Robert Sovner and Dr Henry Crabbe. Dr William Gardner reviewed the perspectives of behavioural methods used to treat people with mental handicap and aggressive behaviour by presenting a comprehensive, functional analysis of aggression with emphasis on environmental factors. The model of service provision which prevailed was community based with admission facilities whenever necessary. The complexities, various and sometimes conflicting principles and opinions of multidisciplinary team members were illustrated by Dr Mark Hauser.

It is encouraging and stimulating that an organisation such as NADD exists which focuses its activities on important issues and dilemmas, presented by the combined disability of mental handicap and mental illness. Although the challenge of correct diagnosis of psychiatric disorders in people with a mental handicap is not a new issue, it has received much more attention in recent years because the process of deinstitutionalisation and community care has increased the visibility of the problem. The coexistence of mental handicap and psychiatric disorder has serious effects on the person's daily functioning by interfering with educational and vocational progress by jeopardising residential placements, and by disrupting family and peer relationships. It can also greatly reduce the quality of life of people affected.

More collaborative work on an international level is required to disseminate knowledge and encourage the exchange of ideas in the field. My only suggestion is that perhaps it is time for NADD to reconsider its name, especially as there is an element of ambiguity, which might be applied to other conditions and hence lead to confusion.

The Mental Health Act and its agencies – are they working together?*

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The 1983 Mental Health Act gave increased responsibility to the Mental Health Act Commission and the Mental Health Review Tribunal to ensure safeguards in the treatment and detention of patients compulsorily admitted to hospital. Although most are agreed that the civil rights of patients admitted to hospital against their will are better protected under the new Act, some psychiatrists are irritated by the necessity to involve these bodies in what they regard as primarily clinical management. The North-East Division of the Royal College of Psychiatrists believed that debate on this issue might benefit both psychiatrists and others involved and this topic was chosen for the Annual Meeting of the Division in York on 28 September 1990. The meeting attracted other mental health care professionals and of the 144 participants almost one-third were not psychiatrists, but mainly social workers and psychologists. The sessions were chaired by the President of the College and Professor Donald Eccleston.

William Bingley, Chief Executive Officer of the Mental Health Act Commission and previously Legal Director of MIND, opened the meeting by asking whether the civil rights of the patient were adequately protected under the present legislation? He emphasised that civil rights were both positive, e.g. the right to care and to receive essential services as well as negative, such as the freedom to be protected from harm. How far patients were able to consent to treatment that impinged on their rights remained a matter of debate. Mr Bingley felt that there was a clear difference between those patients who were incapable of giving consent because of mental handicap or severe psychosis and those who were able to give consent but refused treatment. He believed that future revisions of the Mental Health Act should recognise the distinction between these two different sets of circumstances.

The work of the other main statutory agency, the Mental Health Review Tribunal, was discussed by Professor Sir John Wood, Chairman of this body. The most obvious injustices in the treatment of the mentally disordered patient arose because of detention in the wrong place because of lack of resources. The two basic rules that Sir John felt should always apply, that the patient should be kept in as free an environment as his illness permits and that once a move was indicated it should be offered with as little delay as possible, could often not be achieved because of the difficulty of arranging transfer to a less

**Annual Meeting of the North-East Division of the Royal College of Psychiatrists, 28 September 1990.*

https://doi.org/10.1192/pb.15.5.287 Published online by Cambridge University Press

restrictive setting. Concern was also expressed that many of the cases seen by tribunals were unnecessary. For instance, many patients detained in Special Hospitals are unlikely to be released for a long time because of the nature and circumstances of their crime yet such patients are legally entitled to have annual tribunals. The tribunal should not be convened to give a second medical opinion which is not what the law envisages or what psychiatrists would accept. Sir John felt that the appeal procedures to the hospital managers with regard to detention were unnecessary, with the average patient having only the haziest idea of the nature of the difference between this body and the Mental Health Review Tribunal.

Dr Bee Brockman, Consultant Forensic Psychiatrist from Birmingham, presented data illustrating the point that many mentally abnormal offenders are remanded in custody inappropriately. There is often a considerable delay between reception into a remand institution and transfer to an appropriate medical facility for assessment or treatment. A local pilot study on medical reports and social enquiry reports used by the courts revealed a disturbing feature that the courts only followed the treatment recommendations made jointly by the Probation Officer and psychiatrist in less than 50% of cases where a positive treatment recommendation was made. The advantage of inter-agency working, and early diversion and discontinuance where possible by means such as court-based psychiatric assessment, which enables patients to be admitted to hospital promptly under civil Sections of the Mental Health Act, in addition to use of Part 3 of the Mental Health Act, was emphasised.

The difficulties of ensuring adequate psychiatric care for patients outside a hospital setting were discussed by two speakers. Dr Derek Chiswick discussed the Community Treatment Order and whether this operated well in practice. The evidence from Australia and the USA is that the Community Treatment Order does not enable treatment to be given to patients who would otherwise not receive this, although it may facilitate speedy admission to hospital and persuade those already moderately compliant with treatment to continue with this. Effective imposition of the order requires considerable professional time, organisation and resources. In view of the current paucity of community facilities and public anxiety concerning psychiatric treatment, it does not seem timely to advocate compulsory treatment in the community.

Dr Peter Kennedy, District General Manager of York Health Authority, spoke about the new chronically mentally ill patients who do not fit in with existing services. The recommended provision for these individuals, particularly those with so-called challenging behaviour, is for expensive care units, often in liaison with the regional secure unit, although a number of these patients can cope very well in selected community placements. The successes in these cases are because of the persistence of a clinician or psychiatric nurse who has implemented an individual care plan taking into account the individual's views and those of his family. If money followed these patients as the recent White Papers on the National Health Service has suggested, those individuals who proved to be particularly adept in providing services for these individuals could be rewarded accordingly if there was flexibility of pay.

The final address was given by Mr Louis Blom-Cooper, Chairman of the Mental Health Act Commission, who described where Mental Health Act legislation was leading. The trend over the past few decades has been for society to be more involved in the control over the mentally disordered rather than leaving this to the medical and legal professionals. Mr Blom-Cooper told the meeting that future legislation would be likely to reduce psychiatric involvement under the second opinion system, e.g. with Section 58, and replace this with a multidisciplinary opinion. The role of the Mental Health Act Commission should increase to involve the care of informal patients. Regret was expressed at the involvement of legal processes in patients who were unable to consent to treatment, and statutory ethical committees to endorse medical treatments or otherwise were recommended. With the increased movement of patients into community care, the provisions of Section 117 of the Act should be more rigidly applied. Like Dr Chiswick, Mr Blom-Cooper believed that a community treatment order could not be adequately enforced but that there should be increased use of the Section 7 Guardianship Order.

The subsequent discussion revolved around the future involvement of psychiatrists in treating patients who required compulsory admission. A rhetorical question from the audience asked if the role of the psychiatrist in the future would be simply to endorse decisions regarding the compulsory care of the mentally ill made by others than doctors. Although some claimed that this defensive stance arose from what could be described as a paranoid position, there was a feeling that the skills of the psychiatrist in the assessment and management of the mentally ill might be ignored by well-meaning but inexperienced lay people. One optimist hearkened back to the earlier talk by Sir John Wood regretting inappropriate judicial interference in psychiatric matters. The psychiatrist is the expert in managing the mentally ill, the lawyer knows the law. Each should be able to contribute to the successful resolution of the suffering of the mentally ill if they work together.