d requires only 'special experience' as defined in the Act
e is not a nationally uniform process.

3 Section 12 approval courses:
a have specified requirements
b have recognised national standards
c were initially the responsibility of regional offices
d may include material unrelated to the use of mental health legislation
e are required to include a formal examination process.

MCQ answers

1	2	3
a T	a F	a T
b T	b T	b F
c T	c T	c T
d T	d T	d T
e T	e T	e F

INVITED COMMENTARY ON
Training for approval under Section 12(2). Ethics and implications of assessments

Now that training under Section 12 (Section 20 in Scotland) of the Mental Health Act 1983 is mandatory under the NHS Executive Guidelines HSG(96)3 (1996) both prior to and while maintaining approval, discussion of the educational objectives and how to achieve them is overdue. The article by Brown & Humphreys (2003, this issue) is a welcome introduction to the debate. Given that psychiatrists may move between different legal jurisdictions and that there is a constant stream of new and relevant case law (not to mention that we may soon have a new Mental Health Act), it is clearly important that training is about principles, issues and asking questions rather than a didactic teaching of facts. One must consider what are the relevant issues.

Section 12, Mental Health Act 1983

Section 12 relates only to the authority needed to make one of the medical recommendations to detain patients under the Mental Health Act 1983. If that doctor does not have previous knowledge of the patient, the other medical recommendation should, if practicable, be made by a doctor who does have. This is often interpreted, very reasonably, as meaning a psychiatrist (the specialist) and the patient's general practitioner (previous knowledge of the patient, the family and so on). The Mental Health Act Code of Practice suggests that if neither doctor has previous knowledge of the patient, then both should be approved under Section 12.

Psychiatrists do not need to be approved under Section 12 in order to be the responsible medical officer (RMO) for detained patients or to give evidence to Mental Health Review Tribunals. Since 1996, doctors providing after-care under Section 117 are required to be approved under Section 12, as are doctors acting as RMO for patients subject to Section 25 (Mental Health (Patients in the Community) Act 1995). It could be argued that Section 12 training should deal with issues only in relation to undertaking medical assessments under the Act and providing after-care.

Why, for so many years, was training not thought to be necessary? History, as ever, is instructive. The requirement for two medical recommendations prior to admission to a mental hospital was introduced in the 1890 Lunacy Act. Throughout the 19th century, there had been a vast increase in the number of detained patients who were paupers and this was thought by many people to be unjustified, in part because admission was arranged by relatives to remove their embarrassing kith and kin.

In 1845, James Luke Hansard had formed the Alleged Lunatic Friends' Society 'for the protection of the British subject from unjust confinement on the grounds of mental derangement'. The 1890 Act prevented all admissions to mental hospitals (apart from the Bethlem Royal) unless two doctors certified that the person was a lunatic and therefore could be detained, if others thought it appropriate.

This point is crucial. The role of the certifying doctors was not to say that the person *should* be detained in hospital but they *could* be if others thought it necessary. It is for this reason that doctors do not apply to have patients detained in hospital. The application is made by an approved social

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worker or nearest relative. The role of the doctor is to confirm that the person has a mental disorder, that it is of sufficient severity as to require intervention and that the intervention could not be provided outside hospital. These recommendations are identical to those which doctors make in all branches of medicine to appropriate patients. Section 5(2) of the Mental Health Act, which does give executive authority to a doctor to have a patient held in hospital, is available to doctors in all specialities.

The wording of Section 12 is instructive. It requires that the doctor should have 'special experience in the diagnosis or treatment of mental disorder', so that at least one of the doctors making a recommendation has particular expertise in this branch of medicine. It could be argued that only a minimal understanding of the law is required in order to fulfil these objectives. It may be suggested that, by pursuing a greater understanding of the law, doctors are in danger of moving from the role of recommending on the basis of medical expertise to wishing to take executive decisions in relation to detention. Evidence of this is apparent from the number of times that doctors complain that approved social workers (ASWs) 'turn down' medical decisions. The view is being expressed that the decision to detain has been made by the doctor, only to be thwarted by the ASW. (It is true that some doctors do not complete the forms correctly. Instruction in how to 'write full name' and 'delete as appropriate' should not be too difficult to arrange and could be undertaken by the medical scrutineer of the documentation.)

Responsibilities of a consultant psychiatrist

There is little doubt that consultant psychiatrists who have in-patients under their care require training in order to understand their legal responsibilities. There are specific responsibilities and powers that are only peripherally related to clinical expertise (for example in Sections 5, 7, 17, 18, 20, 21, 23, 25, 57, 58, 61, 62, 63 and 117 of the Mental Health Act), not to mention the abundance of case law. That training is necessary is self-evident although, curiously, it is not currently a requirement. This training is not necessary for general practitioners because they do not have detained patients under their care: they are not the RMO.

Perhaps the most urgent need is for doctors who undertake assessments under the MHA and those who act as RMOs to understand the implications of their decisions. Little attention is paid to the perceptions of either users or carers. How does it feel to be taken forcibly from your home and given medication against your wishes when you have done nothing wrong, on the grounds that someone else thinks it is necessary for your health? Or, having sought help and agreed to admission, to wish to leave because the ward is unpleasant, frightening and so poorly resourced that there are no therapeutic interventions available (other than medication which you could take at home). Or to be sectioned because of this change of mind?

I agree with Brown & Humphreys's suggestions but would put medical ethics and listening to patients high on the list of our educational needs.

Brown, N. & Humphreys, M. (2003) Training of doctors for approval under Section 12(2) of the Mental Health Act 1983. *Advances in Psychiatric Treatment*, **9**, 38–43.

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