

Legal Knowledge of Mental Health Professionals: Report of a National Survey

Jill Peay, Caroline Roberts** and Nigel Eastman****

Summary

This article presents findings from a national postal survey of knowledge of mental health law amongst psychiatrists, GPs, approved social workers and Mental Health Act Commissioners, conducted in England and Wales. The study was designed to assess (amongst other matters) the relative levels of legal knowledge between and within these professional groups. Data from 2022 respondents revealed considerable discrepancies in knowledge scores. Commissioners, approved psychiatrists and approved social workers achieved the highest scores, and non-approved GPs the lowest scores. Within-group differences, for doctors, were correlated with levels of day-to-day experience in using the Mental Health Act and, for approved social workers, with training. The article concludes that the advisability of maintaining the statutory role of GPs in its current form is questionable, given the preponderance of poorly performing GPs. Both use of the Act and training were important in sustaining practitioners' legal knowledge.

Introduction

It is paradoxical that whilst the legal provisions governing the detention (and subsequent treatment) of those suffering from mental disorder are widely thought to be tightly constrained, the wording of the Mental Health Act 1983 (MHA) makes its application highly discretionary. The MHA is, in practice, reliant for its clinical and civil rights effects upon the interpretation and judgement of the practitioners who are required to apply it.¹ Moreover, whether and how the law is applied, and whether it is applied consistently, depends substantially upon the legal knowledge

* *Jill Peay Reader in Law, London School of Economics and Political Science*

** *Caroline Roberts Research Fellow, London School of Economics and St George's Hospital Medical School, University of London*

*** *Nigel Eastman Professor of Law and Ethics in*

Psychiatry, St George's Hospital Medical School, University of London

1 *Eastman, N. & Peay, J. (eds) (1999) Law Without Enforcement: Integrating Mental Health and Justice. Oxford: Hart Publications; Hoggett, B. (1996) Mental Health Law (4th Ed) London: Sweet and Maxwell*

of those practitioners;² impoverished knowledge can lead both to patients being denied treatment from which they might have benefited, and to patients being inappropriately treated. Yet, research concerning what is known by UK practitioners about mental health law is scant. Previous studies have been interview based, relatively small scale and confined to doctors,³ or based on doctors' understanding of the common law.⁴

Methods

A postal survey was conducted in England and Wales using a purposely designed and piloted self-completion questionnaire of mental health practitioners with key responsibilities under the MHA. The surveyed groups were psychiatrists approved under s.12(2) of the MHA as having "special experience in the diagnosis or treatment of mental disorder", non-approved psychiatrists and general practitioners (GPs), as well as approved social workers (ASWs). In addition, all 476 s.12(2) approved GPs on the Regional Health Authority registers and all 147 Mental Health Act Commissioners (MHACs) then active were included. The survey was conducted between February and July 1999, with two re-mailings to non-responders. Response was also encouraged through participation in a prize draw for a week-end for two in Paris.

For the sampled groups, representative samples (proportionately stratified according to region) of 700 non-approved GPs and 600 ASWs were approached, using a 'random start and fixed interval' method. The GP sample was obtained from a commercial NHS database company and the ASW sample from lists of those active on the duty rotas of sixty local authorities (representative in terms of population density and the proportion of households in social classes I and II). A sample of 1500 psychiatrists (including those with and without s.12(2) approval) was taken from membership lists of the Royal College of Psychiatrists. Psychiatrists were 'over-sampled' in order to ensure adequate numbers of s.12(2) and non-approved practitioners were obtained of those specialising in areas of psychiatry requiring regular use of the MHA. Returned questionnaires from psychiatrists were filtered in order to exclude those not fulfilling the sampling criteria. Further details of the sampling procedures, selection criteria and other aspects of the methodology are available elsewhere.⁵

The questionnaire was in three parts. Whilst part 1 concerned attitudes towards mental health issues, this article describes and analyses data from parts 2 and 3. These addressed knowledge of the MHA and the 1993 Code of Practice, and assessed various demographic items including professional experience and training.

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- 2 *Hawkins, K. (1986) On Legal Decision-Making. Washington and Lee Law Review. 43: 1161-1242; Hogarth, J. (1971) Sentencing as a Human Process. Toronto: University of Toronto Press*
 - 3 *Humphreys, M. (1994) Junior Psychiatrists and Emergency Compulsory Detention in Scotland. International Journal of Law and Psychiatry 17, 421-429; Humphreys, M (1997) Non-consultant psychiatrists' knowledge of emergency detention procedures in Scotland. A national survey. Psychiatric Bulletin 21, 631-635; Humphreys, M. (1998) Consultant Psychiatrists' Knowledge of Mental Health Legislation in Scotland. Medicine, Science and Law 38, 237-241; Humphreys, M. & Ryman, A. (1996) Knowledge of emergency compulsory detention procedures among general practitioners in Edinburgh: sample survey. British Medical Journal 312, 1426-3; Bhatti, V., Kenney-Herbert, J., Cope R., et al (1999) Knowledge of current mental health legislation among medical practitioners approved under section 12(2) of the Mental Health Act 1983 in the West Midlands. Health Trends 30, 106-108*
 - 4 *Hassan, T., MacNamara, A., Davy, A., et al (1999) Managing patients with deliberate self-harm who refuse treatment in the accident and emergency department. British Medical Journal 319: 107-9*
 - 5 *Roberts, C., Eastman, N. & Peay, J. (2000) A study of the attitudes and legal knowledge of professionals with responsibilities under the Mental Health Act 1983: Report of a national postal survey. London: LSE and St George's Hospital Medical School*

Measuring knowledge of mental health law

The knowledge part of the questionnaire consisted of 27 true or false statements. The items were intended to vary in difficulty, allowing even those with relatively little experience of using the MHA (namely, non-s.12(2) approved GPs) the opportunity to demonstrate knowledge. The items were presented in a random order with respect to their predicted levels of difficulty. Respondents were asked to indicate whether the item was 'true', 'false' or, if they were unsure of the correct response, that they 'would need to look it up'. Guessing was discouraged.

Given that it would be possible to 'look up' the correct answer to most questions, either in the MHA itself or in a relevant manual, a number of potential validity problems needed to be resolved. A range of approaches was developed in the design phase, including some aimed at easing respondents' anxiety about demonstrating any possibly limited knowledge. However, the most innovative approach adopted was the inclusion of six items designed specifically as 'validity checks'. These allowed both the identification of respondents who had most likely ignored our instructions and referred to materials during completion of the survey and provided a means of evaluating the methodology employed.

Validity questions were of two types. First, 'difficult obscure' statements, where only respondents with a very good general knowledge of mental health law (including knowledge of recent case law, Department of Health guidelines and their relationship) would be likely to know the correct response, since there would be no obvious source for 'looking up'. Secondly, 'difficult technical' statements were included. In order to give the right answer to these it was postulated that resort to the MHA or to a manual *would* be necessary for those respondents unable successfully to guess correctly. Even someone with extremely good knowledge would be very likely to have to look up such answers. Accordingly, a better performance on the former type of validity question than on the latter type was hypothesised. Those who gave correct answers to the technical questions, but not to the obscure questions, were most likely to have referred to a legal source despite exhortations not to do so.

Developing true/false statements

The 27 true/false items developed included both those addressing knowledge of the most basic kind, for example, item 2.4 "mental illness is defined within the MHA 1983" and the six 'validity' questions. Whilst the questionnaire was extensively piloted the selection of items included in the final version required few adjustments beyond changes to wording and better balancing of the number of true and false statements. Table 1 below illustrates answers to seven of the knowledge items by professional group, based on a sample of 2022 questionnaires.

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Knowledge Item	Proportion of respondents giving correct (C), incorrect (I) and 'I would need to look it up' (DK) responses (percentages %)																	
	Mental Health Act Commissioners			s.12(2) Psychiatrists			ASWs			Non-approved Psychiatrists			s.12(2) GPs			Non-approved GPs		
	C	I	DK	C	I	DK	C	I	DK	C	I	DK	C	I	DK	C	I	DK
2.3 Under the MHA a General Practitioner can only make a medical recommendation for detention in hospital if the patient has been on his or her list for at least three months. (False)	85	4	11	83	3	15	89	3	9	65	6	30	84	7	9	64	9	27
2.4 Mental illness is defined within the MHA 1983. (False)	77	19	3	78	18	4	72	26	2	67	26	8	42	44	14	27	33	41
2.19 The legal criteria for compulsory admission to a hospital under the MHA include that the person is unable to consent to treatment. (False)	89	7	4	81	13	6	89	9	3	67	22	11	59	29	13	67	22	11
2.20 Drug treatments above the British National Formulary (BNF) limits always require a second opinion from a doctor appointed by the Mental Health Act Commission (SOAD). (False)	80	10	10	79	11	11	25	28	47	64	14	22	47	11	42	37	10	53
2.23 Under the Mental Health (Patients in the Community) Act 1995 there is a power to convey but not to treat the patient without consent. (True)	81	6	14	78	3	20	74	2	24	59	7	34	39	9	52	20	8	71
2.25 A patient's 'nearest relative' for the purposes of the MHA can be nominated by the patient. (False)	79	16	5	66	13	21	88	7	5	53	22	25	57	19	24	27	23	50
2.27 The legal criteria for admission to a hospital for treatment under Section 3 of the MHA include that the person is in need of detention in the interests of their health. (True)	81	16	3	87	10	4	84	13	3	79	12	9	67	22	11	51	14	35

Table 1 - showing mean responses to seven knowledge items for each professional group

Statistical Analysis

Key comparisons between professional groups were carried out on the basis of mean knowledge scores using Analysis of Variance, and the Scheffé post hoc range procedure (in ANOVA), which allows simultaneous pairwise comparisons of means for all possible multiple-group comparisons. The Scheffé procedure produces more conservative estimates for p-values, thus reducing the probability of making Type I errors.

Calculating the 'adjusted knowledge' score

It was necessary to decide the most appropriate measure of knowledge to use for both between- and within-group comparisons. This involved two processes. First, the generation of descriptive statistics for the items included as validity checks, in order to ensure that respondents had not referred to the Act or a manual whilst completing the true/ false statements. As hypothesised, the majority of respondents performed poorly on these items compared with the other items. The 'difficult technical' items produced the highest number of 'I would need to look it up' responses, as had been predicted would happen if respondents followed our instructions. We also cross-checked to ensure that those respondents who scored well on the 'difficult obscure' items did indeed perform well overall on the knowledge items. Combining these responses gave us confidence in the robustness of our validity items as a method of detecting possible 'looking-up' offenders. Whilst it had been intended that data from such 'errant souls' would be excluded from the analysis, in the event less than ten respondents were considered likely to have breached our exhortations. Since they were distributed across all the professional groups we decided not to exclude them. On the basis of these analyses, however, it was decided that the validity items would be *excluded* from the computation of knowledge score, on the grounds that they did not provide a fair test of actual knowledge. By removing them, overall mean scores substantially increased across all professional groups.

Secondly, an exploratory analysis using Item Response Theory was carried out to determine whether particular items appeared to be differentially difficult for the professional groups.⁶ This involved a logistic test item analysis (using a two-parameter model) using the SYSTAT package (version 5.03 for Windows) to produce Latent Trait Models for each item within each of the four professional groups. Item Response Theory allows an examination of the relative difficulty of each item given a postulated 'ability' level for all respondents. Thus, item difficulty is determined not simply by the proportion of respondents obtaining a correct response, but rather by focusing on the specific characteristics of each item.

Three items (relating to treatment and consent issues) were found to differentiate particularly poorly between psychiatrists (with a high proportion responding correctly across the range of ability) and one item was found to be particularly 'easy' for ASWs (pertaining to their role with respect to the nearest relative). Excluding these items from the computation of the score for knowledge, however, did not affect the overall ranking of the professional groups, nor did it significantly affect the mean scores for each group, and so the items were *retained*. The final knowledge score, therefore, was calculated on the basis of 21 items (i.e. a total of 27 minus the 6 validity items).

6 Hambleton, R.K., Swaminathan, H. & Jane Rogers, H. (1991) *Fundamentals of Item Response Theory*.

It should be noted that, for the purpose of the analyses reported below, data from 169 respondents who had either a high number of ‘don’t know’ responses (10 or more) or for whom there were 10 or more missing values (indicating that they had made no attempt to respond to the items) were excluded; this produced a sample of 1,853 respondents for the comparisons of ‘knowledge’ score (see Table 2 below). Using this most ‘conservative’ score of knowledge (that is, the one which places respondents in the best possible light in terms of their group’s mean legal knowledge) has the advantage of minimising any bias that might otherwise be introduced as between the professional groups due to their differential preponderance to guess correct answers. As might be expected, of the 169 excluded respondents, 123 were non-approved GPs; accordingly, any observations offered below about the lack of knowledge of GPs is based on a sample that has already excluded a significant number of their most poorly performing members.

The final adjustment made to produce as fair a measure of knowledge as was possible involved calculating for each included respondent the number of correct responses, minus the number of incorrect responses. Since we had discouraged ‘guessing’, confidently made incorrect responses were deducted from correct responses, thus penalising inaccurate responses whilst giving appropriate credit for correct ones. Since the view was taken that it was acceptable, in practice, to admit the need to look up information, but unacceptable to give incorrect answers, the ‘I would need to look it up’ responses played no part in the calculation of ‘adjusted knowledge’ score.

Within-group differences in knowledge

Within-group differences in knowledge were explored using multiple regression analyses (Stepwise procedure in SPSS), whereby only those regressors that *significantly* predicted the dependent variable were retained in the model. Thus, regression models were selected not simply on the basis of the magnitude of the R square. Rather, the emphasis of the procedure was on identifying those factors most influential in determining knowledge score. Some further Analyses of Variance were carried out to explore within-group differences where appropriate.

Results

The number of returned questionnaires included in the study was as follows: 125 Mental Health Act Commissioners (85% response rate for included questionnaires), 266 s.12(2) GPs (56%), 306 non-approved GPs (44%), 425 ASWs (71%) and 900 psychiatrists (60%). Of the latter, 716 had s.12(2) approval. The prevalence of s.12(2) approval was greater than anticipated and this, in addition to increased non-response amongst those without approval, led to the under-representation in the survey sample of psychiatrists who had not gained s.12(2) approval (predominantly those who had only recently passed the Membership exam).

Between-group differences

On the basis of the ‘adjusted knowledge’ score described above, the pattern of knowledge levels which emerged was that MHACs had the highest mean scores, followed by s.12(2) psychiatrists and then ASWs (although only by a few percentage points), with non-approved psychiatrists and GPs at the lower end of the scale.

Professional Group	Mean Adjusted Knowledge Score	Standard Deviation	N
Mental Health Act Commissioners	76.9	16.7	121
s.12(2) psychiatrists	76.4	12.8	709
Approved Social Workers	71.5	13.5	421
Non-approved psychiatrists	66.4	15.0	174
s.12(2) GPs	54.5	16.4	245
Non-approved GPs	45.3	14.4	183
TOTAL	68.4	17.6	1853

Table 2 Mean knowledge score for all professional groups (calculated for all 21 items (excluding 'validity items', as total correct - total incorrect). Scores are shown as percentages.

Table 3 below shows the distribution by professional group across six unequal percentiles (based, for the purposes of analogy, on University degree classifications) using the adjusted knowledge scores. It notably demonstrates first, that there were representatives in all the professional groups who scored in the highest percentiles, supporting our argument that the knowledge test was not impossibly difficult for even GPs to obtain good scores. Secondly, the preponderance of MHACs (76%) in the highest percentile is a reassuring reflection of their overall high quality. MHACs, of course, are not only appointed on the basis of their working experience (including lawyers, doctors and social workers) but also receive extensive in-house training. Third, the difference between, on the one hand, ASWs and s.12(2) approved psychiatrists, and on the other GPs (whether approved or not), is most marked at the bottom end of the range. Using a score of less than 40% as a measure of poor performance, not more than 2% of ASWs or s.12(2) psychiatrists fell into this category, but 15% of approved GPs and 30% of non-approved GPs were located in this range.

Within-group differences

First, for all respondents a positive, significant correlation between knowledge and training received in the year preceding the research was found (Pearson's $r = 0.28$, $p_{2\text{-tailed}} < 0.01$). Secondly, however, the multivariate analyses (multiple regression) revealed the complexity of the relationship between knowledge, training and the various demographic and professional experience measures. For example, for psychiatrists (approved and non-approved), levels of knowledge were significantly influenced by their experience of using the MHA (significant variables included attending Mental Health Review Tribunals, writing court reports and participation in MHA assessments during the past year - all of which imply *active* use of the Act). For GPs, the best single predictor of variance in knowledge was participation in MHA assessments during the previous year. Only 22 GPs had *never* participated in such an assessment and their mean knowledge score was significantly lower than for those attending 20 or more assessments in 1998 ($t_{103} = -3.18$, $p_{2\text{-tailed}} < 0.01$). For MHACs one of the greatest influences on knowledge scores was experience of teaching mental health law

Adjusted Knowledge Score (Degree Class)	MHA Comm- issioners (n=121)		s.12(2) Psychiatrists (n=709)		Approved Social Workers (n=421)		Non- approved Psychiatrists (n=174)		s.12(2) GPs (n=245)		Non- approved GPs (n=183)		Total (n=1853)	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
First Class (70%+)	92	76	557	78.6	247	58.7	81	46.6	52	21.2	8	4.4	1037	56.0
Upper Second (60-69%)	14	11.6	83	11.7	104	24.7	39	22.4	55	22.4	24	13.1	319	17.2
Lower Second (50-59%)	7	5.8	43	6.1	52	12.4	30	17.2	58	23.7	41	22.4	231	12.5
Third Class (45-49%)	3	2.5	11	1.6	9	2.1	7	4.0	14	5.7	17	9.3	61	3.3
Pass (40-44%)	2	1.7	8	1.1	3	0.7	12	6.9	30	12.2	39	21.3	94	5.1
Fail (under 40%)	3	2.5	7	1.0	6	1.4	5	2.9	36	14.7	54	29.5	111	6.0

Table 3 Adjusted knowledge score divided into degree classifications – Professional Group Crosstabulation

to others. For ASWs however, the association of greatest significance appears to be that between training and knowledge levels. For, whilst use of the MHA was important, the clearest associations were between numbers of days of training (whether ASW qualification training or days of training received in 1998) and knowledge score.

Discussion

Methodological limitations

Assessing knowledge is fraught with problems and, whatever methodology is adopted, the measures of knowledge produced will have their limitations. For example, the interview based methodology of the studies cited above require respondents to construct or recall an answer. This is likely to be more difficult, particularly when an interview is conducted face to face, than an anonymous postal survey that merely requires the respondent to recognise the correct answer. These earlier studies may thus *underestimate* knowledge. In contrast, a postal survey necessarily risks *overestimating* knowledge levels.

Whilst we are reasonably confident that the validity measures employed in this study enable us to refute that possibility, the very *poor* scores obtained by some respondents confirm that our methodology could reflect real areas of ‘ignorance’. Such ignorance would replicate the universally depressing picture of knowledge painted by the earlier studies. For example, in a study of non-consultant psychiatrists in Scotland, it was found that, “none of the individuals interviewed was able to give an accurate description of all the conditions which must be fulfilled in order to detain

a patient in an emergency”.⁷ Moreover, as Humphreys further observed, some consultants “seemed unashamed or even unaware of their lack of knowledge”.⁸

However, it is important to emphasise that our study was primarily designed not to assess absolute knowledge, but *comparative* levels of knowledge amongst *all* practitioners who have responsibilities under the MHA. It thereby sought to redress the emphasis of the earlier studies on *doctors’* knowledge. Indeed, MHA’s multi-disciplinary framework may ensure that where doctors are deficient in their knowledge, ASWs can serve as a brake, or a spur, where inappropriate action, or inaction, might otherwise result. Whilst these ‘checks and balances’ do not invariably redress any deficiencies in medical legal knowledge,⁹ the ‘structured’ nature of real life multi-disciplinary decision-making does highlight a further limitation of our study. In practice, mental health professionals may both resort to written materials and have access to one another and to other parties, such as family members, who may have no statutory role under the MHA. Whether these individual contributions are likely to be more or less informative is an open question, but this study does indicate that doctors are unlikely to encounter a very poorly informed ASW. The same cannot be said of ASWs’ encounters with GPs.

A third limitation of our study is the relatively lower response rate from non-approved GPs (44%). Whilst this can be attributed to the lesser degree of salience of mental health law issues to general practice, low levels of knowledge remain of concern where all GPs potentially have a statutory role in the process of compulsory admission under the MHA.

Knowledge scores - the order of merit

Whilst there are problems in the interpretation of our findings, a number of points emerge with clarity. The first is relatively positive; namely, those with key responsibilities under the MHA did not perform on the knowledge items as badly as the previous literature specifically concerning doctors might have led us to expect. Indeed, a significant number of individuals in all of the practitioner groups (with the exception of GPs) obtained impressively high scores, reflecting a minimal ability at least to recognise correct answers.

On the negative side, there was also a significant number of individuals who performed poorly, worryingly including some MHACs (although it is notable that MHACs, as a group, performed in the highest percentiles). Also, the *mean* percentage scores (77% for MHACs ranging down to 45% for non s.12(2) GPs) are not particularly impressive overall. To use an academic analogy, three *groups* performed in the first class bracket (MHACs, approved psychiatrists and ASWs); non-approved psychiatrists obtained a middling 2:1 (66%); s.12(2) approved GPs fell in the lower second class bracket (55%), whilst non-approved GPs scraped a third class pass (45%). However, it should be recalled that 123 non-approved GPs were excluded from the analysis, on the basis that, again by analogy, they had turned up at the examination room but had not made a serious attempt at the paper (having had 10 or more ‘don’t knows’ or 10 or more missing values). Whatever their mitigating (medical or not) circumstances this sort of performance should not be condoned. Moreover, while it could be argued that GPs have very limited roles in terms of the frequency of their actual use of the MHA, that cannot be a justification for such ignorance. The MHA gives

7 See Humphreys (above) 1997 at p.632.

8 See Humphreys (above) 1998 at p.239

9 Peay, J. & Eastman, N. (2000) *A study of the decision*

processes and decision outcomes of professionals with responsibilities under the Mental Health Act 1983: Report of a vignette study. London: LSE and St George’s Hospital Medical School

them authority and for those many individuals who are sectioned by GPs, inexperience, and even understandable ignorance can be no consolation.

The order of merit described above also reveals a counter-intuitive finding, namely that approved psychiatrists just outperformed ASWs. We describe it as counter-intuitive because such psychiatrists are required, in order to achieve their 'approved' status, to undergo an average of only one to two days of training in mental health law¹⁰ whereas ASWs undergo three months of training, albeit in mental health generally as well as mental health law.¹¹ It was also notable that, when asked to rate their own confidence in mental health law, ASWs *rated* themselves as *more* confident than did the psychiatrists. To conclude that s.12(2) psychiatrists *are* generally better informed on the knowledge items, whilst ASWs *think* that they are better informed and that no amount of training makes a difference to their knowledge, would be harsh since the difference in their scores is so marginal. However, it is notable that, looking percentile by percentile, approved psychiatrists did outperform ASWs in each percentile. Interpreting these findings is difficult, particularly since the ASW sample was relatively homogenous, whilst the s.12(2) psychiatrist sample was heterogeneous by comparison and the two groups will have had differing training and work experiences. Yet, looking at the differences of the *spread* of scores between *all* the groups, the ASWs' three months training seems to have the advantage that one can rely upon most ASWs being 'quality assured'. Put at its simplest, a patient is relatively unlikely to encounter an ASW or s.12(2) psychiatrist with poor legal knowledge.

Training, refresher training and 'active' training

An important question concerns the amount and nature of training which best serves to ensure that knowledge is both acquired and retained. Should our finding that s.12(2) psychiatrists (with their two days of training) outperform ASWs (with three months of training) lead us to conclude that two days is enough and three months more than enough? Given our reflections above, quite the reverse. However, whilst the ASWs' training may protect them from unacceptably low levels of knowledge, the fact that the approved psychiatrists' knowledge is associated with *active use* of the MHA may indicate that mere *passive training* is not the best method for ensuring that knowledge is retained. Whilst it is possible that ASWs and psychiatrists as groups respond better to differing training regimes, a more plausible explanation is that retention of knowledge, and even its acquisition, is best achieved through active use of the MHA. Thus, one improvement to the training regime in mental health law might be to ensure that it has a more 'experiential' element.¹²

GPs - reasons for concern

What remains of concern however is the relatively low levels of knowledge shown by those who only use the MHA infrequently, and yet who potentially enjoy day-to-day responsibilities and powers under it. The argument is most acute with respect to GPs. GPs had the lowest knowledge scores, yet, for our sample of 572 GPs, only 22 of them had *never* participated in a MHA

10 NHS Executive (1996) *Approval of doctors under section 12 of the Mental Health Act 1983*. HSG(96)3.

11 Central Council for Education and Training in Social Work (1992) *Requirements and guidance for the training of social workers to be considered for approval in England and Wales under the Mental Health Act*

1983. Rev ed London: CCETSW 1003, (CCETSW paper: no 19.19)

12 Harrison, J. (1996) *Training in the Mental Health Act: see one, do one, teach one?* Psychiatric Bulletin 20, 160-161

assessment. It is also notable that GPs, having tackled the knowledge items, showed a marked decrease in confidence, demonstrating that as a group, they at least recognised that they did not know that which perhaps they ought to have known.

How might these findings be judged in a broader medical context? Modern thinking about regulating medical practice has increasingly sought to control practice on the basis of specific experience; thus, surgeons, for example, are allowed to undertake particular procedures, such as mastectomies, only if they perform more than a given number per year. Unfortunately, ignorance of the law is no impediment to its initial application. Quality assurance in maintaining patients' civil rights would, therefore, seem to demand that only doctors who can demonstrate a given level of annual experience (and/or knowledge) in using the MHA, on a number of measures, should be *allowed* to use it. Whilst the Government's Green Paper asserts "(A) key aim of our proposals is to ensure that the provisions of a new Mental Health Act are fairly and consistently implemented"¹³ and the later White Paper confirms that "Practitioners who are responsible for using the powers in mental health legislation need to have a thorough understanding of its scope and purpose"¹⁴ neither of these objectives seem likely to be easily achieved. The existing wide disparity in basic knowledge amongst key practitioner groups is unlikely to be remedied for, whilst the White Paper asserts¹⁵ "Specialist training will be provided for all professional staff authorised to undertake specific functions under the new legislation. Training and regular updating will be statutory requirements for those who are responsible for taking key decisions" there is no assurance that all GPs will be included in this training. Yet GPs are seemingly to retain a statutory role in the decision to assess patients (a process which may last up to 28 days), and, as at present, may be the only doctor involved in an emergency admission.¹⁶ We would suggest, on the basis of this study, that whilst GPs might properly be *consulted* about their patients clinically and in relation to decisions to detain, they arguably should not retain the legal authority to *make* that decision. This more limited approach would contrast with the recommendation of the Richardson Committee,¹⁷ now taken up in the White Paper¹⁸ for potentially expanding the range of specialist mental health practitioners who might *have* such authority. Notably, however, the Richardson recommendation was premised on the crucial importance of adequate training for those specifically empowered under legislation.

Further analysis could be undertaken on the comparative disparities in understanding and non-understanding of the law. Here, we merely observe that misapprehensions about the law, especially in the context of high levels of expressed confidence, may result in unlawful use or unnecessary overuse of the MHA. Equally, the law may be underused. Lest these descriptions be thought anodyne, it is worth stressing that they may disguise what in practice can amount to unjustified loss of liberty for some patients and/or a failure properly to be treated, via detention, for others.

13 Department of Health (1999) Reform of the Mental Health Act 1983. Proposals for Consultation. Cm 4480 London: The Stationery Office Ltd, at p.10

14 Department of Health/ Home Office (2000) Reforming the Mental Health Act. Part I: The new legal framework Cm 5016-1 London: The Stationery

Office Ltd, at para 2.30

15 *Ibid*

16 *Ibid* at para 3.75

17 DoH *op. cit.*, n.13 at p. 48,

18 DoH/Home Office, *op.cit.*, n. 14 at para 3.14)

Conclusion

This study, based on a national survey of varying professional groups, suggests that levels of knowledge vary, sometimes greatly, by group, and that higher knowledge scores are associated within and across groups with more frequent use of the MHA. Mean scores for all groups also demonstrate much better knowledge levels for doctors than the earlier studies. Whilst the relatively low levels of knowledge shown in this study amongst GPs is of concern, since any GP can be called upon to perform their statutorily required function under the MHA, the higher levels of knowledge amongst ASWs and of s.12(2) psychiatrists may serve to ‘protect’ GPs against their own relatively inadequate knowledge. However, such an inter-professional relationship runs counter to the intention of the MHA to maximise civil rights and clinical outcome via independent assessments. The results have significance for clinical governance, for training and for deciding about future medical roles in the planned new Mental Health Act.¹⁹ Whether GPs should retain a statutory function in the admission process, rather than an advisory one, is, on the basis of this study, more than a moot point.

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Declaration of interest: Peay was a member of the Richardson Committee.

Correspondence to: Dr Jill Peay, Department of Law, London School of Economics and Political Science, Houghton Street, London WC2A 2AE

¹⁹ Richardson, G. (1999) *Review of the Mental Health Act 1983. Report of the Expert Committee.* Department of Health; DoH/Home Office, *op.cit.*, n.14

²⁰ Department of Health (2000) *Shaping the New Mental Health Act: Key Messages from the Department of Health Research Programme.* London: Department of Health