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correspondence

'Confused messages'

The issue of whether drug treatment services are providing methadone maintenance in line with the available evidence is an important one. However, the survey by Joseph & Moselhy (*Psychiatric Bulletin*, December 2005, **29**, 459–461) requires further clarification in order to contribute to the debate. In Table 1 they classify services as either 'Community drug teams' or 'Addiction treatment units'. In the discussion they imply that the latter are in fact non-statutory agencies. The discussion also implies that the only community-based services are the community drug teams. It would seem likely that the majority of the services are community based, both statutory and non-statutory, since the 'move towards' community-based treatment in fact goes back 20 years (Advisory Council on the Misuse of Drugs, 1982). The discussion mistakenly states that the Home Office (2000) document *Reducing Drug Related Deaths* advises against the prescribing of controlled drugs to drug users. The next sentence does refer to tablets and ampoules in this context but the reader could be left confused.

The notion of 'opiophobia' is interesting. Reasons which would explain practice by doctors that is out of step with the evidence include lack of awareness of the evidence, philosophical disagreement despite the evidence, and a lack of access to supervision of methadone consumption. In some cases there can be cause for reasonable clinical caution, for example in cases of polysubstance misuse. For patients, possible reasons for opiophobia include lack of awareness and fear of the criticism of family members or childcare agencies of doses perceived as 'high'. Impending incarceration in prison, where effective detoxification from doses of methadone towards the upper end of the dose range may not be available, may also make patients resistant to effective treatment. This is certainly a topic that would benefit from further audit, intervention and re-audit.

ADVISORY COUNCIL ON THE MISUSE OF DRUGS. (1982) *Aids and Drug Misuse Part 1*. London: TSO (Stationery Office).

HOME OFFICE (2000) *Reducing Drug Related Deaths*, p. 72. London: TSO (Stationery Office).

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Is flexible training still an attractive alternative?

As mothers of young children, our decision to train flexibly was made to enable us to achieve an optimal work/home balance. Overall, it has been a favourable experience, although we have encountered some difficulties. The West Midlands training scheme is efficient and encouraging, our consultants are supportive and our peers are understanding. This is in contrast to the situation in other medical specialties, and it is encouraging to report that psychiatry is one of the most accommodating.

However, as flexible trainees we often experience problems with staff in the personnel and finance departments caused by their perceived increase in paper work as a result of flexible training. A recurring complaint from the majority of flexible trainees is the failure of the finance department to pay them the correct wages. This problem has escalated owing to the new pay deal for flexible trainees which does not seem to have been communicated clearly to the personnel and finance departments. There seems to be no alternative than to enter into prolonged and time-consuming discussion with staff in these departments and it can take many months to resolve the situation. Unfortunately we have also discovered that our pensions have been incorrectly calculated. This has caused one of us so much stress that she has chosen to return to full-time training.

At a time of uncertainty for trainees, our hope is that serious thought continues to be given to making flexible training an attractive alternative for those who would otherwise not return to training. Competency-based assessment should suit flexible trainees who often work efficiently in fewer hours. However, improved communication between the deanery and staff in the personnel and finance departments would help to alleviate some of the financial problems encountered.

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Dearth of consultant psychiatrists applying to become Mental Health Act Commissioners

According to the Mental Health Act Commission's *Eighth Biennial Report* (which covers the period 1997–99) there were 150 Commissioners, 25 of whom were psychiatrists. In 2004 the Commission was restructured so that the number of Commissioners was reduced from 180 to 100. The duties of the Commissioners were altered and this was reflected in the new job descriptions for the Local Commissioners and the Area Commissioners.

We are two of only three psychiatrists who were reappointed at the time of this reconfiguration. Chris Heginbotham, the Chief Executive of the Mental Health Act Commission, has told us of his disappointment that so few psychiatrists applied. This dearth of psychiatrists is a great pity as the Commission's role is to safeguard the interests of all people detained under the Mental Health Act 1983 and to keep under review the exercise of the powers and duties contained in this Act.

We do not know why so few psychiatrists applied for the posts of Mental Health Act Commissioners. It may be that doctors employed full time on the new consultant contract find this external commitment difficult to negotiate with their trusts. However, we would strongly recommend that Members of the College apply to become members of the Commission.

MENTAL HEALTH ACT COMMISSION (1999) *The Mental Health Act Commission, Eighth Biennial Report 1997–1999*. London: TSO (Stationery Office).

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columns

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MRCPsych examination – too expensive?

Few topics will engage senior house officers (SHOs) in such animated discussions as the MRCPsych exams. I read with interest the comments made by Dr Finlayson regarding the high pass mark for the MRCPsych part I exam (*Psychiatric Bulletin*, January 2006, **30**, 35). Although I found the exam stressful, the standard was comparable to that of the last 10 years (part of the exam preparation involves working through past papers).

The 'horror' is the cost of the exams given that under the new European Working Time Directive most SHOs have seen their salaries shrink over the last 2 years. The added cost of exam-orientated courses run by private companies and books has made this truly expensive. Long gone are the days when Band 3 SHOs could afford all these.

I understand that to maintain high standards and quality the College needs to spend accordingly. The problem is that the MRCPsych courses run by universities are not sufficiently focused. This inevitably means having to pay for a course that runs the total cost way beyond £1000 per exam. With this kind of pressure a lot of SHOs can't afford to fail.

I am already dreading my part II exam – not because of the standard of the exam but I don't know how I will be able to pay the £593 cost on a 1B salary. With the modernising process underway, is the MRCPsych going to be a 'luxury' that future SHOs will not be able to afford?

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the college

Revised College procedures for ACCEA nominations for England and Wales

The main change proposed is to bring the College procedures for the English and Welsh nominations forward so that the nomination process begins in June rather than in November/December as at present.

The Chairman of the Advisory Committee on Clinical Excellence Awards (ACCEA) has asked the President to ensure that in future the Divisions play a far greater central role in the nomination for awards. It is therefore suggested that the Faculties and Sections begin the College process by preparing their ranked lists in June. They will send these to the Divisions who will refer to them in their nomination process. This should greatly improve communication between Faculties, Sections and Divisions. The individual Faculty, Section and Division lists will be considered at the College meeting in November/December.

The London Division have devised a system which scores nominees against criteria which are largely based on the ACCEA domains. This seems to have been highly successful and it is recommended that the system be adopted by all the English Divisions. Training is available to facilitate this process.

At present only award holders may be representatives on the College's central committee. These representatives are identified by their respective Executive Committees. In future it is recommended that representation at the College Committee will not be limited to award holders, although representatives will continue to be selected by their Executive Committees. Guidance notes will be prepared for Committee members.

It will be made clear in the notice to the membership that members are encouraged to submit nominations to Faculties, Sections and Divisions. Nominations will only come via Officers if for some reason they cannot be submitted to a Faculty, Section or Division. Members will also be reminded that it is their responsibility, and not the College's, to submit their CV questionnaires (CVQs) to ACCEA. Members will also be reminded that trust support is not a prerequisite for College support.

Psychiatrists who are on the Regional Awards Committee should be identified so that they can work more closely with Divisions. The President should contact ACCEA if there are regions without psychiatric representation.

The revised timetable is given below.

January

Prepare notice for *Psychiatric Bulletin* informing membership of College's system for nominating for awards. This will appear in the April edition. Reminder notices to appear on the College website throughout the year.

February

Current College Committee members sent final list of College nominations and informed of date of next College meeting.

April

Details of process appear in *Psychiatric Bulletin*/on the website. Members asked to submit CVQs to Faculties, Sections and Divisions (on the form used the previous year, assuming that the new form is not available at this stage).

June/July

Faculties and Sections hold meeting of Executive Committee to consider and rank nominations. If CVQs are weak, members are contacted and advised to amend them.

As results for awards for the current year will not be known at this stage, Faculty and Section members who have been included on the final College list submitted earlier in January will be included on the new list. Faculties and Sections send ranked list to Divisions.

August to October

Divisions hold meetings of Executive Committee to consider their nominations. The ranked lists from the Faculties and Sections are taken into account. As for Faculties and Sections, members who have been included on the College list submitted to ACCEA the previous January are also included on this list. Lists are forwarded to the College Secretariat.

The Honorary Officers convene a similar meeting but only discuss those nominations which have not been submitted to the Faculties, Sections or Divisions.

November

Divisions, Faculties, Sections and Honorary Officers update their list of nominations and circulate them to each other. After results of previous round are announced by ACCEA, the successful nominees are removed and other nominees move up the list.

Divisions, Faculties and Sections contact individual nominees asking them to complete their CVQ on the new form (assuming that it continues to change each year) and to submit this to ACCEA. The ranked lists of the Divisions, Faculty

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