the percentage of appeals could be much higher than that found in Oxfordshire.

The methodology in Bradley and colleagues' study is well thought through and easy to follow. Interestingly, however, they interviewed their patients on day 13 of the section. If these subjects had been interviewed at an earlier stage of their admission the results might have been different as the subjects' mental state would have been different and would have affected their concentration, initiative, and response rate. Also, the sample was skewed as 40% of the initial sample was excluded.

The authors' conclusions may not be fully justified. This is especially so as only four of the 28 subjects whom they interviewed subsequently appealed against their section. Recently, Blumental and Wesley found that the cost of mental health tribunals had risen considerably; they claimed that about £12m is spent annually in tribunals.[2] Despite these costs it is important to protect the civil liberties of patients. One way forward would be to carry out further audits in other districts and analyse ways of improving the rates of appeal. The Mental Health Commission could take a leading role in coordinating this.

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1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)
2 Blumental S, Wesley S. The cost of mental health tribunals. *Psychiatric Bulletin* 1994;18:274-6.

Managers should review patients who do not appeal

EDITOR,—If authors comment on the law they should cite it correctly. Section 2 (2)(b) of the Mental Health Act 1983 and section 72 (1)(a)(ii), as used by tribunals, both state "health or safety, or . . . etc" and not, as Caroline Bradley and colleagues say,[1] "health and safety, or . . . etc"; this is a considerable difference. The first reason given by the authors for the low rates of appeal against detention is that patients are content to remain in hospital. If that is so, it is said, they should not be detained. Are the authors content to give electroconvulsive therapy to an informal patient in depressive stupor who not unwillingly resides in hospital but who cannot consent? A second explanation given is that patients are deterred from exercising their rights. Could not a third be that the patients are too sick or confused?

No mention is made of patients' responses to explanations given under section 132 (1)(b) of the Mental Health Act 1983, which obliges managers to take such steps as are practicable, soon after detention, to ensure that patients understand their "rights of applying to a mental health review tribunal." These steps "shall include giving the requisite information both orally and in writing." The code of practice advises that a record should be kept of the advice given to each patient; the fact that the information has been properly given; the member of staff designated to monitor the procedures; and, in the case notes, the information given, the patient's reactions, and an assessment of his or her comprehension.

For the patients described, were section 132 procedures not implemented, ineffective, or not recorded? The researchers state, "patients must . . . in the absence of independent help . . . rely on . . . the booklet." Were those who did not appeal given oral explanations under section 132? Did patients who had difficulty in writing an application receive help from members of the multidisciplinary team? It is not uncommon for members of tribunals to see typed or handwritten letters of appeal, or forms, that have only been signed in the patient's own hand.

If more appeals are contemplated do we need the present duality of appeals to tribunals and hospital managers? Patients who appeal to both are often heard twice within days. Was this so for the patients studied, and with what degree of concordance or discordance? Tribunals are costly. Running a parallel system is even more expensive. Should not hospital managers be more concerned about screening those patients who do not appeal to tribunals and refer them on to tribunals if they feel concern? Effectively implementing section 132 should also concern managers.

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1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)
2 *The mental health act 1983.* London: HMSO, 1983.
3 *The code of practice, mental health act 1983.* London: HMSO, 1990.

Intellectually elite are more likely to appeal

EDITOR,—Caroline Bradley and colleagues' conclusions concerning appeals against detention under section 2 of the Mental Health Act are limited since no comment is made about the inclusion of patients with learning disability and mental illness, which could appreciably alter the data.[1] The finding that those educated to A level standard are more likely to appeal is interesting but not surprising and may reflect a bias in favour of the intellectually elite. Patients who do not understand the process of appeal because of mental illness or intellectual handicap, or both, cannot be expected to appeal. We agree with the authors' conclusion that the current procedure does not protect the civil liberties of all patients.

Clearly, the system of appeal against detention needs to be reviewed. The rate of discharge as a result of appeals is low[2]; the current system is expensive to operate; and, as Bradley and colleagues' paper suggests, the process inadvertently discriminates against those it is intended to help. Perhaps a fairer system should be implemented, in which all those detained under the Mental Health Act are automatically reviewed by a local independent body with psychiatric input.

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1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)
2 O'Dwyer J, Neville P. Appeals against section 2 of the mental health act 1983. *Psychiatric Bulletin* 1991;15:225-6.

Low appeal rate may reflect trust in doctors' judgment

EDITOR,—Caroline Bradley and colleagues conclude that too few patients appeal against detention under section 2 of the Mental Health Act and that this would be improved if patients were fully informed of their rights.[1] Our experience in Springfield Hospital does not confirm this. An advice and legal representation project has existed at the hospital since 1982.[2] As the table shows, the rate of appeal against detention under section 2 (15%) is lower than that reported in Oxford. Understanding why most patients do not contest their section may require more than attributing it to lack of either knowledge or time.

It is an error to assume that because patients agree that they need to be in hospital then compulsory detention was, or is, a mistake. The relationship between doctors and patients is complex and can simultaneously include a whole range of conflicting and ambivalent attitudes. Patients can disagree with their doctors' decision to detain them yet retain trust in their judgment and often a remarkable willingness to cooperate with both detention and treatment. Most are nursed in open wards. The Royal College of Psychiatrists' unsuccessful proposal for a community supervision order regularly met with a simplistic characterisation of the relationship between psychiatrist and detained patient which acknowledged only the element of compulsion. Viewed thus, the community supervision order was judged unworkable despite the extensive evidence of its clinical workability before 1986 in England and Wales and its continuing use in Scotland.[3]

Bradley and colleagues' figures may reflect the fact that a sizeable majority of patients detained under section 2 (and perhaps many on section 3 (table)) "agree to disagree" with their psychiatrists yet derive a sense of security and containment from being obliged to be in hospital at a time of personal turmoil. This interpretation fits more closely the clinical experience of very little coercion (other than that afforded by the legal sanction of the Mental Health Act) being required for most detained patients.

The Mental Health Act 1983 contains extensive safeguards for patients' civil liberties. Before an increase in the rate of appeals (which inevitably take time and resources from clinical care) is advocated a greater understanding of the reasons for not appealing is required. Bradley and colleagues have made a start on this process.

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1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)
2 King's Fund. *The advice and legal representation project at Springfield Hospital 1982-1985. An evaluation.* London: King's Fund, 1986. (King's Fund project paper No 59.)
3 House of Commons Select Committee on Health. *Community supervision orders.* Vols 1 and 2. London: HMSO, 1993.

New Zealand's system has much to offer

EDITOR,—Caroline Bradley and colleagues' audit of section 2 of the Mental Health Act suggests that the current appeals procedure is "not a satisfactory way of protecting the civil liberties of patients."[1] Much more equitable (although more costly) would be a routine appeals procedure, based on a combination of the managers' hearing and the review tribunal. A regular weekly session devoted to reviewing people detained under the Mental Health Act, particularly in the inner London areas where up to 90% of patients are so detained, would

Appeals to mental health review tribunals, Springfield Hospital, 1993

	Patients detained	Consulted law centre	Appealed (%)	Discharged under section 23*	Withdrew	Other
Section 2	188	49	29 (15)	8	2	4
Section 3	224	159	47 (21)	10	1	5

*Consultant discharged patient from section under section 23 of Mental Health Act 1983.