enduring emotional attachment and, thus, an abnormal tendency for the will to be influenced by various inner and outer stimuli; they 'blow hot and cold'. They range from excitable to the apathetic."

The term is also found untranslated in the French edition of the ICD–10: "F60.8 . . . inclure: personnalité de type 'haltlos' . . .". But it is certainly not in widespread use in French psychiatry, and I doubt whether it is much used in Germany either.

Incidentally, 'haltlose' is just the feminine form of 'haltlos', the German word for 'personality' (Persönnlichkeit) being feminine.

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Financial implications of Calman changes in psychiatry

Sir: I have sympathy with Zubin Bhagwager's (*Psychiatric Bulletin*, December 1997, **21**, 784–785) comments about the financial implications of Calman implementation in postgraduate training, having previously expressed concerned about the way the College implemented the changes (Double, 1994). I understand the College having taken the approach of minimal change and I do think that it can be proud of its structure of general professional and specialist training. However, I find it difficult to see the motivation for change in the present structure and I do think it needs to move on to meet the needs of current mental health training and services.

The balance between general professional and specialist training is wrong, as I previously argued. Clinical responsibility should be delegated to trainees on the basis of experience and still too much is expected of senior house officers, while their specialist and senior registrar colleagues are able to take advantage of their 'supernumerary' status. As training develops in other specialities, I think this contrast is likely to become more transparent and adversely affect recruitment to psychiatry.

Moreover, general professional training is still too hospital based. The College with some foresight several years ago produced a report by David Julier on 'The Implications for Training of a Shift to a Community Orientated Service', but this report seems to have had little impact and anyway was never radical enough about the introduction of community psychiatry. One of the factors for the present malaise and scandal of mental health services may be the attitudes and practices of consultant psychiatrists. It is difficult to change this situation without introducing proper community psychiatric training at the beginning of structured training, which may require more of an overhaul of training structures than the College seems prepared to contemplate.

DOUBLE, D. B. (1994) The Calman Report on specialist training. *Psychiatric Bulletin*, **18**, 699.

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Psychiatry and the WWW: some implications

Sir: Senior *et al*'s article (*Psychiatric Bulletin*, December 1997, **21**, 775–778) clearly highlights the increasing role the World Wide Web will play in future psychiatric practice and research. One interesting dimension is its use by psychiatric patients. Many of our patients with Chronic Fatigue Syndrome (CFS) have used the information disseminated on the CFS web-site and benefited from it. Concern has been expressed, though, about the range and quality of the information that is available on-line and about the effect on patients of accessing such data sites. The Internet has an important role to play in every aspect of patient care including interviewing patients but caution must be exercised in the extent to which we 'mechanise' such a purely human interaction as a psychiatric interview.

We recurrently assessed a female patient who had taken a potentially serious overdose of simple analgesic and antidepressant tablets with alcohol and left a message on the Internet, meant to be a 'suicide note'. This message was picked up by a stranger in the United States, who fortunately alerted the British police. The patient was alsone at home but the police broke into her house about five hours after the overdose attempt and brought her to the accident and emergency department. Her life was saved because of the 'electronic suicide note' and the presence of mind of the person who picked it up and alerted the police across the Atlantic.

This incident raises some interesting points. First, if this method increases in popularity, this could be very risky as such messages may not be picked up, taken seriously or acted upon. Second, it gives a clue to the high intentionality

of the individual attempting the suicide. Third, the real trigger for the attempt may never be known, even to the family members, if there is no 'hard copy' suicide note. It would be interesting to know the incidence of 'electronic' suicide notes and to ascertain whether it is gaining popularity among patients.

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Community psychiatry in the RAF: an evaluative review

Sir: Reid identified "two omissions of pertinent fact" (*Psychiatric Bulletin*, December 1997, **21**, 786–787) in my paper on Royal Air Force (RAF) community psychiatry (Hughes, 1997). First, he mentioned the changes occurring in the RAF at the time of my study. In an earlier draft (seen by Reid) I agreed that uncertainty in the RAF may have increased the rate of psychiatric referrals. In which case, however, the need for RAF community psychiatrists in 'normal' times would be diminished. But we could both be wrong, because it could be that psychiatric referrals go up after a period of stress.

Second, Reid pointed to changes in the RAF medical services themselves. I referred to these changes in the opening sentence of my paper. How (and whether) the changes in medical services affected psychiatric referrals would need to be established before this became a pertinent fact.

Reid asserted (without references) that audit has shown RAF community psychiatric teams "to be both effective and efficient". He may be thinking of those studies (some of which I cited) from a decade or more ago, but these would seem now to be irrelevant because of the changes already mentioned. The only published study of RAF community psychiatry as recently practised is mine. I should be pleased if it stimulated further research.

This was, indeed, the intention of the paper – to stimulate discussion. As shown by my closing sentences, I am certainly not unsympathetic to military psychiatry. At a time when the armed forces minister has acknowledged the parlous state of the defence medical services, it would be sensible to seek out those areas in which military psychiatrists have something unique to offer (e.g. research into psychological aspects of trauma). Such areas should then be actively fostered. But it may be possible to manage day-to-day psychological morbidity in the RAF community, as I suggested, without RAF psychiatrists.

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Youth attitudes to services in Ireland

Sir: Ninety-three arts students at University College Cork completed a questionnaire on the impact of suicidal behaviour on their lives. The first question asked whether they would seek help if they were in trouble, particularly if they had persistent ideas of self-harm. Friends and family were the most popular options but almost half did not know where they would turn. In response to a second question, inquiring as to what organisations would provide acceptable help, 47 suggested the Samaritans. St Patrick's Private Psychiatric Hospital in Dublin was the only psychiatric service mentioned and general practitioners and local medical services were not suggested at all.

The most striking message of this study is the lack of information about available services among even a relatively advantaged group of young adults and the apparent reluctance of many to seek help outside of their immediate social cricle when distressed or in danger of self-harm. This calls into question the suitability of available services for the group who appear, on the basis of the most recent statistics, to need them most. This is not just a local or Irish problem; similar poor uptake of services bedevil attempts to address this problem elsewhere (Schaffer *et al*, 1988). Would there be a better uptake of services and a reduction in morbidity and mortality, if the services already available for the young were marketed differently?

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Elderly peoples' views of the Care Programme Approach

Sir: Rotherham District General Hospital has a catchment area of 38 000 people over 65. A recent survey found that 33 of these are on level 2 of the CPA, though two were found to be dead. Of the remainder, 16 subjects were suffering with functional illnesses and 15 with dementia. All of the functionally ill patients signed their care programmes. The keyworkers were community psychiatric nurses, social workers, community