

from other disciplines. As Dr Jorsh implies, many psychiatrists cannot feel wholly committed to a bio-medical model, and draw on alternative theoretical sources. Nurses share this unease, and, like their medical colleagues, seek to discover, and understand first hand, a fitting conceptual basis for practice.

The terminology of descriptive psychopathology is useful and important. It is also limiting; and, as Dr Jorsh acknowledges, one must look further for a more complete approach. Nursing is now trying to establish theoretical models and conceptual frameworks; however, inductive theory, whether predictive or descriptive should, of course, be capable of testing for validity and usefulness. The long tradition for doing this in medicine is respected by nurses. Now they emulate it.

Professor Altshul, in the same address cited by Dr Jorsh, described nursing practice which, while outside some nursing theory, equally lay outside the medical model. Such good practice as the development of a trusting, therapeutic relationship, or the creation of a safe ward atmosphere, I suspect might also be valued by Dr Jorsh. If such skills cannot be learnt, then certainly psychiatric nurse education has erred, for their acquisition is a key goal of the teaching approaches being incorporated, from the 1982 RMN (Registered Mental Nurse) syllabus, into many 'Project 2000' mental health branch programmes. (I cannot answer for the single college he assumes to be representative.)

The Avon College of Health, Mental Health Branch Programme uses 'Mental Health and Illness' as one of the main themes of the course. Discussion of the classification of mental disorders and medical diagnosis is followed by developing understanding of different disorders and treatment approaches. This theme cohabits with others, with which there may be some healthy conflict, and a critical approach based on the evidence is encouraged. Practical experience includes attachment to individual clients, with supervision from multi-disciplinary key workers (which could include doctors). Formal teaching from psychiatrists may contribute to theory; however, the financial remuneration they command reduces their involvement to those topics not covered by internal lecturers.

Again, this is evidence from one establishment. I am also aware of approaches in other colleges: eclecticism, holism, and the identification of physical, psychological, social and spiritual needs as the basis for planned intervention, are common features. In order to be approved, any 'Project 2000' course must enable the student to attain the 'competencies' outlined in the amended Nurses Midwives and Health Visitors Act. All of them apply to "sickness and health", and include "The ability to function in a team, and participate in the multi-professional approach".

I hope this adds balance (not 'dogmatism') to a debate about a relationship which I hope will survive even Project 2000!

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*This is a shortened version of a longer response.*

DEAR SIRS

I am very pleased to note that The Avon College of Health appears to be teaching some form of descriptive psychopathology. However, the form that this takes remains unclear. I must confess that I may have been somewhat confused by the jargon in the letter, the use of which supports, rather than refutes, my argument. I note that Mr Rawlinson wrote to add balance (not 'dogmatism') to the debate, but has been unable to expand upon his argument because of the very terms by which he appears to be constrained. I therefore find very little in the letter which causes me to stray from the opinions expressed in the article.

In the interests of balance, I must add that since the publication of the said article, I have been invited to sit as medical representative on the Curriculum Committee of the psychiatric section of the North Staffordshire College of Nursing and Midwifery. With time, the implications of this will become known.

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### *Mental Health Review Tribunals*

DEAR SIRS

I can understand the reasons for Dr West's concern about legal representation at Tribunal hearings (*Psychiatric Bulletin*, June 1991, 15, 372), but would suggest that he is in error on two points. I am assuming that he is referring in the main to Section 2 cases, but he does not say so.

First, as to fact; MHRTs were not conceived as he suggests, in 1983, but were introduced under the 1959 Act as a replacement for the system of independent intervention through the magistracy under the old lunacy legislation.

Second, as to intention. Tribunals are charged with *reviewing* the need for a patient's continued detention and to this end the latter's own views and attitudes are crucial to this process. Many patients are not only inarticulate but sometimes quite disturbed by a Tribunal appearance, however informal

and relaxed we attempt to make the proceedings. The system of paid, regular, advocacy introduced under the 1983 Act sought to assist them in the presentation and promotion of their cases.

One could argue, and indeed, perhaps one should, that the more 'hopeless' (Dr West's word) the case may *appear*, the greater the need for advocate support. In my view, no case should be pre-judged as 'hopeless'; they may be difficult, unpromising and of uncertain or doubtful prognosis – for a wide variety of reasons, but all are deserving of the best possible assistance. By analogy, I doubt very much whether as a physician, Dr West would advocate the withholding of treatment from a very physically ill patient in hospital on the grounds that the case was 'hopeless'. It is just because many of the patients seen by MHRTs are particularly vulnerable and may have been considered 'hopeless' by others, that they require a skilled person to present their cases. Sadly, there have been many recent reminders of just how vulnerable many disadvantaged people are (for example, children in care, the elderly sick and infirm, remand and other prisoners). To place financial expediency above the protection of such people is a potentially dangerous course of action and would be a very retrograde step.

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DEAR SIR

I must disagree with Dr West (*Psychiatric Bulletin*, June 1991, 15, 372). Legal aid is most important for "the patient who can obtain legal representation no matter how hopeless his chances are". The legal representative may break the mould. Other channels of less restrictive and more appropriate care may be looked at. The order may be discharged, perhaps after a delay, when other arrangements have been made. Every patient should have the same rights whatever someone might think their chances of success might be.

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DEAR SIR

Thank you for letting me see the comments by Professor Prins and Dr Kerry.

As a clinician at the sharp end of continued service reductions to stay within budget I believe that, if it is right for me to tread this path, then surely those involved in advocacy services should tread it also. I am not recommending that the 'hopeless' case

should have treatment denied as Professor Prins states but that the Mental Health Review Tribunal system, especially with regard to Section 2 patients, should be reviewed to see if financial savings might be made and perhaps a more efficient system devised.

When one considers the hidden costs of the hearing, i.e. time taken by various professional staff in preparing reports, nurse escort time, time spent attending the Tribunal and the loss of the rights of many other patients as ward rounds, out-patient clinics and Section 117 meetings are cancelled or re-arranged, then a search for a more informal and cost effective system should be made. Only yesterday (Monday) I learnt that I had to prepare a report for a Section 2 Tribunal on Thursday. Thus I must miss most of my ward round and also a Section 117 meeting; all for another 'hopeless' Tribunal.

One suggestion might be that the role of the independent psychiatrist should be extended and that he, with or without a solicitor, replace the Tribunal.

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### *Provision of psychiatric care by GPs*

DEAR SIR

Westbrook & Hawton (*Psychiatric Bulletin*, June 1991, 15, 328–329) report the value placed on psychiatric liaison meetings by general practitioners. Hilton & Tolley, in the same issue of the *Bulletin* (*Psychiatric Bulletin*, June 1991, 15, 360–361) suggest that such meetings may provide information about patients who have been admitted to hospital. They also comment on the value of such meetings to trainee psychiatrists.

I have provided a psychiatric service in a number of general practices over the last three years. In that time I have had an opportunity to see how much psychiatric care is provided by GPs. This is something about which one reads but may not appreciate fully without such direct contact.

It is important to be aware that many GPs have the skills to deal with the majority of potentially psychiatric patients and often have knowledge of the social and family problems, which may be of great importance in understanding and treating patients.

Specialists providing a liaison service must be prepared to listen and learn. Perhaps we should try to evaluate the benefits to psychiatrists (of all grades) of such contacts with GPs. Liaison should be a two-way process.

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