Correspondence

Medically, yes. Legally, no.

DEAR SIRS

The law is sometimes an ass. No doubt this applies all over the world. I shall refer to one aspect of mental health legislation in New South Wales for two reasons: firstly, those who are considering how to improve their own legislation may like to know of difficulties that have arisen elsewhere, and make sure they avoid them. Secondly, comment from overseas may goad the New South Wales Government to deal urgently with a situation that causes considerable unhappiness and frustration.

As in Britain, there has been reform of mental health legislation in a majority of Australia's six States and two Territories in the last decade.[1] Each has its own Mental Health Act (or Ordinance). In New South Wales, the new legislation was enacted in 1983, but large parts of this have not yet been proclaimed.

According to the Mental Health Act 1958:

> " 'mentally ill person' means a person who owing to mental illness requires care, treatment or control for his own good or in the public interest and is for the time being incapable of managing himself or his affairs and 'mentally ill' has a corresponding meaning."

The relevant section of the 1983 Act (not yet proclaimed) replaces 'for his own good and in the public interest', with 'for his own protection' and 'for the protection of others', both being defined at length. It deletes the phrase about incapacity to manage himself or his affairs, it includes a number of exclusionary clauses (e.g. in relation to particular political or religious opinion, sexual preference, developmental disability and the taking of drugs), and it states that the serious and permanent physiological, biochemical and psychological effects of drug-taking may be regarded as indications that the person is mentally ill.

In 1982, Mr Justice Powell determined that dementia is not a mental illness. "That this should be so", he said, "is due to the fact that, despite the emotive overtones which it appears to have acquired in common parlance, the word 'dementia' denotes, not a condition attended by hallucinations or delusions such as are not uncommon in cases of schizophrenia, or by strong and irrational antipathies or fears such as are not uncommon in cases of psychosis, but, rather, a condition evidencing deterioration in, or loss of, the intellectual faculties, which condition is commonly attended by confusion and disorientation reflecting loss of memory."

In November 1986 the same judge found a man with Alzheimer's disease (with severe loss of recent memory, significant loss of medium and long-term memory, language disturbance, impaired recognition of persons, impaired control of aggression and marked disturbances of judgement) to be

> "not 'a mentally ill person' for the purposes of the Mental Health Act 1958 and, thus, that he is entitled to an order for his discharge from the Hospital."

The underlining was the judge's. He went on to say that the man was, in medical terms, 'mentally ill', and in need of treatment. He implied that a person with dementia who also had hallucinations, delusions or other psychotic symptoms could be regarded in legal terms as mentally ill; this man could not. He suggested he be readmitted to a nursing home.

In the course of his judgment, His Honour pointed out the distinction drawn in the 1958 Act between a person who is 'mentally ill' and one who 'is, through mental infirmity, arising from disease or age, incapable of managing his affairs'. The 1983 Act does not have that distinction, and it may be that when it is proclaimed, magistrates will no longer find it their duty to uphold such a distinction.

Magistrates have been criticised for applying the 1958 definition in a very broad fashion, continuing to make orders in respect of patients with dementia.[2] Meanwhile, impossible situations continue to arise. Relatives and GPs find it impossible to arrange admission to psychiatric hospitals of behaviourally disturbed persons with severe dementia. There is no legal way of forcing them into any facility providing care. They must be discharged from hospital; their financial affairs can be protected, but at present there is no provision for detaining or moving them anywhere against their will.

Quite commonly I see very demented people in nursing homes trying to get out. They are detained against their will. Many nursing homes are architecturally unsuitable for good care of restless, severely cognitively impaired individuals. Sometimes (because fire regulations dictate that doors must not be locked) these patients are physically or chemically restrained; a Government document on standards for Australian nursing homes (1987) allows for restriction of freedom of movement where the safety of a resident or others is at risk. Such people are not under a legal order and no appropriate legal order can be obtained at present. It is hoped that relevant guardianship legislation will be introduced shortly. Thankfully, nursing homes are not being taken to court for unlawfully imprisoning persons with dementia.

In the unproclaimed 1983 definition (see above) it is clear that dementia due to drug-taking is to be considered a mental illness. Will this mean an eventual change of view in regard to the other dementias? No doubt there will be a test-case or two, once the rest of the 1983 Act has been proclaimed. While waiting for that or for guardianship to allow us to do what is best for such people (and it may be years away), what can I do for Mr N, who is markedly demented

and aggressive and who (we and Mrs N believe) should remain in hospital? He refuses medication (but is given some). The magistrate has adjourned the hearing for two months, rather than make an order for his immediate discharge. Mr N is one of many.

Incidentally, Mr Justice Powell also determined in 1986 that anorexia nervosa and alcoholism are not mental illnesses.

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REFERENCES

[1]SNOWDON, J. (1983) Alternative proposals for reform of mental health legislation in Australia. *Medical Journal of Australia*, 471–474.

[2]WALLACH, I. (1986) Mental health advocacy in New South Wales. In unpublished proceedings of *Seminar: Medical and Legal Aspects of Current Mental Health Legislation*. Institute of Criminology, University of Sydney.

Medico-legal responsibilities of hospital managers

DEAR SIRS

I wish to write in support of the views expressed by Dr Evans (*Bulletin*, September 1987, **11**, 312) relating to the precipitous closure of one of the wards in an old mental illness hospital well-known in the Mersey Region. I would like to expand on the issues regarding the new Griffiths style of management and the related medico-legal consequences which I foresee.

Firstly, it is bad management practice to have to 'sneak' through such a ward closure without prior consultation. From the manager's point of view this may solve the immediate problem of progressing towards a goal of bed run-down as part of a regional strategy but the long-term effects on the confidence of members of the multi-disciplinary team and their future co-operation do not seem to have been carefully considered. Such a blinkered approach seems to be all too common from my limited contact with the new managerial style where the short-term solutions to such complicated problems are all too readily used. Part of this may be related to the fixed-term nature of such managerial contracts so that a longer term view is seldom taken of their management decisions.

There seems to be a new trend of imposed managerial solutions which often have deleterious clinical consequences for the health professionals who have to pick up the pieces afterwards. Yet I wonder if the managers have ever given careful consideration to their own medico-legal position? In the above scenario a patient could easily have attempted suicide, become seriously behaviourally disturbed or have had a relapse of his treated mental disorder—the decision for ward closure was not taken by the Responsible Medical Officer and would probably have been against his wishes. The Unit General Manager has implicitly taken over this responsibility by taking this decision into his own hands. This responsibility must surely also entail medico-legal responsibility should a claim for compensation be made by one of the patients concerned or his relatives (as the medical practitioner concerned was not involved in the ward closure).

From my own experience I have come across a situation where a ward was seriously under-staffed and numerous representations by the discipline concerned fell on deaf managerial ears. In another situation a telephone system was not just inadequate but dangerous as no emergency line was continuously available. A member of staff became seriously ill in this hospital (with no emergency medical facilities on site) and we were unable to get a line out for an emergency ambulance. Repeated representations to management produced no remedy to the situation. At this time I contacted the Medical Defence Union for advice. I was told that if the medical staff feel staffing level, resources or other working conditions are inadequate for good practice and repeated representations have been made to management, the medico-legal responsibility then rests with the managers for any resultant catastrophe. Such claims are very expensive to settle, and I wonder what effects these would have on any "savings" made. Perhaps a few such medico-legal encounters would exercise the minds (and consultation skills) of management most wonderfully!

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Discharge of long-stay psychiatric patients

DEAR SIRS

I read with interest the letter by Dr M. Evans (*Bulletin*, September 1987) regarding the effects of transferring long-stay psychiatric patients between wards. Although often a routine procedure, such transfers are inadequately studied. Shugar, Smith *et al* in Toronto[1] interviewed both patients and their relatives after such a ward relocation. They found substantial dissatisfaction: they especially complained that they had not had an adequate opportunity to influence the transfer decision.

Equally pertinent in the era of de-institutionalisation is the process of transfer from hospital. Abrahamson[2] interviewed 60 patients at Goodmayes Hospital and found that they were equally divided between those wanting to remain in hospital, wanting to leave, and being undecided or unrealistic.

In part this may be attributable to inadequate information about hospital closure plans and alternative forms of accommodation. In a study of long-stay in-patients I am conducting at Cane Hill Hospital in Surrey, 75% did not report knowing of any plans to change their accommodation, and 55% expressed the desire to remain in hospital indefinitely. It is possible to view this reluctance of patients to leave hospital as, at least in part, a realistic judgement that unless and until community-based facilities are adequately provided, remaining in hospital may be preferable. The reports of patients who have been discharged without