the columns

correspondence

The value of managers' hearings

Sir: In a recent edition of the *Bulletin*, Gregory (*Psychiatric Bulletin*, October 2000, **24**, 366–367) argued for and Kennedy (*Psychiatric Bulletin*, October 2000, **24**, 361) against the role of the hospital managers in hearing appeals by detained patients. We are aware of no systematic evaluation of managers' hearings.

We reviewed 52 case notes of 55 patients (in one community mental health team) who applied to the managers or mental health review tribunal (MHRT) over 4 years. Ninety-seven appeals were made, 35 against Section 2 (28% were managers' hearings) and 62 against Section 3 (59% were managers' hearings).

There were 49 managers' hearings, five patients were discharged and 26 detentions upheld. There were 48 MHRTs, five patients were discharged and 22 detentions upheld. Most of the remainder were previously discharged by the responsible medical officers. Adverse outcomes (re-section or arrest in 1 month) occurred after three of managers' and two of the MHRTs discharges. The mean delays in receiving an appeal date for Section 2 were 13 days (managers' hearings) and 9 days (MHRTs). For Section 3, the delays were 35 days (managers' hearings) and 77 days (MHRTs).

We found similar numbers of appeals to and discharges by the hospital managers and the MHRTs, countrary to Kennedy's comment that discharges by managers "are now unheard of". The average waiting time for a Section 3 MHRT was 42 days longer than for a manager's hearing. The abolition of managers' hearings may erode patients' rights. Larger studies are required before the right of appeal to hospital managers is abolished in the new Mental Health Act.

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Supervised discharge orders

Sir: The editorial on supervised discharge orders by Burns (*Psychiatric Bulletin*, November 2000, **24**, 401–402) raises many interesting issues, not least the fine balance between persuasion, coercion and enforcement. Although the supervised discharge under Section 25 of the Mental Health Act 1983 was primarily concerned with treatment in the form of medication, we would like to report our usage within a learning disability service, where the focus is on ensuring structured support rather than medication.

Working within a medium secure service at a tertiary regional level, all our in-patients are detained. About two-thirds of our patients have a combination of disability and personality disorder (ill defined) rather than 'frank' mental illness. A supervised discharge under Section 25 provides a legal framework, defining what services should be available and certain undertakings on the part of the patient: to live in a particular place; to meet with certain professionals; to attend certain day activities, etc. Even though it is clear that there is no enforcement, this structure does appear to give reassurance both to patients and staff, particularly to staff where the patient is discharged to.

It may be argued that this is no more than a Care Programme Approach (CPA). In our practice, however, we find that supervised discharge occupies an intermediate space between CPA and Guardianship Orders, perhaps a little bit more coercive than persuasive, but not using enforcement. We should be interested in the experience of other practitioners within learning disability services.

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The future (or not) of the medical member

Sir: I agree with Rooth's (*Psychiatric Bulletin*, January 2001, **25**, 8–9) comments on the future of the medical member of a mental health review tribunal (MHRT) and in support would add:

(a) The purpose of a MHRT is to combine legal and medical opinion in a decision that is in the best interests of the patient.

(b) The clinical component of the medical contribution must be based on sound medical practice, which includes access to the case notes and a clinically appropriate and private interview with the patient concerned. The medical member's contribution is not just about theory, it is about a person. It is not about, for example, schizophrenia, but about a particular person who suffers from that malady, who lives in his or her own particular family and social context. Anything less than a full clinical assessment, which cannot be made during the course of the formal MHRT proceedings, will diminish the mental member's clinical judgement and will detract from the quality of the final decision.

(c) The clinical contribution, no less than the legal and lay, must be made before and within the MHRT and within the subsequent decision-making. When the decision includes both legal and clinical components, both should be fully represented at all stages.

(d) Like Rooth, and many other MHRT colleagues of all persuasions, I do not fully understand the concern expressed about the current practice of a preliminary examination followed by medical participation in the MHRT's decision. In my opinion the desired balance noted in (a) can only be optimised via (b) and (c).

(e) All must respect the letter of the law, but I suggest that the process by which a hearing is conducted is a separate issue. When the nature of the hearing, and of a decision, requires that legal and clinical considerations be balanced, I suggest that equal respect has to be shown to both legal and clinical processes. When it comes to process, clinicians operate in a very different way to lawyers. That difference should be respected and reflected in the processes of a MHRT. The White Paper's proposals (Department of Health, 2000) will distort the clinical perspective.

(f) If the fear of the present medical member's role is that evidence from the preliminary hearing may be communicated in private and is therefore not subject to scrutiny in the MHRT, this can be overcome. The patient can be told at the preliminary hearing that it is what is said at the MHRT that counts, with the rider that anything then talked about may

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have to be repeated at the MHRT. Any discovery by the medical member that is not in the reports can be reported, either by the President or the medical member, as the MHRT starts. Alternatively, the medical member may elicit the information by asking questions of the appropriate 'witnesses' before him/her and not by giving it himself/herself as evidence. Medical members need not themselves give evidence.

(g) The patient's representative will have seen the patient before the hearing and increasingly often has gained access to the case notes, thus further diminishing the likelihood of information being concealed. Furthermore, he or she can call for his or her own independent psychiatric assessment, although, since the revision of legal aid regulations, these seem to be sought much less frequently.

In Rooth's view the medical member's "insider perspective is irreplaceable". I would prefer 'integrated' to 'insider', but agree with him wholeheartedly, for the reasons given above, that it is 'irreplaceable'.

DEPARTMENT OF HEALTH (2000) *Reforming the Mental Health Act. Part I: The New Legal Framework*. London: The Stationery Office.

G. E. Langley Medical Member, MHRT, Consultant Psychiatrist (Retired)

Patient or client?

Sir: The use of terms for those who experience mental health difficulties is contentious and political. It is also above all dependent on context. I am not at all surprised that Ritchie *et al* (*Psychiatric Bulletin*, December 2000, **24**, 447–450) found the term 'patient' was preferred by out-patient attendees, I regularly use the term patient without complaint for those who are currently receiving treatment.

However, there needs to be a term for those who have received such treatment in the past and who have a legitimate interest in the workings of the mental health services. 'Patient' is not an appropriate term to identify, for example, someone sitting on a planning committee who is there by virtue of having a personal experience of mental illness. We need a term for this and most people in this category accept the term 'service user'.

Some people prefer to be called 'survivors' and when you listen to their experiences of mental health services this can seem quite appropriate. I would suggest asking people how they identify themselves and then showing them the courtesy of using their preferred term. The suggestion from Hodgkiss (*Psychiatric Bulletin*, December 2000, **24**, 441) that user involvement and empowerment might be derailed by a name change is like expecting a juggernaut to be stopped by a pea. Service user involvement is here to stay. There is a lot of energy in the user/survivor movement (see, for example, http://www.madpride.net).

We should be working with 'service users' in order to improve services for our 'patients'; some of whom may be the same people in a different context.

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Sir: It is with interest that we noted your publication of Ritchie *et al*'s study 'Patient or client? The opinions of people attending a psychiatric clinic' (*Psychiatric Bulletin*, December 2000, **24**, 447–450). As a community adolescent mental health team we wondered about the best way to address the people who were attending the unit. Between February 2000 and May 2000 we conducted a small survey and wrote to 133 people who had accessed the service and in response we received 42 replies. There were a number of questions on the survey, but in answer to the question about the preferred terminology to describe a patient/client the responses were as follows:

Servxice user	3
Patient	15
Customer	1
Client	16
Other	7

The preference was slightly in favour of the term 'client' as opposed to 'patient', with very little preference for service user or customer. It may be significant that our survey was only of clients between the ages of 16 and 19 years, whereas in the Ritchie *et al*'s study the mean age was between 35 and 39 years. This might indicate a shift, which is influenced by age and points to an emerging change in culture. Perhaps the most significant finding was that only 42 clients out of 133 were sufficiently exercised by questions of this sort to return the questionnaire in its postage paid envelope. This question may be of more interest to professionals than clients.

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Sir: The article by Ritchie *et al* (*Psychiatric Bulletin*, December 2000, **24**, 447–450) provides a useful contribution to the debate about the use of titles. I agree that the term 'patient' is appropriate for someone who attends a psychiatric out-patient clinic. However, mental health care is diverse and consists of services provided by numerous agencies. What title should we give the 'patient' who, after attending the clinic then visits a day centre run by a voluntary organisation? This service may be essential for his or her mental health, but surely he or she is not a patient of the centre's manager. Similarly, the 'patient' may need home visits from social services but I doubt whether social workers would regard the person as their 'patient'. Further confusion occurs when we consider people who have been diagnosed with a mental health problem but who are well and not in contact with any services. Ritchie *et al*'s study was context specific and in their context the term 'patient' seems fine. In other contexts 'client' or 'service user' may also be suitable. I see two solutions to this problem. One is an acceptance that one person can have different titles at the same time, each of which represent the relationship that he or she has with the service provider. The other is to use a general title that applies to all situations. How about 'individual' or 'person'?

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St John's wort and ecstasy use

Sir: I learnt from a patient who misuses illegal drugs that St John's wort has become a popular way of avoiding depressive mood swings following heavy ecstasy use. I wonder if this is a practice that is widespread around the country, or merely confined to the Yorkshire region.

G. E. P. Vincenti Consultant Psychiatrist

The limited value of the annual physical health examination in long-term secure care

Sir: We were concerned that psychiatric patients have increased physical morbidity and mortality (Santhouse & Holloway, 1999), yet their general health care may be neglected. Prisoners also end up with reduced access to health care (Smith, 1999). Thus, we wondered how effective the annual physical examination is for our long-stay psychiatric patients at Rampton high security hospital. We felt this was particularly needed as general practice services have extended in recent years.

An SPSS computer program (weighted to ensure case balance for gender, age and ward) randomly selected 120 cases for a sample of 447 patients at Rampton 1995–1998, 72 (16%) of which were

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