recognised "the need for consideration nationally of whether there is a conflict between teaching and service needs, and if so how it should be resolved."[1]

References

1 Department of Health and Social Security. *Review of the Resource Allocation Working Party formula: report by the NHS Management Board*. London: DHSS, 1986.
2 Department of Health and Social Security. *Sharing resources for health in England. The report of the Resource Allocation Working Party (RAWP)*. London: HMSO, 1976.
3 Department of Health and Social Security. *Report of the Advisory Group on Resource Allocation (AGRA)*. London: DHSS, 1980.
4 Bevan G. Protecting the service costs of teaching English medical students by the medical service increment for teaching (SIFT): an exposition and critique. *Fin Acc Man* 1987;3:147-60.
5 Culyer AJ, Wiseman J, Drummond MF, West PA. What accounts for the higher costs of teaching hospitals? *Soc and Econ Admin* 1978;12:20-30.
6 Straf ML. Revenue allocation by regression: national health service appropriations for teaching hospitals. *Journal of the Royal Statistical Society* 1981;**144A**:80-4.
7 Culyer AJ, Wiseman J, Drummond MF, West PA. Revenue allocation by regression: a rejoinder. *Journal of the Royal Statistical Society* 1982;**145A**:127-33.
8 Schelling TC. *The strategy of conflict*. New York: Oxford University Press, 1963.
9 Perrin J. The costs and joint products of English teaching hospitals. *Fin Acc Man* 1987;3:209-29.
10 Craig M. Estimating the resources required to train medical students and provide services: a survey of English teaching authorities. *Fin Acc Man* 1987;3:135-45.
11 Bevan G. Financing English teaching hospitals by capitation. *Fin Acc Man* 1987;3:161-74.
12 Bevan G, Brazier J. Reviewing RAWP: financial incentives of subregional RAWP. *Br Med J* 1987;295:836-8.
13 University Grants Committee *UGC annual survey academic year 1975-76*. London: HMSO, 1977: Appendix V.

Medicolegal

Compulsory treatment in the community for the mentally ill?

CLARE DYER

In recent years many psychiatric patients who would formerly have been detained in mental hospitals have been released into the community. At the same time more effective drug treatments to control acute psychotic disorders, particularly schizophrenia, have become available. Psychiatrists may give treatment without patients' consent if the patients are detained in hospital under the Mental Health Act 1983, but once patients have been released from hospital psychiatrists have no power to treat them without their consent. The result is a cycle in which patients are admitted to hospital and are released when their illness improves, only to relapse, often with great distress to those caring for them, and be admitted to hospital to be treated again.

"Long leash" treatment illegal

Under the 1959 act it was common practice with some long term mentally ill patients, usually with a history of violent or aggressive behaviour, who remained well on medication in the community but relapsed without it, to be put on a so called "long leash" treatment. This entailed admitting patients to hospital for a nominal period and releasing them on the maximum leave of absence of six months subject to conditions about treatment. Patients would then be recalled from leave to spend one night in hospital to allow a further six months' leave to be granted. This practice continued under the 1983 act despite its more restrictive wording. In 1985, however, the divisional court declared that the 1983 act gave no authority for the use of long leash treatment.[1] Mr Justice McCullough ruled that section 3 of the act could be used only to detain people who would be treated as inpatients, not as a means of attaching conditions to being an outpatient, and that section 20 could be used only to renew authority to detain patients whose mental condition was believed to require their detention as inpatients.

London NW1
CLARE DYER, BA, BLS, legal correspondent

Last month the Royal College of Psychiatrists published a discussion document calling for a new power, the community treatment order, which would allow medical treatment outside hospital for mentally ill patients.[2] This document does not propose, however, that patients should actually be given treatment compulsorily outside hospital. It envisages that most patients will consent once an order is made. For those patients who will not admission to hospital will be the sanction after negotiation with the patient.

The Mental Health Act Commission, which oversees the operation of the act, has not been able to reach a collective view on whether patients who are not liable to be detained should be subject to compulsory treatment. It has, however, produced a discussion paper that sets out several possible options, including no change; greater use of the existing guardianship provisions of the act (which do not, however, empower the guardian to consent to treatment); the introduction of a community treatment order (different from that suggested by the Royal College of Psychiatrists and to be operated by social services departments); and an expanded form of guardianship for use in special cases, which would allow the guardian to require the patient to have treatment.[3] The proposals of the royal college and the commission's discussion paper formed the basis for debate at a joint conference held by the commission and the National Association of Health Authorities on 29 September.

Legal questions

Setting the proposed changes in the existing legal framework, John Finch, senior lecturer in law at the University of Leicester and a mental health act commissioner, posed some questions about the operation of any new compulsory treatment order. What mental condition would be required for its operation? Would there have to be consultation, as there is at the moment under section 3 of the act, or would consultation be a substitute for the county court? What about the participation, as under the present act, of other professionals? What about the duty to communicate adequate information and the obligation to ensure the continuing understanding of all those affected? Whose job would that be? A proper system of risk

management would have to be built round the professional ethics, he warned, and health authorities would need to be mindful of health and safety provisions for the protection of employees. He also asked whether the new model would become the norm, and if so with what effect. Would any change really expedite the transfer of resources to community care, or would it merely conceal its non-occurrence?

William Bingley, legal officer of Mind, which opposes the principle of compulsory treatment in the community, said that there were three tests that had to be posed before any proposal was converted into law: there had to be systematic and properly researched evidence about the group of people any change in the law would affect; identification of the problem the change in the law was expected to address; and clear evidence that extending the power would be beneficial and that the benefit outweighed any possible drawbacks and could not be achieved in any other way.

Putting his own views and those of the Royal College of Psychiatrists, Professor Robin Priest of St Mary's Hospital, registrar of the royal college and chairman of the board of studies in medicine of the University of London, said that psychiatrists wanted a change in the law because some patients suffered recurrent episodes of mental illness that even the best teams could not prevent; there were treatments available that were known to be effective; and the long leash treatment had been shown to be illegal.

Eric Bromley, district clinical psychologist for Liverpool and a member of the Mental Health Act Commission, said that he spoke as one of the minority of members of the commission who were not convinced of the need for a community treatment order. He suggested that either there should be guidelines so strict as to limit the powers to very few people or, more likely, many more people than presently envisaged would become subject to the compulsory powers. The general view seemed to be that it would be inappropriate forcibly to inject someone in his or her home, and non-compliers would be compulsorily admitted to hospital so that the treatment could be enforced. Compulsory treatment in the community would simply be an easier way of compulsorily admitting and detaining someone.

Giving the health authority view, Janice Miles, operational services manager, Aylesbury Vale Health Authority, said that, in the case of a few unusual, potentially dangerous patients, members of the health authority found that if they upheld the law a patient and his or her family could have their lives disrupted but if they allowed that patient to lead a virtually normal life they were in effect breaking the law.

Disagreement and a way forward

An analysis of 183 responses to the Mental Health Act Commission's discussion paper shows 73% of individuals and organisations in favour of some change. Although the psychiatrists responding supported the principle of compulsory treatment in the community virtually unanimously, community psychiatric nurses were overwhelmingly opposed to it. Health authorities and social services departments were largely in support. The model favoured by the largest number of respondents was not the compulsory treatment order but the expanded form of guardianship, which was also the preferred option of most of the working party of the Mental Health Act Commission. After further discussion at its meeting on 14 October the commission hopes to put options for a possible change in the law to the Minister for Health and Social Security.

References

1 R *v* Hallstrom and another, ex parte W (No 2); R *v* Gardner and another, ex parte L, [1986] 2 All ER, 306.
2 Royal College of Psychiatrists. *Community treatment orders: a discussion document*. London: Royal College of Psychiatrists, 1987.
3 Mental Health Act Commission. *Compulsory treatment in the community: a discussion paper*. London: Mental Health Act Commission, 1986.

MATERIA NON MEDICA

Like it is

We were standing at the bar of the officers' mess when the medical officer mentioned casually that he'd just been "up" in the Nimrod simulator. If it had occurred to me that civilians would ever be allowed near it I wouldn't have commented, enviously, how much I'd like to see it. They are, I did, the medical officer kindly offered to fix it up for me, and thus it was that I found myself climbing gingerly into the copilot's seat of an AEW Nimrod.

Ahead of us the runway lights stretched away until they merged with the lights of Hong Kong. Above the city China was dimly visible in the darkness. Inside the cockpit the dials and controls were faintly disappointing, more old fashioned than I'd expected in one of the world's most sophisticated aircraft. There was a used feel to it all which added to the reality and helped to dispel the remains of my fantasy of being asked to land it after a brief introduction to the controls. The simulator is not a toy, small boys for the use of, it's a tool of jaw dropping complexity and provides such an accurate representation of flight that, had Nimrod won the early warning battle with the AWACS, pilots could have gone on operations having flown only a simulator.

As the pilot went over the instruments and controls I nodded and "Uh-huhed" as intelligently as I could, trying as hard to look and sound as though I understood as I used to do over a theatre table when the chief's ulcer was on reheat. I was no more convincing, but Peter, the pilot, was more forgiving.

Eventually we prepared to take off. I pushed the throttles forward and tried to steer her as we rumbled down the runway. At low speed you can feel the joints in the tarmac and I was surprised at how difficult it is to steer a big plane. Comes the magic moment, Peter says, "Pull," and I pull the stick—and nothing happens. "No, harder, much harder." I want to stop and explain that I just don't know what to push on with my feet and I'm not really a wally and so on, but I don't because a fabulous thing has happened. The horizon has dropped, and there is the most incredible sensation of power overcoming gravity, and we are flying.

I knew how it was done, of course. Hydraulic legs tilting and turning beneath us, canting us forwards, backwards, and from side to side, hurling the simulator bodily to mimic sudden changes of force and direction. I wondered if I'd be too cynical, looking for flaws in the simulation, but the experience was too exciting for that, and I found my pulse was 120.

As you climb out of Hong Kong you have to bank round to the left, or you collide with China. Peter told me to look down as we banked over the city. "See those lights out to sea? The Kowloon ferry." He predicted cloud from 1500 to 4000 feet, which proved correct; not surprising really, as he'd ordered it, just as he could have laid on a thunder storm. Even in the cloud (a video illusion of course) the sensation of speed was astonishing. There was a real sense of not knowing what might be just ahead. When we broke clear there were stars overhead in astronomically correct positions. Time and again there was a temptation to laugh at the scrupulous attention to detail (the Kowloon ferry moves).

We rendezvoused with a Victor tanker, and Peter flew around it to show me the detail. It deployed its drogue, and we took fuel after a few deliberate misses to show me the effect of too low and too high a closing speed. The drogue slammed about ahead of us, and I flinched as it whipped across in front of us. "We're quite safe, said Peter drily; it hits our bow wave and bounces off."

For all that I knew how the simulator achieved its effects, I was still surprised at how accurately it reproduced those subtle deceleration sensations that you get as you come in to land. We banked back in to land following the strobe lights round over the city and making a very gentle landing. There was still some time left so we took off again and lost both starboard engines just as we lifted off. I was pulling hard enough this time, when suddenly the controls went solid, like a car's brakes losing their servo, and the plane lunged round. There followed a blur of commands and comments as we went round and came in again balancing the asymmetric thrust. Again, the temptation to cheer at the end.

Within a month the AEW Nimrods were out of contention, the equally bizarre AWACS being chosen instead. Occasionally I see them sitting on the runway, a billion pounds or so of investment quietly dissolving in the Lincolnshire rain. Peter hadn't explained one thing: how to get the silly grin off afterwards. But that sight does it for me.—LINDSAY J C EASTON, general practitioner, Lincoln.