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Guidelines for teaching psychology to students of psychiatry

Dear Sirs

Last year the *Bulletin* (April 1982, **6**, 54–6) carried an article, 'Sciences Basic to Psychiatry: AUTP Guidelines', which contained a footnote to the effect that the teaching of psychology as applied to psychiatry was the subject of a joint working party of the College and the British Psychological Society. As Chairman of the Joint Standing Committee of the College with the British Psychological Society, I have asked to write to you to amplify the footnote.

The position, in fact, is that this Joint Standing Committee did produce a document some five years ago on the teaching of psychology to students of psychiatry. On the advice of the College members of the Joint Standing Committee at that time, this was forwarded to the College's Court of Electors who, we were advised, in turn forwarded it to the AUTP. The latter have presumably made what use of the document they chose, and this is reflected in the currently published 'Guidelines'. The Joint Standing Committee is reasonably content with the Guidelines now issued, although it would have liked to have seen: (a) some amplification of the relationship between the basic sciences and their applications; and (b) a more definitive statement on the psychotherapies.

However, there is not at present any working party of the Joint Standing Committee in existence, nor is one planned. There is a survey of teaching requirements under way by the Professional Affairs Board of the British Psychological Society, and the results will no doubt eventually be available to the Joint Standing Committee and thence to the AUTP.

It may also be of interest to know that the Joint Standing Committee's incoming Chairman—Dr J. Jancar (the Chairmanship alternates annually between the College and the Society)—is proposing that a small conference of invited representatives from the two bodies should be set up to consider issues of mutual interest and concern. Teaching Guidelines and syllabuses might well be one item, and the Joint Standing Committee would welcome suggestions for others.

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Training for senior registrars with special interest in psychiatry of old age

Dear Sirs

More or less every week there are advertisements of vacancies for the post of psychiatrist with a special interest in psychiatry of old age. There appear to be large numbers of senior registrars in adult psychiatry who want to have some training in psychogeriatrics. There are a limited number of posts which have been specified for training in psychogeriatrics. In my view, senior registrars who want to become psychogeriatricians need some guidance about the type of training they should try to look for. There is an article by Dr D. J. Jolley, 'Psychiatrist into psychogeriatrician' (*Bulletin*, November 1976, 11–13) which is worth reading.

During some recent meetings with other senior registrars, I had the feeling that there were some questions to be answered about the training needs and I would try to answer some of the questions.

1. Should one have one's first posting as senior registrar in adult psychiatry or in psychogeriatrics when one has already decided to become a psychogeriatrician? I feel that one should complete the training in adult psychiatry first before starting full time in psychogeriatrics. As regards the time limit, six months to one year's training in psychogeriatrics should be sufficient.
2. Are day or two-day attachments over long periods sufficient? I do not think that this is a good idea because one cannot become fully involved in the different aspects of services for the elderly.
3. Should one work full time in geriatrics for three to six months? Theoretically, it appears to be an excellent idea, but there are some practical problems. In my view a psychogeriatrician needs to have or acquire a good knowledge of internal medicine, but there is no need to try to become a geriatrician as well.
4. Should one have attachments full-time or part-time with EEG departments or CAT scan departments? In my view full-time attachments for even short periods may not be necessary. As a consultant psychogeriatrician one needs to interpret results or even interpret the recording which one could do by acquiring sound theoretical knowledge and some knowledge of practical aspects of these investigations.
5. Should one do domiciliary visits? I think one should do domiciliary visits for the experience although senior registrars are not entitled to payment at the moment, but this should not be an obstacle because experience is necessary.
6. Should one spend some time with the community services for the elderly? The answer is 'yes'. One could visit and liaise with Part III Homes, EMI Home or even private nursing homes who admit elderly patients.
7. Must you do research to become a consultant? In my view research is not a must to become a consultant, but in

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geriatric psychiatry there are numerous opportunities where one could do some productive research whilst carrying out clinical work. Facilities for research are not evenly distributed throughout the UK, so it depends on local needs and interests.

In the above paragraphs I have tried to answer some of the questions, but psychogeriatrics is a specialty which has some scope for innovations, and one could keep in touch with different kinds of services by occasional visits to different units in the country.

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Italian mental health reform

DEAR SIRS

On both sides of the Atlantic there has recently been a sudden and unexpected rise in the interest about the Italian Mental Health Reform ('Legge 180'). I was disappointed by the lack of depth in Dr Mosher's review (1982), but I found Dr Benaim's (*Bulletin*, January 1983, **7**, 7–10) quite thorough and balanced, although I could not share his conclusions.

When the above mentioned Act was passed by the Italian Parliament in May 1978, the patient was the last concern in the legislators' minds. The outcome of that law was chaos beyond description, from which the Italian psychiatric service has, after four years, yet to recover. Many have and still are suffering, and the too easy prediction is that we have not yet seen the end of it. The differences of the availability and quality of the services between the North and the South are comparable to those between a modern western society and a pre-industrial third world country. Community psychiatry already existed in the North and represented a good starting point. The South was deprived of any basis, and since this was true also of most if not all medical services, still today there is a total lack of the political will to divert financial resources into this particular area of the newly instituted NHS. Arguably the worse effect of the hurried legislation has been the waste of public money, which should have been used to set up the much needed services. The provincial administrations, both in the North and in the South have had to arrange special schemes with private hospitals in order to cope with a population of new patients, who could not, by law, be admitted to a public psychiatric hospital, but still needed treatment! It must be finally noted that the Universities were not consulted, nor in any way involved in the reform.

The Italian Experiment is far from being a good example of how to reform a psychiatric service, and a partial return to the status quo could revive a near collapsed situation. The prerequisite of any change should 'begin with a recognition of the disturbance, disorder and profound alienation . . . It is these features that make provision of good communal and institutional care so essential' (Scull, 1983). I fear that Dr Basaglia never completed such an analysis. Didn't he believe mental illness to be a myth?

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Creating a hospital information resource

DEAR SIRS

Doctors working in psychiatric hospitals and units frequently receive an abundance of literature from the pharmaceutical houses and from other sources. Some publications are not worth the paper they use and are discarded, but others are of more value. A way of utilizing these is to create a number of files for the medical staff, trainees, registrars, senior registrars and consultants within the hospital or unit. The files can be kept in the hospital's medical library or in the doctors' common room so that they are accessible at any time.

An obvious application is the storage of the more scientific and factual booklets and papers relating to drugs used in the hospital. Once established the system invites extension to include other topics. It may be useful to have at hand information relevant to queries which arise in day-to-day practice such as medico-legal issues, particular psychiatric disorders and methods and procedures appropriate to particular problems.

Trainees can help themselves and their colleagues by adding information about subjects in which they are interested or to which they have needed to pay special attention.

The resource can complement each doctor's own personal collection of literature. It has the advantage that it provides in the hospital informative matter which doctors have not the time and space to keep individually within the working environment.

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