



the columns

correspondence

Locums . . . and the light at the end of the tunnel

Another plea to the altruism of beleaguered clinicians in services already beset by resource and staff shortage, along with chronic demoralisation. No doubt Peter Kennedy (*Psychiatric Bulletin*, August 2003, **27**, 281–283) has patient and not financial interest in mind as he proposes new roles for psychiatrists that in today's conditions will only see them covering larger patches and with greater caseloads.

The current shortage of doctors in psychiatry is the inevitable result of a long deterioration in terms and conditions of service. Peter Kennedy obscures this point and distracts our attention with petty argument focused on financial envy. He goes on to assert that moneys for worthwhile services are being frittered away and I am sure management can confirm this. Where are these worthwhile services? They are long overdue, but I do not think they will come, whether or not there are locums.

Locums are not the problem and for every 'dodgy locum' you could name, there would be more than ten times the number of stories relating to staff shortages that are not covered. While there may be doctors of mediocre performance, commitment to a local service does not render immunity!

Itinerancy is very antisocial and working as a locum difficult. It is no mean feat to arrive in a new work environment and within hours deal with complex issues requiring extensive local knowledge. There is no grace period or induction and performance is expected immediately, your next job depends on it! You may or may not be the focus of financial envy, but there seems no escape from the intellectual contempt with which substantive colleagues regard you.

There is a financial issue and it needs to be addressed. It is time for consultant psychiatrists to realise their bargaining power and take a locum!

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European Convention on Human Rights

Lepping's view that rights under the European Convention on Human Rights were not 'implemented' in Britain until the Human Rights Act 1998 is incomplete (*Psychiatric Bulletin*, 2003, **27**, 285–289). The UK has been a signatory to the ECHR since its outset in 1951. Since 1966, it has granted the right of individual access. The HRA 'incorporates' the ECHR into our law but 'the view that that makes a sea-change is an erroneous one' (Collins, 2001). Indeed, there are clear signs of influence by the ECHR in the 1983 Mental Health Act (Hewitt, personal communication – information available from author on request).

As these two examples show, Lepping may also be mistaken in believing that the HRA will now radically improve the condition and treatment of psychiatric patients.

In *Hercegfalvy v. Austria* a Hungarian refugee was admitted to an Austrian psychiatric hospital in a weakened condition due to a hunger strike. Over several weeks, he was force-fed, sedated against his will, handcuffed, fastened to a security bed by straps and a net, and secured by his ankles with a belt. The European Court held that none of this would breach Article 3. Where a measure was deemed 'therapeutically necessary', it could not be regarded as 'inhuman or degrading'.

In *HM v. Switzerland* it was held that the confinement of an 84-year-old capable woman in a residential home did not breach Article 5, even though she did not consent to it. It was deemed to be in her best interests. This case could have profoundly deleterious effects on the rights of detained patients in the UK.

Finally, a number of serious concerns have been raised regarding human rights abuses that might be introduced by the Draft Bill (which purports to reconcile domestic law with the ECHR).

Contrary to widespread belief, it seems that the standards of the ECHR, at least in terms of protections for vulnerable psychiatric patients, can be really rather low.

HEWITT, D. (2003) Lecture notes, University of Northumbria.

HOUSE OF LORDS AND HOUSE OF COMMONS JOINT COMMITTEE ON HUMAN RIGHTS (2002) Draft Mental Health Bill, 25th Report of Sessions 2001–02, HL Paper 181, HC 1294, 11 November 2002.

PER COLLINS, J. in R. (*on the application of the Secretary of State for the Home Department*) v. *Mental Health Review Tribunal* (2001) A.C.D. 62, para 77.

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The future role of general adult psychiatrists

I was delighted to see that Dr De Silva has further developed his interest in working with Primary Care colleagues (*Psychiatric Bulletin*, 2003, **27**, 326–327) having previously worked in our service in Grampian many years ago, which is fully committed to working with Primary Care, mainly in a liaison consultation model, but also with a clear attachment of specialist services such as outreach and assertive outreach and core primary care aligned mental health teams.

I and many colleagues from all disciplines have worked in this way for over 10 years, holding regular clinics within general practice and regular liaison meetings with primary care colleagues, including joint assessment where necessary. In my opinion, the outcome of this approach has been to dramatically reduce our need for in-patient provision to well below the recommendations of the College (e.g. we will shortly have 23 acute beds per 100 000 population in general adult psychiatry), and I have no doubt that this model has allowed early detection and intervention for patients with significant mental illness, both through the education of general practitioners and through their ability to rapidly access services.

From a personal viewpoint, therefore, I cannot support Dr De Silva's suggestion of a 'sub-specialty model' where different psychiatrists are responsible for community services as opposed to hospital services. I fear this does nothing but