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Sir: We thank Dr Benbow for her comments. We agree that the Freeman & Cheshire study did not reveal strong antipathy towards ECT, but other studies (Selvin, 1987; Durham, 1989) discuss the controversies regarding its use. We have personal experience of strong negative opinions expressed by both professional colleagues and others. Combined with views expressed in the media, which must represent the views of a proportion of the population, we feel that we were justified in using the phrase "widely seen". We are aware of the anecdotal nature of some of this evidence.

Our suggestions regarding the use of other formats to aid explanation of the ECT process were not based on personal experience. We would suggest that further work, looking at the efficacy of these methods, would be invaluable.

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Training in administration of ECT

Sir: A similar survey to Dr Henderson's on ECT (*Psychiatric Bulletin*, 1993, **17**, 154-155) was carried out among psychiatrists of East Berkshire, using an anonymous, self-completed questionnaire. Numbers involved were small but may be of some interest as they compared experiences of present trainees with more senior colleagues.

Questionnaires were sent to all psychiatrists in East Berkshire: seven 'trainees' (t) and 13 'others' (o) (consultants, associate specialists, clinical assistants). All trainees and eight others replied. Average time in training was 103 weeks for trainees and 19 years for others. Thus most others received their training before Pillard & Ellam's original survey of 1981. Questions were asked about points considered to be good practice in training to administer ECT. Respondents

who were no longer trainees were asked to reply with respect to their original training.

Initial questions concerned consultant cover of the ECT department. Three (t) and four (o) knew that there was a consultant responsible for training juniors. No trainees and two others recalled seeing the nominated consultant in the department regularly. Three (t) but all others knew of an allocated person with whom they could discuss problems concerning ECT.

Two (t) and three (o) had received an initial seminar prior to administering ECT. Three (t) and three (o) had the nominated consultant or his deputy present during the initial ECT session, while five (t) and five (o) had ECT demonstrated by a more senior trainee. The number of sessions observed before administering ECT alone varied. Four (t) and three (o) had observed one session, while one of each group had observed more than one.

The study was carried out as part of an audit of ECT in our department. Concern was voiced that trainees' perception of training did not match that of the senior staff who felt that there was a consultant in charge of ECT who made a point of training juniors. The other findings were not challenged. These findings suggest that over the last 10-15 years there has been no great change in the level of training received. In most areas the 'others' did as well as or better than the 'trainees'.

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Care programme approach in Shropshire district

Sir: We would like to report our findings from a study undertaken 16 months following the inception of care programme approach (CPA) in Shropshire district. Professionals involved in the initiation and present workings of the CPA were interviewed.

The Planning and Information Department's role to monitor information, and thereby look for needs and changes for future service requirements, were not wholly met. Computer listing of allocated patients was not sent to the relevant keyworkers. This lead to lack of vital communication. The sheer volume of forms (20,000 a year) was too great to process with available resources and was regarded as yet another exercise in bureaucracy and red tape unlikely to effect change in clinical practice.

The community psychiatric nursing services (CPNS) were aware of their obligation to the CPA and felt it was a realistic objective despite

its present unsatisfactory performance. Lack of community psychiatric nurses (CPNs), poor education and information regarding the CPA, confusion with Section 117 of the Mental Health Act 1983, lack of co-operation in inter-professional working and poor communication were the reasons given. The decision of keyworker status for CPNs continues to be synonymous with the "administration of depot anti-psychotic medication" so their other skills were not brought to bear fruit and their morale and interest lessened.

In contrast, the approved social workers (ASWs) and their manager felt they were given a keyworker status beyond "social work boundaries". They refused to accept this status, tending to categorise their skills. They agreed with the ethos and philosophy of the CPA which increased their awareness of lack of basic resources, ranging from sheltered accommodation to transport. Allocation of key-worker status to ASWs was frequently done in their absence, resulting in lack of communication and, in some instances, inappropriate allocation. Problems of inter-agency workings, understanding and co-operation were identified. These reflected conflict of different philosophical and cultural values.

CPA was perceived by consultant psychiatrists as almost insurmountable, even before the process of implementation. No change in clinical practice was observed. Several patients discharged from hospital or seen in other clinical settings were not assigned to a CPA, as there was a constant tendency to forget! Junior medical staff were not aware of the local CPA policy. The CPA was delayed or not discussed during multidisciplinary team meetings.

Staff nurses and ward clerks were diligent in completing the paperwork, not realising its importance. They expressed frustration that CPA was not instituted for a large number of patients. Patients and carers were not aware of the CPA despite their attendance at discharge plan meetings. When aware, they did not realise that such a system is a statutory policy within the provider-purchaser system.

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Community mental health care programme in Pakistan: new perspectives

Sir: The organisation of mental health services in Pakistan is still at an elementary level and the care and management of the mentally ill is mostly provided in hospitals located in big cities. As most of the population live in rural areas and do not have easy access to these facilities, they turn naturally to spiritual and quasi-medical forms of treatment.

With the changing emphasis towards primary care in world psychiatry, mental health professionals in Pakistan have also started thinking about changing existing mental health care systems. It was in this context that plans were made to decentralise mental health services and to integrate and collaborate with primary health care facilities, intending to make psychiatric services more acceptable and feasible at all levels. Basic health units and rural health centres have been chosen for provision of mental health care facilities and various programmes have been started by different departments of psychiatry in the country (Pakistan Psychiatric Society, 1988).

The Department of Psychiatry, King Edward Medical College, Lahore is contributing to these. A team comprising a psychiatrist, senior medical officer and a psychiatric social worker visits a rural health centre about 30 kilometres from the city of Lahore once a week. The team provides diagnostic, assessment and treatment facilities to those who attend the centre but also serves as a satellite clinic for admission and referrals to the nearest teaching hospital as need arises.

The experience of this service has shown very promising results to date. Comparison of this facility with existing psychiatric services in a general teaching hospital and a nearby mental hospital revealed that patients referred to these clinics were younger and had shorter duration of psychiatric illness than those in hospitals (Javed & Tareen, 1992). Similarly the diagnostic profiles of these patients hospital groups also showed that more cases of minor psychiatric illness were seen at rural health centres.

Like other reports, these findings appear to confirm the need for psychiatric services at the community level. There is no doubt that mental illnesses do exist in rural areas but the delays and difficulties in detection and diagnosis of psychiatric patients make the situation more complex. The results of 100 consecutive referrals to each of rural health centres, teaching hospitals, and mental hospitals showed that those coming to rural health centres were younger (mean 28.8) compared with 30.1 and 31.3, had shorter duration of illness (30.6 months) compared with 41.9 and 36.1 months and had a greater proportion with mood (30%) and neurotic disorders (31%) compared with 21% and 18% for mood disorder and 18% and 7% for neurotic disorder in two hospital groups.

Our results encourage the opening of similar facilities and strengthen the view that there is no need to open new big mental hospitals. Efforts should be made to create small units in the periphery and outreach mental health care programmes should be incorporated in the existing mental health care facilities (Hanfer, 1987).

Although treating mentally ill patients in the community has emerged as a major policy