

# Knowledge of mental health legislation in junior doctors training in psychiatry<sup>†</sup>

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**Aims and method** To assess junior doctors' knowledge of the procedures involved in involuntary admission of patients detained under Sections 5(2), 2 and 3 of the Mental Health Act 1983. A semi-quantitative research study of junior trainees affiliated to two psychiatry training schemes was carried out.

**Results** Trainees' knowledge of professionally relevant sections of the Mental Health Act was patchy. Knowledge correlated significantly with experience in clinical practice and with experience of using mental health legislation. Surprisingly, in-service training in mental health legislation had no effect on participants' knowledge.

**Clinical implications** Lack of knowledge and understanding raises the possibility of inappropriate use of the mental health legislation. This threatens patients' fundamental rights and can lead to complaints or litigation. There is a clear need to address this at an early stage in psychiatry training.

**Declaration of interest** None.

The Mental Health Act 1983 is an important piece of legislation used frequently in psychiatric practice. There has been concern over an apparent lack of knowledge of mental health legislation among medical practitioners, including psychiatrists.<sup>1–3</sup> In his study on non-consultant psychiatrists, Humphreys<sup>4</sup> reported that only 28% were able to give the correct title and year of the Mental Health (Scotland) Act 1984. Furthermore, in a study on consultant psychiatrists, only 10% of the sample were able to give the statutory definition of the term mental disorder.<sup>5</sup> In a survey of Section 12(2)-approved medical practitioners in the West Midlands (England), only a third of respondents correctly identified the four legal categories of mental disorder and none was able to define the term mental disorder as used in the Mental Health Act.<sup>6</sup> In another study on psychiatry trainees in Ireland,<sup>7</sup> patchy knowledge of procedures in compulsory admissions is reported.

Although most of the clinical work pertaining to the use of Mental Health Act is the responsibility of senior trainees or consultant psychiatrists (in particular, approved clinicians as established by the 2007 reforms of the Mental Health Act 1983 and doctors approved under Section 12 of the Act),<sup>8–10</sup> junior psychiatry trainees also come across situations where they have to demonstrate competence in mental health legislation. Trainees carry out most emergency psychiatric assessments as a consequence of their routine clinical duties, although frequently the final decision to use the Mental Health Act is taken by their

supervising senior. Junior psychiatry trainees also frequently come across clinical situations where they might have to detain a patient using Section 5(2), which permits short-term detention in emergency situations. Emergency detention orders are commonly initiated by the most inexperienced trainee psychiatrists, often outside normal working hours and with less immediate access to the advice of a specialist senior colleague.<sup>11,12</sup> In addition, junior trainees are required to prescribe medication, review patients asking to leave the ward and even organise the transfer of patients to medical or other psychiatric units. When the patients involved are (or may be) detained under the Mental Health Act, these decisions necessarily demand knowledge of the relevant legislation. Junior trainees may also be involved in mental health review tribunals and statutory managers' hearings, which all require them to have adequate knowledge of the Mental Health Act.

As the 2007 amendments to the Mental Health Act 1983 are likely to increase the workload for healthcare staff, extra resources will be required to provide additional medical time, increasing the likelihood of trainees getting involved in situations where they have to demonstrate the knowledge of the Act.<sup>13</sup> Despite this, there has been little systematic research into what trainee psychiatrists know about mental health legislation in England and Wales. We therefore conducted a semi-quantitative research study in junior psychiatry trainees, the aim of which was to assess the trainees' knowledge of the procedures involved in involuntary admissions of patients detained under Sections 5(2), 2 and 3 of the Mental Health Act 1983 (as amended in

<sup>†</sup>See commentary, pp. 466–468, this issue.

2007). It is important to recognise that this paper relates to the Mental Health Act in England and Wales only.

## Method

The semi-quantitative research study was conducted through a face-to-face, standardised, open-ended, semi-structured interview of junior doctors training in psychiatry. Interviewing offers the flexibility to react to the respondent's situation, probe for more detail, seek more reflective replies and ask complex questions.<sup>14</sup> The face-to-face interview format was adopted so as to ensure that the participants did not refer to the Act for completion of the questionnaire and to discourage guessing.

Trainees in psychiatry posts form two groups, junior trainees (foundation trainees year 2 (FY2), specialty trainees years 1–3 (ST1–3) and senior trainees (specialty trainees years 4–6 (ST4–6)).<sup>15</sup> Junior psychiatry trainees in England and Wales formed the target population. One hundred junior trainees affiliated to two psychiatry training schemes in the north-west of England formed the accessible population for this study. Of these 100 trainees, convenience sampling was used and 60 trainees volunteered to participate in the face-to-face interview. These included 9 FY2, 18 ST1, 16 ST2 and 17 ST3 trainees. Of the participants, 37 were male and 23 were female.

Participants were interviewed by two authors (O.W. and N.J.) using an open-ended instrument (details available from the authors on request) designed specifically for the purpose of testing the trainees' knowledge of Sections 5(2), 2 and 3 of the Mental Health Act. Draft instruments were critically reviewed by senior trainees and consultants and then pre-tested with a small sample of trainees. This was to ensure content validity of the measurement. The content validity is concerned with adequacy of coverage of the content area being measured and is crucial for tests of knowledge.<sup>16</sup> There are no totally objective methods of ensuring the adequate content coverage of an instrument. Experts in the area are called on to analyse the items' adequacy in representing the hypothetical content universe in the correct proportion.

The instrument used had three parts; part one about Section 5(2) had 12 items and parts two and three (about Section 2 and Section 3 respectively) each had 8 items. In addition, information was collected on demographic characteristics, number of Section 5(2) orders implemented, years of experience in psychiatry, training level (grade) and examination status of the participants. Participants were asked whether they had received specific training in the use of the Mental Health Act and what had been their main source of information. Each interview took approximately 45 min to complete. To decrease interviewer bias, the two interviewers were trained and the interview process was rehearsed before the formal study. Responses were written down verbatim. Data were scored with the help of purpose-designed guide to produce quantitative data. This guide included questions and example answers as well as listing possible acceptable answers. All the variables and responses were analysed using SPSS (version 16.0.1) software for Windows.

## Results

Of the 100 trainees invited to participate, 60 volunteered and completed the study. The groups' male:female ratio and experience in psychiatry were: FY2 – 3 men and 6 women, mean 3.56 months of experience (s.d. = 1.01); ST1 – 10 men and 8 women, 11.39 months of experience (s.d. = 5.35); ST2 – 11 men and 5 women, 28.88 months of experience (s.d. = 6.65); ST3 – 13 men and 4 women, 39.71 months of experience (s.d. = 11.98). The absolute numbers and percentages of correct answers for the four groups of trainees at different levels of seniority are presented below. Specific questions related to basic knowledge of the three sections were analysed on an individual basis.

### Section 5(2)

As can be seen in Table 1, senior trainees were more likely to know that Section 5(2) applies to an informal hospital in-patient ( $\chi^2 (3,60) = 20.10, P < 0.0005$ ), but there was no significant difference in the number of correct answers provided between those who had received formal training as part of workplace induction (26 correct out of 39) and those who had not (16 correct out of 21;  $\chi^2 (1,60) = 0.59, P = 0.443$ ). Of the 32 trainees who had sat at least one part of the formal examinations organised by the Royal College of Psychiatrists, 28 answered correctly, compared with only 14 of the 28 who had sat no exam ( $\chi^2 (1,60) = 10.00, P < 0.0005$ ).

Senior trainees were more likely to be correct in terms of their knowledge as to which professionals can authorise detention under Section 5(2) ( $\chi^2 (3,60) = 11.77, P < 0.01$ ), but there was no significant difference as regards training – 34/39 v. 21/21 respectively for those who had and those who had not received formal training ( $\chi^2 (1,60) = 2.94, P = 0.087$ ). Of the 32 trainees who had sat at least one part of the formal examinations, 30 answered correctly, not significantly different from the 25 of the 28 who had sat no exam ( $\chi^2 (1,60) = 0.39, P = 0.533$ ).

Finally, there was no difference between trainees of different seniority in terms of their knowledge as to whether Section 5(2) empowers treatment without consent ( $\chi^2 (3,60) = 4.04, P = 0.257$ ). Those who had received formal training were less likely to be correct (24/39) than those who had not (19/21;  $\chi^2 (1,60) = 5.63, P < 0.05$ ). With regard to examination experience, 28/32 of those with such experience were correct as opposed to 15/28 without such experience ( $\chi^2 (1,60) = 8.47, P < 0.005$ ).

### Section 2

In respect of questions related to Section 2 (Table 2), there was no significant difference between trainees of different seniority in their knowledge of the core function of the section ( $\chi^2 (3,60) = 6.91, P = 0.075$ ) or between those who had received formal training (37/39) and those who had not (18/21;  $\chi^2 (1,60) = 1.50, P = 0.221$ ). All 32 trainees who had sat at least one part of the formal College examinations answered correctly, but of the 28 who had not sat a College exam, only 23 knew the correct answer ( $\chi^2 (1,60) = 6.23, P < 0.05$ ).

Senior trainees were more likely to know that two medical practitioners must examine a patient under

**Table 1** Correct answers to each question for Section 5(2) at each level of seniority

Questions	Whole group (N = 60)	FY2 (n = 9)	ST1 (n = 18)	ST2 (n = 16)	ST3 (n = 17)
	n (%)				
What is Section 5(2)?					
1. Doctors holding power	52 (87)	6 (67)	14 (78)	15 (94)	17 (100)
To whom does Section 5(2) apply?					
2. Hospital in-patient	40 (67)	7 (78)	7 (39)	12 (75)	14 (82)
3. Who is an informal patient	42 (70)	4 (44)	7 (39)	15 (94)	16 (94)
4. Who wishes to leave hospital	45 (75)	5 (56)	8 (44)	16 (100)	16 (94)
5. For his own health or safety or for the protection of others	44 (73)	6 (67)	10 (56)	15 (94)	13 (77)
6. Not practicable or safe to make an application for Section 2 or 3	10 (17)	2 (22)	3 (17)	4 (25)	1 (6)
Where can it be used?					
7. On the ward for hospital in-patient	54 (90)	7 (78)	15 (83)	16 (100)	16 (94)
8. Not to be used in out-patient clinic or accident and emergency	32 (53)	0 (0)	8 (44)	12 (75)	12 (71)
Who can use the power?					
9. Registered medical practitioner, approved clinician or their nominated deputies	55 (91)	7 (78)	16 (89)	16 (100)	16 (94)
What is the procedure?					
10. Examine the patient	39 (65)	5 (56)	7 (39)	12 (75)	15 (65)
11. Complete relevant form (Form H1)	36 (60)	2 (22)	7 (39)	12 (75)	15 (65)
12. Nurse in charge formally accepts the relevant Form (H1) on behalf of hospital managers and completes Form H3	16 (27)	0 (0)	2 (11)	6 (38)	8 (47)
13. Document reason why informal treatment is no longer appropriate	16 (86)	0 (0)	1 (6)	5 (31)	10 (27)
What additional actions are needed?					
14. Nominated deputy should report the use of section to the person for whom he is deputising	60 (100)	9 (100)	18 (100)	16 (100)	17 (100)
15. Arrangements for an assessment to consider an application under Sections 2 or 3	12 (20)	0 (0)	1 (6)	3 (19)	8 (47)
Does it confer any power to treat?					
16. No	43 (72)	3 (33)	11 (61)	14 (88)	15 (88)
17. In an emergency treatment can be given under the Mental Capacity Act 2005	16 (27)	0 (0)	0 (0)	6 (38)	10 (59)
Does it confer any power to transfer to another hospital?					
18. No	32 (53)	2 (22)	11 (61)	9 (56)	10 (59)
19. In circumstances of 'pressing need' the patient can be transferred under the Mental capacity Act 2005	2 (3)	0 (0)	1 (6)	1 (6)	0 (0)
For how long does it authorise detention?					
20. Maximum 72 hours	56 (93)	6 (67)	17 (94)	16 (100)	17 (100)
21. If the patient is already on Section 5(4) the time starts from the start of Section 5(4)	5 (8)	0 (0)	0 (0)	2 (13)	3 (18)
Does the patient have the right to appeal?					
22. No	37 (62)	2 (22)	8 (44)	12 (75)	15 (88)
Can Section 5(2) be renewed?					
23. No	48 (80)	4 (44)	13 (72)	15 (94)	16 (94)
Who can discharge the patient?					
24. Only the registered medical practitioner or approved clinician	39 (65)	4 (44)	8 (44)	14 (88)	13 (77)

FY2, foundation trainee year 2; ST1, specialty trainee year 1; ST2, specialty trainee year 2; ST3, specialty trainee year 3.

Section 2 ( $\chi^2$  (3, 60) = 15.95,  $P < 0.001$ ), but there was no significant difference in terms of training received (20/39 v. 11/21 for those who had and those who had not received such training respectively;  $\chi^2$  (1,60) = 2.94,  $P = 0.087$ ). Those with exam experience fared better than those without (21/32 v. 10/28;  $\chi^2$  (1,60) = 5.35,  $P = 0.021$ ). Senior trainees were also more likely to know that under Section 2 an approved mental health professional (AMHP)

must examine a patient ( $\chi^2$  (3,60) = 17.84,  $P < 0.0001$ ); however, previous training did not seem to have a positive impact on the results (21/39 v. 21/21 correct for those who had received training and those who had not;  $\chi^2$  (1, 60) = 8.24,  $P < 0.005$ ). On the other hand, exam experience predicted positive results: 27/32 v. 13/28 of those with and without exam experience respectively gave a correct answer ( $\chi^2$  (1,60) = 9.68,  $P < 0.005$ ).

**Table 2** Correct answers to each question for Section 2 at each level of seniority

	Whole group (N = 60)	FY2 (n = 9)	ST1 (n = 18)	ST2 (n = 16)	ST3 (n = 17)
Questions	n (%)				
What is Section 2?					
1. Allows for the compulsory admission and detention in hospital for assessment (or for assessment followed by treatment)	55 (92)	7 (78)	15 (84)	16 (100)	17 (100)
To whom does Section 2 apply?					
2. Patient suffering from mental disorder	44 (74)	5 (56)	11 (61)	11 (69)	17 (100)
3. Ought to be detained for his own health or safety or for the protection of others	37 (62)	4 (44)	8 (44)	11 (69)	14 (82)
4. Where the full extent of the nature and degree of a patient's condition is unclear	2 (3)	0 (0)	1 (6)	0 (0)	1 (6)
What is the procedure?					
5. Two medical recommendations	31 (52)	0 (0)	8 (44)	13 (81)	10 (59)
6. Application by AMHP/nearest relative	40 (67)	1 (11)	11 (61)	13 (81)	15 (88)
Does it confer any power to treat?					
7. Yes	33 (55)	4 (44)	10 (56)	9 (56)	10 (59)
Does the patient have the right to appeal?					
8. Yes	57 (95)	8 (89)	17 (94)	15 (94)	17 (100)
9. Must do so within 14 days	11 (18)	0 (0)	2 (11)	5 (31)	4 (24)
For how long does it authorise detention?					
10. Maximum 28 days	50 (83)	8 (89)	11 (61)	14 (88)	17 (100)
Can Section 2 be renewed?					
11. No (Section 3 should be used if patient needs further detention)	43 (72)	3 (33)	12 (67)	13 (81)	15 (88)
Who can discharge the patient?					
12. Responsible clinician	56 (93)	7 (78)	17 (94)	15 (94)	17 (100)
13. Nearest relative	17 (28)	0 (0)	4 (22)	5 (31)	8 (47)
14. Tribunal	30 (50)	1 (11)	8 (44)	6 (38)	15 (88)
15. Hospital manager	16 (27)	0 (0)	3 (17)	4 (25)	9 (53)

AMHP, approved mental health professional; FY2, foundation trainee year 2; ST1, specialty trainee year 1; ST2, specialty trainee year 2; ST3, specialty trainee year 3.

### Section 3

For questions related to Section 3 (Table 3), there was a significant difference between trainees of different seniority in their knowledge of the core function of the section ( $\chi^2(3,60) = 10.17, P < 0.05$ ), but there was no significant difference between trainees with or without training (31/39 v. 17/21;  $\chi^2(1,60) = 0.02, P = 0.892$ ). Of the 32 trainees with exam experience and of 28 without exam experience, 30 and 18 trainees respectively answered this question correctly ( $\chi^2(1,60) = 8.10, P < 0.005$ ).

Senior trainees were more likely than junior trainees to know the period of time for which Section 3 permits treatment without consent ( $\chi^2(3,60) = 5.76, P = 0.124$ ), and there was no significant difference between trainees with and without training (38/39 v. 21/21 respectively;  $\chi^2(1,60) = 0.55, P = 0.459$ ). All 32 trainees with exam experience answered correctly, not significantly different than the 27 of the 28 who had no such experience ( $\chi^2(1,60) = 1.16, P = 0.281$ ).

Senior trainees were more likely to understand the role of second opinion appointed doctors (SOADs) under Section 3 ( $\chi^2(3,60) = 14.78, P < 0.005$ ). Training did not influence the scores: 9/39 of those who had and 3/21 of those who had not received training were correct ( $\chi^2(1,60) = 0.66, P = 0.417$ ). Trainees were more likely to understand the SOAD role if

they had had exam experience (11/32 v. 1/28;  $\chi^2(1,60) = 8.86, P < 0.005$ ).

To further analyse differences in knowledge in trainees at different levels of experience, simple numerical scores were calculated for the three sections by adding together the number of correct categorical answers in each group of questions. Analysis of variance conducted on these composite scores revealed that the levels of knowledge about all three sections differed significantly between trainees of different seniority. Regarding Section 5(2), mean scores were: 9.00 (s.d. = 2.84) for FY2, 10.72 (s.d. = 5.58) for ST1, 16.50 (s.d. = 5.09) for ST2, and 17.24 (s.d. = 5.05) for ST3 ( $F(3,56) = 25.79, P < 0.005$ ). Mean scores for Section 2: 5.33 (s.d. = 3.17) for FY2, 7.67 (s.d. = 5.09) for ST1, 9.38 (s.d. = 4.88) for ST2, and 10.94 (s.d. = 5.15) for ST3 ( $F(3,56) = 13.64, P < 0.005$ ). Finally, Section 3 mean scores were: 5.33 (s.d. = 3.34) for FY2, 7.56 (s.d. = 5.63) for ST1, 10.31 (s.d. = 4.14) for ST2, and 12.35 (s.d. = 3.44) for ST3 ( $F(3,56) = 20.19, P < 0.005$ ). In each case, *post hoc* Bonferroni tests revealed that the trainees at ST2 and ST3 levels differed significantly from those at FY2 and ST1 levels, but that there were no significant differences between each respective pair.

In addition, comparisons were made between trainees who had received formal training in their responsibilities as part of their trust induction and those who had not, and

**Table 3** Correct answers to each question for Section 3 at each level of seniority

	Whole group (N = 60)	FY2 (n = 9)	ST1 (n = 18)	ST2 (n = 16)	ST3 (n = 17)
Questions	n (%)				
What is Section 3?					
1. Allows for compulsory detention in hospital for treatment	48 (80)	5 (56)	12 (67)	14 (88)	17 (100)
To whom does Section 3 apply?					
2. Patient suffering from mental disorder	39 (65)	4 (44)	6 (33)	12 (75)	17 (100)
3. Where the diagnosis and prognosis of a patient's condition is established and appropriate medical treatment is available	24 (40)	1 (11)	3 (17)	9 (56)	11 (65)
4. It is necessary for his own health or safety or for the protection of others	22 (37)	0 (0)	5 (28)	6 (38)	11 (65)
What is the procedure?					
5. Two medical recommendations	33 (55)	1 (11)	8 (44)	12 (75)	12 (71)
6. Application by AMHP/nearest relative	36 (60)	1 (11)	8 (44)	11 (69)	16 (94)
Does it confer any power to treat?					
7. Doctors may treat patients with medication for their mental disorder for up to 3 months	59 (98)	8 (89)	18 (100)	16 (100)	17 (100)
8. After 3 months, second opinion must be obtained if the patient does not consent	12 (20)	0 (0)	0 (0)	4 (33)	8 (47)
Does the patient have the right to appeal?					
9. Yes	58 (97)	8 (89)	17 (94)	16 (100)	17 (100)
For how long does it authorise detention?					
10. Maximum 6 months initially	38 (63)	3 (33)	11 (61)	10 (63)	14 (82)
Can Section 3 be renewed?					
11. Yes	57 (95)	8 (89)	16 (89)	16 (100)	17 (100)
Who can discharge the patient?					
12. Responsible clinician	57 (95)	8 (89)	16 (89)	16 (100)	17 (100)
13. Nearest relative	21 (35)	0 (0)	5 (28)	6 (38)	10 (59)
14. Tribunal	36 (60)	1 (11)	7 (39)	11 (69)	17 (100)
15. Hospital manager	19 (32)	0 (0)	4 (22)	6 (38)	9 (53)

AMHP, approved mental health professional; FY2, foundation trainee year 2; ST1, specialty trainee year 1; ST2, specialty trainee year 2; ST3, specialty trainee year 3.

between trainees who had sat formal examinations organised by the Royal College of Psychiatrists. These comparisons revealed that those trainees who had sat an external examination had significantly higher scores on all three sections than trainees who had not sat an exam. Thus, the 28 trainees who had not sat an exam recorded mean scores of 10.64 (s.d. = 4.66) for questions related to Section 5(2), 6.96 (s.d. = 2.60) for Section 2 and 7.14 (s.d. = 3.01) for Section 3. In comparison, for the 32 trainees who had sat a College exam, mean scores were 15.69 (s.d. = 3.16) for questions related to Section 5(2), 10.25 (s.d. = 2.53) for Section 2, and 11.28 (s.d. = 2.59) for Section 3 ( $F(1,58) = 24.62, P < 0.005$ ).

Comparisons were also made between those trainees who had received formal training in mental health legislation through the induction training on taking up

their posts in a National Health Service (NHS) trust. Of the 60 trainees, 39 had received such training and 21 had not. Whether or not participants had received such training had no statistically significant effect on scores on Section 2 ( $F(1,58) = 0.68, P = 0.795$ ) or Section 3 ( $F(1,58) = 0.56, P = 0.457$ ), but there was a trend for a group difference in scores for Section 5(2) questions ( $F(1,58) = 3.87, P = 0.054$ ). Examination of the scores revealed that those who had not received formal training in mental health legislation actually had higher mean scores (14.90, s.d. = 4.16) than the trainees who had received such training (12.49, s.d. = 4.73).

Finally, there were strong correlations between scores on all three sections (and overall) and both clinical experience in months and the number of Section 5(2) orders implemented (Table 4). There was, not surprisingly, a

**Table 4** Scores on all three sections – correlations between clinical experience in months and the number of orders implemented

	Clinical experience	Orders implemented
Section 5(2)	$r = 0.663^{***}$	$r = 0.717^{***}$
Section 2	$r = 0.575^{***}$	$r = 0.707^{***}$
Section 3	$r = 0.627^{***}$	$r = 0.668^{***}$

\*\*\* $P < 0.0005$ .

significant correlation between the trainee's clinical experience and the number of Section 5(2) orders implemented ( $r = 0.777$ ,  $P < 0.0005$ ).

## Discussion

This study revealed potentially serious inadequacies in psychiatry trainees' knowledge of key mental health legislation. This is worrying given that the doctors concerned in most cases would have dealt frequently with patients detained under Sections 5(2), 2 and 3 and should be familiar with the various statutory requirements. However, it is reassuring that the knowledge increases with experience, unlike what was shown in previous studies, which had noted no change regardless of experience.<sup>4,5</sup>

Lack of knowledge and understanding raises the possibility of inappropriate use of the Mental Health Act. This is particularly relevant to Section 5(2). Inappropriate use of the Act threatens patients' fundamental rights and can have important consequences for the doctors involved and their employers, potentially leading to patient complaints or litigation.<sup>17</sup>

Lack of emphasis on education and training in mental health law are possible explanations that can account for deficiencies in knowledge.<sup>12,18</sup> The findings from our study clearly show that the limited training received on taking an NHS trust post (induction) is not sufficient. Another area of concern is that doctors are not tested for competencies with regard to applying law. Membership exams do not test the candidates' knowledge of mental health legislation. Even formal Section 12 approval of psychiatrists does not include formal testing in mental health legislation. It is important to bear in mind that the Royal College of Psychiatrists' curriculum defines competencies that psychiatrists have to acquire and demonstrate in their day-to-day clinical practice. Trainees are required to maintain and apply an adequate and up-to-date knowledge of legislation that is relevant to any aspect of their professional practice, including patient care, the rights of patients, their relatives and carers, and research.<sup>19,20</sup>

There must, therefore, be increased emphasis on the importance of training in mental health law and its clinical implications. Trainees should be encouraged to attend formal training courses run by the employing trust, professional bodies or educational institutions. It may also be sensible to focus such training on the specific needs of trainees. Training sessions should be included in their teaching and academic programmes. Research has suggested that acquisition and retention of knowledge is best achieved through active use of the Mental Health Act.<sup>21,22</sup> This needs to be reflected in the type and nature of training courses developed. Suggestions include small-group or workshop teaching with the opportunity to discuss real-life situations, applying the Mental Health Act in case vignettes, observing consultants on Mental Health Act assessments, and attending courses. Such training should not be confined to those individuals seeking statutory approval. It is important and would be timely to explore ways of improving matters and not only to formalise training for psychiatry trainees but also to test their competencies. There is a clear need to address this at an early stage in psychiatric training.

## Strengths and limitations

This is the first study in England which looks at psychiatry trainees' knowledge of mental health law through a face-to-face interview. In contrast to studies from other countries it is concerned not only with legal knowledge but with procedures as well.

The limitations to the approach taken in this study largely relate to the response rate. Difficulties with responses have been noted in previous studies.<sup>5,7,23</sup> With a response rate of 60%, it is likely that our study accurately represents what this group of psychiatric trainees know about one specific area of current mental health legislation. Moreover, the concerns raised should be considered seriously given the likelihood that non-participating psychiatric trainees may have poorer knowledge than the ones who volunteered to participate. It is possible that our results cannot be generalised to other geographical areas; however, there is no evidence to support this concern and it is difficult to identify how this sample might differ from trainees in other parts of England and Wales. No comparisons can be drawn to other countries as legislation varies significantly from one to another. Another possible limitation is that, in the analyses reported here, all the questions asked were considered equally important. This approach was thought more appropriate than potentially highly subjective weighting systems, but it does mean that rather more obscure issues may have been unduly prioritised. It also limits the conclusions that may be drawn from the data and the extent to which specific recommendations can be made to address the apparent lack of knowledge.

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# Mental health law training should be mandatory for all doctors

## Commentary on . . . Knowledge of mental health legislation in junior doctors training in psychiatry<sup>†</sup>

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**Summary** Over many years and with various pieces of new legislation there are significant gaps in doctors' knowledge about mental health law. It is time to ensure that doctors know the law and can apply it to the patients they see. Practising legally and not detaining or allowing people to leave hospital inappropriately should be a mandatory part of training for every doctor no matter what the specialty. Medical schools, deaneries, training programme directors and the General Medical Council should take up the challenge and ensure good-quality training for all doctors to ensure good-quality care in this area is given to all patients.

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The paper by Wadoo *et al*<sup>1</sup> highlights that junior doctors have a lack of knowledge about mental health legislation. It is not the first study to do so and other studies highlight many different areas where knowledge of law is lacking.<sup>2–4</sup> However, this is an important area to highlight.

Wadoo *et al*<sup>1</sup> state that as theirs is a semi-quantitative study methodologically it is difficult to replicate it.

However, it shows what other studies before it have shown: that there is a lack of knowledge regarding mental health law – in this case, specific aspects of the Mental Health Act 1983. This lack of knowledge is not necessarily limited to junior trainees and within the study there are hints of this as it shows that in-service training either had no effects on knowledge or in some areas those that received it fared worse in their knowledge.

The phenomenon of senior colleagues not understanding or being up to date with certain parts of the

<sup>†</sup>See education and training, pp. 460–466, this issue.