the columns

correspondence

Locums . . . and the light at the end of the tunnel

Another plea to the altruism of beleaguered clinicians in services already beset by resource and staff shortage, along with chronic demoralisation. No doubt Peter Kennedy (*Psychiatric Bulletin*, August 2003, **27**, 281–283) has patient and not financial interest in mind as he proposes new roles for psychiatrists that in today's conditions will only see them covering larger patches and with greater caseloads.

The current shortage of doctors in psychiatry is the inevitable result of a long deterioration in terms and conditions of service. Peter Kennedy obscures this point and distracts our attention with petty argument focused on financial envy. He goes on to assert that moneys for worthwhile services are being frittered away and I am sure management can confirm this. Where are these worthwhile services? They are long overdue, but I do not think they will come, whether or not there are locums.

Locums are not the problem and for every 'dodgy locum' you could name, there would be more than ten times the number of stories relating to staff shortages that are not covered. While there may be doctors of mediocre performance, commitment to a local service does not render immunity!

Itinerancy is very antisocial and working as a locum difficult. It is no mean feat to arrive in a new work environment and within hours deal with complex issues requiring extensive local knowledge. There is no grace period or induction and performance is expected immediately, your next job depends on it! You may or may not be the focus of financial envy, but there seems no escape from the intellectual contempt with which substantive colleagues regard you.

There is a financial issue and it needs to be addressed. It is time for consultant psychiatrists to realise their bargaining power and take a locum!

N. Skudder Psyche UK Ltd, PO Box 3031, Sheffield S5 7XD

European Convention on Human Rights

Lepping's view that rights under the European Convention on Human Rights were not 'implemented' in Britain until the Human Rights Act 1998 is incomplete (*Psychiatric Bulletin*, 2003, **27**, 285–289). The UK has been a signatory to the ECHR since its outset in 1951. Since 1966, it has granted the right of individual access. The HRA 'incorporates' the ECHR into our law but 'the view that that makes a sea-change is an erroneous one' (Collins, 2001). Indeed, there are clear signs of influence by the ECHR in the 1983 Mental Health Act (Hewitt, personal communication – information available from author on request).

As these two examples show, Lepping may also be mistaken in believing that the HRA will now radically improve the condition and treatment of psychiatric patients.

In *Hercegfalvy v. Austria* a Hungarian refugee was admitted to an Austrian psychiatric hospital in a weakened condition due to a hunger strike. Over several weeks, he was force-fed, sedated against his will, handcuffed, fastened to a security bed by straps and a net, and secured by his ankles with a belt. The European Court held that none of this would breach Article 3. Where a measure was deemed 'therapeutically necessary', it could not be regarded as 'inhuman or degrading'.

In *HM v. Switzerland* it was held that the confinement of an 84-year-old capable woman in a residential home did not breach Article 5, even though she did not consent to it. It was deemed to be in her best interests. This case could have profoundly deleterious effects on the rights of detained patients in the UK.

Finally, a number of serious concerns have been raised regarding human rights abuses that might be introduced by the Draft Bill (which purports to reconcile domestic law with the ECHR).

Contrary to widespread belief, it seems that the standards of the ECHR, at least in terms of protections for vulnerable psychiatric patients, can be really rather low.

HEWITT, D. (2003) Lecture notes, University of Northumbria.

HOUSE OF LORDS AND HOUSE OF COMMONS JOINT COMMITTEE ON HUMAN RIGHTS (2002) Draft Mental Health Bill, 25th Report of Sessions 2001–02, HL Paper 181, HC 1294, 11 November 2002.

PER COLLINS, J. in R. *(on the application of the Secretary of State for the Home Department) v. Mental Health Review Tribunal* (2001) A.C.D. 62, para 77.

Fareed Bashir Specialist Registrar in Forensic Psychiatry, 1412 Junction Road West, Lostock, Bolton BL6 4EQ

The future role of general adult psychiatrists

I was delighted to see that Dr De Silva has further developed his interest in working with Primary Care colleagues (*Psychiatric Bulletin*, 2003, **27**, 326–327) having previously worked in our service in Grampian many years ago, which is fully committed to working with Primary Care, mainly in a liaison consultation model, but also with a clear attachment of specialist services such as outreach and assertive outreach and core primary care aligned mental health teams.

I and many colleagues from all disciplines have worked in this way for over 10 years, holding regular clinics within general practice and regular liaison meetings with primary care colleagues, including joint assessment where necessary. In my opinion, the outcome of this approach has been to dramatically reduce our need for in-patient provision to well below the recommendations of the College (e.g. we will shortly have 23 acute beds per 100 000 population in general adult psychiatry), and I have no doubt that this model has allowed early detection and intervention for patients with significant mental illness, both through the education of general practitioners and through their ability to rapidly access services.

From a personal viewpoint, therefore, I cannot support Dr De Silva's suggestion of a 'sub-specialty model' where different psychiatrists are responsible for community services as opposed to hospital services. I fear this does nothing but

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reinforce the 'community is good, hospital is bad' divide, which often continues to pervade the thinking of politicians, users and professionals. Furthermore, I believe that one of the greatest strengths of our current system in Grampian is that consultants are made responsible and accountable for their bed usage and thus are also seen as responsible for ensuring adequate community provision wherever possible.

However, for a variety of reasons, the continuum model, which I believe we have successfully offered in Grampian, unlike other parts of Scotland, over many years is now under threat from a number of different sources. These include local management changes, a continued belief from the Scottish Executive that community mental health services are in some way completely separate from hospital mental health services, and thus can be aligned with social care and other services, and from the new Mental Health Act in Scotland, which from 1 April 2005 will undoubtedly push consultant psychiatrists into much more of a pure secondary care situation. It has the potential to completely exclude the general practitioner from the detention process and emphasises repeated appeal against detention in the form of Tribunals.

This may lead to the situation that Dr De Silva describes under his joint working model, in which the consultant psychiatrist has a caseload of a low number of complex, often dual diagnosis patients. Yet I fear for many psychiatrists such as myself that this will be a retrograde step, which will be at the detriment of the very close links that we have achieved with primary care through our aligned services. It will make it much harder for us to work with general practitioners in an educational way, to offer early intervention and adequate management to patients with a variety of psychiatric conditions, and thus to continue to limit our usage of acute psychiatric beds to which admission should be seen as part of an ongoing continuum of care, led by the responsible consultant psychiatrist rather than being seen as a separate process that continues to reinforce the unhelpful hospital *v.* community divide.

Alastair N. Palin Consultant in Adult Psychiatry/Clinical Director, Royal Cornhill Hospital

Less stress or more?

Dr Hampson must be congratulated for the very real achievement of modernising her job plan (*Psychiatric Bulletin*, August 2003, **27**, 309–311). It is surely right to maximise the efficient use of consultant time by excluding routine tasks that can be safely delegated. I wonder however if the new job plan might not be even more stressful for the consultant than before.

My reservation is around the area of 'supervision' of other disciplines and the role of advisor to GPs, a role that involves 'hearing about patients' rather than seeing them.

The processes for communicating a clinical problem involve presenting a short summary of the patient, usually verbally, lasting maybe 5 minutes. It is similar perhaps to the 'elevator pitch' used in the film industry to outline a movie proposal to a prospective producer.

Listening to the elevator pitch is wearing for the recipient (particularly if the metaphorical elevator is a slow one or seems to belong to an unusually tall building). The effect is similar to a PMP exam, where a series of hypothetical problems is laid before the candidate.

Many of the telephone and verbal vignettes may be risk reduction transactions rather than genuine requests for advice. As such they are more likely to be generated by less confident or skilled practitioners, who are also less likely to be proficient at summarising key points. In the new way of working the consultant may increasingly serve as a risk depository. Am I alone in finding delegated working more stressful than direct patient contact?

Tim O'Grady Clinical Tutor for Lincolnshire, Peter Hodgkinson Centre, Lincoln LN2 5UA

Multi-disciplinary team assessments

The article by Simpson and De Silva in the September issue (*Psychiatric Bulletin*, September 2003, **27**, 346–348), outlining two team referral models of multidisciplinary teams (MDT) working in Old Age Psychiatry, was of interest to us, primarily as the debate echoed changes which have occurred within our own service within the past few years. However, we believe that we have moved the service one important step further.

Until August 2002, the Old Age Service in Eastern Hull, a socially deprived urban area, worked largely by the 'Whitby model' described in the article. However, despite this model, a large catchment population, high morbidity and referral rates (including many inappropriate 'urgent' referrals), demanding cover arrangements, and the relative clinical isolation resulting from working in scattered community settings, all contributed to sustained stress and low consultant job satisfaction.

In response, the service was remodelled to involve two consultant psychiatrists working closely together. Although one of the consultants takes the lead for a rural population, both have input into urban Eastern Hull and work as integrated members of the MDT. Each has an area of special interest across the whole patch – one consultant deals with hospital liaison, while the other leads the memory clinic and family therapy. Protected time is provided for CPD, personal and service development issues.

The incorporation of this arrangement into MDT working has, we believe, improved the depth and quality of discussion on clinical issues, cover is simple, and consultant job satisfaction has vastly improved. The MDT values the model and we believe that overall service quality has improved. Others may wish to consider similar service innovations.

David Lawley & John Bestley Consultants in Old Age Psychiatry, Hull and East Riding Community Health NHS Trust, Maister Lodge, Hauxwell Grove, Middlesex Road, Hull HU8 0RB

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