Detention – the grey area

Problems in the use of the Mental Health (Northern Ireland) Order 1986

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In September 1978 the Government published a review of the Mental Health Act (1959).[1] This review was prompted to a large degree by an increasing awareness of the rights of the mentally ill and by an awareness among psychiatrists of the limits of their management procedures. The proposals of this review were largely incorporated into the Mental Health Act (1983).[2] Among the proposals so incorporated was one that persons could not be detained in hospital against their will for assessment or treatment "by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs".

Northern Ireland is generally a few years behind England and Wales with regard to mental health legislation. It is felt that this is beneficial to the practice of psychiatry in Northern Ireland in that it allows psychiatrists there to learn from mistakes which may have been made in the legislation in England and Wales.

In mid-1986 the new Mental Health (NI) Order 1986[3] became law replacing the Mental Health Act (NI) 1961.[4] Similar to the new English Act, the Mental Health (NI) Order 1986 excluded as a reason for detention promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs. In addition, whether due to observations on the application of the English legislation or to the realisation by local psychiatrists of the difficulty in treating non-compliant personality disordered patients, people suffering from a personality disorder only were excluded from detention in hospital under the new legislation in Northern Ireland. However, people with the aforementioned problems can still, of course, be treated as voluntary patients whether in hospital or on an out-patient basis. In addition, there would be sufficient grounds to detain a person in hospital if they were suffering from a mental illness secondary to alcohol dependence, e.g. Korsakoff's psychosis, delirium tremens, etc.

Academic meeting

With the new Order still in its infancy psychiatrists, not unexpectedly, are encountering teething problems. One of these problems is trying to decide upon appropriate management plans for patients who, it is felt, fall into a grey area in the new legislation and where past experience of working with the old Act is no longer applicable.

Two patients who illustrate some of the problems encountered were presented to the weekly academic case conference at Purdysburn Hospital in October 1987. The firm which was involved in the care of these patients was uncertain of the legal grounds for detaining these patients and so the advice of colleagues was sought.

Case 1 Mrs AC, a 39 year old woman, who was separated from her husband, had been admitted as a voluntary patient three weeks previously. She presented with a five day history of alcohol abuse and associated promiscuity since her most recent discharge from hospital. Her only family was a married sister who did not wish to become too involved. She felt unable to help the patient whom she believed to be a danger to herself. The patient's early life was unremarkable. She was never a great coper and abused alcohol frequently. In 1977 the patient was accidently shot in the left side of the head while both she and her husband were intoxicated. She was not expected to live but survived after intensive care. Following rehabilitation she remained disabled with several deficits:

(i) mild right hemiplegia
(ii) marked expressive dysphasia
(iii) altered personality and behaviour
(iv) post traumatic epilepsy
(v) very poor short term memory
(vi) inability to tolerate alcohol.

In 1982 she separated from her husband and initially had care of her four children but it subsequently became apparent that she could not look after the children and the two youngest were taken into care. Since then she has been living on her own, abusing alcohol and engaging in promiscuous behaviour.

She was first admitted to Purdysburn Hospital in February 1987 after becomingly increasingly confused. This subsequently improved and was felt to be due to concussion. She required treatment for a gardnerella vaginalis infection. On discharge in April she was transferred to a general hospital for a tubal ligation. Despite attendance at a day hospital she required three further admissions to hospital due to inability to care for herself. She neglected to take her medication of phenytoin 300 mgm daily while drinking resulting in *grand mal* seizures. From her initial admission to October she remained in the community for less than three weeks. Due to lack of

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insight she was unwilling to accept any form of sheltered accommodation.

Case 2 Mrs ED, a 40 year old woman, who was separated from her husband, was admitted as a detained patient six weeks previously. She presented with a four day history of alcohol abuse since she had discharged herself from hospital against medical advice. From a professional family, her two brothers were unwilling to lend her any support, having been abused by her in the past. The patient had retired from her job as a teacher in 1984. She separated from her husband two years before this. He had custody of their six year old son. The patient had been admitted to Purdysburn Hospital on ten previous occasions since 1980. In addition, she was a frequent attender at the local day hospital. Despite this she had never managed to remain off alcohol for any period of great length. Prior to this admission she had been drinking excessively, refusing to eat. She was unkempt and dishevelled, abusive and aggressive to her neighbours. She slashed her wrists superficially and wandered naked in the street. She was continually telephoning the police and fire brigade and was considered a "nuisance" by them. She was a smoker and had caused a number of minor fires previously. Her neighbours were naturally concerned for their own safety as they lived in a terrace. On admission she walked with an abnormal gait due to long-standing peripheral neuropathy. She displayed circumstantial speech and elated mood. Her cognitive function was impaired with poor short-term memory. She was diagnosed as suffering from Korsakoff's psychosis. She was initially treated with parenteral vitamin injections and when she was presented to the academic case conference her cognitive function had improved considerably.

Comment

Concern had been expressed by services in the community about both these women due to their obvious inability to cope on their own. There was no dissension among those present at the meeting as regards the first woman. It was felt that she undoubtedly had organic brain disease and her inability to cope was secondary to this and not to her alcohol dependence. Therefore, under the new mental health legislation she could be detained in hospital compulsorily. However it was felt that placement in hospital was not the most suitable and a community placement might be more appropriate. Accordingly it was agreed that the social services should be asked to pursue a Guardianship Order. The guardian would be empowered to require the patient to reside at a specified place and to attend at specified places and times for medical treatment, occupation, education and training. Under a Guardianship Order a patient cannot be compelled to take medical treatment, although he/she must attend. However, in this particular case, there was no problem regarding consent to treatment.

The discussion was more lively regarding the second woman. It was agreed that this woman had improved because she was detained in hospital on the basis of her Korsakoff's psychosis. She was fortunate that her cognitive function was intact as in one reported series of patients with Korsakoff's psychosis only one in four recovered full cognitive function.[5] It was felt further improvement, especially regarding her peripheral neuropathy, could be expected if she remained longer in hospital. It was argued that mentally ill patients can be detained in hospital if their judgement is so affected that they are unable to protect themselves against serious physical harm. Others present pointed out that she no longer suffered from a mental illness and so could not be detained in hospital. It was also argued that due to alcoholic brain damage the patient's judgement was indeed affected and she was committing slow suicide. This was not, however, generally accepted and the consensus reached was that under the new legislation this patient should not be detained in hospital.

Current situation

Mrs AC continues to reside in hospital. She presents no management problem whatsoever. At present a Guardianship Order is being sought and it is hoped that she will be more appropriately placed in sheltered accommodation in the community soon.

Mrs ED was regraded to voluntary status and took her discharge from hospital the same day, stopping on her way home to buy some alcohol. She continues to drink heavily, is a constant nuisance to her neighbours and a potential fire hazard. The local constabulary seem unwilling or, like the medical profession, unable to act. It seems likely that she will die by her own actions in the near future. One can only hope that no innocent neighbours are unfortunate enough to be harmed by her actions.

Acknowledgement

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References

[1]Review of the Mental Health Act 1959 (1978). London: HMSO.
[2]Mental Health Act 1983. London: HMSO.
[3]Mental Health (NI) Order 1986. London: HMSO.
[4]Mental Health Act (NI) 1961. London: HMSO.
[5]Victor, M., Adams, R. D. & Collins, G. H. (1971) *The Wernicke-Korsakoff Syndrome*. Oxford: Blackwell Scientific.