Correspondence

Mental Health Review Tribunals and 'restricted' patients

DEAR SIR

In the August issue of the *Bulletin* (p. 153) there is a list of the College's recommendations about changes in the law affecting the consideration of Section 65 cases by Mental Health Review Tribunals. It is stated in Paragraph 1 that 'psychiatrists, particularly in Special Hospitals, should have confidence, as far as possible, in the new procedures'. I am writing to say that the psychiatrists in this hospital do not have confidence in what the College has recommended.

The problems are to be found in Paragraph 5. Here it is stated 'In cases where there is conflicting medical opinion ... the Tribunal would have the power to order a conditional discharge to operate once appropriate arrangements are made'. What does the phrase 'conflicting medical opinion' mean? Does it mean a conflict between the patient's Responsible Medical Officer and the medical member of the Tribunal or between these two doctors and a doctor giving an opinion on behalf of the patient, or is the College thinking about the many cases where the diagnosis has been obscure and various opinions have been given over the course of a long illness? If the conflict is between the current Responsible Medical Officer and the medical member of the Tribunal, does this mean that the views of the medical member must henceforth take precedence not only over the Responsible Medical Officer but also over the lay member of the Tribunal and that the Chairman must always listen to his advice?

The phrase 'once appropriate arrangements have been made' has an air of innocence about it which is quite deceptive, and it opens the way for difficulties the College appear to have ignored. The crux of the matter is deciding who is to make the 'appropriate arrangements'. Presumably in these disputed cases the Responsible Medical Officer will consider that the patient is still dangerous and it is likely that his social worker colleagues will agree with him. It is hard enough these days for us to persuade our colleagues to look after patients we consider to be quite safe. How then does the College suggest we should arrange accommodation, supervision and psychiatric after-care for those patients who, we will have to say, are in our view too dangerous to be in the community? If the Responsible Medical Officer is not to make these discharge arrangements, who should? And who would be responsible if the Responsible Medical Officer's predictions about the patient's dangerousness turn out to be accurate?

Finally, we feel it in order to comment on Paragraph 6. The College is recommending that the Tribunal should have the option of removing restrictions imposed under Section 65 of the Act. Clearly there may be cases where this would be appropriate, but in our view this is a power which should be used sparingly. It must be remembered that since 1960 the courts have imposed restriction orders on an increasing proportion of patients sent to this hospital, and this has enabled Responsible Medical Officers to recommend discharge or transfer for patients who can benefit from long-term treatment, care and supervision in the community or in conventional hospitals. Without these powers proper long-term supervision cannot be imposed and unrestricted patients may find their stay in maximum security unnecessarily prolonged because Responsible Medical Officers, and indeed Tribunals, lack the confidence to discharge patients whose insight is often the first casualty of their mental disorder.

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'Detention' and 'treatment'

DEAR SIR

After reading Professor Bluglass's article (*Bulletin*, August p. 151) I cannot help wondering whether the recommendation of the Special Committee of Council on the Review of the Mental Health Act if implemented will, by increasing the strength of the Mental Health Review Tribunals and so the degree of scrutiny of the grounds for detention under the Act, magnify the present difficulties in deciding what cases can and cannot be detained under Part V.

The public naturally expects the law to protect its members from dangerous persons whether mentally disordered or not, but there seems little provision for detention of persons who are and will continue to be dangerous but who do not come under the Act because their condition is not thought to warrant detention in hospital for medical treatment.

There are cases coming before the courts where there is doubt on this point, and whether or not a Court Order is made will depend to a great extent on which particular psychiatrists are called upon to make assessments of mental state and whether they feel the patient will respond to treatment. The type of case which leads to the most difficulty and controversy is, of course, that which is classified Psychopathic Disorder, and the problem revolves around treatability.

Is detention in hospital itself sufficient to rank as treatment for these patients or should hospital admission be resisted if there is little or no chance of success, even though the patient could be dangerous?

Should a Mental Health Review Tribunal faced with

https://doi.org/10.1192/S0140078900012505 Published online by Cambridge University Press

medical reports stating a patient no longer suffers from a mental disorder warranting detention in hospital for medical treatment discharge a patient without regard to dangerousness because, strictly speaking, he is no longer detainable under the Act, or is it envisaged that some other form of detention will be available.

At present under Part IV of the Mental Health Act it is possible to detain persons with psychopathic disorder or subnomality indefinitely by providing a periodic dangerousness certificate regardless of the degree of the disorder or treatability, although an Order under Section 26 of the Mental Health Act cannot be initiated if the patient is over 21 years.

In whatever way they work, the revisions of the Mental Health Act will probably be both expensive and time consuming, and it is to be hoped that they will at least provide some rationalization of the system.

Any opinions are, of course, my own and do not necessarily represent those of Moss Side Hospital or the Department of Health and Social Security.

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'What should psychiatrists do?'

DEAR SIR

I enjoyed Dr Snaith's letter in praise of psychotherapy (*Bulletin*, September 1981), though it is a pity that he should have been inspired to write only, it appears, by indignation over my effusion on 'What should psychiatrists do?'.

I wrote mainly about the problems raised for psychiatrists by the plight of chronic psychotics, by our inability to effectively treat most patients with personality disorders and alcoholism and by the lack of sufficient knowledge about most other conditions, especially depression, to allow us to treat them on anything better than a trial and error basis. It seems unlikely that Dr Snaith would claim that psychotherapy can at present contribute much to the solution of any of these problems. A further difficulty is that psychiatrists see only a small proportion of people with the neuroses that might respond to psychotherapy, and of course no-one, however enthusiastic, can directly cure patients whom he does not treat.

I think that consideration of these problems should be of overriding importance to us when we are thinking about our professional future. In the meantime, by all means let us wholeheartedly apply whatever techniques are available, including psychotherapy, to patients whom we can help.

Dr Snaith also claims that I think research undertaken by individual psychiatrists is of no value. This is not true. What I did write about was the desirability of individuals co-ordinating their research efforts, whether they work in large institutions or on their own. To give an example from the current issue of the *Journal* (*British Journal of Psychiatry*, **139**, 242-44), a couple of researchers showed that Guatemalan secretaries experienced exhibitionism about as often as those in the United States. As it stands, this finding may be of some interest to Guatemalan ladies and of slight comfort to American ones. For several reasons, it does not allow any firm conclusions to be drawn about the nature of exhibitionism. If, however, similar studies had been undertaken by individual researchers in a variety of different countries, on a range of occupational groups of women, perhaps also gathering data about the prevalence of trouser wearing, the efficiency of zips, the availability of women to unmarried men, etc., information allowing a deeper understanding of this disorder might have been gathered.

Of course useful ideas and interesting observations start with an individual. Unfortunately, as things are, they often end there, too. It is doubtful whether Dr Snaith is really so against us trying to organize ourselves so that the efforts of individual researchers bear fruit earlier and are wasted less often.

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'Nazareth was a small town too!'

DEAR SIR

I so enjoyed reading 'In Conversation with Eliot Slater' (*Bulletin*, September, pp. 158-61; October, pp. 178-81) that I hesitate to offer criticism; and I suppose, by this time, we Scots should be accustomed to Londoners who believe that civilization stops just north of St Albans. But it still offends, even when the comment arises almost unrecognized and at an unconscious level. 'Why did he do that—an extraordinary thing to leave London?' exclaims Brian Barraclough, as if Willi Mayer-Gross must have taken leave of his senses to come and work in this northern peninsula of Britain, so far from the true centre of things!

There can be no doubt that Dr Mayer-Gross gave up professional advantages by leaving London for Dumfries. But, as one of the many young psychiatrists who came under his influence at Crichton Royal—at that time, in the immediate post-war period, an outstanding and innovative treatment centre—I am glad he did. My guess is that he was glad too.

In Britain nowadays, where there seems to be an expectation of grey and mediocre uniformity and where excellence is viewed as perverse or élitist, it is a pleasure to recall the little eccentricities, the humanity, the learning and the keen clinical acumen of Dr Mayer-Gross. In Scotland it may be that he enjoyed the space and time to cultivate these qualities. They had a considerable impact on Scottish psychiatry then and since and, I fancy, have been an influence for good the world over. Nazareth was a small town too!

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