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correspondence

Cost of locum consultants

Sir: I am writing to ask whether there are any other clinical or medical directors in psychiatry that are facing problems concerning the cost of using locum consultants.

I am the Medical Director of Mental Health Services in Herefordshire and, like many parts of the country, we are having considerable difficulty in appointing substantive consultants to vacant posts. We have two current vacancies and although we have advertised on a number of occasions we have not been able to attract applicants. I am aware that this is a national problem, and not just in mental health.

As we are unable to obtain substantive appointments we have to rely on using locums from various agencies. A locum consultant is paid an hourly rate rather than a salary, which would apply to a substantive appointment. As we have to provide a 1 in 5 consultant rota, our locums are being paid at an annual salary of £190 000/year. This is over twice as much as a substantive consultant post. I have recently heard that one of the locum agencies was actually expecting a locum to be paid an hourly rate that would give him/her a salary equivalent of £232 000/year, roughly three times a substantive consultant salary.

Although a number of the locums we have had in the past have been very good, I am afraid some of them have been of sub-standard quality and nearly all of the complaints we have had about our mental health service in the last few years have been regarding locum appointments. Some of the locums we have appointed have either not got enough qualifications to obtain a substantive post, have retired, or, for physical health reasons, are unable to be appointed to substantive posts. We have even had situations where people have applied for locum consultant posts who have not been through specialist registrar training and are, therefore, less qualified than some of the trainees that we currently have working with us. Locum consultants also often play no, or very little, part in teaching, have considerably reduced administration responsibilities and often play no part in the development of services and all of the other aspects of consultant work that would be provided by a substantive appointment. They usually just provide a pure clinical input.

I realise that Herefordshire is not alone with this problem and from informal discussions I have had with a number of other medical directors in surrounding trusts, they are facing similar problems. I am really concerned that it can only be a matter of time before some of my substantive colleagues resign their post and offer to return to work as locums at twice their current salaries and with none of the teaching, administrative or other responsibilities.

I have raised this issue with the Secretary of State for Health but as yet have not received a reply from the department. I would be very interested to know if other mental health departments are facing similar problems and, if so, whether they would be willing to allow me to provide further information to the Department of Health to highlight this problem.

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Ambiguity of the Mental Health Act?

Sir: Ogundipe *et al* conclude that there is perceived ambiguity in the legality of transferring people from one place of safety to another under Section 136 of the Mental Health Act (MHA) 1983 (*Psychiatric Bulletin*, October 2001, **25**, 388–390).

The MHA Commission in its *Sixth Biennial Report* states ". . . it is illegal to move the subject from one place of safety to another once assessment has been instigated" (p. 78). However, it does not cite case law or statute to support this view.

Section 136 of the MHA on a literal reading states nothing at all about transferring persons between places of safety. Indeed, the draftsman has written the language in the singular, not the plural. He uses the terms "a person" and "a place of safety". The issue of transfer is simply not raised at all. This being the case, I submit that Parliament never intended for persons to be transferred under the authority of this Section. If it did, it would have said so.

The Mental Health Act Commission. *Sixth Biennial Report 1993–1995*. London: HMSO.

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Government proposals for Mental Health Act require redesigning

Sir: The current proposals for Mental Health Act reform (Department of Health, 2000) appear to have met with widespread concern from old age psychiatrists. Burton (2001) has perhaps expressed the concern more clearly than most. But the proposal that all those with long-term mental incapacity should have a care plan that is reviewed by a second opinion doctor seems bound to bring deep foreboding to those who work in the field.

It is certainly the case that the lack of safeguards highlighted by the Bournewood case give cause for concern (*R v Bournewood*, 1998) and that there is an absolute need for effective measures to be available that prevent abuse. However, before agreeing to use a safeguard procedure on all patients with long-term incapacity we should at least consider likely effects. Given the large numbers of patients in residential and nursing homes with incapacity, it must be clear that if the current proposals become law, then the time taken to produce care plans and get second opinions look set to outstrip the entire availability of old age psychiatry in the UK. Moreover, and perhaps more importantly, we know that the more rare a positive finding on a screening system, the more stringent is the screening method required to avoid missing a positive case. In long-term incapacity, we

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think that this means that the proposed routine safeguard procedure will miss most abuse. We are also very concerned at the restriction of safeguards to hospital nursing and residential homes. Surely we need some safeguards for patients living at home and in day centres, etc.

The legislation as proposed is cumbersome and bureaucratic. We think that implementation would make access to care harder for those with severe incapacity and will thus be discriminatory (and thus Human Rights Act non-compliant).

We therefore urge consideration of a simpler system. We advocate the use of a broadly accessed but selective system that would only be used when concerns are raised about the care or rights of an individual. In our view anyone who is concerned about the care of an incapacitated person should be able to trigger a review. People able to initiate reviews would include nurses, carers, relatives and perhaps even a milkman or a priest. Once triggered, a review would need to include a proper assessment and second opinion such as that provided by the Mental Health Act Commission now, but would also need to be able to extend its remit beyond the mere principle of detention and administration of drugs as is currently the case. Environment, care standards and staffing levels might all be appropriate for the review. We think that such a process would have the advantages of being both focused where problems have some chance of being detected, as well as avoiding the destruction of old age psychiatry services by their distraction into an ineffective process. We also believe that the process would provide the access to statutory safeguards that are required under the Human Rights Act assessment and second opinion such as that provided by the Mental Health Act.

BURTON, S. (2001) Mental Health Reforms – have you seen what's coming? *Old Age Psychiatrist*, **22**, 4–5.

DEPARTMENT OF HEALTH (2000) *Reforming the Mental Health Act*. London: HMSO.

R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 3 A11ER 289.

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Stigma and Straw

Sir: Is it not heartening to see that well-known telepathic psychiatrist Jack Straw doing his bit for the College anti-stigmatisation campaign. So, Osama bin Laden is now officially, as far as the Foreign Office is concerned, 'psychotic'. Well that's all right then, we don't need bombs, just two psychiatrists and a social worker parachuted into Afghanistan with pink forms to sort this one out. How stupid of us not to have seen it ourselves, obviously bin Laden is bad/evil, therefore he must be psychotic and akin to Hitler. The overwhelming strength of the argument is irresistible . . . to the average *Sun* reader.

In one fell swoop Jack Straw has undone all the good work that has gone on to integrate the mentally ill into society, and provide the public with positive images of mental illness. But I wonder whether anyone should really be surprised given what is around the corner with the new Mental Health Act and severe and dangerous personality disorder legislation. Bring on the gulags.

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the college

Report of the Overseas Working Group

Council Report CR93
£5.00. 20 pp.

The Working Group was established in June 1999 with a remit "to advise Council on the international role of the College: what contributions the College should (and should not) try to make in the next decade to the development of psychiatry and the training of psychiatrists outside the UK and Ireland, and what resources it would be reasonable to devote to these objectives". Its membership consisted of: Dr M. Abou-Saleh, Dr D. Bhugra, Dame Fiona Caldicott, Mrs V. Cameron, Dr J. Henderson, Dr R. Jenkins, Dr R. Kendell (chairman) and Professor J. Watson. The group met on six occasions and took evidence from over 20 people, including several overseas Fellows.

The main conclusions and recommendations of the working group were that:

- The Overseas Liaison Committee should be replaced by a new International Affairs Committee.
- This committee and the College Council should monitor total expenditure on overseas affairs.
- Members and Fellows in low income countries should be offered reduced subscriptions, using the World Bank's four tiered classification.
- In future, the College's most important role in the training of psychiatrists from overseas should be to help psychiatrists who have already obtained a general training locally to obtain higher or speciality training in the UK.
- The Child and Adolescent Faculty should be invited to set up a working group of its own to consider how it might help developing countries to acquire basic skills in its discipline.
- The Research Committee should be invited to consider how it might help psychiatrists in developing countries to acquire basic clinical and epidemiological research skills.
- *The College should not attempt to hold its Membership examination outside the British Isles.*
- *The College should not enrol psychiatrists working outside the British Isles into its continuing professional development programmes.*
- The College should try hard to establish closer links with psychiatrists in other European countries. In the long run the most effective way of achieving this is to persuade, and help, some able British trainees to obtain part of their training in a continental European country.
- College meetings overseas and joint meetings with other national and international psychiatric associations can be an effective way of raising the College's international profile.
- Overseas groups should be provided with some tangible resources.
- The status of Affiliate should be available to psychiatrists who are not resident in the British Isles.
- *Psychiatric Bulletin* should regularly contain a section devoted to overseas news and activities.
- The regulations governing the Kenneth RawnsleyTravelling Fellowship should be amended.

The response of the Court of Electors and Council to the individual recommendations appears in italicised print after each recommendation in the main report. With the exception of the two italic bullet points above, the recommendations were supported and are being taken forward within the College.

The full report is available from the College's Book Sales Office, tel: 020 7235 2351 ext. 146.

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