CORRESPONDENCE

SPECIALIST TRAINING IN CHILD PSYCHIATRY

DEAR SIR,

I read with much interest the article in the July 1978 *Bulletin* (p 127) entitled 'The Role, Responsibilities and Work of the Child and Adolescent Psychiatrist'. I was very concerned to read under heading No. 1 that 'specialist training in Child Psychiatry starts at Senior Registrar level'. This is particularly worrying for me as my position is as a non-rotating registrar in Child Psychiatry in this department. I rotated to this department during my General Psychiatry training for six months in 1976 and then returned in April 1977 to take up a Registrar post in Child Psychiatry. I regarded this as starting my specialist training in Child Psychiatry and continued in this post until the present time. I will find it very difficult if people do not regard this as specialist training in Child Psychiatry when I subsequently apply for other posts, and I wonder on what basis it is said that specialist training in Child Psychiatry only starts at Senior Registrar level.

An additional comment on the article is my regret that the position in Scotland is not elaborated in more detail, the only reference being that the 'situation may be different in Scotland'.

SIMON WILKINSON

Royal Hospital for Sick Children,
3 Rillbank Terrace,
Edinburgh EH9 1LL

DEAR SIR,

Thank you for offering the opportunity to comment on the letter from Dr Simon Wilkinson.

His six months in 1976 spent as Registrar in the Department of Child Psychiatry would be regarded as a desirable part of his general professional training in preparation for the M.R.C.Psych. examination. The view of our Section is that all trainees in General Psychiatry should have some exposure to Child Psychiatry at Registrar level, as part of their training to become general psychiatrists. He, therefore, would have more than fulfilled this requirement.

There are a few Registrar posts in Child Psychiatry throughout the United Kingdom. However, our Section discourages the establishment of further Child Psychiatric training posts at Registrar level on the following grounds. The Child Psychiatry Section considers that the general training to become a psychiatrist should take place at S.H.O. and Registrar level. This would culminate in the trainee obtaining the M.R.C.Psych. diploma. He will then be qualified to start advanced specialist training in Adult Psychiatry or one of the sub-specialties of Psychiatry—and this will properly take place at Senior Registrar level. Experience has taught many Consultant Child Psychiatrists that if they accept a psychiatrist into a Registrar post in Child Psychiatry before the trainee has obtained the M.R.C.Psych., difficulties occur in helping the trainee to pass the examination.

I am, however, quite confident that any Advisory Appointments Committee would accept Dr Wilkinson's length of experience in Child Psychiatry—at both Registrar and Senior Registrar level—as being the determining fact in deciding whether or not he had satisfied the criteria for a particular Consultant post.

The Executive Committee of our Section accepts the criticism that the document was biased towards the practice of Child Psychiatry in England and Wales. In many respects the structure of the Child Psychiatry services in the NHS is different in Scotland and the Working Party did not include a Scottish representative. One example of the differences in Scotland is that it is now most unusual for teaching hospitals to have Registrars in Child Psychiatry on their establishment.

W. LUMSDEN WALKER
Chairman, Child and Adolescent Psychiatry Section
Bristol Children's Hospital,
St. Michael's Hill,
Bristol BS2 8BJ

IMPRISONMENT OF MENTALLY DISORDERED OFFENDERS

DEAR SIR,

I read with interest Dr J. H. Orr's article (*British Journal of Psychiatry*, September 1978, 133, 194–9).

During the course of the past few years, I have been asked to provide a psychiatric opinion on a number of people appearing before the local Courts. Some of these individuals have been on remand in prison for long periods of time and often had a number of previous psychiatric reports from all over the country.

On reading through some of these reports, one is made aware of an extremely worrying aspect of present assessment. In many cases the body of the report was devoted to an accurate description of the symptoms, which in ordinary clinical practice would lead to a diagnosis of schizophrenia. However, when it came to discussing the management of the person, the suggestions made appeared to owe more to expediency than to clinical judgement. The mental gymnastics employed in order to match suggested management to the diagnosis were of Olympic standards. It is frighteningly evident that decisions are being influenced by pressures applied by outside agencies rather than being made on the psychiatrist's

clinical judgement. It is well known that in many hospitals the admission of patients who have been placed on Hospital Orders by the Courts is automatically vetoed by nursing staff. Where this is the case, it would seem more desirable that the psychiatrists concerned should state this in their reports, so that responsibility can be placed where it truly belongs.

If we as a profession are not prepared to do this, then it ill becomes us to criticise the acts of psychiatrists in totalitarian states, as we would seem ourselves to be on the first slippery steps of that particular slope.

K. L. K. TRICK

St. Andrew's Hospital,
Northampton NN1 5DG

REGIONAL SECURE UNITS

DEAR SIR,

The account of Lord Longford's speech on Mentally Abnormal Offenders (*Bulletin*, November 1978, p 189) might lead one to suppose that at Knowle Hospital the Shop Stewards were utterly opposed to the provision of any local care for the Mentally Abnormal Offender. This has been far from the truth. Once they had been acquainted with the clinical problem which the Mentally Abnormal Offender presents, they proved to be extremely helpful and positive in their approach to find a solution at a local level for the appropriate cases. They took the very interesting and stimulating view that a permanently physically secure unit was the wrong way of approaching the clinical and management problems presented by the patients discussed in the Glancy and Butler Reports. Their fear was that such a unit which was permanently and physically secure could easily deteriorate, especially under periods of staff reductions, into a punitive and untherapeutic establishment (*cf* the experience of South Ockenden Hospital). They also feared that the presence of a permanently secure unit would lead to pressure being brought on the managers of the unit to admit more dangerous patients than the unit was really able to cope with. They held the view that a unit should be developed which should, as far as possible, be open (although the facility to lock it or make it secure would always be present if needed for temporary periods). The patients we would be expected to look after would inevitably have to return to the community sooner or later, and therefore the unit, as far as possible, should be community orientated, i.e. have sufficient nursing staff to provide a community nursing service and develop its own 'Group Home System'. It was also seen as very important that the unit should not be isolated and elitist, but fit in with the rest of the hospital in which it was placed.

These principles have, in fact, been incorporated in the Wessex Interim 'Secure' Unit. The efficacy of this unit has been described in a paper read at the Annual Meeting of the College on 6 July 1978. It was demonstrated that the Unit has made a substantial contribution to help alleviate the problem of providing hospital care for the mentally abnormal patients whom conventional hospitals are unable to admit. In the development of this Unit along these lines, the Shop Stewards have been nothing but helpful, and continue to be fully supportive.

M. FAULK

Regional Consultant Forensic Psychiatrist,
Knowle Hospital, Fareham,
Hampshire PO17 5NA

Dr Faulk's paper (abbreviated), will be published in the next issue of the *Bulletin*.

Eds.

APPROVAL PROCEDURES

DEAR SIR,

We have recently been visited for approval purposes by an inspection team from the College, and we understand that our status is to be reduced from 'Fully' to 'Provisionally'. Which, of course, has nothing to do with our writing.

It occurs to us that the time-consuming business of visiting is manna to work-starved obsessionals, and the rest of us should be grateful for the burden they so willingly and cheerfully assume. There may be one or two disadvantages, however, arising from the particular traits of the breed. We would draw attention to the following examples.

1. Perfectionism may lead to unrealistic standards being expected, far beyond what is intended—an obvious source of interjudge unreliability.
2. Rigidity of thinking may prevent appreciation of differing local customs and circumstances, leading to unfair assessment.
3. Personal insecurity may be compensated for by a certain abrasiveness of manner which impresses the visited as unnecessary aggressiveness.
4. Excessive rumination, heedless of the passage of time, may disrupt the clinical work of the visited hospital, and produce further irritation—especially if the visitors arrive late in the first place (excessive hand-washing?).

W. A. ELLIOTT
K. M. G. KEDDIE
A. N. MUNRO

Sunnyside Royal Hospital,
Montrose,
Angus, Scotland