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Declaration of interest

None.

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References

DEPARTMENT OF HEALTH (2001) *Research Governance Framework for Health and Social Care*. London: Department of Health.

FAULKNER, A. (2004) *The Ethics of Survivor Research: Guidelines for the Ethical Conduct of Research carried out by Mental Health Service Users and Survivors*. Bristol: Policy Press in association with Joseph Rowntree Foundation.

INVOLVE (2004) *Involving the Public in NHS, Public Health, and Social Care Research: Briefing Notes for Researchers* (2nd edn). Eastleigh: INVOLVE.

NORTHERN CENTRE FOR MENTAL HEALTH (2002) *Policy for Payment of Service Users and Carers*. Durham: Northern Centre for Mental Health.

TOWNEND, M. & BRAITHWAITE, T. (2002) Mental health research – the value of user involvement. *Journal of Mental Health*, **11**, 117–119.

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ANJUM BASHIR AND SHEILA TINTO

Misapplication of mental impairment under the Mental Health Act 1983

As Professor Eastman (2000) has noted: the law is fond of 'using' psychiatry for its own ends at times, but the Mental Health Act 1983 is an example of psychiatrists using the law as a tool of public policy. This makes their education in and interpretation of it all the more vital. The MRCPsych part II module 'Ethics and the Law' requires candidates to demonstrate knowledge of relevant mental health and human rights legislation, and to illustrate the appropriate application of such information (Royal College of Psychiatrists, 2001). We submit a masked case study that in practice seems to us a misinterpretation of the Act.

Case study

An adult patient was detained under Section 3 of the Mental Health Act 1983 (England and Wales) on the acute ward of his National Health Service (NHS) mental health trust's hospital. He was referred for out-of-area treatment to a brain injury rehabilitation unit, registered as an independent hospital in a neighbouring strategic health authority. This meant that his receiving responsible medical officer (RMO) would be authorised to renew his detention under Section 20 of the Act, but would not be able to act as a new examining doctor in the event of legal challenge, because of Section 12(5). The patient's classification was severe mental impairment. However, his only clinical signs were those of confusion and agitation after a brain injury acquired in adulthood. When this was put to the examining doctors and their legal advisors neither saw any defect and refused to reclassify or re-section him. On transfer, his new RMO reclassified him with mental illness under Section 16. When a Mental Health Act commissioner carried out a patient-focused visit to the independent hospital, she challenged not the problem but the remedy. The second hospital's legal department and specialist mental health law advisors gave conflicting views, but eventually agreed that: (a) the detention was potentially open to legal challenge; and (b) could not be rectified by reclassification.

The patient was informed he would be treated as having informal status pending the examination by two new Section 12-approved doctors. These agreed mental illness of the requisite nature or degree and another approved social worker detained him under Section 3. Since that referral, several others were received from around England, again with mental impairment or severe mental impairment classifications applied to patients acquiring brain injury in adulthood.

The problem

Impairments are losses or abnormalities of anatomical structure, or physiological or psychological function, according to the International Classification of Impairments, Disabilities and Handicaps (World Health Organization, 1980). Poor performance on tests of memory or coordination equate to impairments. They are not limited clinically to the 'mental retardation' pointers of ICD–10 (World Health Organization, 1992) or DSM–IV–TR (American Psychiatric Association, 2000), and mental retardation is not a diagnosis in itself.

In contrast, the 1983 Act defines mental impairment as arrested or incomplete development of mind, with impaired intelligence and social functioning. The *Mental Health Act Manual* (Jones, 2004) equates this with 'mental handicap' and says it excludes those whose handicap derives from accident, injury, illness occurring after the mind has reached full development (e.g. brain injury to an adult or senile dementia). The *Code of*

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Practice (Department of Health, 1999) indicates that no patient should be so classified under the Act without assessment by a consultant psychiatrist specialising in learning disabilities, and a formal psychological assessment. There seems to be precious little mileage in trying to put forward a clinical case that the central nervous system is not fully matured much before 25 years, or a legal one that the age of majority was 21 years when the original form of these terms was passed in 1959. Furthermore, besides referral to the mental health review tribunal there is greater scope for legal challenge at the High Court (for judicial review, habeas corpus, or an application under the Human Rights Act 1998). This became more pertinent when the Court of Appeal ruled in *R v. Ashworth HSH ex parte B* that treatment should only be for the particular classification of mental disorder. In the event the Law Lords (2005) reversed this decision. However, this dealt with a free hand to treat, not the lawfulness of detention itself.

One twist where the European Convention on Human Rights Article 5 might actually be invoked by the examining doctors as 'a procedure prescribed by law' is rectification within 14 days under Section 15. However, this would still mean that they originally sectioned the patient intending one classification, only to agree with the above challenges and change their minds. Section 15 is intended to give substance to what they meant to say in the first place, which is different. Jones (2004) remarks that this does not mean that a completed form which accurately reflects the factual situation can be altered to provide legal justification for detection.

Under Section 19 (2)(a), in the eyes of the law a transferred patient is deemed to have always been in the hospital where he is currently, so the hospital 'inherits' any unlawfulness or questionable authorisations. If we refuse to accept because a detention is 'challengeable', what happens to the patient's neurorehabilitation? Furthermore, this is a medical issue because, although the hospital managers detain the patient, the doctor must scrutinise the legal grounds and ensure compliance with Part IV of the Act (Department of Health, 1999).

Solutions

In many respects this is a problem peculiar to acquired brain injury, as doctors are not in the habit of classifying dementia patients with mental impairment or severe mental impairment. The NHS Health Advisory Service (1997) recommended mental illness as the more appropriate category for acquired brain injury. The Mental Health Act Commission (2003) agrees that adult brain injuries are generally excluded from the mental impairment categories, but that such injury may give rise to mental illness or psychopathic disorder without being either of these things in its own right. In practice, we know the overlap between mental illness (in the clinical sense) and brain injury can be all too real.

The Mental Health Bill abolishes the four treatment classifications and replaces them with a 'catch-all' new definition of mental disorder. Scotland will have its 2003 Act in force by the end of 2005, so we can expect a similar 2–3 year transition while this issue remains relevant. Meanwhile practitioners may wish to take advice on this scenario.

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A.B. and S.T. are both employed by Partnerships in Care Limited. A.B. is a member of the Royal College of Psychiatrists, the British Neuropsychiatry Association and is Section 12(2) approved. S.T. is a member of the Institute of Mental Health Act Practitioners (IMHAP).

References

AMERICAN PSYCHIATRIC ASSOCIATION (2000) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn, text revision) (DSM–IV–TR). Washington, DC: APA.

DEPARTMENT OF HEALTH (1999) *Code of Practice Mental Health Act 1983*, pp. 54, 64, 139. London: Stationery Office.

EASTMAN, N. (2000) Legal use of psychiatry and law as an instrument of psychiatric practice. In *New Oxford Textbook of Psychiatry* (eds M. Gelder, J. López-Ibor & N. Andreasen), p. 2098. Oxford: Oxford University Press.

JONES, R. (2004) *Mental Health Act Manual* (9th edn), pp. 16, 103. London: Sweet & Maxwell.

MENTAL HEALTH ACT COMMISSION (2003) *Placed among Strangers: Twenty Years of the Mental Health Act 1983 and Future Prospects for Psychiatric Compulsion*, p. 77. London: Stationery Office.

NATIONAL HEALTH SERVICE HEALTH ADVISORY SERVICE (1997) *Heading for Better Care: Commissioning and Providing Mental Health Services for People with Huntington's Disease, acquired Brian Injury and Early Onset Dementia*, p. 109. London: Stationery Office.

ROYAL COLLEGE OF PSYCHIATRISTS (2001) *Curriculum for Basic Specialist Training and the MRCPsych Examination* (Council Report CR95), p. 19. London: Royal College of Psychiatrists.

WORLD HEALTH ORGANIZATION (1980) *International Classification of Impairments, Disabilities and Handicaps*. Geneva: WHO.

WORLD HEALTH ORGANIZATION (1992) *The ICD–10 Classification of Mental and Behavioural Disorders*. Geneva: WHO.

R v. Ashworth HSH, ex parte B [2005] UKHL 20.

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