

RANZCP training programme.¹⁻⁴ The 2019 survey of Victorian trainees found that several trainees had sought external psychotherapy training,⁴ presumably in lieu of adequate opportunities within the training programme.

A central tenet of RANZCP training is that the supervisor–trainee relationship is based on the apprenticeship model. This model relies on the supervisor as the repository of knowledge and skills. Thus, it follows that inadequate training in the psychotherapies begets inadequate teaching of the psychotherapies. The available data support this, with the 2003 trainee cohort (who felt inadequately skilled in psychotherapy) going on to become the supervisors of 2013 and 2019 trainee cohorts.

The Psychotherapy Written Case is an important part of training and helps develop foundational knowledge and skills in psychodynamic therapy and reflective practice. However, it does not equip psychiatrists with techniques used in brief, structured psychotherapies. These structured therapies form the core of evidence-based treatment for the high-prevalence disorders that are the bread and butter of our practice. Trainees undertake three mandatory EPAs (therapeutic alliance, supportive psychotherapy and cognitive behaviour therapy [CBT]). The latter is unfortunately often completed with supervisors without relevant expertise, and likewise for the requirement of three non-graded six-session CBT cases. There is also an absence of training or workplace assessment in other evidence-based therapies such as dialectical behaviour therapy or acceptance and commitment therapy.

A critical review of this gap in the RANZCP training programme is required. In the meantime, the College should ensure that psychotherapy supervision is provided by those with suitable expertise and credentials (e.g. psychologists or appropriately qualified psychiatrists). In the era of COVID and telehealth, international and interstate educators may present an accessible option for training and supervision.

Until improvements in psychotherapy education and practice occur, we encourage trainees and supervisors to consider self-funding further training and supervision in the psychotherapies. Such an investment will greatly aid our patients and future generations of trainees.

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Sustainable operation of private psychiatric practice for pandemics

Dear Sir,

The COVID-19 pandemic and similar future challenges prompt measures for sustainable private psychiatric practice. Australian private psychiatrists have provided increased levels of outpatient, and sustained inpatient care, during the first two years of the pandemic.¹ This has been achieved through innovative adoption of telehealth, facilitating continuity of consultations during pandemic lockdowns.¹ Telehealth for psychiatrists to provide care to

hospital inpatients will further enhance the resilience of the private mental health system.²

We provide advice on maintaining the business operation of private practice during pandemics, including:

1. Adapting practice management to allow for flexible work arrangements that include working from home, such as practice management software/services that allow for remote referrals, booking, billing (EFT-POS or similar), correspondence transcription, handwritten-note conversion-to-text, and records management.
2. Adopting a purpose-designed telehealth web platform, compliant with Australian cybersecurity recommendations.³ Preferably, platforms will be interoperable with practice management software/services, and service providers fully compliant with Australian health and privacy legislation. Cybersecurity is essential as there has been increased cybercrime during the pandemic.⁴
3. Implementing protocols for patient and practitioner attendance at the practice in accordance with public health measures, especially lockdowns, as well as assessing the suitability of telehealth for individual patients.⁵ These protocols should also include when to resume face-to-face consultations.
4. Ensuring availability of and adherence to pandemic public health protective measures such as masks and PPE, hand-washing, distancing and contact-tracing check-in within the practice.
5. Contingency-planning for virus exposure predicated on (1-4) above, for example, a psychiatrist or staff-member who has unknowingly attended an identified exposure site may trigger the quarantine of staff, necessitating remote working from home.

6. When working from home, ensuring privacy and confidentiality for workflow and patient consultations, as well as compliance with work health and safety requirements. This includes ergonomics, provision of specific equipment and software (antivirus-security, practice management, telehealth platform), furniture and so on.
7. Maintaining regular communication amongst practitioners and staff, coordinated through the practice manager and/or practice principal via secure electronic messaging.
8. Through temporary adoption, low activity period stress-testing of these operational methods.

We have outlined some of the measures we have found useful to enhance sustainability during the pandemic, and encourage colleagues to share further advice through the journal and the RANZCP.

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Information-seeking on pandemic health threats for persons with schizophrenia

Dear Sir,

With the recent bushfires and ongoing COVID-19 pandemic, the Australian community has been subjected to serious threats. Repeated waves of widespread SARS-CoV-2 outbreaks have been described as the biggest threat of the 21st Century, heightened by the recent emergence of the highly infectious Delta variant.¹ Therefore, it is useful to explore factors which may influence how people deal with health threats, including innate levels of optimism, cognitive style and access to a support person (<https://www.blackdoginstitute.org.au/news/10-tips-for-managing-anxiety-during-covid-19/>). We explored these issues in patients with schizophrenia, and general practice attendees, as part of a larger study on risk perception during the 2009 swine influenza pandemic.² We are not aware of a similar study during the current COVID-19 pandemic.

The sample included 48 patients with a diagnosis of schizophrenia (Scz) recruited from inpatient and community health care settings in the Australian Capital Territory, matched (age, gender, and employment status) with a sample of 48 patients from general practice (GP) settings without a diagnosis of schizophrenia. The mean age in both groups was 35 (SD =11; range = 19–65). Each group comprised 27 males. This study was ethically approved.

There were no statistically significant differences between the Scz and GP

groups for: optimism; having a support person to turn to; and having a tendency to avoiding thinking about threats when faced with them (Table 1). However, there were significantly fewer people with schizophrenia who reported seeking more information when faced with, and in order to deal with, a threat, compared with the GP group.

One in five people in both groups reported feeling optimistic none or only a little of the time. However, 61% of the people in the GP group saw themselves as being optimistic all or a lot of the time compared with only about 42% of people in the schizophrenia group. Approximately one in three responders in each group viewed themselves as having a tendency to push aside thoughts about new health threats confronting them. Only 58.7% of people with schizophrenia reported seeking to gather more information about a new health threat in order to work out the best way to deal with it, compared with 78.3% in the GP group. The majority (80%) of people in both groups reported having access to a support person some, a lot, or all of the time.

People with schizophrenia, already at greater risk from SARS-CoV-2 due to comorbidity, might benefit from encouragement and/or assistance from their psychiatrist, GP, and carers to seek information and advice on how to deal with new health threats. This should include guidance related to public health messaging, including vaccination hesitancy, related to the COVID-19 pandemic.

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