in musical improvisation the musical relationship between therapist and patient may be seen as revealing aspects of the patient, which include his or her capacity for establishing, sustaining and developing a relationship with another person. Alternatively, the improvisation may be seen as an adjunct or trigger to a verbal relationship between therapist and patient, in which feelings elicited during the musical activity may be discussed. Improvisation may also be used with patients who have physical disorders, where it provides an opportunity for them to hear their movements in sounds which are given musical meaning by the therapist. The therapist can provide the possibility for extending these movements, by improvising music which invites and motivates the patient to play (and move) in different ways.

Although the studies cited by the authors provide an important theoretical foundation for the use of music in therapy, the profession has evolved well beyond the patient as passive listener, or even music-as-recreation. This is thanks to the pioneering work of figures such as Juliette Alvin, Mary Priestley, Paul Nordoff and Clive Robbins. Kenneth Bruscia's book *Improvisational Models of Music Therapy* (1987, Charles C. Thomas, Springfield, Ill) provides a commanding overview of music therapy.

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Responsibility of the Child and Adolescent Psychiatrist in Multidisciplinary Teams

DEAR SIRS

At a recent meeting of the Wessex Child Psychiatrists the advice contained in the *Psychiatric Bulletin*, (September 1989, **13**, 521) was discussed.

The paragraph containing the sentence "such clinical responsibility must be terminated only by agreement with the child's general practitioner" gave rise to much concern. Our group felt that the need for termination of clinical responsibility should be determined by the consultant. In addition we agreed with many of the points raised in the letter of the Leicester Child Psychiatrists group (*Psychiatric Bulletin*, March 1990, **14**, 175).

We thought that it would have been helpful if the advice had been circulated in draft form by the College for comments by the members before a definitive statement was issued.

W. A. SAUNDERS
Chairman
Wessex Child Psychiatrists

DEAR SIRS

This note is a comment on the two letters that have appeared in the *Psychiatric Bulletin* on the responsibility of child and adolescent psychiatrists in multidisciplinary teams. Issues of medical protection are only one of the many areas where the enlightened practice of child psychiatry (and increasingly other branches of psychiatry and community paediatrics), fit uneasily into the mould developed for the main body of medical practice.

Following detailed discussion with the medical protection agencies guidelines for practice were outlined, and were discussed with the Child Psychiatry Section Executive Committee and other relevant College committees before approval by Council in June 1989.

The letters raised the matter of consultation. Members of the Section must be aware that there are many similar issues being dealt with by their elected Executive Committee. While it is not College policy to circulate draft documents to the total membership, the current officers have instituted a newsletter for the membership. This is intended to inform members of the ongoing issues being considered and to invite comment. It is hoped that members will make use of this opportunity to join in the debate.

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Qualifications for appointments to substantive consultant posts

DEAR SIRS

In his letter (*Psychiatric Bulletin*, January 1990, **14**, 43) Dr Cottrell looked forward to the day when members of Advisory Appointments Committees would finally obtain "... relief from the grim ritual of making no short lists or appointments from a field largely comprised of locum consultants with no senior registrar training of any kind".

Training at the senior registrar (SR) level is important, and I fully support this programme as part of the process of maintaining good standards of clinical practice in the emergent corps of consultants. Nevertheless, as we all know, there are many 'intangible' factors that go into the making of a consultant. Is SR training the only way to acquire these qualities?

One of the 'intangible' factors that distinguish consultants from non-consultant medical staff is experience. The locum consultants to whom Dr Cottrell refers have done, and continue to do, all the things consultants do. Some have been involved in teaching

and research and have contributed articles and papers to journals. Many have planned and developed new services for their Health Authorities. They have the experience of being consultants.

As far as I know, and as demonstrated by actual experience, Members of the Royal College of Psychiatrists who have had no SR training have no difficulty fulfilling the duties and responsibilities of consultants in clinical work, teaching, research or administration. There is also nothing to suggest that their colleagues who have had the full SR training make better or more competent consultants. (If there are data to the contrary, could the College make these available to us through the pages of the *Bulletin*?)

There is no doubt that, having become a Member of the Royal College of Psychiatrists, a doctor does need a further period of training and experience in order to qualify for appointment to a substantive consultant post. However, there do not appear to be real or demonstrable grounds for the insistence on formal SR training as a *sine qua non* for qualification for these appointments.

The point I would like to make is that this requisite further experience could be obtained either through the formal SR training scheme, or through working as a locum consultant.

My recommendation is that, in order to qualify for appointment to a substantive consultant psychiatrist post, the candidate would either have undergone the full four-year SR training, or been in continuous, locum consultant appointments for the same period, with at least two years devoted to the specialty in which the candidate is interested. In either case, the candidate would need to have shown interest in academic matters, and have good references.

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JCHPT requirements regarding locum consultant posts – a warning letter

DEAR SIRS

There are a number of post-membership psychiatric trainees who, for one reason or another have not achieved senior registrar appointments but who have had alternative psychiatric experience, not infrequently in extended locum consultant posts. These doctors are now experiencing serious difficulties in progressing their careers to a substantive consultant appointment.

We wish to re-affirm the importance which the JCHPT and the College attach to higher training in psychiatry beyond the MRCPsych level for all trainees aspiring to consultant appointments. Higher training in psychiatry is normally arranged so as to provide a grading of supervised responsibility from post to post. An unsupervised locum consultant post cannot substitute for this aspect of training otherwise it would be appropriate simply to proceed from registrar to consultant, a procedure which neither the JCHPT nor the college would accept. It is for these reasons that the JCHPT Handbook (1987 edition) clearly indicates that consultant locums should be undertaken only in the latter stages of higher training and then for no longer than three months. We sympathise with individuals who have undertaken locum consultant appointments in order to help provide a service where it has not been possible to make a substantive appointment and who may have been advised inappropriately. However, the present Handbook is clear concerning the regulations and the revised Handbook, which will appear later this year, will contain a statement emphasising the danger of taking consultant locums for too long a period and at too soon a point in a training career.

The College has been particularly successful in acquiring a further 90 senior registrar posts following the JPAC negotiations. These posts will in future help to solve the bottleneck existing between general and higher professional training. However, in the meantime we strongly recommend trainees to familiarise themselves with the contents of the Handbook regarding training requirements.

J. R. M. COPELAND
Chairman
Joint Committee of Higher Psychiatric Training
(*See pp.* 543–548)

Requests for early film footage

DEAR SIRS

I am a film researcher working on a television series for BBC2 on the social history of sexual attitudes in Britain during this century.

I am trying to find early film footage which shows life in mental institutions, 'mother and baby' homes and VD hospitals/clinics.

I would be most grateful to know if anyone knows of such film. Maybe it was amateur film shot by a member of staff of the institution or maybe it was an 'instructional' film that has been kept within the hospital archives.

We are aware that the contents of such films would have to be treated with extreme sensitivity and would like to stress that the programmes will be a serious and detailed history of the subject area.

MAGGI COOK

Domino Films
8 Stockwell Terrace
London SW9 0QD