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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 disappointing 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 They also take a swipe at nationally agreed terms and conditions with their outdated criticism of the NHS pension scheme and Clinical Excellence Awards, implying their support for a more casualised medical workforce governed by market forces.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.

DEPARTMENT OF HEALTH (2007) In-patients Formally Detained in Hospitals Under the Mental Health Act 1983 and Other Legislation, NHS Trusts, Primary Care Trusts and Independent Hospitals; 2005–06. http://www.ic.nhs.uk/pubs/mha0506.

HOLLINS, S. (2007) Are they in or out? Commentary on . . .The College and the independent sector. *Psychiatric Bulletin*, **31**, 407.

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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 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.

HOLLINS, S. (2007) Are they in or out? Commentary on . . .The College and the independent sector. *Psychiatric Bulletin*, **31**, 407.

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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.

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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

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health services to erode the human rights of individuals who fall liable to treatment under mental health legislation. Corporations that thrive financially from the forcible treatment of vulnerable individuals deserve more scrutiny. Unless the College can demonstrate the highest standards of integrity in this sensitive area, it will rightly lose its influence in our democratic institutions and squander the high regard in which it is held by the public. I feel sure that all members of the College would share my concerns.

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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 co-operation 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 adapt 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.

COID, J. & MADEN, T. (2003) Should psychiatrists protect the public? A new risk reduction strategy, supporting criminal justice, could be effective. *BMJ*, **326**, 406–407.

VAN MARLE, H. J. C. (2002) The Dutch Entrustment Act (TSB): Its principles and innovations. *International Journal of Forensic Mental Health*, **1**, 8–92.

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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.'

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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.

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