

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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