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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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

happen for two contrasting reasons. Firstly, an inexperienced doctor may not have the components of his reasons well organised towards addressing the criteria demanded by law. Alternatively, the experienced doctor may, as do all, form an intuitive judgement (not necessarily incorrect), based on a scarcely conscious appraisal of the steps by which he reached the decision. Either doctor, when asked to defend his opinion, may, unless he has prepared his case, find it difficult to instantly submit coherent reasons for arriving at his conclusion, and become embarrassed.

Of course, doctors may simply not like to have their opinions challenged, but are we not now more enlightened than that? This is not to say that it is necessarily any easier to be challenged on reasons for holding an opinion, rather than on the opinions themselves. Establishing facts, assessing probabilities, and above all defending value judgements, may all prove contentious in debate, but at least forewarned is forearmed.

A Tribunal can only base its decision on the evidence (written or oral), and the arguments, that are presented at the full hearing. At this time two of the three members will not have seen the clinical records, will not have previously talked to the patient and will only be aware of facts as presented. When it comes to drawing conclusions from the facts, the non-medical members (and even the Tribunal doctor!) may not necessarily be sufficiently knowledgeable to draw their own conclusions from the facts without the reasoning behind the conclusions being explained (and therefore open to test). Even if the RMO considers his conclusions to be self evident he will need to make his reasoning explicit, even on basic points, so that they may enter the proceedings and be accepted or refuted.

The moral of all this would appear to be for doctors addressing Tribunals to prepare themselves beforehand, not only for the expression of opinion, but also for the conscious and coherent presentation of the reasons for holding their opinions.

To do so effectively requires an understanding of the issues on which opinions have to be expressed. So far, in this letter, only the process by which these opinions are formed and presented has been discussed. Both opinion and reasons have to be based on the clinical features of the individual case, and directed to the points of law that have to be addressed. Should, on that day, the detention be maintained, or cease?

The legal dimensions of this decision are in the Mental Health Act 1983 and are: Is mental disorder (illness, etc.) present? Is it of a nature or degree which warrants detention in hospital? For assessment? For treatment? For health, or safety, or the protection of others, etc? Attitudes to all these issues have to be presented and agreed or disputed. To provide, in advance, in depth reasons for every opinion offered on each separate point of law could be very tedious, but in disputed cases may be necessary; in most cases the skill lies in addressing the crucial issues. Even these may be difficult to predict in advance and every case will post its own peculiar problems.

The Tribunal art is to find the most effective path towards basing a fair decision on sound reasons. As Dr Woolf says, a Tribunal can be a creative and constructive event in the treatment process, but to be so both the aims and process of decision making need to be understood.

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Supplementary Reports for Mental Health Review Tribunals

DEAR SIRS

When providing reports for the Mental Health Review Tribunals on patients appealing against section, one is given the option under rule 6(4) to provide supplementary information of a confidential nature for the eyes of tribunal members only. This is not a facility I have availed myself of on many occasions. However, on two of these occasions the supplementary report has regretfully ended up in the patient's hands, as a result, as far as I can tell, of a lapse in procedures in the tribunal office. On the first of these occasions in 1986, when admittedly the arrangements were relatively novel to everyone, elementary procedures in damage limitation appeared to patch up the problem without too much difficulty. In the most recent example in July of this year, however, when a supplementary report on a 19-year-old schizophrenic boy was made available to his schizophrenic mother, the consequences were roughly comparable to the explosion of Krakatoa. In fact, my efforts at damage limitation on this occasion remind me somewhat of a fireman running around with a bucket of water prior to the explosion of the said volcano trying to douse the lava!

As I have used the supplementary report facility so infrequently, and yet confidentiality has been breached twice, I am wondering if I am the unique victim of incompetence in this regard, or if others have had similar experiences. It will certainly make me very circumspect indeed about providing