Requirements for submission of manuscripts

DEAR SIRS

In comparison to other journals, requirements for submission of manuscripts to the *British Journal of Psychiatry* and *Psychiatric Bulletin* are sparse. The single page of instructions for submissions to the *Brtish Journal of Psychiatry* (**158,** 591) concerns style and format. In contrast, the *BMJ* provides four pages of requirements for submissions to those journals adopting the 'Vancouver style' (*BMJ* 1991, **302,** 338–341). This includes details of the qualifications for authorship and the responsibility of authors for content and veracity. All authors are required to sign a covering letter acknowledging compliance with the requirements.

The recent paper 'Careers in psychiatric specialities 7. Substance Misuse' (Black *et al*, 1991) provides an example of how things may go wrong under the present system. I essentially wrote the whole article and would have therefore expected to be the sole (or certainly first) author. More importantly, I wrote the article in draft form, requesting amendments from the other authors. The draft article was submitted for publication unchanged and without my having any opportunity for correction or revision. Further anomalies included my title and place of work being incorrect.

I have previously been in a similarly invidious position when writing to the editor of another psychiatric journal requesting the return of a manuscript submitted without approval from the three senior authors. If I, an author of modest output, have twice been affected in this way, how many more have had their work hi-jacked in such a fashion and how many journals have published in good faith an inferior product? Has the time not come for the *British Journal of Psychiatry* and *Psychiatric Bulletin* to institute more detailed requirements for publication and to insist on the signature of each author acknowledging responsibility?

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References

BLACK, D., GUTHRIE, E. & MERRILL, J. (1991) Careers in psychiatric specialities 7. Substance Misuse. *Psychiatric Bulletin*, **15**, 276–277.

DEAR SIRS

We are loathe to enter an unseemly dispute about a practical article but are so astounded by Dr Merrill's comments that we feel bound to respond.

We conceived the idea for the series of articles about careers in psychiatric specialities after arranging a training workshop for senior registrars at which it became apparent that this sort of information would be useful.

For each of the nine articles we wrote a draft and then asked a recognised expert in the speciality to add comments and suggest any modifications. This procedure was followed in each of the articles including that written with Dr Merrill. Thus, we wrote the draft, sent it to Dr Merrill, asking *him* to collaborate with *us* and comment on and modify the article as he considered appropriate. We found his modifications helpful and sent off this amended article, without further alteration, to the *Bulletin*. Dr Merrill's letter implies that he thought up the idea, and that he wrote the article asking us to comment on it. This is entirely misleading and inaccurate.

All the other eight collaborative authors in this series were entirely happy with the articles: indeed, one or two expressed surprise that we wished to include their names as they regarded their contributions as being of such a minor nature.

We are, therefore, at a loss as to why Dr Merrill has been so upset.

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Editorial note

The instructions to authors have been amended (see inside front cover, this month's issue).

Legal aid for representation at Mental Health Review Tribunals

DEAR SIRS

Dr A. West's views on financial assistance to patients applying to the Mental Health Review Tribunal (*Psychiatric Bulletin*, June 1991, **15,** 372) invite detailed comment, not only as to their inaccuracy.

The Mental Health Review Tribunal and the right to legal representation before it date from the 1959 Act not from the changes made in the early 1980s. However, the absence of legal aid meant that, for most patients, these rights were illusory. For restricted patients the position was made even worse by the tribunal not even possessing any power of diacharge.

The Mental Health (Amendment) Act 1982 changes expanding the powers of the tribunal and the

Legal Aid Act changes providing financial assistance for the representation of detained patients both resulted from litigation under the European Convention on Human Rights and Fundamental Freedoms. It was successfully argued that patients detained for public protection should have access to a judicial hearing and that financial assistance for those without means was essential in order for the proceedings to be fair, just and respecting of the human rights of detained patients.

Legal aid before the tribunal, as with detention associated with suspected criminal behaviour, must be generally available because of the nature of the proceedings and their impact on the person detained. Unlike the pursuit of some claim in private law, it should not have to be justified, as Dr West suggests, by crudely testing the chances of the applicant succeeding. In any event, recent research conducted for the Lord Chancellor's Department has demonstrated that legal advocacy increases those chances by 20–35%[1].

With, for example, 45% of cases handled by the Southern MHRT Office having no patient representation at all[2] the injustice to those detained would appear to be not too many lawyers but, shamefully, too few.

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References

1 GENN, H. & GENN, Y. (1989) *The Effectiveness of Representation at Tribunals* (July 1989) Lord Chancellor's Department.
2 Details supplied in 1991 by Clerk to the Mental Health Review Tribunal, Southern Region to Mental Health Sub-Committee of Law Society.

The patient's perspective

DEAR SIRS

I write in reply to David Pilgrim's letter (*Psychiatric Bulletin*, June 1991, **15**, 370) concerning our study entitled 'Psychiatric In-patient Audit – The Patients' Perspective'.

I agree with him that when treating patients it is important to have a proper discussion of the beneficial and adverse effects of treatment. I think, for example, that if one is commencing a patient on long term depot injections, one would have to mention important adverse effects such as tardive dyskinesia, but this would be in the context of mentioning the low incidence of such a side effect and also the advantages of having the treatment.

He describes ward rounds as being an anachronistic ritual and although I would not use these exact words myself, I would agree with him that ward rounds are somewhat unsatisfactory and stultifying, even when attempts are made to make them user friendly.

I am not sure, however, whether there is a suitable alternative. If one considers the possibility of performing business rounds without the presence of patients, this might be considered more satisfactory. However, if decisions are made at these business rounds and are then conveyed to the patients subsequently, who then reject these decisions and recommendations, one could then find oneself involved in a rather tedious round of shuttle diplomacy between the patients and the members of staff attending the business round.

I certainly agree with him, however, that in future we have to listen much more carefully to what patients are telling us about our psychiatric services.

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The doctor in the Mental Health Review Tribunal

DEAR SIRS

Within the last year both Dr Woolf (1991) and I (Langley, 1990) have commented upon the role of doctors involved in the proceedings of Mental Health Review Tribunals. I would like to take the discussion a stage further.

Dr Woolf rightly differentiates between a clinical case conference and the proceedings of a Mental Health Review Tribunal (MHRT) (although with a holistic approach to patient care the difference might not be as great as at first appears). In a Tribunal the central issue is whether there is a *current* need for the patient to be detained. This is a matter of opinion for all concerned and, of course, any opinion may be disputed. Dr Woolf and I both suggest that, in his words, doctors can "take umbrage" when their judgements are challenged. In these circumstances it is worth examining further the process by which opinions are formed.

Whatever opinion (or judgement) is proposed, or decision reached, the view taken has to be justified by reasons that are sufficient to make the case. Judgements, both clinical and judicial, have to be based not only upon agreed facts (as far as they are ever ascertainable in psychiatry), but also on the probabilities attached to predicting from these facts (whether "hard" or "soft"), and an element of value judgement (about the acceptability of present and predicted behaviour, civil liberties etc).

I submit that the taking of umbrage occurs most often when difficulty is experienced, not in expressing an opinion, but in marshalling and presenting specific reasons for holding that opinion. This may