it can be seen that feelings experienced by this therapist could easily have passed unnoticed. As a result she might have continued to feel unsupported and unacknowledged in her work, adversely affecting the therapy. The way feelings became focused on lazy doctors who don't help with the coffee was also an object lesson. For such feelings, originating from the therapist's work, anxiety can easily become established as staff battles which in turn may affect the functioning of the whole unit.

Communication

An acute admission ward is often hectic. The ward one left last night may be very different the next morning. There is so much to do, and it is under this sort of pressure that good ward communication is most needed, particularly between the disciplines. This is important for the efficient transfer of information and ease of decision-making. But also, as mentioned previously, it serves to prevent the build up of unnecessary high anxiety within one particular group or individual.

On our Unit, communication between disciplines, for example between doctors and nurses, was good; but it lacked system. Nurses would find themselves briefing different doctors individually and patients were not systematically discussed on a daily basis. As the business of keeping everyone informed would drag on through the morning, it was an inefficient use of time. The lack of system also brought little cohesion to the Unit, and at worst prolonged anxieties because of the delay and unpredictableness in communication. It was interesting to compare the nurses' intra-disciplinary communications system—a well-established, highly systematic handover occurring between each shift.

To meet these limitations, a daily 15-minute meeting at 8.45 was instituted. The responsible ward nurse runs the meeting, and all doctors attend, other disciplines participating less regularly. Each patient is mentioned. Incidents, ward atmosphere, admissions and discharges, and plans for the day are highlighted. Any urgent decisions are taken.

The aim of the meeting is to focus communication into a predictable regular forum. Repetition is reduced, since everyone is informed at the same time. Secondary aims include minimizing anxiety that results from poor communications; recognition that the sharing of information may have a supportive function when staff are under particular stress; emphasis of the nurses' role since this is an important meeting managed by them; and finally, fostering team spirit.

Some problems encountered

The primary therapist group is large, often containing ten people. Although learning takes place by observing others, there is insufficient time to share around to everyone. Staff in training, for example student nurses and medical students, are not included, partly for reasons of size, partly to ensure the group has constant membership and develops a high level of trust. Usually trainees receive supervision elsewhere. Another constant problem is the nursing shift system, and the demands of ward work also diminishes nurses' attendance. Clarifying the precise areas of responsibility between primary therapists and the junior doctors has been a problem. Encouraging nurse therapists to participate fully in decision-making about their patients is sometimes related to the under-valuing of their role both by themselves and by others.

Problems with the daily morning meeting have chiefly concerned the efficient use of the short time available, resisting the tendency to expand according to Parkinson's law into any space available. It has been an education for me, having been brought up on three-hour ward rounds, to see just how much can be communicated and decided in a space of just 15 minutes.

Parliamentary News

The Bill in the Lords: Committee Stage

The Mental Health (Amendment) Bill was further debated in the Lords by a Committee of the Whole House on 19 and 25 January and on 1 February 1982.

The Government speakers were Lord Elton, of the DHSS, Lord Belstead, of the Home Office, Lord Cullen of Ashbourne and Lord Sandys.

Medical Peers who took part were Lord Hunter of Newington, Lord Richardson and Lord Winstanley, the last, however, speaking more as a politician than as representing a medical point of view.

Peers who proposed and spoke to amendments included Lords Wallace of Coslany, Wells-Pestell, Elystan-Morgan and Lady Jeger from the Labour benches; Lords Winstanley and Hooson and Lady Robson of Kiddington from the Liberal side, often associated with Lord Kilmarnock. Lady Faithfull was an assiduous speaker and proposer of amend-

ments, mainly concerning the social work aspect. Others were Lady Masham of Ilton and Lords Craigmyle, Avebury, Mottistone and Renton.

A summary of the Bill as originally presented appeared in the February issue of the *Bulletin* (1982, 6, pp. 30–33).

Amendments proposed at this stage fall into four groups as regards their outcome:

1. Proposed by Lord Elton on behalf of the Government, and passed.

2. Proposed by opposition or other Peers:

(a) Withdrawn, but the Ministers in charge promised to introduce an alternative amendment at a later stage, or at least to give the matter further consideration;

(b) Withdrawn, but in many cases the proposer 'might come back' at a later stage;

(c) Defeated on a Division.

(1) Only two substantial amendments were moved by Lord Elton. The first, brief and surprising, was devised after consultation with Lord Renton. It substitutes the term 'mental impairment' for 'mental handicap', and adds to the definition words similar to those defining psychopathic disorder—'and is associated with abnormally aggressive or seriously irresponsible behaviour'. The object was stated to be to emphasize the distinction between this condition and mental illness and to restrict the circumstances in which such persons may be detained. It seems very strange that the latter object is sought to be achieved by altering a definition rather than by amendments to the sections dealing with compulsory admission.

The second amendment was the expected one dealing with Section 65 patients, following the judgment of the European Court. Mental Health Review Tribunals will have the power to discharge such patients, and the Home Secretary will no longer have the last word. For such cases Tribunals will be strengthened by having Circuit Judges or Recorders as chairmen. Implementation of this principle is by means of a lengthy and complicated Schedule added to the Bill.

(2a) On an amendment stating that all patients should be informed of their rights 'within 24 hours', Lord Elton undertook to introduce a better drafted amendment at the Report stage. An amendment to give better protection to the Mental Welfare Officers and relatives in relation to procedures under the Act was met by an undertaking to give the matter further thought.

Under the existing proposals, persons accused of murder would not be eligible for remand to hospital. The Minister promised to consider further whether they could be included.

Regarding the 'code of practice' to be issued by the Mental Health Act Commission, it was urged that the code should be extended to cover good practice in compulsory admission procedures. The Minister accepted this and undertook to introduce an appropriate amendment on Report.

On an amendment requiring the Mental Health Act Commission to furnish an Annual Report to be laid before Parliament, Lord Sandys declared himself willing to negotiate, the objection being the time and manpower involved. In the discussion some speakers queried the need for creating this Commission, but no amendment aiming at its abandonment was proposed. Another amendment relating to the Commission is mentioned below.

(2b) A large number of amendments were opposed by the Government and were withdrawn, at least for the time being. Some were merely 'probing' amendments: for instance, one suggesting that the Special Hospitals should be transferred to the jurisdiction of the Home Office—designed to elicit an assurance that this would not happen! Others overlapped or were concerned with minor details. The following were the main amendments of substance in this group—the official reason for rejection is given in brackets where possible.

It was proposed:

To omit 'any other disorder', etc., from the definition of mental disorder. [This covers as yet undiagnosed conditions.]

To add 'and for short-term treatment' to 'admission for assessment'. [No agreement yet about wording.]

That only the social worker, and not the relative, should be allowed to make an application for admission. [Not always possible; family should be involved.]

To restore age limitations for admission of certain patients. [Treatability criteria preferable.]

That no one should be admitted under Section 26 unless previously detained under Section 25. [Direct Section 26 appropriate for recurrent or other patients known to need long-term care.]

To involve social workers in renewal procedures. [Good practice, but it is the doctor's responsibility.]

To give courts power to impose a duty on the Minister to comply with a hospital order. [Impracticable! One cannot compel a hospital to accept a patient!]

To involve a Mental Health Review Tribunal in the procedure for the transfer of a prisoner to a hospital for mental disorder. [Tribunals are meant to deal with patients already in hospital.]

To enlarge the powers of Tribunals, e.g., imposition of supervision conditions. [Impracticable.]

To repeal Section 141 and substitute the Director of Public Prosecutions for the High Court as the preliminary 'sieve' before a criminal action can be brought in regard to steps taken in pursuance of the Acts. [The Section, intended for the protection of staff acting in good faith, also covers civil cases. However, a case is being heard by the European Commission of Human Rights in which it is being contended that Section 141 is itself in breach of the Convention. If necessary, changes will be made after the case has been decided.]

That every patient should have a physical examination by

a physician to discover possible bodily causes for his mental disorder. ['A waste of physicians' time'—Lord Hunter.]

To extend the scope of the Mental Health Act Commission to 'the interests of informal patients'. [Manpower precludes, but they will not 'disregard' these patients.]

That the proposed 'approved' social workers should be 'qualified'. [This would exclude some valuable and experienced workers doing the job now.]

That the role of the approved social workers should be spelt out in great detail. [Not desirable.]

(2c) Two important amendments opposed by the Government were defeated on a Division. The first, by Lords Elystan-Morgan and Wallace of Coslany, proposed that applicants to a Tribunal should have the right to be legally represented at the expense of the legal aid fund. A connected amendment by Lords Kilmarnock and Hooson sought to do away with the usual 'reasonable grounds' test for legal aid. Lord Elton pointed out that legal aid could be extended to Mental Health Review Tribunals by regulation, and this would be done 'as soon as money and resources allow'; besides this, mental patients should not be put in a more favourable position than other litigants.

The amendment was rejected by 82 votes to 77. All three medical peers voted for the amendment.

In the second case, the Division was taken on the first of a series of amendments by Lords Hooson, Winstanley and Kilmarnock relating to the 'treatment' clauses of the Bill. Taken together, the amendments proposed that, except in emergencies, the question of a patient's capacity to consent to treatment would have to be decided by a Mental Health Review Tribunal after a full hearing; if he were incapable the medical member would then certify that the treatment should be given. The amendment was supported with much eloquence and not a little wild exaggeration. ('The liberty of the people is at stake').

Lord Elton accepted some minor details of the amendments, but pointed out that Tribunals were judicial bodies with a clear function relating to discharge and should not get involved in continuing matters of care and treatment; he also stressed the practical impossibility of imposing such additional burdens on Tribunals.

The amendment was defeated by 52 votes to 35, and subsequent related amendments were not moved. This time Lord Hunter and Lord Richardson voted with the Government.

I will conclude this summary by describing one exchange between speakers which I found illuminating. Lord Wallace of Coslany had moved an amendment (not mentioned above) to prevent an application for a patient's admission to a hospital being made by a social worker whose principal place of employment was at that hospital, on the grounds that the worker's judgment would not be independent. Lady Faithfull, arguing that, on the contrary, it could be very desirable for the social worker to be one acquainted with the patient, said: 'I believe we have all read exactly what he said in a pamphlet which I think he has received from a certain organization.' I have noticed the same thing elsewhere in the debate, e.g. a criticism of the Mental Welfare Commission for Scotland taken word for word from a similar document circulated by probably the same organization.

Report and Third Reading

The Report stage of the Bill was taken on 23 and 25 February and the Third Reading on 4 March 1982.

The principal further Government amendments were:

1. 'And other medical treatment' to be added to 'admission for assessment'.
2. Amendments to the sections dealing with the powers of crown courts and the making of orders to remand a prisoner to hospital for a report, including amendments to the Bail Act 1976 in respect of persons accused of murder.
3. An addition to the section dealing with the administration of treatment to a non-consenting patient: 'having regard to the likelihood of its alleviating or preventing a deterioration of his condition.' Consent will not be required for any treatment other than those specified.
4. The proposed code of practice will be extended to cover admission procedures.
5. The Mental Health Commission to publish a report in every third year, to be laid before Parliament.
6. The managers to take steps to ensure that a patient understands his status and rights (as far as may be practicable).

These were all passed. Various amendments on lines similar to those moved in Committee were withdrawn. On the question of legal aid in Tribunal proceedings, it was stated that the matter of cost was under urgent consideration and a further statement would be made. An amendment on this point was, however, pressed to a Division and defeated by two votes.

On the second day an amendment was proposed by Lord Winstanley to substitute a panel of three, including one 'psychiatrist' for the one doctor provided for in the Bill for the purpose of giving the 'second opinion' when it is intended to administer a treatment 'of special concern' to a detained patient. This was defeated on a Division, but on Third Reading Lord Elton promised that a similar amendment with a more limited scope would be moved in the Commons.

On Third Reading also an amendment was proposed by Lady Masham laying a duty on Health and local authorities to provide after-care was carried on a Division against Government advice. The authorities already have this duty. The Bill as amended was then passed.

ALEXANDER WALK