to compare 'rich' and 'poor' countries, why are Japan and other South East Asian countries included and Latin American countries excluded? Such a category cannot impart meaningful information.

Starting from this grave category error, the result is an article full of content errors. Lack of affective expression may be true in Japanese culture but is not true of Middle Eastern culture. Many traditional Asian medical systems fully recognise the link between mind and body. Bullying may be a problem in some schools, but certainly not more so than in the West. Suicide rates in the young are as variable between Afro–Asian countries as they are in the West. Parents not listening to children is not a consequence of culture and can happen in any culture.

SAMMI TIMIMI, *Department of Psychological Medicine, Great Ormond Street Hospital, London WC1N 3JH*

Author's reply: The article was an attempt to record the observations and anxieties about some of the pressures that were brought to my attention by colleagues in mental health, paediatricians and educationalists in the course of overseas attachments since 1978. The article is unscientific and my first hand experience of children under these pressures is very limited. It was the recurrence of the theme in India, Pakistan and Thailand in particular that moved me to write.

Dr Timimi infers that I (or my subconscious) believe that Western parents know how to do all the right things by their children. I would point out that I allude to pressurising in worldwide and British contexts in the first paragraph. Dr Timimi is wrong in suggesting that I invoke Western child psychiatry to solve this problem. All the ideas I mention are from the recommendations of the 1978 WHO report *Child Mental Health and Psychosocial Development*. This excellent document is antipathetic to expensive Western style child psychiatric services and favours the development of basic mental health skills and primary care levels.

Thirteen years ago I wrote in the *Indian Journal of Psychiatry* that "the adoption of Western child psychiatric practices will need to be watched very carefully. Child Psychiatry must be related to society and culture – possibly more so than in any other specialism". I still hold this view.

LESLIE BARTLET, *Paediatric Department, Southampton General Hospital, Southampton SO16 6YD*

## Procedures for Election to the Fellowship of the Royal College of Physicians of London

Sir: I am writing to correct a statement regarding the mode of election to the Fellowship of the Royal College of Physicians of London. In his recent article in the *Psychiatric Bulletin* (1996, **20**, 185–187) your Registrar indicated that election to our Fellowship was 'almost an automatic entitlement'. This is not the case. Although all Physicians working in England and Wales who have been in a Consultant post for three years or more are automatically considered, they are by no means automatically elected; indeed the overall success rate, which includes this group as well as Members who are not Physicians or work in other countries, runs at approximately 50%. In order to be elected, a candidate has to satisfy one or more defined criteria in addition to the 'good standing and reasonable seniority' suggested in your article. We regard our Fellowship as a mark of distinction, as indeed it is so described in our Bye-laws. I hope that this brief explanation will clarify the situation for your readers.

DAVID LONDON, *Registrar, Royal College of Physicians, 11 St Andrews Place, London NW1 4LE*

## Parole board guidelines

Sir: I refer to the article "Parole board guidelines" in The College section of the May 1996 issue of *Psychiatric Bulletin* (**20**, 315–316). I decided to put these guidelines into practice recently when preparing a report on a life sentence prisoner. When the typed report came back for signature the Senior Medical Officer of the prison pointed out that the report did not conform to the official guidelines and so he had inserted headings at intervals through the report in order to make my report match his guidelines. He gave me a copy of the headings which are required to be used in reports and they are as follows:

(1) knowledge of the prisoner – including your qualifications
(2) attitude to the offence
(3) insight into offence related behavioural problem
(4) behaviour in prison
(5) external support
(6) assessment of suitability for release
(7) any other comments
(8) assessment for Grendon.

Furthermore, he showed me a memorandum from the "Lifer Liaison Officer" which indicated: "any reports submitted which do not comply with the standard format as indicated in Annexe C will



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be returned to the author WITHOUT EXCEPTION".

I have looked at the two sets of guidelines and obviously there is some overlap but I am left with the feeling that the left hand does not know what the right hand is doing!

KEITH J. B. RIX, *Consultant Psychiatrist, Leeds Community & Mental Health Services, Ilkley, West Yorkshire LS29 6AQ*

## Driving and dementia: DVLA guidelines?

Sir: Paul Thompson and Deborah Nelson (*Psychiatric Bulletin*, June 1996, **20**, 323–325) report their questionnaire survey of psychiatrists' knowledge of DVLA regulations. They state that in early dementia "driving is permitted if no significant disorientation and insight and judgment are retained". This is a quotation from the literature, forming part of a discussion in *Medical Aspects of Fitness to Drive* (Taylor, 1995), but is by no means a clear guideline. There is no clear relationship between the degree of dementia and driving ability, nor is psychometric testing particularly helpful (Friedland, 1988).

It seems at the moment that the best ways of assessing fitness to drive in dementia are a combination of history of driving ability from the patient and caregiver, and in uncertain cases on-road or off-road driving tests (Odenheimer, 1993). There is also the possibility of a driving simulator test, although this is not routinely used in this country.

FRIEDLAND, R. P. (1988) Motor Vehicle Crashes in Dementia of the Alzheimer Type. *Annals of Neurology*, **24**, 782–786.

ODENHEIMER, G. L. (1993) Dementia and the older driver. *Clinics in Geriatric Medicine*, **9**(2), 349–364.

TAYLOR, J. F. (ed.) (1995) *Medical Aspects of Fitness to Drive*. London: The Medical Commission on Accident Prevention.

WALTER BOUMAN and HAZEL JOHNSON, *Department of Health Care of the Elderly, Queen's Medical Centre, Nottingham NG7 2UH*

## Care Programme Approach (CPA) in the community

Sir: We were interested to read the correspondence from Mark Evans and his colleagues on the CPA (*Psychiatric Bulletin*, July 1996, **20**, 444–445). We have recently conducted a survey of members of staff about their opinions on the benefits and problems associated with CPA implementation. Our survey indicated that many staff were experiencing severe logistical difficulties with the Care Programme Approach. Ninety-three per cent of the sample ($n$=45) agreed that administrative tasks, such as arranging and attending meetings and completing documentation, were putting extra demands on their time, to the degree that it decreased their contact with patients. The reason for this appeared to be the policy of assessing and recording the needs of every patient within a large Trust, currently having over 9000 contacts each year. It seemed to us that attention was being paid to the bureaucratic external manifestations of the CPA for all patients, to the detriment of improving service provision for those in most need.

The demands made on professionals by CPA administrative tasks are impractical. For example, discussion of CPA generated matters added 110 minutes to a multidisciplinary meeting involving 14 professionals, some of whom had cancelled ward rounds and home visits to be there. Thus, in one day 25.7 hours of time had been effectively lost to patient care.

In our view, given the limited resources and manpower available, care programming must be effectively targeted at the most vulnerable patients. The ideal of always tailoring care to the needs of every individual patient, while laudable, may not always be realistically achieved.

CLAIRE EASTON and FEMI OYEBODE, *South Birmingham Mental Health NHS Trust, Research and Development Unit, Edgbaston B15 2QZ*

## Supervision registers

Sir: I read with interest Mr Vaughan's survey of the application of the supervision register in four Regional Health Authorities (*Psychiatric Bulletin*, March 1996, **20**, 143–145). I have also addressed the question of how the Health Service Guidelines concerning supervision registers have been implemented by auditing the register of one Trust. This revealed similar findings to Vaughan's study – a register "absorbed organisationally but less accepted professionally".

The Trust in which I conducted the audit serves a catchment area of 100 000 people. There are three consultant psychiatrists. The supervision register was implemented in accordance with the Health Service Guidelines on 1 October 1994. In May 1995, 12 patients were registered – one 54-year-old woman and 11 men, six of whom were in their forties. Six of the patients had a diagnosis of schizophrenia, two had a diagnosis of affective disorder and two had a diagnosis of alcohol abuse or dependency. Seven had been detained under the Mental Health Act 1983 at the time of inclusion on the register. For each patient the reason for inclusion on the register was clearly documented – significant risk of suicide, serious harm to others and/or risk of serious self-neglect.