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We were not sure whether there would be adequate numbers of core cases of serious mental illness to justify a specialist service, and whether it would be possible to identify and engage these individuals in treatment. In addition, the service could be overwhelmed by requests to review homeless people who were in distress and/or misusing drugs and alcohol, but who did not have symptoms of treatable mental illness. From the outset we wished to maintain close links with colleagues in the adult psychiatric services, while establishing links with other homeless agencies who do not traditionally have such close contact with mental health professionals.

Our experience, thus far, suggests that we have been able to attract referrals for core cases, and that a significant proportion has engaged with the service and chosen to settle locally. It is impossible to determine how many core cases within the homeless population have not been referred, although there is evidence that untrained staff who work with the homeless have considerable skill in picking out those who are mentally ill (Sclare, 1997; Marshall, 1989). Homeless individuals with less severe mental health problems have been assessed and referred on to more appropriate services.

This project has confirmed that individuals with serious mental illness can be found among the homeless in small cities. By appointing one specialist CPN, realigning the existing psychiatric services and establishing working relationships with colleagues in social work, housing and the voluntary sector, it has been possible to identify and treat a significant number of homeless people who otherwise would remain symptomatic and rootless.

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DAVID McCRINDLE, JOANNA WILDGOOSE AND RICHARD TILLETT

Survey of psychotherapy training for psychiatric trainees in South-West England†

AIMS AND METHOD
A telephone questionnaire to assess psychotherapy training in the 12 psychiatric training schemes in South-West England was conducted in April 1999. The findings were compared with the 1993 guidelines recommended by the Royal College of Psychiatrists.

RESULTS
Only one scheme was achieving the standards set by the College guidelines. The majority of trainees in this region were not receiving adequate psychotherapy training.

CLINICAL IMPLICATIONS
Psychotherapy training for psychiatric trainees needs urgent review in South-West England.

In 1993 the Royal College of Psychiatrists up-dated the previous guidelines for psychotherapy training for psychiatric trainees (Royal College of Psychiatrists, 1986; 1993).

Few schemes are able to achieve the standards recommended in the guidelines and trainee disquiet has been demonstrated by a number of previous papers in the *Psychiatric Bulletin* (Arnott *et al*, 1993, for South-West England; Hamilton & Tracy, 1996, for Northern Scotland; Hwang & Drummond, 1996, for a national sample; Byrne & Meagher, 1997, for Eastern Ireland; Davies, 1998, for South Wales; Maloney, 1998, for Oxfordshire; Rooney & Kelly, 1999, for Ireland). College approval visits frequently find deficiencies in psychotherapy training and a number of recent visits in the South-West have highlighted the need for improvement in local schemes. The present study was conducted to establish the trainees' perspective of training in the South-West. The aims were, first to discover what psychotherapy training occurs in the South-West, second to compare these findings with the College's guidelines for psychotherapy training and third to identify trainee perceptions of teaching, clinical and supervision difficulties.

†See editorial, pp. 124–125, this issue.

The study

Twelve psychiatric training schemes were identified in the South-West by the College. A semi-structured questionnaire was designed to assess what theoretical teaching,

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clinical work and supervision occurred in this region, as well as what trainee difficulties existed with psychotherapy training. This questionnaire was administered by telephone interview to the trainee chairperson or the most senior trainee of each scheme in April 1999.

The aims of the study were described to each interviewee and a convenient interview time was subsequently arranged. This allowed the interviewee time to collect any data if needed. Each interviewee was asked to describe the average experience of a trainee for the 3-year training period up to that date.

Semi-structured questionnaire

We asked for the following initial information:

(a) Does your scheme have full or limited College approval?

(b) How many trainees does it have in post?

(c) Does it offer a 6-month psychotherapy post?

(d) Does your scheme use the College logbook?

The College lists four major groups of psychotherapy: individual dynamic psychotherapy (IDP), behavioural therapy/cognitive–behavioural therapy (BT/CBT), family therapy (FT) and group therapy (GT). We asked the following questions for all four major groups and included a fifth group for other types of therapy:

(a) Did you receive theoretical teaching?
How many hours did you receive?

(b) Did you do clinical work?
How many patients did you see?
What was the duration of each therapy?

(c) Did you receive supervision?
How many hours did you receive in practice?
Was this individual or group supervision?

We asked about the following psychotherapy training problems:

(a) Regarding teaching, clinical and supervision sessions; was there a significant timetable clash between psychotherapy training and other service commitments?

(b) Regarding clinical sessions specifically, was there a significant problem with, selected patient availability; therapy room availability; and/or secretarial support?

We also asked what other difficulties trainees have had with their local psychotherapy training.

Findings

The 12 schemes included 95 trainees (87 full-time and eight flexible). Ten schemes had full and two schemes had limited College approval. Ten of the 12 schemes offered some psychotherapy training, including both schemes with limited approval. One scheme had a 6-month psychotherapy post, shared with child and adolescent psychiatry. Seven schemes were using the College logbook.

Only one scheme was achieving the standards set out in the College psychotherapy training guidelines, offering sufficient training in all four major groups of psychotherapy (Table 1). Five schemes offered (and delivered) theoretical teaching and nine schemes offered some clinical practice and supervision in some of these four major groups. Two schemes offered no psychotherapy training at all.

Table 2 shows that eight schemes had some training (i.e. theoretical teaching or supervised clinical practice, or both) in IDP, six schemes in CBT, five schemes in FT and only one scheme in GT. Other types of therapy included: cognitive analytical therapy, client-centred therapy, interpersonal therapy, psychodrama, 'eclectic therapy' and eye movement desensitisation. All clinical work received regular supervision, except for one scheme offering no supervision for FT and one scheme giving supervision for IDP and CBT only every 3 weeks. The majority of supervision happened in a group rather than individually.

There was a large variation in the amount of training across the schemes that offered psychotherapy training (Table 3). If one considers IDP, for example, the range of theoretical teaching for the four schemes that actually received teaching for this was 6–33 hours, the range of clinical practice for the eight schemes that experienced this was 10–120+ hours and the range of supervision for this was 7–120 hours. When this was taken into account

Table 1. Availability of therapy training in each scheme

Therapy type	Scheme One	Two	Three	Four	Five	Six	Seven	Eight	Nine	10	11	12
IDP[1]	T[2],C[3],S[4]	T,C,S	T,C,S	T	C,S	C,S	C,S	C,S	C,S	–	–	–
BT[5]	T,C,S	C,S	–	–	–	–	–	–	–	–	–	–
CBT[6]	–	–	T,C,S	T,C,S	T,C,S	C,S	–	–	–	–	–	–
FT[7]	T,C,S	C,S	T	C,S	C	C,S	–	–	–	–	–	–
GT[8]	T,C,S	–	–	–	–	–	–	–	–	–	–	–
Other: CA[9]	T,C,S	–	–	–	–	–	T	–	–	–	–	–
CCT[10]	–	–	–	–	–	–	–	–	–	C.S	–	–
IPT[11]	–	–	–	–	–	C,S	–	–	–	–	–	–

1. Individual dynamic psychotherapy. 2. Theory. 3. Clinical practic. 4. Supervision. 5. Behavioural therapy. 6. Cognitive–behavioural therapy. 7. Family therapy. 8. Group therapy. 9. Cognitive analytical therapy. 10. Client-centred therapy. 11. Interpersonal therapy.

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Table 2. Overall availability of each form of training in the South-West region

	Number of schemes offering		
Type of therapy	Theoretical teaching	Clinical practice	Supervision
IDP[1]	4	8	8
BT[2]	1	2	2
CBT[3]	3	4	4
FT[4]	2	5	4
GT[5]	1	1	1
Other: CAT[6]	2	1	1
CCT[7]	–	1	1
IPT[8]	–	1	1

1. Individual dynamic psychotherapy. 2. Behavioural therapy. 3. Cognitive–behavioural therapy. 4. Family therapy. 5. Group therapy. 6. Cognitive analytical therapy. 7. Client centred therapy. 8. Interpersonal therapy

for all the major types of therapy, only the following schemes were partially following the College guidelines: two schemes for IDP with one long-term case and several brief cases; three schemes for BT/CBT with one intensive case and several brief cases; five schemes had FT clinical experiences and one scheme had GT experience.

Of the 10 schemes offering training, six had significant problems with timetable clashes between psychotherapy training and service commitments and five had problems finding a suitable therapy room. Trainees felt that it was not possible to solve these problems without the backing of a psychotherapy department. On a positive note, only one scheme had a problem with finding suitable patients for therapy and with receiving adequate secretarial support.

Eleven schemes expressed dissatisfaction with their psychotherapy training. The major difficulty was the lack of available training in all the recommended types of psychotherapy. No local consultant psychotherapist, poor consultant psychiatrist support, the opinion that psychotherapy training was an optional extra and rotating posts were other important factors. Often psychotherapy training was available to trainee clinical psychologists, especially in CBT, FT and GT, but was not available to psychiatric trainees because it was not arranged as part of their programme.

Discussion

In the light of poor questionnaire response in previous surveys (Lawson, 1996; Hwang & Drummond, 1996; Rooney & Kelly, 1999), we conducted our survey by telephone. This enabled information to be collected from each scheme, but limited the response to one representative from each scheme.

Our findings demonstrate that the majority of psychiatric trainees in the South-West do not receive adequate psychotherapy training according to the 1993 College guidelines.

A previous survey of psychotherapy training in the South-West (Arnott *et al*, 1993) reached a similar conclusion. Both studies found that IDP and FT training were fairly commonly available and it appears that the availability of BT/CBT training has improved recently. Training in GT remains uncommon. One of the region's two specialist 6-month psychotherapy placements has been lost in recent years. Both surveys revealed a high level of trainee dissatisfaction with psychotherapy training in the region. It is clear from these and other findings that trainees value psychotherapy training (Drummond & Ramsay, 1996; Lawson, 1996; Hwang & Drummond, 1996). What is not clear however, is whether this dissatisfaction also occurred with other aspects of psychiatric training. This warrants further research.

Only seven schemes were using the trainee logbooks, although these have been recommended for use in all schemes and are particularly helpful for recording psychotherapy training (Maloney, 1998). The two schemes with limited training approval offered more opportunity for psychotherapy training than some fully approved schemes, suggesting that larger schemes do not necessarily offer better psychotherapy training.

Theoretical teaching in psychotherapy is limited on MRCPsych courses in the South-West, unlike some other regions (Kerr *et al*, 1998). Only four schemes in the region provided local theoretical teaching. Clinical experience

Table 3. Overall amount of each form of training for all the schemes offering training

	Range of total hours for the 3-year period up to April 1999		
Type of therapy	Theoretical teaching (hours)	Clinical practice (hours)	Supervision (hours)
IDP[1]	6–33	10–120+	7–120
BT[2]	18	10–54	5–54
CBT[3]	1–24	10–20	8–14
FT[4]	1–18	1–100	10–48
GT[5]	18	60	60
Other: CAT[6]	1–18	32	54
CCT[7]	–	30	54
IPT[8]	–	12	12

1. Individual dynamic psychotherapy. 2. Behavioural therapy. 3. Cognitive–behavioural therapy. 4. Family therapy. 5. Group therapy. 6. Cognitive analytical therapy. 7. Client centred therapy. 8. Interpersonal therapy

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was highly valued by trainees and appears to be most effectively provided on a formal basis with adequate supervision. Our survey showed that in this region most clinical experience was adequately supervised though there were problems with FT, IDP and CBT supervision (on two schemes).

What distinguishes a successful from an unsuccessful psychotherapy training programme?

Our survey suggests that the following factors are important:

(a) formal organisation of the training programme
(b) protected bleep-free time for training
(c) adequate theoretical teaching in each of the four major therapy groups (IDP, BT/CBT, FT and GT)
(d) supervised clinical practice with selected patients.

We support the College's recommendation of a half-day release model for psychotherapy training; this not only provides protected time for training, but also provides a structure within which it can be organised on a formal basis. Our findings and those from other areas suggest that a more informal approach to training is often unsuccessful.

Conclusions

The standards recommended by the Royal College of Psychiatrists' guidelines for psychotherapy training for psychiatric trainees were not being met in South-West England (April 1999). Training provision was extremely variable, with only one out of the 12 training schemes achieving the recommended standards. The major difficulty for the trainee was the lack of available psychotherapy training in the four recommended types of psychotherapy. Despite several local initiatives, psychotherapy training is in need of ongoing review in South-West England.

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ILYAS MIRZA, RACHEL DAY, MICHAEL PHELAN AND VICTOR WULFF-COCHRANE

Oral health of psychiatric in-patients

A point prevalence survey of an inner-city hospital

AIM AND METHOD
The aim of the study was to get an estimate of oral health needs of in-patients on acute general adult wards in an inner-city psychiatric unit. Information was collected by means of a cross-sectional survey with patient interviews and a brief oral examination.

RESULTS
A significant majority of patients had carious teeth, inflammation of gums and oral plaque. A majority of patients complained of pain during the preceding 3 months and problems with teeth.

CLINICAL IMPLICATIONS
Oral health of patients admitted to an acute psychiatric unit is worse than compared to the general population. There appears to be a need for basic dental health education and easy access to dental care on psychiatric wards.

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