Correspondence

Rehabilitation of long-stay patients

DEAR SIRS

The psychological hazards of long-stay wards have long been realized. The helplessness and passive dependency engendered by such an environment, where food, clothes, linen and even staff appear like magic through the door, is recognized as contrary to the desired aims of rehabilitation. The drive towards community care got under way following the Royal Commission in 1957. After an initial flux of rapid and successful rehabilitation of the best candidates from the back-wards, we are all aware of a slowing-up. With the combination of increasingly difficult clinical material and decreasing resources, this is predictable. The chronic behaviour patterns of the remaining long-stay population, combined with the minimal staffing levels, are a recipe for despair. Any move towards increased independence by these patients is welcome, and we believe we have made one.

The long-stay wards, and various other units where medical staff only visit intermittently, give Knowle Hospital a resident population approaching 500 patients. Their steady crop of physical ailments makes a high demand on the psychiatric medical staff which can easily distract attention from the need for regular psychiatric review. In order that the senior psychiatrists can apply themselves fully to psychiatric management, we have established a 'Physical Treatment Unit' within the hospital, where a trainee psychiatrist holds a surgery each morning. Physical problems can be brought to the surgery for consultation without appointment. The incapacity of the long-stay resident usually means a nurse escort is required, but even when this is the case, it is still a good simulation of leaving home to visit the doctor, as is normal in the community. This makes a goal, needing effort to get a reward, and so makes a good exercise in rehabilitation, as well as getting the work done by those best able to do it (the trainee with recent experience in physical specialties) in a place designed for this purpose. The most outstanding benefit became apparent when preparing patients for the recently opened hospital hostel; gaining experience in attending this surgery was one of the many preparatory adjustments to their way of life, which made their move to the community a success. In the first year of the scheme about 700 consultations have been made, averaging two or three per day.

Situated near the pharmacy, the Physical Treatment Unit also houses the optician, dentist, ECT unit and soon the X-ray department, making a convenient centralization of demands for dressings, instruments and drugs.

We feel others may like to know of this scheme, which has been approved by providers and users alike.

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'The Rising Tide'

Dear SIRS

The Health Advisory Service has just issued a publication, *The Rising Tide*, concerning the development of services for mental illness in old age. I note that in paragraph 83 of the document it lists various 'key staff' who should be involved in a comprehensive service for the elderly, but does not include senior trainees amongst the core group of staff.

In hospital practice the senior trainee often plays a vital role in the day to day management of the unit and has the opportunity to bring with him fresh ideas learned from recent experience in other branches of psychiatry. Furthermore, he provides a back-up for the consultant at time of absence, having first-hand knowledge of the methods of working in the unit, thereby improving continuity and benefiting both staff and patients.

Unfortunately, there are many psychogeriatric units which, as yet, do not have the services of a senior registrar to provide a link between consultant and junior staff. Many of these units would provide good training experience towards a consultancy in the health care of the elderly. There are still too few good training posts available in psychogeriatrics. If the services for the elderly are to expand there will need to be a steady supply of well trained senior registrars. *The Rising Tide*, by omitting to mention senior registrars in the document, has missed an opportunity to encourage developments in senior registrar training.

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'Sciences Basic to Psychiatry'

DEAR SIRS

The AUTP Guidelines on 'Sciences Basic to Psychiatry' (*Bulletin*, April 1982, **6**, 54–56) were produced as an attempt to inform trainees and those concerned with the organization of training. A separate working group charged with the production of guidelines on dynamic and phenomenological psychology was dogged by illness and other problems, but has now been reconstituted and hopes to report by the end of this year.

Dr D. A. Black (*Bulletin*, April 1983, **7**, 74) on behalf of the Joint Standing Committee of the College with the British Psychological Society, also expressed a wish for some amplification of the relationship between the basic sciences and their applications. This is a desirable objective and one which motivates those who wish to see a broader representation of the basic sciences in the final Membership Examination.

The present guidelines take into consideration the fact that the Preliminary Test (Part I) is largely, if not exclusively, non-clinical. In the future a more clinically orientated Part I may enable a closer examination of clinically relevant behavioural science in both parts of the examination.

Any changes will be reflected in future guidelines produced by the AUTP.

The Association represents those academic departments providing undergraduate and postgraduate education in psychiatry, and as such is an interdisciplinary group providing a forum for the discussion and dissemination of knowledge relating to such teaching.

I hope that psychologists, social workers, sociologists and other non-medical specialists active in medical teaching will join the Association and play an important part in its deliberations. At present each academic department sends three representatives to the Standing Committee which meets regularly to formulate Association policy and exchange information.

Anyone who is not a member of the Standing Committee may, through their local representative or by writing to the Secretary (Professor A. C. P. Sims, Leeds), communicate their views to the committee. A newsletter (Editor: Dr J. Connolly, Westminster) will publish letters or articles on teaching and related matters.

If anyone does wish to give us advice on the relationship between the basic sciences and their application, on the guidelines generally or, indeed, on any other matter, I or the other officers of the Association would be pleased to hear from them.

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Collaboration between psychiatrists and geriatricians

DEAR SIRS

Your correspondents, Drs Langley and Wilson (*Bulletin*, April 1983, **7**, 73), draw attention to possible areas of concern for psychiatrists and geriatricians in their endeavours to work together.

To combat these difficulties, the geriatricians and psychogeriatricians of the Medway Health Authority jointly formed a Department for the Care of the Elderly which has admirably overcome the difficulties they itemize by the solutions they propose.

Such a department engenders a sense of team work based upon mutual trust and respect, and directed towards a common goal. Problems previously seen as only affecting one 'side' and not necessarily the other, are now shared, and from the understanding of each other's difficulties (particularly the limited resources) arises the spirit of shared adversity and a common determination to work together towards the common end—the service to the elderly.

Mistrust and suspicion can all too readily arise if each specialty sees the other as a rival rather than a partner (as can occur between the Health and Social Services).

Such a department with a comprehensive oversight of the total service needs, can collect relevant statistics, monitor its performance and argue with added strength for better resources against other bids.

At a clinical level the geriatrician and psychogeriatrician hold a monthly out-patient clinic to which each can refer patients for joint discussion on treatment and management. There is in addition a twelve-place Day Assessment Unit available to each consultant which allows a full social, psychological, domestic and physical assessment of patients, to be undertaken without the use of an in-patient bed. Obviously having the Geriatric and Psychiatric Units on the one campus of a District General Hospital greatly facilitates clinical and administrative co-operation, yet ultimately a good working relationship and the efficiency of the service for the elderly must depend upon mutual goodwill at all levels. It needs the sense of purpose, belonging and direction between all members of the consultants' teams, and in our view, this cohesion and drive can only be obtained within an administrative and clinical framework which unites the two disciplines in a common task.

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Insanity and genius

DEAR SIRS

I share Little *et al*'s concern about the Lundbeck Limited method of advertising 'Depixol' in the context of art and psychosis (*Bulletin*, March 1983, **7**, 55).

The question of creativity, whether in the arts or sciences, is a complex issue, recognized by most, questioned by some and explained by few. Amongst the few, the late Arthur Koestler's 'Act of Creation' is perhaps the most illuminating attempt at characterizing this basic human quality. To juxtapose men of great creative abilities alongside psychotropics belittles the achievement of both, or in Koestler's words, it would dismiss 'The Ghost in the Machine'.

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