I set up, with unanimous support from colleagues, the N. Ireland Section of the Irish Division. The NHS provisions and changes which we had been able to monitor and follow when there was the Irish Division of the RMPA necessitated a continuity of linkup through the Irish Division of the new Royal College. It seems this Irish solution to an Irish problem has worked, our colleagues in the south realising that, although NHS involvement is only in a small area of the total island, the population of N. Ireland is just about half of that of the Republic.

Ivor has stuck to his vision of community psychiatry development over the years. I have nothing but admiration for this, seeing it from a close viewpoint without personal involvement, when others have held equally sincerely opposing views. Ireland has produced several distinguished psychiatrists but it is pleasant to see one who has given such admirable service at home honoured by a special place in the *Bulletin*.

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Mental handicap training

DEAR SIRS

Reading 'Training Psychiatrists for Work in the Community' (*Psychiatric Bulletin*, **16**, 23–24) there is evident similarity between the issues now being looked at in community psychiatry and those looked at in community mental handicap services at the beginning of the '80s. Perhaps this reflects the current position of mental handicap on the spectrum between biological and social disorders, it being considered more of a social problem than general psychiatry despite its more obvious organic roots.

Trainers in general psychiatry might look at mental handicap training to see how issues of the hospital v. community, multidisciplinary team working, and clinical role v. organiser, have been worked out within the community mental handicap services. Many senior registrars in mental handicap spend time within a hospital service and time within community services as part of community mental handicap teams, and through this community service gain experience within the full range of community settings.

Community settings are less structured than hospital settings and it is easy to get sucked into managerial and organisational meetings and while these have their value, trainees must learn how to protect clinical time; it is knowledge of patients which informs these other roles of the consultant. Most problematic has been the relationship between the consultant and other team members, and no doubt this is one of the major issues within community psychiatric services. There is much written on this topic and many models have emerged. The understanding of other disciplines is an essential part of training as this allows the consultant to take some over-view and not become bogged down in interdisciplinary dispute.

If general psychiatry trainers are wondering how to give trainees organised and supervised experience in community psychiatric settings, it may be worth looking at the local mental handicap services for part-time sessional input which might be of mutual benefit to both services and training.

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Psychiatric training in Singapore

DEAR SIRS

Robertson *et al's* article on psychiatric training in Singapore (*Psychiatric Bulletin*, January 1992, **16**, 36–38) stated that "suicide remains an offence under Singaporean law, but no action is taken for deliberate self-harm, unless it is related to national service". This implies that some form of disciplinary action will be taken in cases of deliberate self-harm related to national service, which is not entirely accurate.

Based on my experience as a psychiatrist in the armed forces, all cases of deliberate self-harm are reported. A board of inquiry will be convened and its findings submitted to a review board. The review board sits to discuss the findings and these reports are routinely circulated to the psychiatrist for an opinion on the soldier's mental competency (Lim & Ang, 1992). Depending on the causes, appropriate action will then be taken. Disciplinary action is not the only means of disposal. Very frequently, the soldier concerned is referred for counselling, or to a psychiatrist for treatment of an underlying psychiatric problem.

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Reference

LIM, L. C. C. & ANG, Y. G. (1992) Parasuicide in the male conscripts – a Singapore experience. *Military Medicine* (in press).

Senior registrar in psychotherapy

DEAR SIRS

Competition for public sector funds will set medical psychotherapists against others, especially clincal psychologists. Other disciplines will compete very favourably, on price. They will also often compete

favourably, on choice, against medically trained analysts.

Senior registrars will need to address a difficult balance: College (JCHPT) guidelines, which fit comfortably lucrative private practice; the needs of varied and sizeable catchment populations; the economic pressure of the developing "market" in health care. There can be few medical psychotherapists who are not afflicted by, or witnessing paranoid anxieties, in these uncertain times.

The medical psychotherapeutic community and its potential clientele have two reasons for thanking Dr Ryle (*Psychiatric Bulletin*, January 1992, **16**, 30–32); for his good sense in the *Bulletin* and for having elucidated cognitive analytic therapy, which can serve as a realistic bridge between ideology and reality. I wish Dr Caldicott and her committee every success in their deliberations on these vitally important matters.

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Psychiatric services for old people in the UK and Australia

DEAR SIRS

Professor Andrews' response to Dr Snowdon and myself (*Psychiatric Bulletin*, January 1992, **16**, 48–49) that "the elderly themselves are suspicious of mental health services, fearing institutionalisation in a mental hospital. They *therefore* (my italics) seek mental health care from general practitioners and geriatricians". There is no factual foundation for this statement. Having recently visited services in Australia, I believe that older patients do not seek help from psychiatrists primarily because it is often not available.

I disagree that there are no means to decide whether predominant Australian or British models are best. Studies comparing specialised and non-specialised services in Britain (Wattis, 1989) generally show specialist old age psychiatry services to be better. Also, I have listened to grumbles of Australian geriatricians about psychiatrists' unwillingness to be involved with elderly patients. There are also areas of Australia where psychogeriatric services have developed and these could be compared with areas where such services are not available.

Finally, there are two fallacies in Professor Andrews' final sentence. Firstly, even if nursing home care is cheaper *per person* it is not cheaper *overall* if a substantially larger proportion of the elderly population is placed in such care. Secondly, good specialist psychogeriatric services have potentially cost saving functions (e.g. identifying and treating depressive illness in the community, so avoiding nursing home care) and are not necessarily associated with placement of patients in long-stay mental hospital care.

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Reference

WATTIS, J. (1989) A comparison of "specialised" and "non-specialised" psychiatric services for old people in the United Kingdom. *International Journal of Geriatric Psychiatry*, **4**, 59–62.

Managing a challenging case

DEAR SIRS

I was intrigued by Drs Joyce and Palia's correspondence inviting suggestions on management for their challenging case (*Psychiatric Bulletin*, January 1992, **16**, 52).

Though brief, the history reveals a married 68-year-old woman (S.T.) who presumably has a family. She has had frequent admissions to the same hospital over a period of 34 years, which suggests that she has repeatedly entrusted her care to the medical staff who in turn have developed a working relationship addressing her needs. Her current diagnosis is unclear. She appears to have chronic schizophrenia with depressive features now prominent. I am unsure whether her lack of insight refers to the ongoing schizophrenia or the more recent depression. Her cognitive functioning is impaired which may be due to the depression, the presence of an early dementing process or environmental factors. She is obviously not capable of independent living, being resident on a long stay ward. The presence of a bladder calculus exposes her to repeated urinary tract infections, leaves her anaemic and on analgesic medication. Anti-cholinergic side-effects of her psychiatric medications pose future risks to her in addition to the more obvious consequences of leaving the calculus *in situ*.

Central to the authors' dilemma is the conflict between the autonomy of their patient and their duty of care to her. If they follow a paternalistic line, should they consider S.T. to be competent but misguided and therefore arrange the operation because its in her best interests? Or should they consider S.T. as incompetent by virtue of the fact that she is making an illogical decision in refusing the operation? Either of the above choices leaves them running the risk of being held guilty of trespass to the person, but equally if they withhold that treatment, they may be in breach of a duty of care owed to S.T.

In S.T.'s case the interpretation of her wishes is uncertain, considering her history, current mental state and her physical health. A judgement has to be made on her behalf and despite her wishes being clear, I feel it is appropriate to do so. S.T. appears to