leaving the scheme in the seven years, 50 of them left without completing four years training in psychiatry, and of these 16 went into general practice and 19 continued psychiatric training either part-time in the Mersey region or full-time elsewhere. In our paper mentioned above we found that the average length of stay in the scheme for these trainees was 1 year 7 months.

If only the trainees who completed four years psychiatric training are considered, out of 62 trainees (100%), 39 (63%) gained senior registrar posts, eight (13%) went abroad, either emigrating or returning home, and only five (8%) failed to pass the MRCPsych examinations.

From these results we would agree with the authors' conclusion that a well organised scheme improves the trainees' chances of passing the Membership examinations and of obtaining senior registrar posts. The advantage of a region-wide scheme such as the Mersey Scheme is that all trainees gain experience of working in the peripheral hospitals and in the teaching hospitals and therefore all trainees in the region enjoy equal opportunities for progression in their career.

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## *Cognitive therapy in literature*

DEAR SIRS

I enjoyed Dr Paul Crichton's comments on 'Cognitive Therapy in Literature' (*Psychiatric Bulletin*, March 1993, **17**, 173). In this he makes a comment that "Aaron Beck's great achievement was to recognise the importance of the principles of cognitive therapy." In doing this I think he forgets to mention the work of the other pioneer in this field, Albert Ellis, who developed what he first called "Rational Therapy" and later "Rational Emotive Therapy." Both approaches have many similarities and I believe that Ellis's work may actually have preceded Beck's, although both were pioneers in this field and I feel both merit recognition.

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## *Community care and registrar training*

DEAR SIRS

I read with interest the article by J. Abbati and G. Oles (*Psychiatric Bulletin*, March 1993, **17**, 140–141) on the continuity of care in serious mental illness. The importance of the continuity of care for these patients raises questions for the role of psychiatric trainees in a multidisciplinary team caring for the long-term severely mentally ill. This article highlights the difficulties for the patients of frequent changes of carers and this has to be balanced against the needs of individual doctors' training requirements for frequent changes of post to provide a range of experience. Individual attachments when a psychiatric registrar are often of six months duration, as recommended by the College (*Psychiatric Bulletin*, 1990, **14**, 110–118). Other authors have highlighted the need for psychiatric trainees to be familiar with the conduct of community psychiatry (Freeman, 1985) and maybe this cannot be best met by a six month post.

Perhaps the right balance for all these conflicting needs can best be met by trainees having 12 month posts which can be split partly with a community psychiatric team and partly with an in-patient team to gain the same psychiatric experience over a 12 month period but with less disruption to the care of the seriously mentally ill we are endeavouring to help. This may require imagination to develop these kinds of posts for registrars but, as for senior registrars (Malcom, 1989), may provide a more useful and enjoyable post.

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## *The "mini-team" system: an improved multidisciplinary approach?*

DEAR SIRS

The Child Psychiatry Pre-adolescent Unit at Queen Mary's Hospital for Children, Carshalton, Surrey, consists of ten beds with an additional emergency bed and space for up to three day patients.

Until October 1991, management decisions concerning each child were taken by the consultant-led multidisciplinary team during a two hour session held once per week where each child was discussed. Regular case conferences could take place only every six weeks or so.

https://doi.org/10.1192/pb.17.7.434-b Published online by Cambridge University Press

In October 1991, a completely new system of management was introduced, wherein multidisciplinary discussion and planning was delegated to "mini-teams". Each mini-team consists of three or four staff members drawn from the pool of nursing staff, junior doctors, on-site school staff, occupational therapists etc. The mini-team is chosen by the clinical nurse manager in liaison with the consultant and senior registrar and an attempt is made to match the particular difficulties of the child with the expertise available. The team is chosen before the child is admitted and always includes the key nurse.

The mini-team meets as frequently as required, at short notice if necessary. The mini-team oversees the child's progress and is free to make day to day decisions asking for advice as appropriate. Also, each child has a full multidisciplinary review in the presence of the consultant, on average once every three weeks, and the mini-team is at this time expected to play a key part in immediate, short and long-term planning.

The reason for changing the system in this way included a hoped-for improvement in the working of the multidisciplinary team and in particular:

(a) improved access for all staff members for information regarding the children
(b) broader and more in-depth involvement by staff members in the management of children
(c) the safeguarding of time for discussion of the less challenging or threatening children
(d) to facilitate and prompt thoughtful crisis management between busy weekly meetings.

All staff involved in mini-teams were recently asked to take part in an anonymous survey of this new system. This showed overwhelmingly that the changes made were popular and have been felt to have led to better management of the children. In particular, it was felt that aims (a)–(d), previously outlined, had been attained.

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## *Correct dose of imipramine in panic disorder*

DEAR SIRS

In their article on the prescribing of antidepressants for anxiety disorders, Tyrer & Hallstrom (*Psychiatric Bulletin*, February 1993, **17**, 75–76) are incorrect in advising a dose of imipramine of 100–150 mgs daily in the treatment of panic disorder. Patients suffering from this form of anxiety disorder are intolerant of the side-effects. If imipramine is prescribed in the dose usual for the treatment of depressive disorder, most patients with panic disorder will be unable to tolerate it and an extremely effective treatment for the disorder will be lost. This fact was noted by those who first advocated the treatment (Zitrin *et al*, 1978). Many of us, who recognise the therapeutic potential of antidepressants in panic disorder, advocate commencement at low dose (Snaith, 1991). Fortunately, because of its use in paediatric practice for eneuresis, imipramine is available in a 10 mg tablet. The better tolerance of this low dose regime, with gradual increase, has been demonstrated by Nutt & Glue (1991). They found that once tolerance had been established, the dose may be increased up to 100 mg daily. My experience is that frequently, when panic attacks occur in the absence of a concurrent depressive state, the attacks are effectively controlled by the 10 mg daily dose alone.

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## *Reply*

DEAR SIRS

Dr Snaith emphasises a point that was already indicated in our article, when we described the dosage range (wrongly typed as 'rate') as between 3 and 300 mg/day. It is certainly a sound clinical strategy to begin with low dosage but we do not yet know whether some patients respond to a final dosage below that of a daily imipramine dose of 100–150 mg. Until we have studies which indicate significant imipramine/placebo differences in low dosage the recommendation for the higher dosage remains.

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## *Training in liaison psychiatry – the place of old age psychiatry?*

DEAR SIRS

In their recommendations for training in liaison psychiatry (*Psychiatric Bulletin*, February 1993, **17**,

https://doi.org/10.1192/pb.17.7.434-b Published online by Cambridge University Press