
columns

ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS (2004) *The Royal Australian and New Zealand College of Psychiatrists Equivalence Guidelines*. http://www.ranzcp.org/pdffiles/training/exempt/Equivalence%20Table%20Revised%20June%202004.pdf

Varuni de Silva Senior Lecturer in Psychiatry, Faculty of Medicine, University of Colombo, Colombo, Sri Lanka

Professor Khan echoes a sentiment shared by hundreds of psychiatrists who have passed the MRCPsych exams after a great deal of hard work; it is frustrating to see others who have never been through the process still get the MRCPsych. Dr Bhugra states that this 'College is the only Royal College which has tried to be inclusive'. By doing what – handing out Membership for free! This is certainly *not* something to be proud of. This is a mere gimmick to entice psychiatrists to work in the UK and in my view greatly lowers the credibility of the College.

I moved from the UK to work in the USA and it is very common to see psychiatrists who trained in the UK and have moved here. Psychiatrists still continue to come here from the UK, many even after passing the MRCPsych. One of the most common reasons cited is the inherent unfairness of a system where everything is based on need rather than on merit. In contrast becoming a Board-certified psychiatrist in the USA involves passing the exams of the American Board of Psychiatry and Neurology after the required number of years of training. There are no exceptions based on fame, repute or need.

MRCPsych is an award I was proud to add after my name and despite moving to the USA, I have continued to pay my fees to the College. However, I no longer see any point in paying over £300 a year for something that anyone can have and have decided to stop paying my annual Membership fees. However, since my fees are currently up to date, I continue to add MRCPsych after my name for the time being!

Maju Mathews Assistant Professor of Psychiatry, Drexel University College of Medicine, Philadelphia, Pennsylvania, USA,
e-mail: maju.mathews@drexelmed.edu

In his excellent article Professor Khan raises concerns regarding the awarding of Membership of the College without adequate checks. He points towards the College's high standing and its ability to guide opinion in countries which have not yet developed such structures for themselves. The British Medical Royal Colleges have traditionally had this role throughout those Commonwealth countries that have largely adopted a UK-style postgraduate education system and teach in English. This is an enormous responsibility and at the same time reason for the College's dilemma. The College is not merely the guardian of professional standards and education but also provides professional guidance beyond its own borders. This is further complicated by the fact that to get a job as a specialist a psychiatrist does not necessarily have to be a member of the College, so the College has no effective role in controlling access to work as a specialist. This latter point is in stark contrast to Royal Colleges or similar bodies across the European Union whose primary role it is to control access to specialist jobs. It is this complex role with no effective control function regarding access to jobs that causes the dilemma faced by our College and exacerbates the problems described by Professor Khan. The answer could be to subdivide the three roles of: (a) controlling access to specialist jobs; (b) controlling education; and (c) setting standards and giving professional guidance at home and abroad.

Peter Lepping Consultant Psychiatrist/Honorary Lecturer, University of Wales, Llwyn-y-groes Psychiatric Unit, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham LL13 7TD, Wales,
e-mail: peter.lepping@new-tr.wales.nhs.uk

I fully agree with the views expressed by Dr Khan and I appreciate the comments made by Professor Bhugra (*Psychiatric Bulletin*, January 2006, **30**, 3–6). It is heartening to note that the College is striving hard to maintain the highest standards of training and ethics and that certain steps are being taken to establish new guidelines and criteria to uphold these standards across the board. MRCPsych is undoubtedly the most prestigious qualification and therefore it should not be awarded to those who fail to meet its standards.

Professor Bhugra mentions two groups of people who could be awarded this qualification without examination. However, there is another group which he fails to mention. Under Article 14, the Postgraduate Medical and Education Training Board (PMETB) can now consider the applications of many middle grade doctors for specialist registration who do not have the accredited higher specialist training or who have previously been unsuccessful in the MRCPsych examination. If some of these applicants are successful, then they will move on to the specialist register of the General Medical Council, thereby automatically qualifying for Membership of the College.

I suggest that the College sets up a tier system whereby these potential awardees, before being granted Membership, either take some form of modular examination or undergo a series of training workshops and courses. By implementing such a system the College will be able to appraise the knowledge and skills of these doctors objectively. It will also enable these doctors to match the standards achieved by those who acquire MRCPsych through normal means. If this is not possible then the College should seriously consider amending the Bye-Laws once again.

Rameez Zafar Consultant Psychiatrist, Peter Hodgkinson Centre, Lincoln LN2 5UA,
e-mail: Rameez.Zafar@lpt.nhs.uk

I am writing to express the view of the Collegiate Trainees' Committee (CTC) on the issue of Membership without examination as discussed at the last CTC meeting. Although acknowledging the importance of recognising senior psychiatrists of international repute, trainees are opposed to the idea of indiscriminate awarding of the MRCPsych to overseas psychiatrists if they have not passed the UK examinations.

There are two lines of reasoning supporting this argument. First, there seems to be a plethora of ways in many countries to obtain a postgraduate psychiatric qualification, one of the eligibility criteria for the awared of Membership without examination (*Psychiatric Bulletin*, January 2006, **30**, 3–6). As some of these qualifications are not underpinned by training, assessment and quality-assurance systems as robust as those in the UK, awarding the reputable MRCPsych to holders of only these qualifications would seriously devalue the MRCPsych in the eyes of not only the medical community but also the public at large. Second, awarding the MRCPsych to those who have not toiled through a very rigorous UK training and assessment system would seriously discriminate against past, present and future generations of postgraduate UK trainees who have done so.

If the College feels the need to recognise psychiatrists who have not passed both parts of the Membership exam, it should ensure that there is some way to differentiate their title from that of those who have undergone the rigorous UK training.

Amit Malik Chair, Collegiate Trainees' Committee, The Royal College of Psychiatrists,
e-mail: doctmalik@hotmail.com

Response of College

The College has closed the category of Membership without examination on legal advice. The College wishes to make it possible for psychiatrists practising at consultant level in the UK or Ireland to become associated with the College at the earliest possible stage wherever they trained, qualified or gained experience. A consultation exercise is currently underway seeking the views of members

https://doi.org/10.1192/pb.30.5.193-d Published online by Cambridge University Press

columns

and other psychiatrists on how this can best be achieved. The consultation form, which has been circulated widely, can also be downloaded from the College website http://www.rcpsych.ac.uk/membership/ConsultAsso_06.pdf

Choosing a career in child and adolescent psychiatry

Lamb *et al* (*Psychiatric Bulletin*, February 2006, **30**, 61–64) have reported the views and experiences of trainees in child psychiatry placements and their influence on the choice of child and adolescent psychiatry as a career.

The College recommends that 'trainees should have considerable experience in child and adolescent psychiatry at senior house officer level'. However, it seems that by the time trainees start a child psychiatry placement most have already decided on their career plan.

Senior house officers are accustomed to working within in-patient adult psychiatry units. The transition to a child and adolescent psychiatry placement can be disconcerting. Trainees have to work within a multidisciplinary team where their role and objectives are unfamiliar and seem remote from adult services. Trainees also find that their skills and work experience are not centre stage.

The College specifies that probably the most important ingredient of clinical training is regular direct supervision either individually or in a small group by the consultant (and where available) by specialist registrars. Regular direct supervision would also be valuable to help trainees reflect on their career goals.

We believe that providing a mentor (a senior colleague, specialist registrar) at the beginning of the placement, early involvement in novel training experiences (e.g. family therapy) and in-house workshops and seminars (e.g. child protection issues) could help create a rewarding training experience that could encourage trainees to perceive child psychiatry as a future career.

***A. Cadinouche** Senior House Officer in Psychiatry, Northgate Clinic, Edgware Community Hospital, Middlesex HA8 0AD, e-mail: haac@doctor.org.uk,
F. Gainza Consultant in Child and Adolescent Psychiatry, Northgate Clinic, Edgware Community Hospital, Middlesex

Disseminating psychological skills in old age psychiatry services

It was encouraging to read about the level of interest in psychological therapies for older people in Wales (*Psychiatric Bulletin*, January 2006, **30**, 10–11). Older people will become more aware of psychological therapies and will request them more in the future.

The multidisciplinary team training in cognitive–behavioural therapy (CBT) which was devised and developed by Chris Williams is aimed at training a community mental health team in basic CBT skills, without the jargon associated traditionally with CBT. Hence, it is easily accessible to team members who have no formal training in the discipline. The system is designed to be used in part or whole by practitioners and can therefore provide a range of sessions for varied needs. Training material can be downloaded from http://www.calipso.co.uk

Having trained in Glasgow, I am now imparting these skills to my colleagues from the multidisciplinary team in north Dublin and they have been well received. It is difficult for any service to gain protected time for training. Whitfield *et al* (*Psychiatric Bulletin*, February 2006, **30**, 58–60) highlight the need for supervision, the development and maintenance of CBT skills as well as for the training and supervision of others. I suggest that the challenge in disseminating these skills is to locate and establish local centres of expertise which would provide supervision and ongoing training. This might prove particularly difficult in areas where no such therapies have previously been available.

Fiona Fenton Consultant in Old Age Psychiatry, Mater Misericordiae Hospital, 61 Eccles St, Dublin 7, e-mail: fmfenton@eircom.net

Evans and Reynolds highlight the limited access to psychological therapies for older people in Wales. Similar problems exist in England despite a commitment to psychological therapies in the National Service Framework for Older People (Department of Health, 2001) and the National Institute for Clinical Excellence guidelines for anxiety and depression (NICE, 2004).

A survey across Suffolk, Norfolk and Cambridgeshire for the National Institute for Mental Health in England (East Region) in 2004 showed that in several areas the availability of psychologists was very limited (survey available from NIMHE East Region or by e-mail from dm214@aol.com). College guidelines suggest there should be 0.5 psychologists per 10 000 population aged over 65 years, but few areas achieve this level and some have none. Interviews with community team leaders revealed that several had unfilled psychology posts owing to recruitment difficulties. Psychologists frequently support memory clinics, but the availability of drugs enhancing cognition has also increased the need for psychologists in the community.

Psychology resources are key for the supervision of other staff providing psychological therapies, behavioural therapy and psychometry where a diagnosis of dementia is in doubt. Unfortunately our survey revealed insufficient A grade psychologists to supervise assistants, and therefore the old age specialty was not attracting new entrants. Community psychiatric nurses (CPNs) are often trained in psychological therapies, but with a threefold variation in CPN numbers (from 2000 to 7000 population aged over 65 years per CPN), time for delivering these therapies was often limited. If we are to provide psychological therapies to older people with mental illness, the shortage of psychology resources needs to be addressed.

DEPARTMENT OF HEALTH (2001) *National Service Framework for Older People*. London: Department of Health.

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2004) *NICE Guidelines to Improve the Treatment and Care of People with Depression and Anxiety*. London: NICE.

Susan Bedford Associate Specialist in Old Age Psychiatry, Wonford House Hospital, Dryden Road Exeter EX2 5AF, e-mail: dm214@aol.com

Psychiatric comorbidity in foetal alcohol syndrome

With increasing media interest and public awareness and reports from North America regarding the prevalence of psychiatric comorbidity in foetal alcohol syndrome (FAS; Famy *et al*, 1998), concerns are being raised locally as to the knowledge of mental healthcare professionals of this issue. Clinical work with this group suggested that the wider mental health community has limited knowledge of FAS as a condition, despite international figures suggesting a prevalence rate of 1% in the community (O'Leary, 2004). Hence one of us (R.A.S.M.) devised a brief questionnaire to determine mental health practitioners' knowledge of the condition. The questionnaire was used at three local academic programmes attended by a mix of mental healthcare professionals.

Everyone (n=33) had heard of FAS as a condition but only five professionals felt able to recognise it. One person (a psychologist) considered FAS in the differential diagnosis and nine knew where to refer a person with FAS if the diagnosis was suspected or found. Only one individual with foetal alcohol spectrum disorder (FASD) was known to those professionals attending the programmes.

These results are similar to those from other studies (Nanson *et al*, 1995) and highlight the need for education in this area in order to guide UK practitioners in the recognition of the condition and what can be done to help affected individuals and their families. We believe there is an

https://doi.org/10.1192/pb.30.5.193-d Published online by Cambridge University Press