dicting response to treatment in all patients encountered. Another problem is the absence of normative data with which to compare one's own findings. The answer for this would be to compare findings with a senior colleague who had run a similar survey of his own work.

A high degree of co-operation and goodwill would be needed. Perhaps the major difficulty lies in the interpretation of negative findings; a self-examination which reveals no faults must be suspect. I tried to overcome this possibility by studying only patients who were seen regularly by my consultant, who would act as a corrective influence on my assessments. Further investigation into formal self-audit schemes would be valuable.

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Report of a Session of the AGM, 1980

The Statutory Registration of Psychotherapists

At the recent Annual Meeting of the College in July 1980, the opening session was devoted to the issue of the statutory registration of psychotherapists—a topic at present keenly debated. (See discussion paper by Michael Shepherd, this issue page 166.) A general report of the session is printed below.

MR PAUL SIEGHART, Chairman of the Professions Joint Working Party, summarized the Report of that body published in 1978. Seven organizations, including the College, had representatives on the Working Party and four additional bodies sent observers. Mr Sieghart explained the difference between the two varieties of professional registration currently in use. Functional registration was appropriate where it was possible to define precisely the scope of the work, e.g. in dentistry or in optician practice. Indicative registration was where the statute protected names or titles, e.g. in medicine or nursing. A register of psychotherapists could only be indicative because of the great difficulty in delimiting the field. If legislation were enacted, it would be unlawful to state or to imply that one was a psychotherapist if not on the register. Control would be exercised by a Council (analogous to the GMC) who would protect the public against unqualified or unscrupulous persons, maintain standards, regulate training and prescribe a code of ethics.

The Working Party had reached agreement that registration was desirable, but the representative of the British Association for Behavioural Psychotherapy had entered a Note of Dissent in the Report.

DR IRVING KREEGER, who represented the College on the Working Party, was strongly in favour of establishing a register. After setting out the practical difficulty of identifying psychotherapists, he discussed the constitution of the proposed Council and emphasized the importance of regulating training, which he considered should be the principal criterion for registration. Despite the many varieties of psychotherapeutic work, there had been a remarkable consensus in the desire for legislation. He disputed the view that the registration process would split psychiatry and psychology so that those not on the register would cease to concern themselves with psychotherapy.

DR ANTONIA WHITEHEAD, the representative on the Working Party of the British Association for Behavioural Psychotherapy, was in favour of registration, but did not regard training as a suitable criterion. Subscription to a code of ethics should be a key factor. The other principal criterion should spring from the critical evaluation of a psychotherapeutic procedure as effective or not. She questioned sharply the value of training to carry out treatments of dubious validity. She believed that psychoanalysts tended to equate psychotherapy with the dynamic approach. Registration would be a costly undertaking, and she hoped that in the event it would truly serve to protect the public rather than the practitioner.

DR PAMELA MASON, speaking for the DHSS, said that the Government saw no objection in principle to a system of indicative registration similar to that provided for professions supplementary to medicine. However, such a system would not be effective in prohibiting or restricting the activities of dubious fringe bodies, and there would be the prospect of a never-ending list of additional protected names and titles. The potential value of the Report lay in the possibility of its commanding the support of the professions, including those not represented on the Working Party. The Report was not unanimous—the British Association for Behavioural Psychotherapy had dissented and had queried whether valid training could be defined and thought controls would be best applied by professional bodies, and the British Psychological Society did not necessarily share the Working Party's views. The issues were complex and there was a need for continuing discussion by the professions.

There was no Government time available for legislation. If a Private Member's Bill should seem likely, certain questions

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would need answering—what happened in other countries, including the EEC, and how serious were the risks to the public of the current situation. The view prevailing in the DHSS was that the risks from some of the practices which now went under the name of psychotherapy, and from practices of a similar kind under other names, were real and very worrying, but were probably not susceptible to prevention by statute.

PROFESSOR MICHAEL SHEPHERD's paper (p. 166) was a searching criticism of the Report, with the conclusion that registration was pointless unless concerned with a well-defined field of work, effective in achieving its aims.

KENNETH RAWNSLEY

Correspondence

Mental health and apartheid—A case to answer?

DEAR SIR,

Over the last five years, the South African government has been accused of abusing Blacks in psychiatric institutions and also of involuntary psychiatric detention for political reasons. The charges have come from sources within South Africa (de Villiers, 1975), the British and European press (Deeley, 1975; Wästberg, 1976) and the World Health Organization (WHO, 1977); a *Lancet* editorial in 1977 expressed considerable concern. More recently, the American Psychiatric Association has published the findings of its committee which investigated the allegations (1979). The President of the APA wrote: 'the most powerful impression made on us was that the evils of apartheid do not stop at the hospital door' (Stone, 1979).

The WHO Report—a preliminary review of available information on mental health services in South Africa—first gave credence to various accusations of political abuse of psychiatry. The Report is an indictment of the South African government's policies in the organization of mental health services for Blacks; these are noted as inadequate not only in comparison to those provided for the white population but also in relation to the most elementary essential human needs and rights.

Moreover, there is collusion of interest between private companies and the State, as the care of chronic patients is handed over to private, profit-making companies. These companies make profit, using government subsidies; government spending through this arrangement is less than it would have to be if mental health care for Blacks were provided directly by the State Health Service.

The most disturbing aspect of the WHO Report is the claim that psychiatric facilities could be used for political and social control of Blacks. Legislation concerning the rehabilitation of pass law offenders (i.e. Blacks convicted for remaining in a white area without valid authorization) equates the non-observance of apartheid laws with mental disorder. The proclamation about rehabilitation institutions in the Bantu homelands was approved in 1975 and this established institutions for 'rehabilitation', 'treatment' and 'training' of ordinary offenders against the pass regulations. The aims of the 'rehabilitation' procedures are defined in paragraph 5 of the proclamation, and they imply that any African who does not observe the laws of apartheid is mentally disturbed and in need of compulsory improvement of his 'physical, mental and moral condition'.

The APA Report confirmed most of the WHO allegations, finding evidence of bad medical care resulting in needless deaths, inadequate sanitation and deficient psychiatric treatment at most of the private psychiatric institutions for Blacks. On the other hand, there was no evidence that Blacks were confined in psychiatric hospitals for political reasons. The Americans were shown selected psychiatric institutions only, and their visit was arranged and co-ordinated by the South African Ministry of Health. They were prevented from visiting any State-controlled hospitals for Blacks. As the APA Report says: 'We were prevented from investigating a crucial link in the mental health service system'. In other words, the Committee was not in a position to deny or substantiate the allegations of political abuse of psychiatry.

Following the publication of the WHO Report and the *Lancet* editorial, Professor Gillis, of the Society of Psychiatrists of South Africa, denied the allegations and commented: 'it is unwarranted to tie the apartheid tin to the tail of the psychiatric cat, no matter how much of a pleasing din it makes' (Gillis, 1977). As Jablensky subsequently (1978) pointed out, Gillis had failed to address himself to the main issue raised in the WHO Report—whether to regard 'socially harmful policies in the areas of health' as a legitimate ethical concern or as 'frankly political issues'. Clearly, South African psychiatrists need to take stock of the situation, particularly following the APA Report.

The College has so far not commented on the South African issue, although it has spoken out courageously on similar issues—such as the Soviet misuse of psychiatry for political purposes. The College's silence is not only worrying but is likely to be interpreted as condoning what is happening in South Africa. I am sure there are many members, like myself, who feel that the College should speak out on

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