the columns

correspondence

Improving working lives

Rafey Faruqui is quite right that appropriate workloads and good working conditions are essential ingredients for maintaining good recruitment and retention of consultant psychiatrists (*Psychiatric Bulletin*, November 2003 correspondence, **27**, 437). The question that my editorial, 'Locums – and the light at the end of the tunnel', tried to address is: how can those things be achieved when there is such an imbalance in supply and demand, causing work overload for many psychiatrists (*Psychiatric Bulletin*, August 2003, **27**, 281–282)? Dr Faruqui agrees that reliance on a locum workforce is 'pathological', and no kind of a solution. In that respect, the letter by Skudder, of Psyche UK Ltd (*Psychiatric Bulletin*, November 2003 correspondence, **27**, 437), which grossly misrepresents what I wrote, invites the question of whether a declaration of interest of a locum agency should have been made.

The recent expansion of medical schools will not be felt for more than a decade at consultant level. Meanwhile, demands on psychiatrists working in traditional ways will very likely continue to grow. It is hopeful, therefore, to see so many items appearing in the Bulletin about how roles and working practices of psychiatrists can change to reduce their case-loads and improve working conditions.

The College *is* addressing this complex issue, and consulting its members on the options through the College website (www.rcpsych.ac.uk) and the Bulletin. It is an issue of crucial importance to the future of the profession and mental health services. Therefore, the views of specialist registrars will be particularly important.

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In defence of locum consultant psychiatrists

Peter Kennedy (*Psychiatric Bulletin*, August 2003, **27**, 281–282) has concerns about the quality and cost of locum consultants. Quality would be best assessed by the Royal College of Psychiatrists, as with CCSTs, perhaps by a retired consultant. The lack of a national database represents a failure of management at the Department of Health, as does its failure to establish a register of those other expensive wanderers, patients with Munchausen syndrome.

Do I detect a note of envy at the £180k that locums receive? Fewer would be needed if three sessions extra were paid to over-worked general consultants. My impression is that home graduates tend to do less demanding jobs in liaison psychiatry, cognitive–behavioural therapy, and eating disorders, leaving the 'dirty jobs' to those qualified abroad. The pits of medicine, namely psychiatry, geriatrics and inner-city GP posts, have traditionally been filled by graduates of South Asia (Passage from India, *Guardian*, 27 August 2003). Recruitment remains difficult, due to under-financing and bed closures, against a doubling of the incidence of schizophrenia in London (Boydell *et al*, 2003). If a similar increase were to be found in epilepsy or diabetes, then extra resources, both in hospital and community, would be made available.

How much are consultants worth? The answer is £450–500k, which is the payment at direct treatment centres for surgical waiting lists.

Declaration of interest

I may do some locum work, at the rate the market will bear.

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Tribunal panels

The College included a mail shot with the December *Psychiatric Bulletin*, making members aware of changes in recruitment to Mental Health Act 1983 Tribunal Panels. The College mentioned the decrease in the period of 'consulthood' required before an application to join would be considered. They raised the issue that there was a shortage of consultants willing to sit on tribunals, and that this was a way of addressing the issue.

Is it possible that poor pay compared to the new consultant contract (£390 for the day versus £282 for a fifth-year consultant), that the fee would be retained by the employing Trust if performed during working hours, and that a minimum commitment of 30 programmed activities (PAs) per year are significant obstacles [Terms & Conditions of Service 2003: An agreement between the British Medical Association's CCSC and the Department of Health for Consultants in England, 2003]. A year of Monday mornings is 42 PAs (52 per year minus 10 weeks annual leave, study leave and statutory leave). Further barriers may include the minimal compensation for cancellation (£50.00 if cancelled after 15:00 the day before the Tribunal) [Part-time Medical Members of the Mental Health Review tribunal (2004) Guide for Applicants. DCA, 2004] and the limited indemnity provided [Luce Report, Department of Health, 2003].

I do not dispute that the work is stimulating, educating and fulfils an important role in social justice. I do wonder if doctors remain undervalued, and that the scandal of waiting times for Tribunals is not as important as those for surgery!

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Psychotherapy training in the Northwest – a survey

Training in psychotherapy is now recognised as a significant component in the overall training of psychiatrists. The College has delineated psychotherapy training requirements for trainees in different stages of their training, but these are not yet a precondition to sitting the MRCPsych examination (Bateman & Holmes, 2001; Royal College of Psychiatrists, 2001). We conducted a survey of trainee experiences in psychotherapy and existing training resources in Northwest England. Questionnaires were sent to college tutors and psychiatry SHOs in Manchester deanery (response rate 40–60%). Information from trainees suggests that a third of year 2/3/4 trainees had not undertaken a single psychotherapy case.

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Most trainees did not report any experience with systemic/family therapies. However, a majority of trainees had attended interview skills training courses and case discussion/Balint groups.

Information from college tutors suggested that all responding hospitals offered interview skills training and an active case discussion/Balint group. Psychotherapeutic skills were included in educational contracts of trainees in a smaller majority of responding hospitals. Individual-therapy training and supervision (in supportive-dynamic and/or cognitive modalities) was available (locally or through regional psychotherapy departments) in all responding hospitals, but systemic therapy experience was limited to only few hospitals in the region.

The findings suggest that resources are available to introduce trainees to psychotherapy at a basic level, but may be less adequate to meet individual and systemic therapy training needs of more senior trainees. There is a need to develop a regular and accessible system of supervision of trainees in individual (especially cognitive) and systemic therapies in the region.

BATEMAN, A. & HOLMES, J. (2001) Psychotherapy training for psychiatrists: hope, resistance and reality. *Psychiatric Bulletin*, **25**, 124–125.

ROYAL COLLEGE OF PSYCHIATRISTS (2001) Requirements for psychotherapy training as part of basic specialist psychiatric training (Bateman, A.W. (convenor), Anderson, H., Bhugra, D., Freeman, C., Hughes, P.). London: Royal College of Psychiatrists.

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Re: Unpacking Personality Disorder

I read with interest Peter Snowden and Eddie Kane's Editorial on personality disorder (*Psychiatric Bulletin*, November 2003, **27**, 401–403). It appears to me that personality disorder will be broken down into multiple subtypes in the future. The two particular subtypes I have become aware of are those with personality disorder who also meet the criteria for adult attention-deficit hyperactivity disorder (ADHD) and have had childhood ADHD. This type will need the underlying ADHD to be treated. The second type is an autistic psychopathy which was described by Hans Asperger. It appears to me that a small number of patients with personality disorder meet the criteria for autistic psychopathy or Asperger syndrome, and these will require treatments focusing more on theory of mind skills and empathy deficits (Fitzgerald, 2001).

FITZGERALD, M. (2001) Autistic psychopathy. *Journal of the American Academy of Child and Adolescent Psychiatry*, **40**, 870.

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the college

The Royal College of Psychiatrists and the Law

Colleagues will be aware of the College's submissions in relation to planned legislative changes such as the Draft Mental Incapacity Bill and the Draft Mental Health Bill.

It is very much less common for the College to become directly involved in court cases. This has happened, to a greater or lesser extent, in three recent and important cases.

Colonel Munjaz and Mersey Care National Health Service Trust and S. and Airedale NHS Trust and (1) The Secretary of State for Health and (2) The National Association for Mental Health (MIND)

This was a Court of Appeal hearing in relation to the two cases mentioned above. Both cases related to the legality of seclusion and the status of the Mental Health Act 1983 Code of Practice. In the former case (Colonel Munjaz), the patient had taken action against Ashworth Hospital because the seclusion policy and practice at Ashworth was not in line with the Code of Practice. In the latter case (S.), the patient took action against Airedale Hospital because of the specific circumstances in which he was kept in seclusion, again being outside the parameters set out in the Code of Practice. In both circumstances, the patients had lost their cases in the High Court and both had appealed. The Court of Appeal heard both appeals together.

The National Association for Mental Health (MIND) was extremely concerned about the judgements because both Judges had appeared to diminish the importance of the Code of Practice. MIND approached the College, through me, to ask if we would be prepared to make a statement that could be included in their submission. I made a formal witness statement on behalf of the College, giving examples as to why we thought it essential that the Code should be considered the usual standard of practice other than in defined circumstances and for good clinical reasons.

The final judgement concluded that the policy in Ashworth was unlawful and Airedale were not justified in keeping Mr S. in seclusion for the length of time that they had done so. The Judgement made mention of the College's submission and said the following:

> 'hence we conclude that the Code should be observed by all hospitals unless they have a good reason for departing from it in relation to an individual patient. They may identify good reasons for particular departures in relation to groups of patients who share particular well-defined characteristics, so that if the patient falls within that category there will be good reason for departing from the Code in his case. But they cannot depart from it as a matter of policy and in relation to an arbitrary dividing line which is not properly related to the Code's definition of seclusion and its requirements'.

The Queen (on the application of I.H.) and (1) Secretary of State for the Home Department and (2) Secretary of State for Health and (3) East Midland and North East Region Mental Health Review Tribunal and (4) The Royal College of Psychiatrists and (5) Nottinghamshire Health Care NHS Trust

This was heard in the House of Lords.

I.H. was a patient in Rampton Hospital detained under Section 37/41 Mental Health Act 1983 (MHA). A Mental Health

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