6 The psychiatric patient and the law

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In a typical day most general practitioners will assess and treat patients presenting with psychological symptoms and psychiatric illness. In fact New Zealand studies show that up to 30 percent of patients present with such symptoms as a result of a primary psychiatric disorder or secondary to a physical problem. Most present seeking help. Some don't and assessment and treatment may need to be mandated under mental health legislation (Mental Health [Compulsory Assessment and Treatment] Act 1992 – MHA). This chapter defines and discusses mental disorder and practical aspects of using the Act. Other forensic terms are briefly discussed as in giving evidence in court.

The World Health Organisation (WHO) estimates that one in five persons will present with a mental disorder over their life time. Many presentations will be dealt with in a social context (e.g. counselling by a priest), never coming to medical notice. Most of those who do present to medical services will be assessed and treated by a primary practitioner (e.g. general practitioner). Up to three percent will be referred to secondary (or psychiatric) services.

Mentally ill persons are vulnerable because of their impaired judgment and autonomy and because of their capacity to harm themselves, harm others or to be unable to ensure self care. The MHA protects the mentally disordered person, ensures assessment and treatment and upholds their rights.

Other protective legislation includes

- Protection of Personal and Property Rights Act 1988
- The New Zealand Bill of Rights Act 1990
- Alcohol and Drug Addiction Act 1966
- Children, Young Persons and their Families Act 1993

The Mental Health (Compulsory Assessment and Treatment) Act 1992

The Act

- Defines mental disorder in terms of mental abnormalities rather than social deviance
- requires a range of clinicians to be involved who must respect a person's cultural beliefs, and
- has certain time limits, appeals and oversight provisions to ensure that it is properly applied and that the person's rights are properly respected.

The definition of mental disorder

This is given in sections 2 and 4 of the Act;

Mental disorder in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature) characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it

a. poses a serious risk of danger to the health or safety of that person or of others; or

b. seriously diminishes the capacity of that person to take care of himself or herself.

Section 4 states that

The procedures prescribed in Parts I and II of this Act shall not be invoked in respect of any person by reason only of

a. that person's political, religious or cultural beliefs; or
b. that person's sexual preferences; or
c. that person's criminal or delinquent behaviour; or
d. substance abuse; or
e. intellectual handicap.

Abnormal state of mind

This refers to a qualitatively different presentation, distinct from people of similar cultural or religious backgrounds.

Continuous or intermittent

Most mental illnesses and disorders follow a fluctuating course. This is why taking both the "cross sectional" and the "longitudinal" histories are important from both the patient and from their care givers. Therapy or treatment has two aims; firstly to get well, second to stay well. Sometimes it is important to invoke the protection of the Act in order to prevent deterioration.

Delusions

These are defined as fixed false beliefs out of keeping with the culture or religious beliefs of a similar person

Disorder of mood
Mood is a pervasive and sustained feeling state. It can be "low" as in depression, or "high", as in hypomania. True depression or hypomania comprise mood states that affect world view, judgment and ability to function adaptively. Abnormal mood states can occur secondarily to other illnesses such as personality disorder and schizophrenia.

Disorder of perception
This includes hallucinations and usually occurs in the psychotic illness.

Disorder of volition
Volition is a reference to "will" and may be seen in depressive-stupor, catatonia, disinhibited states or in the "frontal lobe syndrome" following a head injury.

Disorder of cognition
Cognition refers to the process of thinking. The disorder covers the disordered thoughts of psychotic disorders (such as the disorder of thought form), the increased rate of thoughts in mania and the slowed process of thoughts as seen in depression.

Severity or threshold criteria, "to such a degree that…"
Persons can only be committed under the Act if their disorder is so severe that it endangers themselves, others or seriously impairs their ability for self care. Assessment of risk must encompass the following points
- the nature and magnitude of the harm
- its imminence
- its frequency
- circumstances and conditions that increase the likelihood of harm
- balancing the alleged harm on one hand and the removal of an individual's autonomy on the other.

Section 4 exclusion criteria
Compulsory assessment and treatment should only be applied to those with major mental disturbance, not to those with a disagreement with the state or those whom we dislike or disagree. Those who have a conflict with the state can be dealt with under the provisions of the Criminal Justice Act 1985 (CJA).

Procedures for civil commitment

Compulsory assessment is initiated by a request from a member of the public (usually a family member) and certification by a medical practitioner under Section 8 of the Act. These certificates are given to a Duly Authorised Officer (DAO), usually a nurse employed by the local mental health service. The DAO determines the grounds for further assessment and arranges that, informing the patient (by section 9). A psychiatrist (or a training registrar) will complete the assessment (section 10) thereby stating that there are grounds for suspecting that

the person may be mentally disordered (or the contrary). If the assessment is that the person may be mentally disordered, a period of five day compulsory assessment begins. This is usually in a mental health inpatient unit but could be in the community. The patient's assessment and treatment fall under the responsibility of a Responsible Clinician (RC), usually a psychiatrist. Before the end of five days a patient can be released, or following the initial assessment, a further 14 day period of assessment can begin (section 12). At the end of this period the patient must be released or an application made for a Compulsory Treatment Order (CTO). This order is made by a Family Court judge at a hearing arranged for the purpose. The judge must determine whether or not the person is mentally disordered, if an order is necessary, and what type of order should be made (i.e. to the community or to an inpatient unit). A CTO is usually of 6 months duration and patients must be regularly reviewed by their RC and by a District Inspector (DI), a lawyer appointed by the Minister of Health. Patients can appeal their compulsory detention (to the High Court) or to the Mental Health Review Tribunal (MHRT).

All services under the Act are the responsibility of the Director of Area Mental Health Services (DAMHS), often the same clinician as the Director of Clinical Services.

Issues in civil commitment

Under a CTO a patient is obliged to take their medication. They can request a second opinion from a psychiatrist of their choice.

The viewpoint of the family and other carers is important and the Act now mandates consultation with the "family" unless there is good clinical reason not to do so or it is not practicable.

Known risk to others

Ordinarily the doctor patient relationship would prevent disclosure of confidential information to a third party. However if there is a known, serious and imminent risk to a third party, doctors have a common law and ethical responsibility (see disclosure, chapter 13) to warn them of such a risk and take appropriate action. This may mean invoking the powers of the mental health act. When in doubt you should discuss with a colleague, with your medical defence organisation or with the local DAMHS.

Guardianship Order (Protection of Personal and Property Rights Act 1988: PPPR Act)

This provides for those whose competence is impaired to make certain decisions about their health welfare and property. It can be invoked in respect of persons who *lack, wholly or partly, the capacity to understand the nature, and to foresee the consequences of, decisions in respect of matters relating to (his or her) personal care and welfare* (section 6(1)(a). It provides for the least restrictive orders necessary to address the issues of care and welfare. It can apply to the mentally disordered but more commonly is applies to the care and welfare of the

intellectually disabled and/or to those with acquired cognitive impairment (as in head injuries or dementia). Application of this Act involves the appointment of a "welfare guardian".

Criminal matters

For those persons before the court for any matter, provision is made in law for their assessment to assess

- fitness to stand trial
- mental status at the time of committal of the alleged crime ("insanity defence")
- matters concerning sentencing and disposal.

These provisions are found in section 38 and associated sections of the Criminal Procedures (Mentally Impaired Persons) Act 2003 (CP (MIP) Act 2003.

Disability

Natural justice demands that a person understand what he/she is charged with, know the plea options and their consequences, understand the legal process and be able to work with a lawyer in order to defend him or herself. Being unfit to stand trial (or being "under disability") is defined in section 38 of the CP (MIP) Act 2003.

Insanity

This defence is defined in section 23 of the Crimes Act and concerns those who *when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable*

(i) *Of understanding the nature and quality of the act or omission; or*

(ii) *Of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.*

The term applies only to the period immediately surrounding the period of commission of the crime.

Less than ten people a year are acquitted on the grounds of insanity. Unless agreed by both the Crown and the defence, the jury must hear all the evidence, including the testimony of defence and crown psychiatrists, and be satisfied on the balance of probability that the defendant was not only mentally ill at the time but either didn't know what he/she was doing, or didn't know their actions were morally wrong.

Special patients

There are four categories of special patient

- short term remandees (section 38 CP (MIP) Act 2003)
- remand and sentenced prisoners who require assessment and treatment in hospital (section 45 and 46 MHA)
- those who are under disability (section 24 CP (MIP) Act 2003
- those who juries assess as "not guilty by reason of insanity" (section 24 CP (MIP) Act 2003.

The statute governing their leaves, reviews and release to the community are rigorous and set down in Part IV MHA.

Medical practitioners and testimony in court

There are three types of witness

- witness to fact (when the witness sees or hears something relevant to the case)
- the clinical witness who becomes involved by virtue of the doctor/patient involvement
- the expert who has special knowledge and experience in a defined area (see chapter 16).
- If you are asked to be a witness in court you need to know why, how your testimony will be used and what procedure is required (i.e. will you need to supply a report?). If your relationship with the patient may be compromised you are best to request a subpoena. This makes your obligations (to the court and to the patient) clear. You are also strongly advised to discuss the issue with your medical defence organisation.
- The medical witness is in court for two reasons.
- to assist the court to come to a sound decision
- to explain complex issues.
- It is important to
- be clear why you are there as a witness. Request written instructions
- prepare carefully; have your notes; be able to define the words you use.
- know that you don't have to "take sides". You are not on trial. Nor do you have to prove anything. You are there to assist the jury.
- Be relaxed and nondefensive. Don't give your opinion beyond your expertise. If you don't know, say so. Use plain words.

References

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2. Bell S, Brookbanks W. *Mental Health Law in New Zealand*. Brookers, Wellington 1998. Ministry of Health website www.moh.govt.nz..