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**Should psychiatrists support CPA guidelines and routine outcome measurements?**

Sir: Dr Paul Lelliott, Director of the Royal College's Research Unit, exhorts us to look favourably upon CPA clinical guidelines and routine outcome measurements (*Psychiatric Bulletin*, January 1997, **21**, 1-2). The case he makes in support for CPA, however, is rife with internal inconsistencies.

He tells us that "psychiatrists should be working to develop guidelines which incorporate the evidence for, and therefore justify, what are often expensive and protracted interventions". He then tells us that CPA was introduced as a result of "apparent failures of community care" and goes on to suggest that a poll of lay people would no doubt indicate strong support for the principles underlying CPA. The next section of his article tells us that practice guidelines should "incorporate evidence from recent and systematic reviews".

CPA has been introduced without evidence of its effectiveness and, now that it has been introduced wholesale across the country, it is very difficult to assess whether or not it is helpful. At the time of its inception, an opportunity was missed to allocate patients randomly to CPA or no CPA and to assess psychiatric and social outcome. The Royal College's Research Unit might have been ideally situated to coordinate such a project.

It is quite possible that outcome measures and clinical guidelines will lead us towards practising evidence based medicine. CPA, on the other hand, is time-consuming "hunch based medicine".

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**Politics of psychiatry**

Sir: It is my impression that psychiatrists are not asserting themselves in medico-politics to the extent that their numbers would justify. We recently lost Mental Health Officer status for new entrants into the speciality with remarkably little complaint, and with what complaint there was being wholly ignored by the British Medical Association. At present the British Medical Association seems to be considering requesting an abolition of the 10% private practice earnings rule for those on full-time contracts. The alternatives proposed seem to be a reduction in sessions for all contracts to 10 sessions, which would mean a pay cut for those presently on 11 sessions, or an increase in sessions to those presently on a maximum part-time contract. It is quite clear which option managers and politicians would choose, and it is also quite clear that both options would disadvantage those consultants on whole time contracts. It is my impression that the majority of psychiatrists are on whole time contracts. Again, therefore, it would seem that the BMA is acting in a way prejudicial to our speciality's best interests. We should assert ourselves, question the proposals, and probably oppose them.

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