Correspondence

The real cost of waiting in a prison for a hospital psychiatric bed

Forrester et al’s study on the delays in hospital transfer from prison focuses on an important clinical issue, given it is common knowledge that there is a shortage of secure beds in the country.1

The recently published, government commissioned Bradley report2 recommended that the Department of Health should develop a new minimum target for the National Health Service (NHS) of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting. There are plans to include the minimum waiting time in the local mental health contracts for prisons. The study highlights an important issue of prisoners remaining in inappropriate environments while waiting for a transfer. In prison settings, without the protection of the Mental Health Act, it is difficult to justify using the Mental Capacity Act 2005 to treat a mentally ill individual repeatedly.

The study calculates, based on unit costs,3 the ‘saving’ to the NHS of £6.759 million. Although this ballpark figure is a good starting point, the true costs to the NHS as a result of delayed transfers may well be higher based on the following factors.

The longer the patient remains in prison the longer their psychosis remains untreated. Marshall et al4 concluded in their systematic review that a longer period of untreated psychosis was associated with more severe overall symptoms, depression/anxiety, negative and positive symptoms, and worse overall function. Furthermore, people with longer duration of untreated psychosis were less likely to experience remission at 6, 12 or 24 months. We suggest that ‘delayed transfer patients’ could have longer in-patient stays and require higher levels and more frequent episodes of observation, due to the higher degree of their mental disorder, thereby potentially increasing the costs to the NHS.

The other potentially significant effect of delayed transfers is escalation of self-injurious behaviour and risk to others, in the context of deteriorating mental health. Arguably, the escalation of risk behaviours may result in some prisoners eventually requiring placement in higher levels of security than if they had been transferred earlier in their illness. The evidence for this is reflected by higher prevalence of constant watch, higher incidence of the use of safer cells, care and separation units and transfers to general hospital for treatment. They are also seen more frequently in clinics by visiting psychiatrists and mental health in-reach teams. This increases the demand on meagre resources and arguably increases the overall cost of patient care.

The apparent initial ‘savings’ made from prisoners waiting to be transferred are negated by clinical and financial costs to the NHS in the long term. Finally, from the perspective of equivalence, prisoners should have the same timely access to appropriate mental health services as mentally disordered individuals in the community.


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First things first

Recruiting psychiatrists is indeed a Sisyphean task.5 To counter this, the Royal College of Psychiatrists aims to engage more closely with college students. However, there seem to be more fundamental problems which need addressing.

The College wants to ensure that medical students are aware of the advantages of a career in psychiatry. Before we can do that, however, we have to first make careers in psychiatry more attractive. Although the intellectual stimulation and the challenges that psychiatry brings, the working environment, the increasing confusion about the role of psychiatrists, the current state and future of psychiatry, New Ways of Working and the continuous dismissal of psychiatry as a scientific field by the spin doctors and political gurus are areas of concern.

Compared with other fields, such as general practice, providing better and more flexible working environments in psychiatry does not seem to be part of the government’s plan for the future of the National Health Service.2 Most of the agendas that are damaging the reputation of psychiatry and allowing people to question its scientific credentials are politically driven, but senior psychiatrists are also to blame for colluding with politicians and not doing enough to preserve the integrity of the field.5

Training opportunities for junior trainees are being compromised by replacing out-of-hour on-call rota with other mental health professionals, purely to cut costs. Many trainees are struggling to get decent supervision, while some senior psychiatrists are too busy training nurse prescribers. There is nothing wrong with training other professionals but we need to get our priorities right. While the College and schools of psychiatry encourage higher trainees to get involved in medical education and recruit medical students, and there are many highly enthusiastic trainees willing to do this, the reality is that New Ways of Working and the new training schemes provide very little opportunity and time for the trainees to undertake any such activities.
While we must continue to encourage people to join the most fascinating field of medicine, we also need to get our house in order.


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Are psychiatrists natural leaders?

Professor Buckley is arguing for training in leadership skills for psychiatrists.1 He has not, however, made an obvious distinction between leadership and management, although they can be considered two separate attributes. Management is more of the here and now, the day-to-day stuff, the efforts to keep the wheels moving, as opposed to leadership which involves almost designing a new or better set of wheels. Leadership is about the future – the ability in some ways to be able to look into the crystal ball, get others to look too and somehow achieve that vision. Leadership is much more challenging, although day-to-day management looks as if there are no more challenges left. Leadership is, of course, much more satisfying.

There is also an argument whether leaders are born or can be made. Is the US president, Barack Obama, a born leader or is he a product of the PR guru working overtime? Were Mandela or Gandhi born leaders or just born into a situation that made them leaders?

It is even more difficult to argue that psychiatrists are natural leaders. In our profession it is usually said that we need ‘good communication skills’ – every candidate for a post in psychiatry will put this down as one of their attributes. But what does this mean? What communication skills are we talking about? When we are training, the non-verbal communication is always pointed out as an important part of assessment. When we talk about communication, do we mean listening skills too? Are well-known world leaders good listeners as well? Or do we identify them more with their oratory skills?

It is a myth to think psychiatrists are natural leaders. We must not delude ourselves in thinking so. If anything, we just about match up to the rest of the medical profession. We have had good leaders in psychiatry, but we need better ones. It almost looks as if we need to make some, they are not born these days.


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Doctor’s ethnicity also matters

Niforoooshan et al recently examined the rates and outcome of appeal against detention under the Mental Health Act 1983 for different ethnic groups. They found that Black Caribbean and White Irish groups, although lodging significantly more appeals compared with other ethnic groups (at 63% and 68% respectively compared with 39% White British), were under-represented in the group of patients who successfully had their detention discharged. These findings are revealing, but they would have been more useful if the ethnicity of the tribunal members overseeing the appeal had also been taken into account.

The 2005 Census by the Royal College of Psychiatrists2 reveals the ethnic breakdown of British psychiatrists by grade and highlights the increasing ethnic diversity of psychiatrists in Britain today. Morgan & Beestecher3 recently studied general practitioners’ practices and found that ethnic minority patients tend to be cared for by ethnic minority doctors. Hence any analysis of the impact of ethnicity on the individual treatment of a patient and of the system of care as a whole would be incomplete and potentially flawed without the inclusion of the ethnicity of the professionals involved. In the decades-old debate on the institutional racism of mental health services, the trend so far has been to assume by default that psychiatrists are ethnically or culturally White British. It is important that future studies take into consideration the evolution of the workforce in terms of ethnicity, but also gender and social class.


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WPBA or CASC/OSCE: where is it going wrong?

I have been involved in all aspects of training and workplace-based assessment (WPBA) as a consultant, chair of annual review of competence progression panels and a Royal College of Psychiatrists’ examiner for the past 6 years, and experience the problems discussed by Menon et al1 and commentators2,3 regularly. The inherent weaknesses of WPBAs have been well documented in these studies, but one also needs to seriously consider why trainees who are proclaimed as competent in clinical skills (as evidenced by successful WPBAs) are performing so poorly at the College’s Clinical Assessment of Skills and Competences (CASC) exam, where the success rate has dropped to less than a third?

As an examiner, I sometimes have been exasperated at the poor standards of performance in the recent CASCs where problems have been evident in all aspects of clinical and communication skills (knowing, knowing how, showing how and doing). Is that a reflection of failure of training systems and
assessments (WBPA) or should the obvious conclusion be that there is no correlation between demonstrating competence in clinical practice and performing in an exam (something many may argue has been present all the time)? Should we then do away with the final exam altogether (as run-through training under Modernising Medical Careers may allow in some specialties) or return to the old-fashioned part II clinical exam which some (examiners and trainees alike) may argue was a better test of clinical competence and, more importantly, excellence? These are very important questions that the College and the Postgraduate Medical Education and Training Board need to consider, as one should not lose sight of the ultimate goal (becoming a specialist/consultant) of being in a postgraduate medical training programme in any specialty.

Following Lord Darzi’s recent review of the National Health Service (NHS), it has become ever so important for consultants to be at the forefront of driving quality in the modern-day NHS, something that will be difficult to achieve if we do not produce adequate numbers of quality-trained consultants. This may paradoxically suit many strategic health authorities, primary care trusts and NHS trusts! Many medical managers like me are constantly put under pressure to reduce medical costs (there is anecdotal evidence that consultant posts are not being advertised or retiring consultants are not being replaced throughout the country). As consultants remain relatively expensive units, it would suit the NHS ultimately to have fewer. New Ways of Working is another tool of reducing consultant workload and perhaps ultimately numbers. Thus, if we continue with the current framework of training and assessment, we may inadvertently be facilitating that process.

5 Department of Health. New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services through New Ways of Working in Multidisciplinary and Multiagency Contexts. TSO (The Stationery Office), 2005.

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We all have thought processing difficulties from time to time . . . it’s just the way we react that differs

The underlying issues raised by Kingdon and King are those in the foundations of the theory and practice of psychiatry. Interestingly, the views expressed echoed, at least in part, some of my own views expressed in another publication:

‘Mental illness is never far away as it is simply one end of normality. In other words, we all have thought processing difficulties (TPD) from time to time. Depression is the best example of a thought processing difficulty. However, difficulty may become a disorder when the normal thought processing mechanisms and adaptations fail. A basic mental breakdown, without complicated diagnostic categories, takes place. The manner of the breakdown is unique to the individual sufferer whose internal life is surely more than the standardised criteria set in the scriptures (ICD–10 and DSM– IV)’

The definition of stress adopted by the UK Health and Safety Executive recognised it as relating to pressure and demands: ‘the adverse reaction people have to excessive pressures or other types of demand placed on them at work.’ The intuitive thinker will immediately see the metaphorical relationship to a hydraulic or fluid-based system. If we accept that the mind is metaphorically fluid, then there will be no real boundaries and categories, making vague but universal concepts valid according to the demands of the specific situation. Thought processing difficulty/disorder is as defensible as ‘stress’ from a psychopathological perspective as well as in terms of social acceptability and (best of all) accuracy. I have creatively used the acronym TPD (with ‘D’ meaning either difficulty or disorder according to the patient’s preference) to successfully resolve diagnostic disputes with virtually all my patients who felt stigmatised and erroneously labelled as schizophrenic or as having borderline personality disorder. Most chose ‘D’ as representing a difficulty for which they seek help in a collaborative fashion. It is of course less bruising to anyone’s ego to accept having a difficulty (or stress) than to accept having a disorder (an implicit indication of socially undesirable or deviant behaviour). Thought processing difficulties/disorder has indeed been my Occam’s razor for all psychiatric diagnoses and I recommend it to fellow colleagues. I understand that it will not be specific enough for the ‘square thinker’ – to use Robert Pirsig’s reflection of the views of some African Americans who believed that too much intellectuality and too little soul made a person square. Such a person could not recognise quality, and nothing was real for them unless it was put into boring categories and defined.

1 Kingdon D. Everybody gets stressed . . . it’s just the way we react that differs. Psychiatr Bull 2009; 33: 441–2.

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Screening tests for dementia

Only a tiny proportion of the laboratory and radiology tests identify potentially reversible causes of dementia. However, I would like to sound a note of caution against reducing the use of blood investigations like vitamin B12, folate and thyroid function tests in practice.
In the largest study in terms of sample size the authors found that although a potentially reversible cause was found in only 4% of people with dementia overall, it rose to 19% when limited to people with a young-onset dementia. They also showed that concomitant conditions that were reversible, like vitamin B₁₂ deficiency and thyroid deficiency, were more frequent in patients with mild cognitive deficits than in those meeting the criteria for dementia. Although treatment of these conditions may not always lead to complete resolution of cognitive symptoms, it is important to identify any concomitant conditions in this group to prevent a misdiagnosis of dementia. The recent national dementia strategy has also placed a strong emphasis on specialist assessment and accurate diagnosis.

I agree that subjecting a frail older person in their 90s with a clear history of insidious onset and gradually progressive memory loss to all the battery of investigations may be unwise, but I feel that these investigations should remain an intrinsic part of a comprehensive assessment of someone presenting with a mild cognitive impairment in their 70s or earlier.

CORRECTIONS

Get Through Workplace Based Assessments in Psychiatry (2nd edn) (review). Psychiatric Bulletin 2009; 33: 358. The author of this book is Sree Prathap Mohana Murthy. The publishers apologise to both the author and to Dr Oakley for this error, which has been corrected in the online version in deviation from print and in accordance with this correction.

Review needs re-review (letter). Psychiatric Bulletin 2009; 33: 483. This letter was published in error: the mistake described was the publishers’ own. The publishers apologise for any embarrassment caused to Dr Oakley.

The Psychiatrist cover image, vol. 34 issue 1: the following notice should have been printed: ©iStockphoto.com/Steve Cady. Used for illustrative purposes only; the person depicted is a model. The online journal has been corrected post-publication, in deviation from print and in accordance with this notice.

do: 10.1192/pb.34.2.73a

Obituaries

Dr Ruth Seifert
Formerly Consultant Psychiatrist at St Bartholomew’s and Hackney Hospitals

Ruth was born in North London on 20 December 1943, into a large, radical Jewish family. Her father, Sigmund, was a well-known left-wing lawyer, and her mother, Connie, a political activist. Reportedly very noisy and hospitable, the Seifert household produced four energetic siblings, Ruth’s three brothers excelling in law and academe, and her sister becoming a leading head teacher. Ruth attended Camden School for Girls and then went to Guy’s Hospital Medical School, marrying Charles Clarke, a neurologist (and Everest mountaineer), in 1971. At the time, she was a senior house officer in psychiatry at Guy’s, but moved on to the Maudsley & Bethlem Royal Joint Hospital in 1973, where she completed her postgraduate training. A major influence at the Maudsley was Dr Denis Leigh, a wise and practical physician/psychiatrist of the old school, who wore a white coat and enjoined comprehensive clinical management and a personalised approach to managing chronic neuroses.

Ruth’s stay at the Maudsley was prolonged by having her first daughter Rebecca in 1973 and her second, Naomi, in 1976. Their presence in the hospital canteen, with Ruth (as often as not Gauloise in mouth) declaiming loudly, was one of the joys of training there in the 1970s. Moving to Barts and Hackney (the in-patient psychiatric unit was based at the latter) in 1980, after initially working as a locum, Ruth took on one of the most demanding clinical posts in London.

Until her retirement in 1998, taken early because of her despair at the repetitive changes of NHS management, Ruth worked often single-handedly to provide a proper service. Hackney Hospital, with its five acute wards stacked up in ‘F Block’, was a Victorian infirmary workhouse, decrined as a ‘rat-pit’, intermittently affected by clostridial infections, and sitting on a network of tunnels and outbuildings in which patients would get lost. Never designed as a psychiatric