Correspondence

Collaboration between psychiatrists and physicians in geriatric medicine

DEAR SIRS

In 1979 the Standing Joint Committee of the British Geriatrics Society and the Royal College of Psychiatrists approved 'Guidelines for Collaboration Between Geriatric Physicians and Psychiatrists in the Care of the Elderly'. These have since been widely published (Royal College of Psychiatrists, 1979; DHSS, 1980; Norman, 1982; Post and Levy, 1982) and also have been circulated to members of the British Geriatrics Society.

Arising from variations in, and uncertainties over, the responsibilities of joint working, the Liaison Committee of the Royal College of Psychiatrists and the British Geriatrics Society explored joint assessment—a discussion paper is available from the Royal College of Psychiatrists. These discussions of joint assessment revealed persistent anxieties amongst psychiatrists and physicians in geriatric medicine about their *total* area of collaboration. The areas of continuing concern were found, in most cases, to be already covered by the guidelines, but later discussions highlighted areas of particular difficulty. This letter draws attention to the continuing problems, and some suggested remedies, as seen personally by the signatories, who also wish to reaffirm the central position of the original advice.

1. *Imbalance between the level of provision in related psychiatric and geriatric services*
   Co-operation would be promoted by:
   (i) Psychiatric services for the elderly that are comprehensive and provide domiciliary, out-patient, day patient, acute in-patient and continuing care.
   (ii) Defined psychiatric commitment to aged patients with a range of psychiatric diagnoses and preferably not to those only with a diagnosis of dementia.
   (iii) The presence of at least one designated consultant in psychiatry per District with special responsibilities for the clinical care of elderly patients, organization, liaison and planning.
   (iv) The consultant and other members of the psychiatric team committed to the elderly remaining in strong association with the rest of the psychiatric services.
   (v) Similarly, consultants in geriatric medicine will promote co-operation from psychiatrists by providing a range of services and showing reasonable willingness to take responsibility for mentally disordered patients with sufficient physical disorder who do not present with prohibitive* problems of behaviour.

*Prohibitive is here defined as compulsive wandering, suicidal depression, paraphrenia and psychopathic personality.

2. *Divergent clinical practices between psychiatrists and physicians in geriatric medicine*
   The co-ordination of the psychiatric and geriatric services would be assisted by general agreement about the characteristics of patients appropriate to each. In this task the preponderance of physical disability, mental impairment and socially disturbing behaviour will need to be considered. Agreement in this and other spheres of work is fostered by working together in a clinical setting.
3. *Poor availability of extended care beds and disagreement about their use*
   Co-operation between specialist psychiatrists and other consultants in psychiatry on admission rights and appropriate ways of sharing the pool of continuing care beds will be reassuring to physicians in geriatric medicine. Similarly, specialist psychiatrists and physicians in geriatric medicine will need to agree on the type of patient appropriate to extended care in their respective services. It is essential that both psychiatrists for the elderly and consultants in geriatric medicine should have access to enough long-stay beds to enable them to arrange essential transfers from the acute units with the least possible delay.
4. *Lack of clarity within the specialist services with regard to admission rights*
   For admission to acute units in both services to proceed smoothly an accepted policy about who can agree to the admission of a patient will be required. For pure geriatric and psychiatric streams this is unlikely to present difficulties (in some areas limited cross-admission rights have been negotiated). Where there are joint units, the proportion of beds available to each service has to be negotiated. A decision may have to be taken regarding the extension of admission rights to the Social Services Departments.
5. *Lack of clarity in both primary and secondary care services as to the type of patient appropriate for referral*
   General practitioners and consultants need to be informed about the way in which the specialist services for the elderly are to be made available to individual patients. They will also need guidance on the clinical characteristics which would point to the referral most appropriate to the patient's needs. It is essential that general practitioners should be clearly responsible for examining patients before referral. Care outside the hospital by secondary care workers should not encroach on primary care.

G. E. LANGLEY
L. A. WILSON

Exe Vale Hospital
Exeter

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Guidelines for teaching psychology to students of psychiatry

Dear Sirs

Last year the *Bulletin* (April 1982, **6**, 54–6) carried an article, 'Sciences Basic to Psychiatry: AUTP Guidelines', which contained a footnote to the effect that the teaching of psychology as applied to psychiatry was the subject of a joint working party of the College and the British Psychological Society. As Chairman of the Joint Standing Committee of the College with the British Psychological Society, I have asked to write to you to amplify the footnote.

The position, in fact, is that this Joint Standing Committee did produce a document some five years ago on the teaching of psychology to students of psychiatry. On the advice of the College members of the Joint Standing Committee at that time, this was forwarded to the College's Court of Electors who, we were advised, in turn forwarded it to the AUTP. The latter have presumably made what use of the document they chose, and this is reflected in the currently published 'Guidelines'. The Joint Standing Committee is reasonably content with the Guidelines now issued, although it would have liked to have seen: (a) some amplification of the relationship between the basic sciences and their applications; and (b) a more definitive statement on the psychotherapies.

However, there is not at present any working party of the Joint Standing Committee in existence, nor is one planned. There is a survey of teaching requirements under way by the Professional Affairs Board of the British Psychological Society, and the results will no doubt eventually be available to the Joint Standing Committee and thence to the AUTP.

It may also be of interest to know that the Joint Standing Committee's incoming Chairman—Dr J. Jancar (the Chairmanship alternates annually between the College and the Society)—is proposing that a small conference of invited representatives from the two bodies should be set up to consider issues of mutual interest and concern. Teaching Guidelines and syllabuses might well be one item, and the Joint Standing Committee would welcome suggestions for others.

D. A. Black

Broadmoor Hospital
Crowthorne, Berks

Training for senior registrars with special interest in psychiatry of old age

Dear Sirs

More or less every week there are advertisements of vacancies for the post of psychiatrist with a special interest in psychiatry of old age. There appear to be large numbers of senior registrars in adult psychiatry who want to have some training in psychogeriatrics. There are a limited number of posts which have been specified for training in psychogeriatrics. In my view, senior registrars who want to become psychogeriatricians need some guidance about the type of training they should try to look for. There is an article by Dr D. J. Jolley, 'Psychiatrist into psychogeriatrician' (*Bulletin*, November 1976, 11–13) which is worth reading.

During some recent meetings with other senior registrars, I had the feeling that there were some questions to be answered about the training needs and I would try to answer some of the questions.

1. Should one have one's first posting as senior registrar in adult psychiatry or in psychogeriatrics when one has already decided to become a psychogeriatrician? I feel that one should complete the training in adult psychiatry first before starting full time in psychogeriatrics. As regards the time limit, six months to one year's training in psychogeriatrics should be sufficient.
2. Are day or two-day attachments over long periods sufficient? I do not think that this is a good idea because one cannot become fully involved in the different aspects of services for the elderly.
3. Should one work full time in geriatrics for three to six months? Theoretically, it appears to be an excellent idea, but there are some practical problems. In my view a psychogeriatrician needs to have or acquire a good knowledge of internal medicine, but there is no need to try to become a geriatrician as well.
4. Should one have attachments full-time or part-time with EEG departments or CAT scan departments? In my view full-time attachments for even short periods may not be necessary. As a consultant psychogeriatrician one needs to interpret results or even interpret the recording which one could do by acquiring sound theoretical knowledge and some knowledge of practical aspects of these investigations.
5. Should one do domiciliary visits? I think one should do domiciliary visits for the experience although senior registrars are not entitled to payment at the moment, but this should not be an obstacle because experience is necessary.
6. Should one spend some time with the community services for the elderly? The answer is 'yes'. One could visit and liaise with Part III Homes, EMI Home or even private nursing homes who admit elderly patients.
7. Must you do research to become a consultant? In my view research is not a must to become a consultant, but in