of such recordings. While recognising his reasons for focusing on these issues, I feel it important to point out that patients tape-recording interviews can be a positive part of their therapy. Over the last seven and a half years as a consultant, I have had a number of patients who have taped sessions with me so as to allow the time to reflect upon the content of the sessions.

Attending out-patient sessions or indeed any other therapeutic interaction can be stressful so the ability to take in information can be impaired. For these patients, the ability to tape-record their interactions with me was valuable in that it enabled them to go over issues they could not clearly remember or to use the tapes to help them to write down questions which they could put at their next interview. While having a tape recorder going could influence the nature of the interaction, I found that it much less intrusive than patients trying to write down key issues by hand which made the interviews much more stilted.

I would agree with Dr Stephenson that tape-recordings do not take the place of patients being able to read their own notes and do have an uncertain legal status, but I feel it important to recognise that if a patient wishes to have a tape recording, then this should be approached positively as it may have important therapeutic benefits.

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A model for an integrated psychotherapy service

Sir: We were interested to read Drs Holmes & Mitchison's article proposing a model for an integrated psychotherapy service (*Psychiatric Bulletin*, April 1994, **19**, 209–213). In the inner city area of City and Hackney we are building a Department of Psychological Therapies which closely mirrors the model proposed. In our service the consultants, a psychoanalyst and a cognitive psychotherapist work with dynamic and behavioural specialist nurse therapists, a specialist nurse counsellor and a psychologist as a core team. As a young department we are learning to work together while maintaining our individual identities, but unlike Holmes & Mitchison, do not see this as our main problem. Our major difficulty is of obtaining resources. The model we are aspiring to cannot be financed simply by psychotherapists altering their working practices; is a radical move outwards which, to be done properly, needs adequate financing. There are some similarities to the move to the community of general psychiatric services. It now seems to be well recognised that without adequate planning and resourcing it is sadly too easy to be in a position of providing a less caring and less effective service to our patients. We hope we can apply some of these painfully gained lessons to our own service.

We welcome Holmes & Mitchison's suggestions as to ways to address these issues and would be very interested in hearing of other departments' experiences.

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Overseas training experience

Sir: I support Ruth McCutcheon's comments (*Psychiatric Bulletin*, March 1995, **19**, 161–162) about the value of an exchange of trainees between the UK and other countries. She highlighted the teaching role of UK trainees in sub-specialities, and I would add that this should be a mutual exercise, involving an exchange of clinical and academic ideas.

Singapore, my country of origin, is an interesting example in examining how the sub-specialities are practised. As described by Robertson *et al* (1992), learning disability does not fall entirely within the remit of psychiatry; voluntary associations mainly provide for the learning disabled.

Drug rehabilitation centres (DRC) are run by the Prisons Department. Addictive behaviour specialists would be keen to argue that psychiatry should figure more prominently; an exchange programme would offer insight into the workings of the DRCs.

Forensic psychiatry provides another insightful exercise. The equivalent of a medium secure unit (360 beds!) operates in Singapore's only government psychiatric hospital (Singapore's population is 3 million). Meanwhile, there is a maximum secure psychiatric facility within the Hospital Wing of Changi Prison. Here, there is unique

cooperation between Health and Home Affairs ministries, with the former providing the medical manpower, the latter the facilities. There is no Hospital Order in Singapore and indeed the Judiciary would argue that there is no need for it.

I agree with Ruth McCutcheon about overseas training experience at senior registrar level (a point to consider for the future specialist registrar grade). Piachaud (1992) suggests forging links with a view to establishing a list of approved overseas centres for the purpose of higher psychiatric training. The recent establishment of the Institute of Mental Health in Singapore heralds an important move towards more research and development; the service would certainly welcome a partnership in this endeavour.

As a possible training centre, Singapore offers a unique blend of East and West, continues to use English as the first language, and has highly advanced information technology. The logical first step would be an exchange exercise in the sub-specialities and I invite the Joint Committee of Higher Psychiatric Training (JCHPT) to consider this.

PIACHAUD J. (1992) Overseas doctors—training ethos. (Letter). *Psychiatric Bulletin*, **16**, 666.

ROBERTSON, J. R., HALSTEAD, S., TAN, T & LAWRENCE, J. (1992) Psychiatric training, Singapore. *Psychiatric Bulletin*, **16**, 36–38.

JEYABALA BALAKRISHNA, St George's Hospital, London SW17 0QT

Sir: Dr Balakrishna supports the value of overseas training experience for higher psychiatric trainees and suggests a two-way exchange.

The approval of higher training overseas is not entirely straightforward, since there is no exact equivalent in other countries of this grade, with its expectations of training and supervision rather than purely service. In many countries also the differentiation of psychiatry into six specialities (general adult psychiatry, old age, child and adolescent psychiatry, psychotherapy, forensic, mental handicap) is not as well developed as in the UK. However the JCHPT recognises the value of overseas experience and one year of the minimum three year higher training period spent overseas can be approved for higher training. Because of the differences in training and the impracticality of inspecting overseas placements, this is currently required to be by outposting and approval from a higher training scheme in this country. Similar recognition will apply to higher training in the new specialist registrar grade.

The JCHPT is also exploring, with the College, a pilot scheme to enable overseas psychiatrists to come to this country for higher training.

E. S. PAYKEL, *Chairman, Joint Committee on Higher Psychiatric Training, Royal College of Psychiatrists*

Lithium prescribing and monitoring in general practice

Sir: The letter from Dr A. D. Armond (*Psychiatric Bulletin*, February 1995, **19**, 117) concerning lithium prescribing and monitoring in general practice has been widely reported in the general practice press; the views expressed on management cannot pass unchallenged. Dr Armond suggests that lithium prophylaxis should not take place in general practice even when the patient is stabilised, and that the complex pharmacology of lithium and the variability of supervision make general practitioners (GPs) unsuitable to administer this drug. This view correlates with the perception among some psychiatrists that GPs are "particularly liable to make inappropriate choice of drug and dose" (Brown, 1993).

It is unusual for a GP to initiate treatment with lithium. Those patients with severe affective symptoms requiring lithium will not have responded adequately to neuroleptic or antidepressant treatment. The help of a psychiatrist is then often needed. Some patients, however, refuse to see a psychiatrist because of perceived stigma associated with a psychiatric referral. Therefore, I have started some patients on lithium for its mood stabilising effects, and also as adjunctive treatment for depression. Dr Armond's anxieties about the interaction between lithium and other drugs has been largely obviated by the development of computer programmes in general practice which will warn the doctor, at the time of prescribing, about possible interactions.

Lithium undoubtedly needs to be monitored carefully within the community. Psychiatrists may not be aware that the trend for monitoring chronic disease is to involve primary care where possible, and there are drugs of equal