THE WHITE PAPER ON THE MENTAL HEALTH ACT: THE COLLEGE'S COMMENTS*

1. INTRODUCTION

The Mental Health Act 1959 was based on the Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957 (the Percy Report). At the heart of the Act lies the principle of informal admission to hospital for psychiatric treatment wherever this is possible.

Shortly after its foundation the College established a Working Party to review the Act. Its Report was published in October and November 1974, and its recommendations were submitted to the Inter-departmental Committee set up in 1975.

The Government published a Consultative Document in 1976 (*A Review of the Mental Health Act, 1959*, H.M.S.O.) and the College's comments on this were published in January 1977.

The Government has now published a White Paper and has indicated that it intends to translate most of its proposals into an amending Bill. No further comments have officially been requested, with the exception of the new proposals for compulsory powers in the community. Despite this, the College has been anxious to give close and careful consideration to the contents of the White Paper and a Special Committee of Council was established to carry out this task and also to consider a related document, the Discussion Paper on the Procedures of the Mental Health Review Tribunals.

The College, like the Government, has taken the view that, in general, the Mental Health Act has been very effective in promoting liberal developments in psychiatric treatment and care. It therefore welcomes an approach which aims to improve practice but does not introduce a fundamental change in philosophy. However, throughout the White Paper the influence of the National Association of Mental Health (MIND) is very evident, and the College is concerned by the impression that recurs that psychiatrists are biased in favour of compulsion, restriction and the use of 'hazardous' forms of treatment and that they have too little concern for the 'rights' of patients. There is little evidence for these assumptions.

2. THE SCOPE OF THE ACT AND THE DEFINITION OF MENTAL DISORDER (CHAPTER 1)

Informal Patients (1.2-1.4)†

One of the most important objectives of the Act was to give informal psychiatric patients the same status as informal non-psychiatric patients. However, informal psychiatric patients may at present be subject to Section 90 (deportation), to Section 134 (patients' correspondence) and Section 141 (limiting the ability of an informal as well as a detained patient to initiate legal action against staff). The College approves the intention to amend Sections 90 and 134 but considers that Section 141 *should* continue to apply to informal patients (as well as detained patients).

There are other (perhaps inevitable) differences between informal psychiatric patients and non-psychiatric patients. If the patient refuses an invitation to enter hospital informally the result can be a compulsory admission (an alternative which cannot be applied to non-psychiatric patients). Similarly, at a later stage, an informal patient who wishes to leave hospital but is considered a potential danger to himself or others may, in good faith, be detained for further care and treatment.

At the present time, the wish of psychiatrists to admit patients informally wherever possible results in some patients being persuaded to accept treatment informally in order to avoid invoking compulsory powers. The appropriate use of Section 26 would be a more honest and open procedure.

The White Paper recommends (1.8) that, in the case of a patient who does not have the mental capacity to agree (or object) to admission to hospital, and where there is any doubt or likelihood of dispute (for example from relatives) the appointment of a guardian under the Act, to give decisions on the patient's behalf, should be considered. The College agrees with this principle, but believes that the suggestion is impracticable because the appointment of a guardian cannot usually be arranged expeditiously.

The White Paper emphasizes that the powers, duties and responsibilities of doctors, nurses and other staff in relation to informal psychiatric patients are the same as those of staff in relation to non-psychiatric patients. The College considers this to be a naive appraisal. Freedom to consent and the subjection to control while in hospital are different for psychiatric and non-psychiatric patients.

An increase in the number of formal procedures would lead to more demands upon staff time and availability at the cost of a reduction in time for treatment and nursing care.

The College believes that the Government has seriously underestimated the resource implications of

†In this report, figures in brackets refer to paragraphs in the White Paper.

*An abbreviated version of the full document for which the Editors take responsibility. It is hoped that nothing of importance has been omitted.

its proposals and the need for more staff to raise standards and compensate for time spent in carrying out statutory procedures.

The White Paper discusses (1.11) the principles upon which emergency treatment can be imposed. The College agrees that in situations which are not emergencies the correct course would be to seek proper authority under an appropriate section of the Mental Health Act. It is however, impossible, as the White Paper states (1.13), to legislate for every eventuality.

The College supports the proposal (1.14) to provide an informal patient with a written statement of his rights on admission to hospital and to inform him of any change in his status. The information should be communicated to the patient in a simple and understandable form.

3. Definitions (1.15-1.32)

The College is disappointed that its proposals to abolish the sub-categories of mental disorder have been rejected.

4. Mental handicap (1.18)

The College is pleased to note that mental handicap is to remain under Mental Health legislation. (1.18)

The White Paper intends to replace the terms 'subnormality' and 'severe subnormality' with 'mental handicap' and 'severe mental handicap'. The College considers that the use of the term 'handicap' could lead to confusion and result only in an ephemeral change in attitudes. The College has noted the widening of the definition of mental handicap to include social functioning in addition to impairment of intelligence; this appeared to have resulted in some degree of confusion in the White Paper.

The College views with concern the new proposed definition of 'treatment' (1.23) which does not include a requirement for *medical supervision*. The College takes the view that medical supervision (and ultimately responsibility) is an essential element in hospital care (although not necessarily in community care) which must not be excluded.

5. Psychopathic disorder (1.24-1.27)

The College regrets that psychopathic disorder has been retained within the scope of the Act as a specified condition. However, the Government's definition (which removes age bars and adds a requirement that 'a prospect of benefit from treatment' should be incorporated into the criteria for compulsory admission and renewal of detention) is an acceptable compromise.

The other proposals in this Chapter 1 (28-1.32) (excluding alcohol, drug dependency and sexual deviancy from the terms of the Act unless accompanied by mental disorder) are accepted.

6. COMPULSORY ADMISSION TO AND DETENTION IN HOSPITAL (Chapter 2) (2.1-2.47)

THE SHORT-TERM POWERS (2.2-2.35)

The short-term powers are:

(i) emergency admission for observation under Section 29;

(ii) admission for observation and assessment under Section 25;

(iii) removal to a place of safety under Section 135;

(iv) power of a constable to remove a person from a public place under Section 136;

(v) short term detention of an informal patient already in hospital under Section 30.

In its paragraph on the use of Section 29 (2.3) the Government expresses the hope that the 'increasing development of the 24-hour crisis intervention services will in time reduce the need for Section 29 admissions'. These services have not yet developed and are not likely to replace adequately the need for Section 29 powers. The College fully agrees with and supports the proposed amendments to Section 29 (i.e., that it should provide a short period of assessment in its own right and that there should be tighter monitoring of its use), apart from the proposal that the 'place of assessment', could be redefined to include the use of other accommodation as well as hospital. (2.8)

The College welcomes the proposals for clarifying the use of Section 25 (2.9-2.12), as it suggested in evidence; that Section 25 should explicitly provide for short-term assessment and *treatment* (and this should be expressed in the official title of this Section). The College welcomes the decision to leave the scope of Section 25 otherwise unchanged (2.13) and considers that the safeguards suggested in relation to this Section are acceptable.

The College welcomes, the suggested amendment to Section 135 of the Act (to make it apply to the case of two mentally disordered persons living together) (2.21).

The College accepts the need to retain Section 136 but believes that it should only be used in an exceptional emergency. The continued need for its use is a result of poor and insufficient emergency services in certain areas. It would be valuable for the police to be required to record in writing their reasons for using Section 136.

7. Section 30—Short-term detention of a patient already in hospital(2.29-2.32)

The College supports the proposal for a new 'holding power'. It should be available to nurses approved by the managers of the hospital (not only to Registered Mental Nurses). The College believes that the holding power should have a time limit of *three hours* only. The College welcomes the acceptance of its recommendation that a nominated deputy might invoke Section 30 on behalf of the doctor in charge of the case.

8. Section 25—Period of detention (2.35)

The College welcomes the proposal to provide explicit statutory backing for the use of Section 25 for *treatment* in addition to assessment and approves continuation of the present period of detention (28 days).

9. THE LONGER-TERM POWERS (2.36-2.47)
Sections 26 & 60—compulsory powers for longer-term admissions

10. Age limits and treatability (2.38)

The College accepts the proposal to remove the age limits for the admission under Section 26 of patients suffering from psychopathic disorder or subnormality (2.38)

11. 'Benefit from treatment' clause (2.39-2.40)

The College welcomes this clause, which would make 'the prospect of benefit from treatment' a requirement for the compulsory admission of mental handicap or psychopathic patients. Cases where the only likelihood of benefit would be prevention of deterioration should not be excluded.

12. Criteria for renewal of detention (2.43-2.47)

These proposals (a) that renewal is necessary in the interests of the patient's health or safety or (b) to protect others *and* (c) that there is likely to be benefit from further treatment and for the mentally ill and the severely mentally handicapped only, grave incapacity or likelihood of serious harm to others are approved.

13. Admission procedures (Chapter 3) (3.1-3.22)

14. Section 28—Doctors approved under 'Section 28' (3.3)

No attempt has been made in the White Paper to set out the standards required for the approval of doctors under Section 28. The DHSS should be asked to require a representative of the College to be a member of the panel approving doctors under Section 28.

The College agrees that there is a need to relax the regulation preventing a recommendation being made by two doctors on the staff of the same hospital but could not see why the second signature should have to be made by a doctor who 'works most of his sessions elsewhere'. (3.4)

The White Paper proposes that the 'approved doctor' making a medical recommendation under Sections 26, 60 or 72 should have special experience in the particular form of disorder from which the patient is suffering (3.6). The College believes that, for the purpose of assessment, a psychiatrist with special expertise in one field is well able to give an opinion relating to another. For the purpose of admission however, good practice would suggest that the doctor on the staff of the receiving hospital should be one of the signatories.

15. The role of the Mental Welfare Officer (3.7)

The College welcomes the White Paper's realization of the need for greater specialization by social workers working in the field of mental health, and the proposal (3.9) that mental welfare officers should be 'approved' in a similar way to doctors (under Section 28). Approval at a local level is favoured.

The College notes the White Paper's proposal that the Act should give the approved social worker: (i) a statutory duty to interview the person concerned before making an application for compulsory admission: and (ii) a responsibility to satisfy himself that the care and treatment offered is in the *least restrictive conditions practicable in the circumstances.*

The College strongly objects to this second proposed duty of the social worker. It suggests that the social worker (rather than the doctor or anyone else) is the sole arbiter of the patient's welfare and implies that the task of the social worker is to restrain the psychiatrist's enthusiasm for 'restrictive' action. Decisions about the need for compulsory medical care are medical matters, as are decisions relating to the conditions in which patients are treated. The College would wish to be concerned with the design of a code or practice on admission procedures suggested by the White Paper. (3.13)

The College considers that the definition of the role and responsibilities of the mental welfare officer as laid out in Section 54 of the Act at present are satisfactory.

16. The role of relatives (3.14-3.17)

The amendments proposed regarding the definition and responsibilities of 'the nearest relative' (i.e., the 'nearest relative' to be defined as the first in a list of relatives caring for the patient, and his or her power of

discharge to be extended to Section 25 patients) are approved, but the College feels that, as far as possible, relatives themselves should be encouraged to take responsibility and continue to be involved in admission and discharge procedures rather than to relegate this entirely to a professional group (social workers). The natural reluctance of some relatives to be involved is understood and appreciated. In some circumstances the relative who has been responsible for the patient's care could take precedence over the 'nearest' relative.

17. The role of health authorities and social service authorities (3.18-3.22)

The requirement for Authorities to establish special committees to ensure that proper procedures for admission are observed is approved.

18. Guardianship and compulsory powers in the community (Chapter 4) (4.1-4.21)

The Government has particularly requested comments in relation to these proposals, which have not previously been discussed.

The College has given careful consideration to the three options suggested by the Government to widen the use of compulsory powers in the community for a small minority of people. These options are:

(i) guardianship in a revised form (i.e., with minor changes);
(ii) Community Care Orders—similar to Hospital Orders, continuing after the patient's discharge from in-patient care;
(iii) An 'essential powers' approach—giving limited powers regarding residence, attendance for treatment, occupation or training and to allow access for a particular professional worker to visit the patient's home or elsewhere.

The College tends to favour Option (iii); the 'essential powers approach' (4.17) but with reservations. Who would be in control of the patient's medical care? Who would have the authority to execute the order? How may it be enforced? The principles of guardianship have considerable merit but powers to impose treatment in the community are undesirable. (4.18)

Moreover, without more and better facilities new powers would be of little value and would be utilized infrequently.

19. OFFENDER PATIENTS (Chapter 5) (5.1-5.67)

The White Paper discusses the current difficulties relating to the care of offenders requiring treatment in hospital. The College would stress that these problems result from a constellation of causative factors prominent among which is the failure of the Government to provide resources. The DHSS should ensure that resources are adequate and that various levels of security are provided in each Health Region.

The White Paper quotes MIND's recommendations that courts must be empowered to compel AHA's to admit offender patients to hospital if they were refused admission without reasonable grounds or in bad faith. MIND appears to have overlooked the fact that an offender can leave an open hospital without difficulty. Area Health Authorities have a duty to ensure that all facilities are available. The College believes that provision of more resources in terms of staff and facilities for these patients is the only way by which attitudes towards them will change.

Para. 5.35 discusses the difficulty in management of a recalled conditionally discharged patient (under Section 65), and the College supports the recommendation that it should be possible for the Home Secretary to order the patient's detention in a 'place of safety' for up to 72 hours, pending the establishment of secure units.

20. Transfer of prisoners to hospital

Section 72—sentenced prisoners (5.38-5.42)

The White Paper reviews the use of Section 72 and notes that in the majority of cases a restriction order is added. The College considers that the recommendations of the Butler Committee should be given more consideration. There is a need for a provision that would allow a 'less disturbed' prisoner to be transferred.

21. Right of prisoners transferred subject to restriction orders (5.43-5.51)

The College endorses the proposal that restrictions under Section 74 should cease to apply on what would have been the earliest date of release of a prisoner transferred to hospital under Section 72. (5.49)

22. Other prisoners (5.52-5.58)

The College has given its views on the proposed changes in the law regarding disability in relation to trial in its reply to the Home Office's consultative paper on this subject, issued in April 1978.

23. Remands to hospital and interim hospital orders (5.39-5.66)

A consultative paper was issued by the Home Office in June 1978 which reviewed the Butler Committee's proposals on these topics. The paper concludes that courts should be able to remand defendants to hospital, both where a psychiatric report is required

and where the defendant requires treatment in hospital. Courts should also be able to make interim hospital orders to ascertain whether treatment in hospital was appropriate.

The College considers that patients remanded to hospital under the proposed order would require secure conditions of care and, this implies the use of Regional Secure Units or a few special units. This implies a wider role for the new Regional Secure Units than has previously been envisaged. The implementation of the new order should depend upon the provision of additional resources over and above the present funding.

Further, the College would wish to be reassured; (i) that the consultant is involved from the outset in considering the suitability of a remand to hospital order; (ii) that ordinary psychiatric hospitals will not be expected to take patients under a remand to hospital order and (iii) that this legislation is implemented only when appropriate units are available.

24. SAFEGUARDS FOR PATIENTS AND STAFF
Chapter 6 (6.1-6.35)
Mental Health Review Tribunals (6.1-6.13)

The College has already prepared comments on a Discussion Paper on Mental Health Review Tribunal procedures*. The White Paper concentrates on the functions, powers and constitution of Tribunals.

25. Entitlement to Tribunal hearings (6.2)

Proposals are made for reducing the time periods during which patients under Sections 26 and 60 can be detained. These proposals are endorsed by the College. It is noted, however, that a *conditionally discharged restricted patient* has no right of appeal to a Tribunal to have his status changed. Such patients should be given a right of access to the Tribunal.

The College is concerned that the widening of the Tribunal's work will mean a corresponding extra burden on psychiatrists and hospital staff in preparing reports and attending hearings. This should not be under-estimated, particularly in relation to hospitals which care for a relatively high proportion of detained patients.

26. Automatic reviews (6.3-6.4)

The College accepts the proposals for *automatic reviews* for patients who have not exercised their right to apply within the normal intervals. The suggested intervals seem arbitrary; other time periods might be more rational and practical, and research studies would be helpful. Too frequent reviews may lead to a stereotyped procedure which would be self-defeating.

27. Powers of Tribunals (6.5-6.6)

Although the College welcomes the proposal which would enable Tribunals to order a conditional discharge, it is concerned about the situation which would arise when the Tribunal ordered a conditional discharge against the advice of the RMO (and vice versa). The relationship between the psychiatrist and his patient could suffer, and this needs to be borne in mind.

The Tribunal should have the power to delay a discharge or conditional discharge to ensure that appropriate arrangements have been made in the community to receive the patient. (6.5)

The recommendation not to allow an application to be withdrawn without the Tribunal's permission (and if withdrawn before being heard, not to disallow a further application) is endorsed. (6.6)

28. Tribunal membership (6.7-6.8)

It is agreed that more use should be made of the existing power to appoint a fourth Tribunal member, but it should not be a statutory requirement that a social worker should be a member. (6.7) It is agreed that there should be a more frequent involvement of forensic psychiatrists where appropriate. (6.8)

29. Restricted patients

The comments about restricted patients that Tribunals should continue to be involved in reviewing their detention, (in addition to the Home Secretary's Advisory Board) are endorsed, and the College's views in relation to para 6.2 (above) are reiterated.

30. Consent to treatment: treatment of detained patients (6.14-6.30)

One of the most important objectives of the Royal (Percy) Commission was to make psychiatric treatment available like other kinds of medical treatment. The suggestions in the White Paper in relation to consent for psychiatric treatment are a step in the opposite direction, as can be seen by comparing the recommendations concerning treatment for conditions unrelated to mental disorder. (6.24)

It would appear that there are two interlinked problems in relation to treatment, one concerning consent and the other the nature of the treatment being offered. Where informal consent is available it is difficult to see the need for barriers to the administration of treatment. Detained patients are, however, compulsorily detained *for treatment* and the question of consent has already been dealt with legally by

* To be published in a future issue of *The Bulletin*.

arranging compulsory detention. The proposals in the White Paper suggest that a particular treatment may be hazardous in some patients or in some conditions, but not in others. Clinical judgment is obviously required here, and it would seem impossible to codify this in an Act of Parliament. If a treatment is particularly hazardous or not fully established psychiatrists welcome a second opinion and seek it themselves. Second opinions are an integral part of medical practice.

31. General principles (6.18-6.21)

The White Paper proposes that an approach on the lines suggested by the Butler Committee is most likely to provide the right balance. The College rejects this proposal as inadequate and considers the criteria for compulsion laid down by the Percy Commission as the most acceptable. These criteria for giving treatment without consent were (paras. 316-17):

(a) 'There is reasonable certainty that the patient is suffering from a pathological mental disorder and requires hospital or community care; and

(b) 'Suitable care cannot be provided without the use of compulsory powers; and

(c) 'If the patient himself is unwilling to receive the form of care which is considered necessary, there is at least a strong likelihood that his unwillingness is due to a lack of appreciation of his own condition deriving from the mental disorder itself; and

(d) 'There is also either-

(i) 'good prospect of benefit to the patient from the treatment proposed—an expectation that it will either cure or alleviate his mental disorder or strengthen his ability to regulate his social behaviour in spite of the underlying disorder, or bring him substantial benefit in the form of protection from neglect or exploitation by others;

or

(ii) 'a strong need to protect others from antisocial behaviour by the patient.'

In Summary: 'when the use of compulsion is necessary for the patient's own welfare or the protection of others.'

32. Valid consent (6.23)

The White Paper states that valid consent implies the ability, given an explanation in simple terms, to understand the nature, purpose and effect of the proposed treatment. A patient may be able to understand the nature, purpose and effect of one treatment but not of another and his capacity to understand may vary from time to time.

The College agrees with this view, but would also stress that a valid consent not only includes understanding, but implies agreement, the opportunity and ability to make a reasoned judgment and an equal opportunity to give a valid refusal.

33. Treatment for conditions unrelated to the mental disorder (6.24)

This paragraph in the White Paper is naive. It suggests that physical conditions are invariably unrelated to mental disorders. The psychiatrist is concerned with the health of his patient as a whole. Clinical judgments and good practice are essentially no different whether the doctor is treating a physical condition in a mentally disordered patient or the mental illness itself. It would be unacceptable for the doctor to be required to consult a multi-disciplinary panel about these purely medical matters.

34. Different forms of treatment (6.25-6.26)

The College considers it wholly unjustified to discriminate with respect to psychiatric patients and psychiatric treatments. Specialists in other fields of medical and surgical practice are equally involved in making fundamental decisions about the treatment of their patients; psychiatrists should be no more subject to statutory restraints in making their clinical judgments than are their colleagues.

The College accepts that psychosurgery is an irreversible form of treatment for which a second opinion might be regarded as mandatory. Brain surgery is carried out by neurosurgeons, and therefore, from the the mere fact of referral, at least two opinions are always given.

There are hazards in all forms of treatment in varying degrees. The psychiatrist's training prepares him to be aware of the circumstances and principles which should lead him to seek a second opinion.

The College finds it unacceptable on similar grounds that a second opinion should be required for informal patients who have given consent.

With regard to 'treatments not in general use or whose safety and efficacy have not yet been fully established' (6.25), hospital ethical committees (which include lay members) have the function of giving 'second opinions' and their role would be unacceptably superseded by the proposed legislation.

35. Patients detained for short periods (6.27)

The College agrees that no separate arrangements are necessary to control treatment given under Section 25 of the Act, and treatment is not usually authorized under Section 29.

36. The form of a second opinion (6.28-6.29)

The College, as indicated, regards it as sensible practice to seek a second opinion from a professional colleague in any circumstances of doubt. A second opinion should be from a consultant who is not involved with the patient's care or treatment.

The membership of the College has expressed its overwhelming objection in the strongest terms to the proposal (6.28) to establish a multi-disciplinary panel for the purpose of providing a second opinion. A multi-disciplinary panel, albeit with a medical membership, would not be competent to give a technical opinion, make a professional judgment, or take responsibility for the patient.

This proposal is firmly rejected by the College.

37. Rights of patients (6.30)

The College agrees with the principle of ensuring that patients are aware of their rights, but considers that this should apply equally to non-psychiatric and psychiatric patients. This would accord with the Government's aim to discriminate as little as possible between the two groups. The patient's rights with regard to imposed treatment should be made clear to him. There are, however, considerable difficulties about giving the patient an alternative choice of doctor (for instance, sectorization in many hospitals). There is a need for a greater flexibility of practice in order to implement this principle.

38. Other safeguards (6.31-6.35)

The first safeguard against abuse of patients' rights must be the standards of training, qualifications and seniority of those who make clinical decisions. The College is very disappointed that the Government has rejected (6.33) the College's proposals to establish Mental Welfare Commissions analagous to the Scottish Welfare Commission which would incorporate all the various protective functions to ensure that patients' rights are safeguarded.

The College believes that the value of a single body would be considerable and should be given further consideration.

39. Safeguards for staff (Chapter 7) (7.1-7.19)

Section 141

This Section of the Act provides that civil or criminal proceedings against a person acting or purporting to act in pursuance of the Act can be brought only with the leave of the High Court.

The Government proposes that with respect to criminal actions it will be the Director of Public Prosecutions who has to give leave before a prosecution is brought. The College does not oppose this change.

It is also proposed that this provision should not apply to informal patients. The College considers that the Section should apply to informal patients and that staff do require the protection afforded by it.

The College welcomes the intention to clarify the legal position of staff in difficult areas of activity (7.11)

40. The right to search patients and their belongings and to withhold items in the interests of security (7.12-7.16)

The White Paper states that guidance will be issued in respect of informal patients setting out the scope and limitations of legal protection to staff and suggesting procedural safeguards. The College would like to be represented in the formulation of such guidance.

41. Other matters (Chapter 8) (8.1-8.30)

Patients' mail (8.1-8.17)

Patients' mail (8.1-8.17)

The College agrees that there are insufficient grounds for retaining powers to withhold the mail of informal psychiatric patients, and supports the proposal to repeal Section 134.

The College supports the proposals regarding detained patients' mail (i.e., that power to withhold mail should be limited to the case where a person has given notice that he does not wish to receive it.) (8.12-8.17)

The new powers proposed in respect of patients in Special Hospitals and secure units are supported. (e.g., power to inspect for purposes of security)

42. Compulsory return of patients who abscond (8.18-8.24)

The College supports the amendments in connection with absconding patients. (i.e., no power of compulsory return for patients on short-term orders)

43. Compulsory removal from the country (8.25-8.30)

The College supports the proposals to limit the powers of this Section to patients detained under Section 26 or 60.

The College wishes to draw attention to the considerable delay which is frequently experienced in transferring patients from this country.

The College accepts the proposed amendment to provide a power of recall over restricted patients who return to this country after removal.

44. Resource implications (Chapter 9) (9.1-9.10)

The College believes that the resource implications of the proposed amendments have been seriously underestimated. The amendments will result in a considerable amount of extra work particularly in relation to Mental Health Review Tribunals, automatic reviews and related matters.

Attention is again drawn to the need for more financial resources to allow Local Authorites to make provision for community care. The failure of Local Authorities to undertake these responsibilities represents one of the most serious weaknesses in recent developments in the mental health services.

ACKNOWLEDGEMENTS

The Special Committee wishes to express its thanks to all the Sections, Divisions and individual members of the College who sent their observations and opinions to the Committee. Every comment received was carefully considered in compiling this report and the help that these contributions made was very much appreciated. There was a close agreement from everyone about the main issues.

The Committee would also like to express its thanks to Miss Jane Boyce of the College secretariat for her assistance and advice.

MEMBERSHIP OF THE SPECIAL COMMITTEE

Dr R. S. Bluglass (Chairman)
Dr B. Ward (Secretary)
Drs P. Bowden, V. Cowie, W. A. Elliott, J. Hamilton, D. McDonald, E. W. Shepherd, H. Rollin, P. G. Woolf, J. Roberts

N.B. The Special Committee's full report may be obtained from the College Secretary.

PRE-REGISTRATION POSTS IN PSYCHIATRY

As a result of the General Medical Council's amended Regulations (May, 1978) pre-registration posts in Psychiatry could be developed. The Council of the Royal College of Psychiatrists has endorsed the principle of the establishment of such posts and would encourage their creation.

1. *The Current Problem:* Psychiatrists who have hitherto attempted to establish pre-registration posts in their discipline have encountered difficulties. They arose because of the dominant claims for newly qualified doctors to obtain pre-registration experience principally in Medicine and Surgery. Psychiatrists were disappointed that the proposals of the Merrison Report for extending pre-registration training were not accepted. Nevertheless, the recent amendments by the GMC would seem to encourage the provision of experience in specialties such as Psychiatry for up to 4 months, so long as the total period of twelve months service shall include not less than 4 months in Medicine and not less than 4 months in Surgery.

2. *Objectives:* The aims of including Psychiatry in the pre-registration year are:

(i) to extend the influence of psychiatric teachers in developing a whole person approach in the practice of Medicine, and in combating negative attitudes towards patients with emotional problems.

(ii) to widen particularly the psychiatric experience of doctors likely to enter general practice. This experience is more important for the future General Practitioner than the future psychiatrist who will have ample opportunity to obtain psychiatric experience during his postgraduate training. Nevertheless, it is hoped that continuity of psychiatric teaching, including the pre-registration year, will encourage recruitment into Psychiatry.

3. *The Cost:* Pre-registration posts in Psychiatry would require an educational content of a high standard. A considerable effort would be demanded from psychiatric teachers. This, and the inevitably short duration of the posts in Psychiatry, would render them of limited value from the point of view of the clinical service. Pre-registration posts should therefore not be provided at the cost of senior house officer appointments.

4. *Practical Considerations:* The design of pre-registration posts in Psychiatry would include the following features:

(i) the house officer could rotate with a psychiatric post for a full-time period of at least two months and preferably four months. Such rotation could include four months in Medicine,