adversarial situation. However, £12,000,000 is a lot of money; are we spending it wisely and appropriately? Should we detain people when there are insufficient facilities for what is considered adequate treatment (Eastman, 1994)? It may be argued that *all* compulsorily admitted patients should have a tribunal or a managers' appeal. This would very greatly increase numbers and costs. Further, if all patients incapable of giving consent (e.g. those with confusion) were compulsorily admitted there would be a vast increase in demand for tribunals and appeals. Under these circumstances a form of rationing would have to be introduced as, quite apart from costs, the service just could not cope with the work such numbers would produce.

Has there been a similar study to look at the cost of managers' appeals? Further studies on tribunals and appeals should determine why appeals are made; it may be on the advice of a fellow patient or of an enthusiastic member of staff, who has the individual patient's right (or other matters) at heart, not the overall costs and running of the service.

The Mental Health Act Commission, on its annual visit, collects figures for population served, admissions, sections, tribunals and appeals, cancellations and outcomes. (The word 'success' is not to be used concerning tribunals or appeals; success is that a fair and proper hearing was given, not that a particular decision was made). The processing and publication of such data would help individual units or regions to consider their rates.

Perhaps the day will come when there are 'preliminary screeners' for tribunals and appeals. Such a person would look at *every* case and could then choose as many cases as could be 'afforded' which would then be passed on to subsequent, more detailed, hearings.

EASTMAN, N. (1994) Mental health law; civil liberties and the principle of reciprocity. *British Medical Journal*, **308**, 43–45.

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Sir: I was delighted to see the recent article by Blumenthal & Wessely (*Psychiatric Bulletin*, May 1994, **18**, 274–276) pointing out the cost of Mental Health Review Tribunals and calculating that the total cost of these tribunals are £12,274,380 per annum.

It has long been my contention that these tribunals are of no real benefit to patient care and waste a great deal of the time of doctors and social workers. I have noted the bizarre situation whereby psychotic patients of mine are asked shortly after admission on section 2 and section 3 of the MHA if they would like to appeal against their section. Being psychotic they have no insight into their mental illness and so take up the offer of appeal against section. They are assisted in so doing by the Legal Advice Project at the hospital.

At the tribunal itself the lawyers use an adversarial principal which makes me appear to be an unreasonable person who is seen to be locking away patients and depriving them of their civil liberty. This is far from the case, as like most psychiatrists, I compulsorily admit patients only when necessary, and always in their best interest.

Money is being poured into Mental Health Tribunals which could be used to fund better community care. The 1959 Mental Health Act provided a perfectly good system of appeal using Mental Health Review Tribunals, but it was less frequent and did not involve the additional burden of managers' hearings.

The 1983 Mental Health Act uses a legalistic and expensive system which is of no benefit to patients and the College should take urgent steps to reform it.

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General practice training for psychiatrists

Sir: I was interested to read Burns *et al*'s paper on general practice training for psychiatrists (*Psychiatric Bulletin*, May 1994, **18**, 286–288), having been one of the 18 trainees who took part in the placements, and thought a 'user's perspective' might be worth recording. I was probably unusual in actually volunteering for the post as it certainly was one of the 'hard to fill' spots on the rotation at the time. My reasons for volunteering were two-fold. One was a glimmer of interest in general practice as a career, the second was that I had been involved in regular liaison meetings with the practice to which I would be attached in my preceding psychiatric registrar post.

I valued the six month placement enormously. The partners were all extremely accommodating to my psychiatric training needs, even allowing me to attend additional family therapy commitments. I found my opinions on psychiatric issues being valued, while it was still expected that I would be a 'normal' GP trainee and not the resident psychiatrist. My general medical skills improved, my awareness of minor psychiatric morbidity increased and the pressures this created for GPs understood far better. It was actually quite difficult at times to decide who should be referred on to mental health professionals and I became slightly more sympathetic

https://doi.org/10.1192/pb.18.9.578 Published online by Cambridge University Press