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

reduced accommodation have been compounded by the large proportion of women prisoners who show disruptive behaviour, and 'in many cases are suffering from mental disorder'. The Prison Department estimates that on 31 December 1977 there were 127 women and girls in custody who were suffering from mental disorder of a nature or degree warranting their detention in hospital for medical treatment and 81 women already had a history of being so detained.

In view of this rise in the number of unstable and disruptive prisoners both male and female, the continuing demand by courts for psychiatric reports, and the continuing difficulty of getting patients into NHS facilities, it is surprising that this year there is no comment about prison medical policy in regard to psychiatric services. We know from the policy recently ratified by the College, for example, that the joint appointments between the prisons and the NHS are to be reduced or phased out, and we have evidence from the recent paper given by Dr Orr, Director of the Prison Medical Service (1978), that at least one influential senior doctor within the service is still very unhappy with the current position. Orr believes that 'prisons can offer little more than custody to the mentally disordered . . . (and) that a significant number of offenders become mentally disturbed in some way *as a result* of their containment in prison. . . . The prison environment is therefore hardly a therapeutic one.' He criticises current mental hospital admission policies and urges them to return to their traditional role and include security among the facilities offered to their catchment area patients. The implication of Orr's paper is that the prisons are increasingly reluctant to provide special psychiatric facilities. It would be interesting to know whether this really is to be future policy and if so what this means for the special psychiatric facilities such as those at Parkhurst and Grendon prisons which have such a high reputation.

One rather surprising comment included in the Report refers to the role of the prison medical officer, which, it is claimed, is sometimes misunderstood: 'All registered medical practitioners—including those in the Prison Medical Service—are bound by the same ethical code of practice in their relationship with their patients. Who employs them does not affect the issue. The basis on which the medical treatment of inmates is given is therefore no different from that which applies to the community at large'. No doubt this comment has been stimulated by the recent attacks made on prison doctors claiming that prisoners are being given psychotropic drugs for non-medical reasons. An unhappy sidelight on this particular controversy has been the recent lawsuit between members of the College which was settled out of court with substantial damages in favour of two prison doctors who were accused by the BBC and by a psychiatrist of drugging large numbers of prisoners for non-therapeutic purposes. (BMJ 1978).

At a time when medical institutions of all sorts are coming under increasing attack, it may be reassuring to some to have an explicit statement that the prison medical officer's position can be equated with that of any other practising doctor. Those of us who are closely acquainted with the Prison Medical Service do not need such reassurances and are well aware of the ethical standards adopted by our colleagues in ministering to an unattractive group of patients who have frequently been completely rejected by NHS staff. It would be surprising indeed if prisoners were not dissatisfied with their lot, and it is almost inevitable that whatever medical services are provided they will complain about them. To alleviate this level of discontent, society should surely arrange that absolutely minimal numbers of citizens are sent to prison and that the most disturbed prisoners are treated in NHS hospitals. One other improvement might be to allow prisoners to seek a further medical opinion from their own GP in the same way that they can seek other advice from their own MP. Not many GPs would welcome this arrangement, but it would be an avenue of communication which could occasionally be helpful to doctors and patients alike.

The message conveyed to me by this Report is that we should all notice the numbers and type of people we are rejecting to institutions who cannot say 'No, we don't think this person is suitable for admission', and we should be trying to find ways of assisting staff who are also, inevitably, stigmatized by the fact that they look after the rejects. Will the College be able to come up with some constructive policies in respect of the mentally abnormal prisoner, now that the joint consultant experiment is said to have failed?

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Footnote:

As this comment was being drafted the news of a riot at Gartree Prison came through. This is particularly pertinent to the points under consideration in the Report, as it illustrates the kind of disruptive problem the Prison Department is currently having to cope with, and the stated basis of the riot was that prisoners believed a fellow prisoner had been given drugs unnecessarily.