agency in Liverpool received £300 000 (Hunt, 1995).

We have no doubt that this money was thoroughly deserved and will be spent wisely on improving and delivering services to those with drug problems. However, we are concerned that such large grants may cause an imbalance in the provision of services when not part of an overall local strategy. The position of agencies which do not receive such sums may be undermined by not having these resources available to them.

Most areas will expect agencies to adhere to any strategy negotiated locally (Liverpool Health Authority, 1995), but funds that bypass the normal funding mechanisms can undermine this strategy. Applications for funding would normally have to submit bids to health purchasers (or joint commissioning consortia if social services are involved) and these would have to satisfy criteria on effectiveness, outcomes and quality.

Self-interest groups with no need to comply with these regulations can proselytise their service, justifying their own agenda to win funds, whereas statutory services will be committed to the public health agenda. Lottery Commissions may be unaware of the wider implications and are unwittingly encouraging perverse incentives. They will never be allowed to fund mainstream statutory health services, possibly to the detriment of professional care and to those who are committed to the public health agenda.

The new Drug Action Teams (1995) will have to be aware that any decisions they make on the way services should be formed or purchased may be contrary to the initiatives supported by the Lottery Commission. Other health disciplines should be aware they may face similar problems.

DRUG ACTION TEAMS (1995) *Tackling Drugs Together: A Strategy for England 1995*. CM 2846. London: HMSO.

HUNT, A. (1995) Charity numbers come up. *Liverpool Echo*, 20 November, 15.

LIVERPOOL HEALTH AUTHORITY (1995) *Strategy: Substance Misuse*. Liverpool: Annual Public Health Report.

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Certificate of Completion of Specialist Training (CCST): implications for higher training in psychiatry

Sir: There are a number of concerns regarding the implementation of the recommendations of the Calman Report which are germane to psychiatry. The Royal College of Psychiatrists proposes to award CCSTs after a total of three years of higher professional training, with a minimum of two years in a chosen speciality. Our understanding is that individuals training in specialities (old age, forensic, etc) will only be granted a CCST in that speciality. For a trainee to be awarded a CCST in both general adult psychiatry and a speciality will require a minimum of four years' training (two years in general adult psychiatry and two years in a speciality). Dual accreditation is highly desirable. The approach to provision of psychiatric services by Trusts is liable to change, and clinicians in specialities may be required to undertake work in general adult psychiatry in the future. Furthermore, participation in 'on call' rotas which cover general adult psychiatry may also require accreditation as a general psychiatrist. The consequence of this is that the length of training for disciplines other than general adult psychiatry has been increased, contrary to one of the principles underpinning the Calman Report. This is ironic given the dearth of suitably qualified applicants in some psychiatric specialities, for example old age psychiatry. In addition, any doctors training in the UK wishing to practise elsewhere in the EU may not be able to do so without CCST in general psychiatry as many EU counties may not recognise accreditation in some specialities.

The situation in the rest of Europe is very different. The Calman exercise took place in order to bring the length of specialist training in the UK into line with the rest of Europe. Despite this, considerable inequality remains. According to the College (Collegiate Trainees' Committee, 1995), the award of a CCST, whether granted in the UK or other countries in the European economic area will bring automatic inclusion in the new Specialist List. In many EU countries individuals will obtain CCST or its equivalent after just four years' postgraduate training. Under these circumstances they will be included in the Specialist List held by the General Medical Council (GMC) and hence be eligible for consultant posts in the UK.

COLLEGIATE TRAINEES' COMMITTEE (1995) Collegiate Trainees' Committee position on structural training. *Psychiatric Bulletin*, **19**, 455–458.

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JAMES P. WARNER
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Sir: Unfortunately Drs Cervilla and Warner have not portrayed the College's proposals concerning the award of the CCST in the psychiatric specialities accurately.

In each of the recognised specialities (child and adolescent psychiatry, forensic psychiatry, general psychiatry, the psychiatry of learning disability, psychiatry of old age and psychotherapy),

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the structured training programme published by the College and the Joint Committee on Higher Psychiatric Training (JCHPT) is of three years in length. This is in contrast to the current situation where the JCHPT states that for each psychiatric speciality higher training is "at least three years in duration, and desirably four years".

Drs Cervilla and Warner refer to "the minimum of two years in a chosen speciality". This relates to the fact that in most psychiatric specialities a year's higher training in one of the other specialities is a recognised part of the programme, e.g. in general psychiatry for those specialising in old age psychiatry.

While agreeing that dual accreditation is highly desirable, and that the approach to the provision of psychiatric services by Trusts is liable to change, I do not know what the evidence is for the statement "clinicians in specialities may be required to undertake work in general adult psychiatry in the future".

It is not the case that "participation in 'on-call' rotas which cover adult psychiatry will also require accreditation as a general psychiatrist". I have clarified this issue with the officers and officials of the GMC and have been assured that the specialist list will be indicative in the sense that it will show the completed specialist training undertaken by an individual, but not that he or she is not competent to provide cover in related areas of medical practice.

The length of training for the psychiatric specialities other than general psychiatry has not been increased as I have indicated above. A specialist in the psychiatry of old age will be eligible to apply for consultant posts in that speciality upon receipt of a CCST in it after three years' higher training, just as they can at the moment.

In relation to the point that is made about doctors who wish to practise elsewhere in the European Union (EU) than in the UK, it is true that many EU countries do not recognise some of the specialities of psychiatry which are recognised in the UK. It is important to point out that a CCST in a speciality is not an absolute requirement for approval to practise in another EU country but more importantly each sovereign state of the EU is able under European law to decide which specialities of medicine (and therefore of psychiatry) it wishes to train doctors in for practice at home.

It is not accurate to say that "the Calman exercise took place in order to bring the length of specialist training in the UK into line with the rest of Europe". Dr Calman's initiative in relation to specialist postgraduate medical training related to the threat of infraction proceedings against the UK government as some Colleges were issuing certificates of 'completed' specialist training for the EU after a shorter period of higher training than 'accreditation' required for eligibility for consultant practice in the UK. Again it is important to state that the length of specialist training stipulated for practice in an individual country is a matter for that sovereign state.

It is gratifying that in discussions on the European Board of Psychiatry (of which I am the Secretary), which is accountable to the Mono-specialist Section for Psychiatry of the UEMS, most other European countries are striving to lengthen their training to bring it in line with the UK and Ireland.

It is true that some European countries currently award CCSTs or their equivalent after four to five years' postgraduate training. Such individuals will be eligible for consultant posts in the UK. However, it is important to point out that there is a difference between eligibility and appointability as employers will wish to be assured that applicants are fluent in English and have appropriate expertise and competence, e.g. in legal aspects of psychiatric practice such as Section 12 Approval to undertake the responsibilities of a particular post.

I trust that my counter-arguments to Drs Cervilla and Warner's letter are clear. The administrative officer of the College responsible for our implementation of Dr Calman's recommendations is Suzanna Gray and I hope that any Member, Fellow or inceptor of the College who is not clear about the arrangements that are being put in place will contact her so that accurate information about particular situations can be promulgated.

FIONA CALDICOTT
President, The Royal College of Psychiatrists

Psychiatrists' complementary skills

Sir: Dr S. Timimi questions "whether research among trainees is desirable" (*Psychiatric Bulletin*, November 1995, **19**, 707), but then suggests that he has an unusual understanding of scientific principles and of 'psychiatry's scientific framework'.

Dr Timimi believes that "psychiatry's scientific framework and categorical validity rests on an idea of common consensus, as opposed to discretely measurable phenomena". He appears to be confusing our (currently) syndromal systems of classification with the evidence upon which practice in psychiatry is based. The latter has become far more objective over recent years, with its emphasis on rigorous research methodology and more objective measuring tools, with stated validity and reliability. He suggests that more importance should be given to "developing theoretical understandings that allow the trainee to question and criticise the scientific assumptions made by researchers". The whole point of scientific research is that assumptions are

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