efforts and enthusiasm which he put into his work, made him a central figure for many years. His many colleagues, supervisees and former patients are saddened by his somewhat premature death but his many achievements as a teacher, organiser and therapist will long hold our memories.

He was a Foundation Fellow of the College.

MP

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Mental Health Act Commission

Credibility and resource

BRIAN LILLINGTON, Regional Chairman, Southern Region, Mental Health Act Commission

This article examines the background to the Mental Health Act Commission, its structure and function, and claims that its key resource is the skill and experience of its members.

The social milieu

As it put a premium on treatment, as opposed to containment or property rights, the 1959 Mental Health Act was a considerable landmark in British social policy. It apparently freed sufferers from mental disorder from legalistic constraints, unless they appeared before the courts on criminal charges, although it is important to note that Scottish legislation did not take this course. Acts of Parliament do not automatically produce resources, and there followed a long saga of regret that more was not achieved; but the major criticism of the '59 Act as the years passed was that it put insufficient focus on patients as *people*, who should be encouraged to take as much responsibility as they could for their own lives.

The 1983 Act has brought our mental health legislation up to date in this respect, recognising the considerable advances that have been made in civil rights and responsibilities in society in general. Apart from legally recognising the roles of nurses and social workers in the compulsory detention process, the Act has put a high premium on patients', and nearest relatives', rights to information, access to the detaining authority (DHA), tribunals, and perhaps most significantly, it spells out in detail the conditions in which detained patients (as well as informal patients in the case of irreversible treatments) have a right to express consent or not, together with a right to the protection of a second opinion, where they are incompetent to give a valid consent, or have refused. Such a step for a relatively marginalised minority is a landmark indeed.

It is to the credit of most practitioners that they accept these provisions constructively, and use them wisely to establish a growing personal responsibility by patients for their own well-being. There is, however, a worrying significant minority of practitioners who take the view that the Act is inappropriately

legalistic, and interferes with clinical freedom. Such an attitude demonstrates the wisdom of the Royal College in pressing for a regulatory body during the passage of the Act through Parliament, despite opposition from a number of sources.

The Mental Health Act Commission

So, with delegated powers from the Secretary of State, the MHAC was created, as a special health authority itself, to undertake this regulatory process, through the appointment of medical practitioners (and laymen/women for irreversible treatments) for second opinion purposes, the investigation of complaints, and the visiting of patients actually in detention to identify how the protective mechanisms of the Act actually work in practice for patients, nearest relatives, and the professionals concerned.

The Commission must constantly pay regard to its credibility to undertake this task. Structurally, it consists of doctors, lawyers, laymen/women, nurses, psychologists, social workers and specialists such as chaplains, pharmacists and occupational therapists, who have achieved a notable standard of skill, practice and commitment within the mental health services. The Commission constructs its visiting teams on a multidisciplinary basis so that a rich blend of skill, knowledge and experience is available for each visit. These geographically based teams work together long enough to be responsive to need, and draw on a basic knowledge of local services. Team convenors, who come from any discipline, ensure that tasks are shared across all Commissioners – indeed one of the Commission's notable achievements has been always to address a matter on a multidisciplinary front. Professional jealousies are rarely encountered within the Commission.

Despite the many things we, and others, would wish that we could do if more resources were available, such as a remit to regulate *de facto* detention, our critical resource is the skill, knowledge and experience of the Commissioners brought from clinical practice, and tempered and winnowed within Commission experience. A considerable body of knowledge has been built up over the past six years, and it is essential that it is preserved. Further, it is important that the Commission, understandably needing to grow into its next phase of life, post-Review, listens to the experiences of Commissioners at the front line in the corridors, day rooms and dormitories of our hospitals as they meet patients and staff day by day, if it is to report on how the Act works in its biennial report to the Secretary of State.

Challenges for the future

The mental health service is in a grave state of change. Large hospitals are closing, DGH patients and staff worry about psychiatric patients wandering the corridors from their Units, small family units are starting to appear in the community, often without sufficient skilled support, many patients are finding themselves adrift in a community that is not always welcoming. The outcome of the Griffiths recommendations is to place a burden on social services departments to devise packages of care rather like brokers, hopefully devising a more personalised response wherever they can find it. The time is ripe for the private sector to step into the limelight. Patients, including those detained or liable to be so, are starting to appear in rare and strange places. The mental health services in general, and the Commission in particular, will have an interesting challenge in the next few years to know where their patients are, let alone protect their rights. Training, reassessment of priorities and service distribution, as well as better forms of information technology, must figure largely in our thinking in the next few years. As these issues pre-occupy us, the need to hang onto good practice and care philosophies that recognise people as individuals will be crucial.

Good luck!

"To those who knew him publicly he was an extremely astute, cynical and often biting and depressing observer of the social scene. To those who knew him privately he was much the same."
I. K. ZOLE ON ERVING GOFFMAN

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