psychotherapeutic expertise to multidisciplinary teams.

In clinical work these principles mean that consultant psychiatrists in psychotherapy assess and manage complex cases, deal with issues of risk and take special responsibility for patients with a combination of medical and

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