

A new regional scheme for psychiatric registrars in South East Thames

DEAR SIRS

We thought we should let you know that the arrangements outlined in the account of our new scheme (*Psychiatric Bulletin*, 1991, 15, 552–554) have been put in jeopardy by changes in regional administration and policy since the article was accepted for publication.

South East Thames have agreed a policy to devolve as much as possible to what they refer to as 'Units', which may be in Trusts or in District Managed Organisations. Also, they are engaged in the task of setting the Regional Dean's budget which is supposedly to cover the costs of postgraduate education. We understand that all regions are engaged in these exercises.

Problems for a regional scheme seem inevitable from a deliberate policy to so devolve responsibility, and at present we do not know whether or not it will be possible to preserve this scheme in an educationally acceptable way. The regional education budget appears to be being set to cover Postgraduate Centres in Districts and relatively little else, so that the hope expressed in the last sentence of our article ('adequate funding for these activities for the first time') seems likely to be a pious one.

Problems like these seem inevitable in all regions. Not only is local vigilance once again required, but the College may need to make major efforts to ensure the preservation of rotational training scheme structures. One local good sign is that our region has acknowledged the existence and importance of regional training committees concerned with registrar and senior registrar training.

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'Consultant Psychotherapist'

DEAR SIRS

Following the publication of 'The Future of Psychotherapy Services' (*Psychiatric Bulletin*, 1991, 15, 174–178) and the increasing impact of the NHS changes, I am concerned that the term 'Consultant Psychotherapist' will become a disadvantage to the profession when the full force of the internal market is felt.

As psychiatrists, we know that it implies a medical background, a general professional training in psychiatry and then a four year JCHPT approved higher specialist training – but other medical colleagues are not aware of this and many non-medical

managers are certainly not. 'Psychotherapist' means any individual who has had a psychotherapy training, although that training is not yet a statutory requirement before using the title. 'Consultant' is being increasingly used by other professional groups, outside as well as inside health care, and its implication is now more of a role than a title implying training, status or carrying responsibility.

At a recent College meeting between psychotherapy trainers and trainees, there was a realisation that we need to start learning the new 'NHS language' to define, describe and publicise just what it is that we can offer by virtue of our medical and psychiatric backgrounds. Patients with somatic complaints or suicidal symptoms immediately come to mind, as does communication with other doctors and the ability to carry ultimate clinical and medical responsibility. The authority and willingness to *not* prescribe medication is becoming increasingly important as public disillusionment with the prescription of psychotropic drugs increases. Another area to which we could actively contribute is preventative work: as Obholzer (*Psychiatric Bulletin*, 1989, 13, 432–434) states, "Raising awareness of the factors that generate psychological disturbance is a better use of our resources than concentration solely on the provision of psychotherapy services".

That the term 'Consultant Psychotherapist' has lost its medical roots is of particular concern because purchasers (be they GPs or Directors of Public Health) and employers will not see that we have something to offer that justifiably costs more than private therapy or NHS treatment with non-medical therapists. I wonder if the term 'Consultant Psychiatrist in Psychotherapy', which has a tidy parallel with 'Consultant Psychiatrist with Special Responsibility in Psychotherapy', would be a better one with which to market ourselves?

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What's in a name?

DEAR SIRS

Since taking up my post last February I have been referred by learned and lay colleagues by a variety of titles, including Consultant Geriatrics/Psycho Unit, Consultant Psycho Unit, Consultant in EMI Services, Consultant Psychogeriatrician, Consultant Psychiatric/Geriatric, Consultant in Psychiatry of Elderly, Consultant in Old Age Psychiatry (my preference). This confusion is clearly not an idiosyncrasy of Coventrians as judged by experiences of other colleagues. I wonder if the College can take a lead in

guiding learned and lay people by universalising the consultancy as one in old age psychiatry. Clearly with the sub-specialism now being recognised as such there is a need for uniformity.

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J. A. BOODHOO

DEAR SIRS

I agree. The *specialty* (not subspecialty) is Old Age Psychiatry. Colleagues are encouraged to use this designation and to ask their employing authorities to do the same. They are also asked to collect data to reflect their work under the heading OAP!

DAVID JOLLEY

*Chairman
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of Old Age*

Psychiatric court reports

DEAR SIRS

In Hong Kong, I share the opinion of Dr Azuonye (*Psychiatric Bulletin*, 1991, 15, 576). Similar difficulties are encountered by local forensic psychiatrists in the preparation of court reports.

For more serious cases heard in the District Court or the High Court, there is usually a 'Summary of Facts' prepared by the Prosecution which describes the circumstances of the offence. Witnesses' statements can be traced if necessary. However, most of the cases are heard in the Magistrates Court and this is where the problem lies. The criminal history and sometimes the brief facts of the case, which are prepared by the police, are often not available before the scheduled court hearing date. In such cases, the police are reminded by phone calls and letters. I have occasionally written to the Magistrate direct stating the reason of delayed provision of psychiatric reports.

I agree with Dr Campbell (*Psychiatric Bulletin*, 1991, 15, 576-577) that persistence is required in obtaining useful information from other parties. However, our persistence should not be limited to individual cases; it should be consistent in our daily practice to avoid preparation of misinformed reports. The legal profession and the police should be made aware that undue adjournment of the hearing because of insufficient information supplied to the psychiatrists is both unfair and anxiety provoking to the defendants.

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The psychiatric liaison schemes to magistrates' courts

DEAR SIRS

In Home Office Circular 66/90 on provision for mentally disordered offenders, several schemes for psychiatric liaison to magistrates' courts were described as examples of good practice. We have been running a similar scheme at Clerkenwell Magistrates' for the last 18 months and have published some of our findings (James & Hamilton, 1991). We hear rumour of many similar schemes being planned or initiated in other parts of the country.

The joint Home Office/Department of Health Review into this area is gathering information from many quarters and is due to report in mid-1992. But as yet, there is no central co-ordination or register of court liaison initiatives, and no forum in which to share or compare experience. We wish to collect details of all court liaison initiatives in order to rectify this situation, and would be very grateful if all those who participate in, or have knowledge of such schemes, would write to us with details.

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Reference

JAMES, D. V. & HAMILTON, L. W. (1991) The Clerkenwell Scheme: assessing efficacy and cost of the psychiatric liaison service to a magistrates' court. *British Medical Journal*, 303, 282-285.

Lack of information on prison visits

DEAR SIRS

I have been struck for many years by the lack of background information in the prison medical records when visiting prisoners on remand to prepare psychiatric reports. The situation came to a head when on one visit, the only information in the prison medical notes was ? GBH ? Murder!

A barrister friend advised me to write to the Lord Chief Justice, Lord Lane, which I did in November 1989. With apologies for the delay, I have just received a most helpful response, which I think is of general interest.

I received a copy of a letter from Sir Allan Green, former Director of Public Prosecutions, to Lord Lane, which reads as follows.

"You may recall that you wrote to me on 21 November 1989 enclosing correspondence from Dr Richard Lucas about the lack of information available to doctors who are asked to prepare psychiatric reports on prisoners remanded in custody.