The College and the independent sector

Sugarman & Nimmagadda (Psychiatric Bulletin, November 2007, 31, 404–406) argue persuasively for equivalent access to Continuing Professional Development, revalidation and appraisal requirements for both private sector and National Health Service (NHS) consultants. But it is dis-appointing that they attempt to drive a wedge between private and NHS (‘government service’) psychiatrists, arguing without evidence that the latter are more mired in administration and are less focused on clinical work. They also take a swipe at nationally agreed terms and conditions with their outdated critiicism of the NHS pension scheme and Clinical Excellence Awards, implying their support for a more casualised medical workforce governed by market forces.

The article highlights the need for the College to take a more critical stance than the one afforded by Hollins (2007) on the involvement of the private sector within publicly funded services. Of all detained patients in March 2006 17.1% were located at private hospitals (Department of Health, 2007) and it is surprising that increasing private sector development at the expense of local NHS development has not led to the same level of debate as the Independent Sector Treatment Centres within surgical specialties. The authors are correct to challenge myths about the competencies of clinicians working in the private sector but legitimate concerns regarding the relative costs of care, increased geographical isolation of private units, and poaching of NHS-trained staff on often inferior terms and conditions should not be dismissed lightly or ignored as the elephant in the room.


Darran Bloye Consultant Forensic Psychiatrist, Wathwood Hospital RSU, Gipsy Green Lane, Wath-upon-Dearne, South Yorkshire S63 7TQ, email: Darran.Bloye@nottshc.nhs.uk
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Sugarman & Nimmagadda (Psychiatric Bulletin, November 2007, 31, 404–406) have highlighted a very topical issue. It is interesting that psychiatrists in general feel stigmatised and discriminated against by their colleagues from other medical specialties. Yet, NHS psychiatrists themselves seem keen to encourage stereotypes about psychiatrists working in the independent sector. The prejudice increases logarithmically when the independent-sector psychiatrist happens to belong to an ethnic minority or works in an ‘unfashionable’ specialty (for some that would be, for instance, learning disabilities).

Although psychiatrists working in the independent sector are perceived to be earning huge salaries and working in cushy jobs, they do not have the job security that NHS psychiatrists enjoy. The authors have rightly pointed out that independent-sector psychiatrists do not benefit from the generous NHS final-salary pension scheme.

The performance of independent-sector psychiatrists is constantly monitored. They do not tend to have armies of trainees to assist them and they provide a consultant-delivered service, not unlike in the US system. As they are under increased scrutiny working in the independent sector, the feeling of isolation and lack of peer support is a huge problem. Hence the benefits are balanced by the personal costs and a decision to work in the independent sector is often a difficult choice.

As Professor Hollins rightly alludes to in her commentary (Hollins, 2007), with the expansion of the private sector and possible difficulties in obtaining NHS employment, this is a choice that senior trainees will increasingly have to make.


Prabhat Mahapatra Consultant Psychiatrist, CARE Principles, Cedar House, Dover Road, Barham, Kent CT4 6PW, email: p.mahapatra@cedarhouse.careprinciples.com
doi: 10.1192/pb.32.2.73a

We read with interest the debate on the turbulent relationship between the independent sector and the College (Psychiatric Bulletin, November 2007, 31, 404–406). We recently attended a seminar organised by one of the leading independent service providers and strongly recommend the experience to other senior psychiatric trainees. We learned facts and numbers which confirm that this sector has grown tremendously since the 1980s and currently plays a significant role in providing specialist care in areas such as forensic services and psychiatry of learning disabilities. The trend appears set to continue and includes more mainstream services with the support of Her Majesty’s government. Professor Hollins is correct to point out that in the near future many Certificate of Completion of Training holders might turn to the independent sector for job satisfaction, while for others this move might be compulsory. In practice, their professional environment might be similar to their current one since many foundations trusts are adopting management styles and policies associated with private institutions. The NHS will need to shift from the mentality of a monopoly state employer and provide better incentives in order to compete for highly motivated and skilled individuals. Choosing other paths for self-fulfilment by future consultants should not be viewed as a betrayal or a dereliction of duty. Since the trend appears irreversible, the College should be more proactive in embracing, monitoring and guiding independent practitioners. It should also help trainees gain exposure to the reality of working in this sector through expanding already available training opportunities in private hospitals.

*B Joseph KHOURY Specialist Trainee in Psychiatry, Berkshire Healthcare Foundation NHS Trust, Mental Health Unit, Heatherwood Hospital, Ascot SL5 8AA, email: Joekhouri@yahoo.com, Bhanu Gupta Specialist Registrar in Psychiatry, Leeds Partnership NHS Foundation Trust, Leeds
doi: 10.1192/pb.32.2.73b

Sugarman & Nimmagadda (Psychiatric Bulletin, November 2007, 31, 404–406) make declarations of potential conflicts of interest in their piece on the independent sector. What they fail to do is to consider the potential for profit-driven mental
Can we harmonise forensic psychiatry across Europe?

In their article Gordon & Lindqvist (Psychiatric Bulletin, November 2007, 31, 421–424) refer to harmonisation of forensic psychiatry in Europe. We agree with the authors that, although laudable in principle, such undertaking is difficult, if not impossible, to achieve. However, it is possible to share experiences and learn from each other. One example of cooperation in forensic services between European countries is the development of the Dangerous and Severe Personality Disorder Programme (DSPD) in England, which was initially inspired by the Dutch *Terbeschikkingstelling* (TBS) system.

Under TBS, the Dutch Criminal Code allows the detention of high-risk offenders with mental disorder. TBS has two components – a prison sentence followed by treatment in designated forensic units (van Marle, 2002). The duration of the sentence depends on the nature of the crime committed and the level of culpability.

Although it seemed prudent to adopt the TBS model, which had been tested over time, the final DSPD proposal came out fundamentally different. TBS order is issued and terminated by the courts, whereas in DSPD, offenders are detained under the provisions of the Mental Health Act 1983. This is despite earlier calls to develop a new strategy for high-risk offenders led by the judiciary, with psychiatrists’ support (Coid & Maden, 2003). The result has been criticism that psychiatry is being used for exercising social control. In our opinion such a composite arrangement meets neither the Dutch rehabilitative approach nor the public protection agenda.


*Najat Khalifa Clinical Lecturer in Forensic Psychiatry, The University of Nottingham, Duncan Macmillan house, Porchester Road, Nottingham NG3 6AA, email: najat.khalifa@nottingham.ac.uk, Mark H. Taylor Acting Consultant Forensic Psychiatrist, East Midlands Centre for Forensic Mental Health, Leicester

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We read with great interest and appreciation the article ‘Forensic psychiatry in Europe’ by Gordon & Lindqvist (Psychiatric Bulletin, November 2007, 31, 421–424).

The wide variety of forensic psychiatric practices in the 45 member states of the Council of Europe is not unlike what exists in the 50 states of the USA, each with its own criminal code and set of laws that frequently require the involvement of forensic psychiatrists. Indeed, the article could have been titled ‘Forensic psychiatry in Europe and America.’

In the section on ethics in forensic psychiatry the authors call attention to reports of differences in the canons of ethics pertaining to US and British forensic psychiatrists. The fact is that one or two prominent US forensic psychiatrists visiting the UK have misinformed our British colleagues that forensic psychiatrists in the USA follow principles of ethics that are different from the code of medical ethics applicable to psychiatrists everywhere. We feel it is important for our British colleagues to know that the vast majority of US forensic psychiatrists do not subscribe to the notion that the so-called ‘forensicist’ operates outside the medical framework and does not act as a physician. Forensic psychiatrists throughout the USA would agree with Drs Gordon and Lindqvist that the knowledge and expertise on which the psychiatrist bases his or her work ‘is that of medicine and psychiatry and the ethical framework is that grounded within [his or her] profession.’

In rejecting the overtures by ‘forensicists’ that a special code of ethics for them be adopted, the Ethics Committee of the American Psychiatric Association has declared that ‘psychiatrists are physicians, and physicians are physicians at all times.’

*Abraham L. Halpern Professor Emeritus of Psychiatry, New York Medical College, 720 the Parkway, Mamaroneck, New York 10543-4299, USA, email: alhalpern@verizon.net, John H. Halpern Assistant Professor of Psychiatry, McLean Hospital, Biological Psychiatry Laboratory, Harvard Medical School, Belmont, Massachusetts

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Mental health training for homelessness agencies

We are encouraged to see that at least one trainee has pursued an active interest in homelessness/shelter populations (Psychiatric Bulletin, September 2007, 31, 326–329). However, we would like to throw further light on one of the author’s conclusions. Stating that training is needed for shelter staff implies that there is little or no training available. In fact, a programme of training for voluntary sector organisations involved in homelessness was set up in London about 12 years ago. The Homelessness Training Unit is based in the Short Term Assessment and Rehabilitation Team (START, a mental health outreach team for homeless people) in Southwark but supplies modules of training to agencies all over London. CRISIS permanent staff receive training from the Unit team every year, although owing to the sheer number of volunteers (several thousand every year) it is only possible to train a tiny fraction of them. However, working with CRISIS is only a small part of what the Unit does.

In 2006 we ran 72 training courses for trainees from a total of 70 different organisations, double the number that were run 3 years ago. The courses ranged from general (Understanding and Recognising Mental Health Problems) to particular (Working with Schizophrenia). Agencies ranged from large, such as St Mungo’s, to small, such as Romford YMCA. Many of the courses were bespoke, in-house training sessions developed with the client organisations. The feedback for these training modules has been consistently excellent.

One of the limiting factors in training CRISIS volunteers is the lack of time and their large numbers. However, most homeless people who attend a CRISIS shelter will be in touch for the rest of the year with one of the other organisations we offer training to, whether it be a hostel, a day centre or a street outreach team. It may well prove more cost-effective to focus on those working permanently with homeless people as their daily experience is likely to cement what they have learnt in their training.

We have been able to offer these courses free to cash-strapped voluntary agencies because of access to central funding. However, this central budget is being devolved to individual boroughs and it is uncertain how many of them, with their own cost pressures and local strategies, will wish to retain this funding.

*Philip Timms Consultant Psychiatrist, South London and Maudsley Trust, email: philip.timms@slamt.nhs.uk, Steve Gardner Training Manager, START Team

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NICE guidelines on treating schizophrenia – audit

We recently carried out an audit of clinical practice in our assertive community treatment team, against the National Institute for Health and Clinical Excellence (NICE) clinical guidelines on ‘core interventions in the treatment and management of schizophrenia’ (NICE, 2002). The guidelines included recommendations that clinical practice should be audited against them and guidance about how to do this.

Our audit aimed to study the compliance with NICE guidelines in a specific team, using direct care-coordinator inquiry and to try to identify reasons for patients not receiving interventions recommended by NICE. Of the assertive community treatment team 84 case-load, 61 were diagnosed with schizophrenia (ICD–10). An eight-item audit tool was used to collect data from care coordinators, using a structured interview method.

We found variable levels of compliance, ranging from 0% for production of advance directive to 85% for the provision of written information to service users/carers. Where interventions were not carried out, this often appeared understandable. In the example of family therapy, only 20% had received formal approach but of the remainder 20% had received formal therapy, only 20% had received formal support for implementation and uncertainty about who should monitor compliance.

We found the results of the audit interesting and it has enabled a form of reflective practice at the team level. We would be interested to hear from other teams that have gone through a similar process, and recommend the method used as a simple way to benchmark a team’s work and consider training needs. Further audit and research into the impact of guidelines on meeting the needs of individuals with severe mental illness is needed.


Rob Macpherson Consultant Rehabilitation Psychiatrist, Wotton Lawn, Horton Rd, Gloucester GL1 3WV, email: rob.macpherson@glos.nhs.uk, Nicola Hovey Audit Manager, Gloucestershire Partnership NHS Trust, Rikenell, Montpellier, Gloucester, Krishen Ranganath Specialist Registrar in Psychiatry, Amjad Uppal Specialist Registrar in Psychiatry, Wotton Lawn, Gloucester, Andy Thompson Consultant Psychiatrist, Orygen Youth Health, Melbourne, Australia

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Highlighting a neglected component of recovery

Schranks & Slade’s article on recovery in psychiatry (Psychiatric Bulletin, September 2007, 31, 321–325) is important for three reasons. First, it provides an exhaustive coverage. Second, many components contributing to recovery are also non-specific therapeutic factors, like: (a) accepting the illness; (b) hope; (c) self-confidence; (d) courage, including an attitudinal readiness to experiment with tolerable risks; (e) responsibility and control, encompassing ‘internal locus of control’; (f) recognising one’s values, strengths and limitations, which includes self-monitoring and evaluation. Similar factors also constitute desirable therapist qualities. Third, and the most important, is that the authors have resurrected the age-old concept of ‘determination’.

I believe that this concept is closely related to that of ‘will’, which is probably even more fundamental as regards mental health recovery. Determination also shares some common components with psychological phenomena – placebo effect, motivation and expectation, and it plays an important role in clinical outcomes, for example in cancer survival.

The concept of will (as in ‘will power’) on the other hand, is deeply embedded in all human cultures. A ‘will to survive’ has appeared in war and heroic anecdotes throughout centuries and a ‘will-to-win’ has been the mantra in competitive sports. Even though this concept is difficult to operationally define, it is unquestionably worthy of investigation by the mental health profession.

Channapatna Shammasundar Consultant Psychiatrist, Bangalore, India, email: drshamasundar@hotmail.com

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A Devil’s advocate

Whelan et al’s article on Medical Training Application System (MTAS) fiasco (Psychiatric Bulletin, November 2007, 31, 425–427) reincarnates the proverbial dead horse. Was there another side to the story? Why do the Colleges tend to forget that they had been consulted on the process before it was implemented? Our College organised meetings on MTAS in London and then pulled out senior house officers from the farthest corners of the UK to sell it. Did they raise a brow regarding the questions on the application form?

But more importantly, was it wise to have changed horses mid-stream? As someone who went through MTAS’ birth pangs, I can say that the panic started when ‘surprisingly’ many were not short-listed. Forgotten was the lost tribe who had been on the list and as we went through the interview process, we found that most of those who were short-listed had more than two interviews. Hypothesis: was the system more specific than sensitive, as all screening processes ought to be? Had the process been allowed to run through its original programme, the second round...
would have seen many vacancies, as those who had been through the first round would have taken only one run-through slot despite being offered many interviews. Hypothesis: could then the system have balanced it, as second round vacancies would be proportionate to the candidates unsuccessful in the first round?

Were we too unnerved to give the system a fair trial as designed (now conspiracy!!) originally? Would any process of selection in future be credible not only in finding a doctor, but distinguishing a surgeon’s glove from a psychiatrist’s couch?

Vellingiri Raja Badrakalimuthu
Specialty Registrar, Drug and Alcohol Services, Norfolk and Waveney Mental Health Partnership NHS Trust, Great Yarmouth, email: dr_vellingiriraja@yahoo.co.uk

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