reflects very closely their representation in the senior registrar grade, but there was a sharp fall in 1977. The numbers applying for posts have exceeded the number of home graduates (except in 1976), although overseas graduates stand rather less chance of being interviewed. Nevertheless, over the four years the proportion of interviewees who were overseas graduates—491—was higher than would be expected from the number of overseas graduates holding senior registrar posts. There are no ready explanations for this finding although light may be thrown on this when the senior registrar follow-up study is completed[1,2], but one possibility is that there are a comparatively small number of overseas senior registrars who repeatedly apply for posts and who then meet with no early success. Another discrepancy is between the proportion of senior registrars in mental deficiency and the proportion of overseas graduates appointed to posts, but here the small number of appointees may be producing an artefact.

PETER BROOK, *Sub-Dean*

References

[1] The Senior Registrar Survey: First Year Follow-Up *News and Notes*, May 1976. 14-15.

[2] The Senior Registrar Survey: Second Year Follow-Up: *British Journal of Psychiatry*. 132, 96-98.

REFLECTIONS ON MENTAL HEALTH REVIEW TRIBUNALS*

By JAMES A. COOKE

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Towards the latter part of 1959 some thirty lawyers met at the Ministry of Health under the chairmanship of the late Sir Sidney Littlewood. We were the first members of the legal panels of the Mental Health Review Tribunals for the four London regions.

All of us had a considerable experience of advocacy and Court procedures—mainly in Criminal Courts; none of us had any knowledge of the treatment of mental disorders or of mental hospitals.

At the time, the Ministry had little idea of the volume of applications to be dealt with in the early days. The only guidance we received was within the covers of the Act itself and the Mental Health Tribunal Rules. We were left to devise our own procedures and to set our own standards.

Tribunals should not be regarded by psychiatrists as a challenge to their competence or Tribunal's decisions a criticism of their judgement. It should be remembered that the Tribunal's decision is based on the patient's condition after a period of treatment, that is at the time of the determination, and the situation may have changed since the order was made or last renewed.

There is not, in essence, any conflict of interest between the RMO or the detaining authority on the one hand and the Tribunal on the other. Both are seeking to hold a delicate balance between the qualified right of the individual to his liberty on the one hand and his welfare and the needs of the community on the other.

One should sympathize with the psychiatrist who has to exercise his powers alone. He should not resent the opportunity of sharing a heavy burden with the Tribunal. Indeed it is the practice in at least one Special Hospital to invite patients seeking discharge to ask for a reference to a Tribunal.

Above all a patient should never be discouraged from making an application or influenced to withdraw. Every withdrawal is investigated by the Tribunal to make sure it is not made under duress. An application, once made, exhausts the patient's rights until the next renewal. An application withdrawn is a valuable right thrown away. Hence the change suggested in the recent Discussion Paper.

Each Regional Tribunal has developed over the years in isolation from all others save in those few cases where there has been a common Chairman of more than one Tribunal. There has been little opportunity for developing a cohesive system throughout England and Wales, or for achieving common standards.

After the initial formalities the only procedures which each Tribunal must necessarily follow are the ones laid down in the Act and the Rules.

The Rules purport to divide determinations into two classes namely informal determinations and formal hearings. In fact there is very little difference. It

*Abbreviated from a paper read at a meeting of the Southern Division of the College, 20 September 1978.

is clear that in order to gather the necessary evidence the Tribunal must come together as a body invariably at the hospital where the patient is detained or in the nursing home or, in the case of guardianship, at the offices of the Local Authority or some convenient place. Naturally therefore it has become common practice to hold a hearing in every case, although this is not compulsory for informal determination.

In my view Tribunals should be obliged to have a hearing. Although the procedures may be informal they should be structured to ensure that proper safeguards are prescribed and also to provide for consistency. I welcome the proposal to do away with the artificial distinction between formal and informal determination.

I think that it is essential that an applicant (and the patient if different) should have the right to know the case he has to answer in order that he may prepare a rebuttal. He must have a fair opportunity to refute any inaccurate part of the assertions and assumptions upon which the detention is justified.

In the normal case it is in the interests not only of the patient but also of the detaining authority and particularly those responsible for the care and treatment of the patient that they should be able to hear each other's point of view and be free to ask relevant questions of each other and to bring information to the attention of the other as well as the Tribunal. Very often this is one of the rare opportunities for the RMO to meet the nearest relative or other persons from the community who may be able to give some support or who may be able to correct some impression which the doctor has gained from the records. Such an approach gives the Tribunal an opportunity to demonstrate both to the patient and the RMO its unbiased approach to the application.

Clearly there are exceptions to this general rule. If a patient's condition is such that it could adversely affect his health to see or hear the opinion of the psychiatrist or if the psychiatrist's report is based upon certain confidential information which it would be wrong to disclose to the patient or if there are any serious doubts as to diagnosis or as to the prognosis which could adversely affect a patient's progress, then clearly the patient should be excluded from that part of the proceedings in which such topics are discussed.

In the case of applications for discharge from a Section 26 Order, the nearest relative having declined the opportunity to discharge the patient will probably be opposed to his discharge unless either he is ignorant of his rights or there has been a restriction on the discharge under Section 44 or 48 of the Act.

In any event there are frequently stresses and strains in the relationship between a patient and his relatives which would be embarrassing for them to discuss in the presence of each other and which could have an adverse effect upon the future relationship between them should the patient be discharged.

For those reasons the Tribunal will normally exclude the patient when hearing relatives but would normally allow a representative of the patient and the responsible authority (usually the RMO) to be present.

On the other hand, frequently the case load of the RMO is so great that he does not wish to remain throughout the hearing, and of course once he has given his evidence to the Tribunal he is free to leave. Nevertheless, I have known many cases, some of them very startling, when a psychiatrist has completely changed his attitude towards the treatment and particularly the detention of a patient after he has had an opportunity of bringing up to date his knowledge of family background and the social circumstances of the home to which the patient could be discharged. I have also known a number of cases where a doctor's beliefs and assumptions of the background of patient and of incidents which have formed a relevant consideration in the treatment of the patient have been radically changed on hearing first-hand information of what has really occurred. I think, therefore, it is very helpful for the doctor to remain to hear all the evidence if he is able to do so. There is no reason why the RMO should not be represented by a responsible member of his medical team having day to day care of the patient. Evidence from such a doctor is often very valuable either in addition to or in substitution for that of the RMO.

Of course in an ideal situation the doctor would have all the time in the world to make these enquiries for himself or would be able to call on adequate social reports from the staff available to him. We all know, however, that this is an ideal situation and in reality these opportunities rarely exist.

Clearly in order to make a determination the Tribunal has an obligation to search into all the information which is available to it. It is not in any way concerned with commenting upon or seeking to influence the treatment of the patient. Its only concern is with his detention or discharge. However, in order to form an opinion as to whether or not to discharge the patient in the exercise of its discretion the Tribunal will necessarily wish to know how the medical team in charge feel about the prognosis and the treatment which can be afforded to a patient in the hospital.

It was clear in the beginning and unfortunately has continued to be the case that although many psychiatrists welcome the Tribunal system and even regard the application to the Tribunal in some cases as having therapeutic value, or as helpful in the making of a difficult decision, there is a body of psychiatrists who are greatly resentful of the right of the Tribunal

to enquire into their cases and to examine their records and their patients and generally to override their decisions. This in some cases has been taken to the extreme so that there are psychiatrists who refuse, partly for this reason, to admit detained patients. The net result is that there are patients, particularly in some catchment areas, who are denied treatment because they are unwilling to accept (or incapable of accepting) voluntary treatment on an informal basis. The prison population is swollen now with persons who might in many cases properly be treated as patients suffering from a mental disorder but who are deprived of the opportunity of hospital admission.

There is a resentment also that Tribunals can call for a medical report which can be published against the wishes of the psychiatrist concerned to the patient and to the applicant. It is true that the Tribunal has the power of overriding the wishes of a responsible authority to exclude part of its report including the medical report from publication to others. Originally we found many cases where the whole of the medical report was so excluded by the authority but in recent years the number and extent of exclusions has declined to a significant extent. In my view there are few cases where publication of a report to a patient will have an adverse effect upon that patient's health.

Some doctors feel that what is called the doctor/patient relationship may suffer harm as a result of Tribunal proceedings. I do not believe that to be the case and I have never experienced an example. In my experience this complaint usually comes from the doctor who has failed to establish a satisfactory relationship with his patient. In many cases the interchange of views helps to relieve tensions and very often assists in an improved relationship and communication between the patient and his doctor.

It is essential that the Tribunals should maintain a balance between those who are present before it so that neither one side nor the other feels that an advantage is being given to the other or that he is being treated as a superior or as an inferior, but that all are treated with equal impartiality.

After considering all the available evidence the Tribunal will communicate its decision in writing to all concerned. I should emphasize that the Act is misleading when it refers to the Tribunal discharging a patient. What the Tribunal decides is whether or not the patient should continue to be liable to be detained. Even though there may not be any further justification for detention frequently a patient will require treatment and will often accept it as an informal patient following the decision of the Tribunal. Indeed the Tribunal is very often influenced by the attitude of the patient towards his future treatment and residence.

*Mental Health Review Tribunals: Applications and references during 1974, under the Nottingham Office (A), the London Office (B), and the Liverpool Office (C)**

Region	Applications by or on Behalf of Patients				References by Secretary of State	
	Valid Applications	Applications Determined†	Discharges Directed	Discharge Rate	Made	Considered
Northern (A)	23	17	3	18%	1	1
Yorkshire (A)	19	14	4	28%	2	2
Trent (A)	236	240	63	26%	167	167
E Anglia (B)	7	11	1	9%	—	—
N W Thames (B)	26	40	2	5%	35	32
N E Thames (B)	16	15	2	13%	5	5
S E Thames (B)	11	13	1	7%	2	2
S W Thames (B)	10	8	3	38%	—	—
Oxford (B)	51	39	2	5%	91	77
S Western (B)	28	28	7	25%	10	10
W Midlands (C)	12	10	1	10%	7	6
N Western (C)	15	11	—	—	8	6
Mersey (C)	120	108	20	19%	70	66
Wessex (B)	5	6	1	17%	1	1
Totals	579	560	110	20%	9	375

*The figures were obtained directly from the clerks to the MHRTs.
†These figures include any made but not determined or considered in 1973.

Unfortunately at the present time, the Tribunal can only say that a patient shall be discharged forthwith from compulsory detention or shall remain subject to detention. It cannot impose any kind of condition upon a patient's discharge. I welcome the recommendation in the White Paper proposing an extension of the Tribunal's powers to defer discharge for up to three months and to enable conditions to be imposed upon a discharge. A Tribunal always has a complete discretion as to whether or not to discharge a patient. There can never be a case where a Tribunal is obliged to continue the detention of a patient.

In the exercise of this discretion the Tribunal will wish to look into all relevant factors. It will clearly be concerned to know about the patient's mental condition, the prognosis, the proposed treatment in hospital and whether or not this will have any effect on improving the patient's health. It will want to know also about the patient's background, the home circumstances, the possibility of a relapse and the availability of community support and suitable accommodation.

It may not be unduly perturbed if it feels that a patient may at some time relapse and need to come back into hospital for treatment. We all know that happens with a large number of patients who are treated on an informal basis. I myself am not unduly influenced by the argument which is often put forward that it is kinder or more humane or simpler to recall a detained patient from leave than to re-detain a discharged patient. These are arguments for changing the system of detention rather than for detaining a patient who otherwise should be entitled to his liberty.

The discharge rate for Tribunals varies greatly as can be seen from the table on the facing page, taken from *A Human Condition* Larry Goatin. (NAMH, 1976).

Tribunals have now gained a considerable amount of expertise. It is never possible to make any objective assessment of the 'success rate' of discharges. The best one can say is that from the limited statistical evidence available it would appear that the re-admission rate of patients discharged by tribunals is much the same as the re-admission rate of patients discharged by consultants.

So far, except for the Special Hospitals, case loads have been light. The proposals for new legislation contained in the White Paper *Review of the Mental Health Act, 1959* provide not only for additional powers to be given to tribunals but also for a substantial increase in the amount of work they will be required to undertake. It is therefore appropriate that there should now be a reappraisal of the procedures of Mental Health Review Tribunals.

A Discussion Paper has been produced by an Interdepartmental Committee proposing certain substantial changes in procedures and it is highly desirable that all those involved in the treatment and care of patients suffering from mental disorders should consider the procedures and in particular the changes which are proposed with a view to making a contribution at this time to a system which is clearly going to be of greater impact in the future.

REPORTS AND PAMPHLETS

Report on the Work of the Prison Department 1977
Home Office, Cmnd 7290, HMSO, London
(pp 85, £2.25)

It is quite clear from this year's Annual Prison Report that all is not well with our penal system. Whilst the usual startling rise in population has not been recorded, the Report makes gloomy reading nevertheless. As the Introduction puts it, 'Previous Annual Reports have drawn attention to the growing number of difficult and subversive prisoners with which the prison service is having to contend . . . the increase in crimes involving violence in recent years, particularly among young adults, taken along with the wider and most welcome availability of non-custodial penalties for less serious offences, has meant that prisons today are having to deal with a less mature and stable type of prisoner who is far more prone to violence than was his counterpart of a decade ago.' As if to amplify this point, the Report comments on the escape, at the beginning of 1977, of William Hughes, on remand at Leicester prison, who attacked two officers with a knife and subsequently murdered four members of a family before being shot dead by the police. This closely followed a major riot at Hull prison in September 1976. All this has to be set in the context of a fall in the recruitment of male prison officers over the last three years.

Even the opening of the new Holloway Prison is a discouraging story, as 1977 saw a sharp rise in the number of women and girls in custody, with a peak figure of 1440 in September. The move into the new prison has reduced the capacity available to women and girls and by the end of 1977 up to 350 people were having to be housed in the new accommodation designed for only 222. The problems within this