



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](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.

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### 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.

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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](mailto: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.

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### 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