TABLE I
Comparison of allocation into groups by the two methods of analysis

		Neural network	
		Depressed	*Not depressed*
Discriminant function	Depressed	3	3
	Not depressed	0	12

McNemar's Test (Binomial 2 tailed test) $n = 18$ $P = 0{\cdot}25$.

the discriminant function allocated the 18 test cases between the two groups (i.e. agreement between prediction of group membership).

It is clear therefore that this neural network compares favourably with a well established method of case assignment, namely discriminant analysis.

In developing 'Expert Systems' to aid clinical diagnosis and decision making, the technology of pattern recognition used by neural networks is intrinsically suited to the clinical process. This is in contrast to earlier attempts to implement rule-based logical systems which, apart from a few specialised applications, have not lived up to their initial promise. The use of neural network technology and its application to a wide variety of clinical problems merits further study.

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Reference

LUCAS, C. P., RIGBY, J. C. & LUCAS, S. B. (1989) The occurrence of depression following mania – a method of predicting vulnerable cases. *British Journal of Psychiatry*, **154**, 705–708.

Difficulties facing post MRCPsych registrars

DEAR SIRS

I would like to report the findings of a CTC working party which was set up to look at the difficulties facing post MRCPsych registrars. The initial difficulty that faced the working party was in identifying the 'pool' of these registrars. No adequate details of numbers were available. A recent survey (Bhate, to be published) did suggest that out of a total of 1034 registrars (for whom information was available) 26 were still registrars after eight years in psychiatry.

Following a letter in the *Psychiatric Bulletin*, eight post MRCPsych registrars agreed to answer a few questions on their experiences. Half had been 18 months post MRCPsych and the rest for a longer period. The number of jobs applied for varied from 3–60 and the times respondents had been shortlisted varied from none to eight. All were advised to "do some research – any research"; "publish something – anything!". The tutors had been instrumental in giving career advice. Three of the registrars were working as locum consultants.

The working party would like to make the following recommendations:

(a) An inbuilt mechanism ought to be created to look at the actual numbers of post MRCPsych registrars.
(b) Appointments at SR levels should be monitored and suitable advice available to the unsuccessful candidates.
(c) The College through the Tutors' Committee or Education Committee could take on the task of advising such registrars on presentation, interview techniques and skills.
(d) Closer links with teaching and nonteaching hospitals, easy access to research supervisors and an increase in research training either through the College or The Regional Health Authorities (RHAs) should be encouraged.
(e) Regional advisers could be asked to monitor the numbers of post MRCPsych registrars in various regions.
(f) The time table of such registrars should reflect their status and each case could be assessed on an individual basis for the possibility of accreditation in deserving cases.

The members of the working party were Drs D. Double, S. Griffin and O. Junaid.

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Registrar training

DEAR SIRS

I would like to make some comments in support of Drs Haigh & Wear's article in Trainees' Forum (*Psychiatric Bulletin*, October 1989, **13**, 556–557) entitled 'Training for An Uncertain Future'. Specifically, they were presenting some suggestions for change in registrar training, especially including some time as a general practice trainee.

Following my psychiatric training at Maindiff Court and Pen-y-fal Hospitals in the mid-seventies under the auspices of the University of Wales, I spent ten months as a GP trainee attached to a rural practice centred on Abergavenny. This experience

certainly increased my general medical knowledge, while giving a more realistic cross-section of psychiatric illnesses. The GPs were pleased to have a physician with a psychiatric background, and referred a large number of their patients to me. Consequently, the percentage of "straightforward, successful" treatments was considerably higher than the more difficult cases who tended to become psychiatric out-patients or in-patients. I was also able to impart some of my clinical skills to my colleagues.

For myself, I acquired a different perspective and a considerable amount of useful experience which has been very helpful when coordinating treatment with other specialists. I am currently employed in a health maintenance organisation of managed medical care, Group Health, and as a geriatric specialist with the local community mental health centre in Kitsap County, Washington State. Both these positions are out-patient oriented, with minimal hospitalisation, and my background in general practice has been very helpful. By way of comparison, some of my American psychiatric colleagues have much greater experience in training in the psychotherapies, but sometimes this was at the expense of general medical experience. Eventually, one hopes, a satisfactory blend of training will be achieved for most general psychiatrists, with additional training in specialised areas.

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Health Service staffing in child and adolescent psychiatry

DEAR SIRS

In 1987 the North East Thames Child and Adolescent Psychiatrists Committee began to collect data on manpower within Child and Adolescent Psychiatric Departments and Child Guidance Clinics within the region to look at the levels of staffing and trends. There was a great deal of concern about the gradual erosion of staff from the service at a time of increasing demand on the specialty. Dr Black's paper on consultant manpower in the region (*Psychiatric Bulletin*, January 1989, **13**, 32–35) outlines areas of particular increased demand, e.g. child sexual abuse, effects of marital breakdown, forensic work, liaison services, drug abuse, child care proceedings, etc.

At the same time changes have taken place in the organisation of other disciplines which in the past had a major role in service provision within child and adolescent psychiatry or child guidance. Educational Psychologists are now almost exclusively employed within the School Psychological Service with a resultant loss of their clinical time. The loss of the Psychiatric Social Worker and the frequent employment of generically trained social workers under direct social services management being placed in clinics has meant a change in the nature of their input. In many instances posts have been lost, for example in West Essex four out of six posts. There has been no corresponding increase in manpower provision by the Health Service whose contribution has remained largely static, at least since 1984, the earliest year for which I have figures. In December 1988 there was an establishment of 36 consultant posts for the region, population 3·75 million (one post per 140,000 population). There were seven WTE consultant posts vacant for over four months, some as long as two years. In one district a locum has been in post for 14 years. One of the Regional Adolescent In-patient units is closed; there is no alternative provision in the interim until it reopens. This has resulted in the loss of 20 beds and staff.

Only 10 out of 16 districts have any junior staff. Of these, only three have both senior registrar and registrar, two a senior registrar only, four a registrar only and six neither.

There is very little manpower to support the consultant sessions. The next largest group of professionals in this region are child psychotherapists (27.2 whole time equivalents) who may or may not be organised in the district to work together with the consultant. Regionally there are also 1.5 WTE clinical assistants, 2.4 WTE clinical psychologists, 7 CPNs, 26.5 nurses and 11.3 administrative staff. (These figures do not include services provided by two Special Hospital Authorities geographically located within the Region.)

This is a specialty struggling to meet an increasing demand on its time with decreased resources, making an increasing burden on fewer staff. Given that 10–20% of children suffer from psychiatric disturbance depending on whether they live in rural or inner-city areas, the resources compare very poorly with those available for adult mentally ill or physically ill children.

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Local Government Finance Act, 1988 –mental impairment and poll tax

DEAR SIRS

Most general practitioners and psychiatrists are, sooner or later, going to be confronted with the dilemma of certifying someone as suffering from severe mental impairment at the request of Community Charges Registration Officer in respect of a person who is seeking exemption from liability to