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

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supplementary reports containing confidential and potentially controversial information for tribunals in the future.

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Cannabis psychosis

DEAR SIRS

Dr Cembrowicz (*Psychiatric Bulletin*, May 1991, **15**, 303) states that psychiatrists responding to his questionnaire, as in Dr Littlewood's study (Littlewood, 1988) "felt that major tranquillisers were the best treatment" for cannabis psychosis. Cannabis and alcohol have been the commonest causes of major psychosis in young adults admitted to my ward for some time (Cohen & Johnson, 1988) and the psychosis with cannabis may either be of a manic type (Rottanburg *et al*, 1982) or it may be schizophreniform; organic features can often be detected in the mental state if the examiner looks beyond the obvious psychotic features. In all cases the disorder subsides very rapidly when the cannabis is stopped but you have to make absolutely certain that its use is not continuing clandestinely. If cannabis continues to be used then major tranquillisers are not effective and if it ceases they are not necessary. The 'best treatment', indeed the *only* treatment, is to stop the cannabis; the use of other drugs except temporarily for the control of very disturbed behaviour is both illogical and inappropriate.

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Section 5(2) Audit

DEAR SIRS

Drs Joyce, Morris and Palia wrote detailing results of a Section 5(2) Audit at the Glanrhyd Hospital, Glamorgan (*Psychiatric Bulletin*, April 1991, **15**, 224–225, letter). I felt it would be worthwhile to submit the findings of a similar procedure undergone at Hollymoor Hospital, Birmingham.

This hospital provides in-patient psychiatric care for a catchment population of approximately 250,000. I studied all Section 5(2) applications over the 15 months to 31 December 1990. Our policy is that Section 5(2)s should be signed by the patient's Responsible Medical Officer. If he or she is not in the hospital, the junior doctor on call is designated as the nominated deputy. He or she may complete Section 5(2) after discussion of the case with the RMO or other acting consultant. The total number of admissions in 1990 was 850. Thus, extrapolating for the 15 month period, there were just over 1,000 admissions. During this time, 34 Section 5(2)s were applied. Data were collected on 33 of the cases and notes were not available for the 34th.

There were 16 males and 17 females. Eight patients were married, 19 single, four widowed and two were separated or divorced. One patient was aged under 17, 16 were 18–35, 12, 36–64, and four were over 65. For eight patients this was their first admission to hospital; in 25 cases there had been one or more previous admissions; in 11 cases the application of Section 5 was within one day of admission. In a further eight cases, the application was within five days of admission, in four cases, 5–14 days, and in ten cases more than 14 days.

The time of application was between 0900 and 1700 hours in 18 cases, although four of these were at weekends; in 12 cases, the application was between 1700 hours and midnight; in three cases between midnight and 0900 hours. The Section was applied by a member of the home team, consultant or junior, in 20 cases, and by the hospital duty doctor in 13 cases. Discussion with, or involvement of, the RMO occurred in 18 cases, and with the duty consultant in a further eight cases. In seven cases the application appeared not to have been discussed with any consultant.

There was an immediate change in observation level in 11 patients but not in 22. During the period of Section 5(2) the patient was assessed by a member of medical staff in 32 cases but not in one case. The assessment for further detention involved the junior doctor in six cases (these junior doctors were in some instances Section 12 Approved), the senior registrar or associate specialist in four cases, and the patient's consultant in 26 cases. In some instances there was a combination of staff involved as judged by scrutiny of the notes.

After the Section 5(2), 21 patients were detained under another Section of the Mental Health Act, 12 were not. The time to discharge was less than one day in no cases, 1–7 days in one case (who took his own discharge), 7–28 days in 12 cases and over 28 days in 20 cases. The final diagnoses recorded in the case notes were schizophrenia on 10 occasions, affective disorder on 18 occasions, personality disorder once and other diagnoses, mainly organic conditions, on four occasions.

It was worrying that a number of patients were detained within a day of admission, particularly so as

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