the columns

correspondence

The value of managers' hearings

Sir: In a recent edition of the *Bulletin*, Gregory (*Psychiatric Bulletin*, October 2000, **24**, 366–367) argued for and Kennedy (*Psychiatric Bulletin*, October 2000, **24**, 361) against the role of the hospital managers in hearing appeals by detained patients. We are aware of no systematic evaluation of managers' hearings.

We reviewed 52 case notes of 55 patients (in one community mental health team) who applied to the managers or mental health review tribunal (MHRT) over 4 years. Ninety-seven appeals were made, 35 against Section 2 (28% were managers' hearings) and 62 against Section 3 (59% were managers' hearings).

There were 49 managers' hearings, five patients were discharged and 26 detentions upheld. There were 48 MHRTs, five patients were discharged and 22 detentions upheld. Most of the remainder were previously discharged by the responsible medical officers. Adverse outcomes (re-section or arrest in 1 month) occurred after three of managers' and two of the MHRTs discharges. The mean delays in receiving an appeal date for Section 2 were 13 days (managers' hearings) and 9 days (MHRTs). For Section 3, the delays were 35 days (managers' hearings) and 77 days (MHRTs).

We found similar numbers of appeals to and discharges by the hospital managers and the MHRTs, countrary to Kennedy's comment that discharges by managers "are now unheard of". The average waiting time for a Section 3 MHRT was 42 days longer than for a manager's hearing. The abolition of managers' hearings may erode patients' rights. Larger studies are required before the right of appeal to hospital managers is abolished in the new Mental Health Act.

Katherine Scott Specialist Registrar in Psychiatry, **Michael Campbell** Specialist Registrar in Psychiatry, **Robert Chaplin** Consultant Psychiatrist, St George's Hospital Medical School, London SW17 0RE

Supervised discharge orders

Sir: The editorial on supervised discharge orders by Burns (*Psychiatric Bulletin*, November 2000, **24**, 401–402) raises many interesting issues, not least the fine balance between persuasion, coercion and enforcement. Although the supervised discharge under Section 25 of the Mental Health Act 1983 was primarily concerned with treatment in the form of medication, we would like to report our usage within a learning disability service, where the focus is on ensuring structured support rather than medication.

Working within a medium secure service at a tertiary regional level, all our in-patients are detained. About two-thirds of our patients have a combination of disability and personality disorder (ill defined) rather than 'frank' mental illness. A supervised discharge under Section 25 provides a legal framework, defining what services should be available and certain undertakings on the part of the patient: to live in a particular place; to meet with certain professionals; to attend certain day activities, etc. Even though it is clear that there is no enforcement, this structure does appear to give reassurance both to patients and staff, particularly to staff where the patient is discharged to.

It may be argued that this is no more than a Care Programme Approach (CPA). In our practice, however, we find that supervised discharge occupies an intermediate space between CPA and Guardianship Orders, perhaps a little bit more coercive than persuasive, but not using enforcement. We should be interested in the experience of other practitioners within learning disability services.

J Piachaud Consultant Psychiatrist, **D Chayda** Consultant Psychiatrist, Eric Shepherd Unit, Woodside Road, Abbots Langley, Hertfordshire WD5 0HT

The future (or not) of the medical member

Sir: I agree with Rooth's (*Psychiatric Bulletin*, January 2001, **25**, 8–9) comments on the future of the medical member of a mental health review tribunal (MHRT) and in support would add:

(a) The purpose of a MHRT is to combine legal and medical opinion in a decision that is in the best interests of the patient.

(b) The clinical component of the medical contribution must be based on sound medical practice, which includes access to the case notes and a clinically appropriate and private interview with the patient concerned. The medical member's contribution is not just about theory, it is about a person. It is not about, for example, schizophrenia, but about a particular person who suffers from that malady, who lives in his or her own particular family and social context. Anything less than a full clinical assessment, which cannot be made during the course of the formal MHRT proceedings, will diminish the mental member's clinical judgement and will detract from the quality of the final decision.

(c) The clinical contribution, no less than the legal and lay, must be made before and within the MHRT and within the subsequent decision-making. When the decision includes both legal and clinical components, both should be fully represented at all stages.

(d) Like Rooth, and many other MHRT colleagues of all persuasions, I do not fully understand the concern expressed about the current practice of a preliminary examination followed by medical participation in the MHRT's decision. In my opinion the desired balance noted in (a) can only be optimised via (b) and (c).

(e) All must respect the letter of the law, but I suggest that the process by which a hearing is conducted is a separate issue. When the nature of the hearing, and of a decision, requires that legal and clinical considerations be balanced, I suggest that equal respect has to be shown to both legal and clinical processes. When it comes to process, clinicians operate in a very different way to lawyers. That difference should be respected and reflected in the processes of a MHRT. The White Paper's proposals (Department of Health, 2000) will distort the clinical perspective.

(f) If the fear of the present medical member's role is that evidence from the preliminary hearing may be communicated in private and is therefore not subject to scrutiny in the MHRT, this can be overcome. The patient can be told at the preliminary hearing that it is what is said at the MHRT that counts, with the rider that anything then talked about may

https://doi.org/10.1192/pb.25.4.153-a Published online by Cambridge University Press