----------Introduction Concepts----------

Community Treatment Powers under NZ's MHA

- A duty placed on the patient to accept community treatment: authorising it to be provided
- Patient to accept visits and attend appointments
- To live in a certain kind (or level) of accommodation
- A power of entry: at certain times, for certain purposes
- Swift recall to hospital, without re-certification
- Police assistance to health professionals, on request
- Treatment without consent in a hospital or clinic
- No 'forced medication' in the community

(= many community powers and even more powers in the hospital setting, it clearly affects many basic human rights)

Human Rights implicated by compulsory treatment under MHA

Rights:

- To liberty, autonomy, self-determination (the 'right to be left alone')
- To bodily and psychological security (the 'right to refuse treatment')
- To freedom of movement and association
- To personal privacy

Clear legal sources of authority or justification are therefore required, for intervention to be lawful

Two concepts of liberty…

1. 'Negative' liberty = the right to be 'left alone'
2. 'Positive' liberty = to have capacity for 'self-governance', to 'be moved by reasons not causes', to be able to maintain meaningful relationships of one's choice

What other parties would have an interest in the patient's treatment?

Family/whanau/friends, Mental health professionals, in dhbs, Especially psychiatrists and psychiatric nurse, Supported accommodation providers (ngos), The police, Prison staff, Family court and criminal courts, Mental health review tribunal, Lawyers, including district inspectors

Some sources of legal authority or justification for intervention…

1. Legislation
   - MHA
   - Criminal Procedure (Mentally Impaired Persons) Act 2003
   - Protection of Personal and Property Rights (PPPR) Act 1988 - adult guardianship
2. Common law
   - Justifications/ defences - to crime and tort
   - Especially, the doctrine of 'necessity'
   - Recognised by the courts as justifications

Some Notes on Community Treatment Orders in NZ

- Legal criteria for order to be made:
  - 'Mentally disordered' in the necessary, statutory sense
  - 'Can be treated adequately as an outpatient'
  - 'Appropriate treatment is available'
  - 'Social circumstances in the community would be adequate'
  - The order is 'necessary'
- Two routes of entry:
  - By order of a judge; or
  - By transfer from In-Patient Order, at the responsible clinician's discretion
- The patient 'shall attend for treatment' by a 'specified service' and 'shall accept' that treatment. There is no express power to 'restrain and medicate' the patient in a community setting.
- There is a power of entry into patient's residence 'at all reasonable times', for the purposes of treatment.
- If the patient refuses to attend for treatment they may be apprehended by community mental health professionals, taken to hospital or a supervised clinic, and medicated there without consent.
- Police assistance with that process is available if required.
- The patient can be recalled to hospital by their responsible clinician.
- Up to 14 days in-patient treatment is then authorised; followed by compulsory re-assessment, if required. If inpatient care continues beyond that date the patient is seen by a judge and an Inpatient Order may be made.
- Duration of the CTO: 6 months, then a further 6 months, then indefinite, subject to a regular right of appeal to a tribunal for discharge from the order.
- Legal representation is available, and inquiries into any breach of rights may be made by a District Inspector (a lawyer with special investigatory powers under the Act).

----------Defining Mental Disorder----------

*forensic route to commitment = occurs through the criminal process
*special patients = directed into the MHA as quasi-criminal patients, they are very restricted

NZ's civil commitment process under the MHA…

- Application for a person's compulsory psychiatric assessment (by someone who is over 18)
- 1 medical certificate completed (by doctor or nurse specialist)
- (Apprehension and transportation to assessment)
- Compulsory psychiatric assessment examination
- Second medical certificate (by psychiatrist, if available)
- 1 month's compulsory assessment & treatment (5, 14, 14 days - at the end of each of these days, a qualified medical professional is appointed as your responsible clinician who is personally responsible to direct your treatment and carry out certificates to confirm the patient is still mentally disorders)
- Hearing before Family or District Court - to decide whether the patient clearly meets the requirement of being mentally disordered
- Compulsory Treatment Order (6 months, renewable) - people can go under the Act for any amount of time (i.e. 2 hours or 30 years)
- Formal clinical review after 3 months
- Right of appeal to Mental Health Review Tribunal
- Discharge required: when *'no longer mentally disordered'.* - this test exists throughout your care

'Mental disorder' = an abnormal state of mind; of a continuous or intermittent nature; characterised by [one of the listed disorders of mental function]; that is of such a degree that it poses (the nexus); one or more of the five listed serious consequences under (a) and (b) (sometimes called the 'severity', 'consequential', or 'dangerousness' criteria).

- This is a legal definition drawn partly in the language of psychiatric symptoms.
- The definition is qualified at some points in the civil commitment process by the addition of further words or phrases: e.g., 'reasonable grounds to believe' a person 'may be' mentally disordered are sufficient during the compulsory assessment period. In addition, the definition should be read in light of section 4's exclusionary rules.

Basic criteria for civil commitment under the MHA in New Zealand:

(2) '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 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's Exclusionary Rules - No person shall be committed under s4 'by reason only of' -

- Political, religious or cultural beliefs; or
- Sexual preferences; or
- Criminal or delinquent behavior; or
- Substance abuse; or
- Intellectual disability.

The 'abnormal mental state' criteria

'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 poses ….[one of the listed consequences]

NZ's Mental Health Review Tribunal said, in *Re IM* [2002] NZMHRT 57/00 at [68], that…

Specialised terms, like 'delusions' and 'disorder of mood' and 'perception' in the MHA should be given:

- "a specialised meaning which has evolved over 200 years of psychiatric and psychological scholarship.
- "These meanings cannot be cast aside and nor can psychiatrists be required to cast aside their own understanding of these terms because it might be inconvenient due to the circumstances … of a specific and unique case."

<u>Some ways in which psychiatrists classify 'mental disorders'</u>

- Major groupings of disorders of a similar kind:
  - E.g., mental illnesses, intellectual disabilities, substance abuse disorders, eating disorders, personality disorders
- Particular diagnoses:
  - E.g., schizophrenia, bipolar disorder, anorexia nervosa
  - disorder of mental function plus characteristic behavior with a certain time course
- Disorders of particular mental functions:
  - E.g., disorders of mood, perception, thought, motivation
- Specific symptoms:
  - E.g., 'despair', 'TV talking to him', 'flight of ideas'

The legal criteria includes specific kinds of psychiatric terminology, not groupings or diagnosis's, only includes characteristics of particular mental functions. This may be due to the emergency situations of committing someone, there may not be time to diagnose that person. This also allows a division between the criminal and mental health system, i.e. they need to be experiencing these particular characteristics that defines mental disorder.

The psychiatric evidence in *KMD's* case

How does the psychiatric evidence relate to the listed characteristics of an 'abnormal state of mind' in the statutory definition of 'mental disorder'?

<u>The psychiatrist's evidence for KMD</u>

- *KMD is 54 years old. He has been given a diagnosis of bipolar disorder and his current medication is haloperidol decanoate 75 mg every two weeks (by injection).*
- *30 years ago, when he was 24, KMD suffered major head injuries in a car accident. He 'experienced a psychotic reaction with religious themes when wakening from a lengthy coma'. The initial diagnosis was schizophrenia.*
- *KMD has since undergone a long history of admissions to hospital for psychiatric treatment, including several compulsory admissions under the Mental Health Act. Some admissions have lasted several months. But he was not admitted to hospital between 1985 and 2003 (ie, for a period of 18 years), during which time he got married. However, he separated from his wife in 1999.*

- *More recently, while on a general hospital ward after total hip replacement surgery, he was found to be 'exhibiting manic features, pressured speech, disinhibition, religiosity and grandiosity'. He also 'appeared to be responding to auditory hallucinations'. These were symptoms of a 'manic relapse'.*
- *KMD has shown 'poor compliance' with psychiatric treatment. His condition meets the definition of an 'abnormal state of mind'.*

Does the evidence show that KMD has:

"an abnormal state of mind (whether of a continuous or an intermittent nature), characterized by delusions, or by disorders of mood or perception or volition or cognition"?

Particular diagnoses:

- *'schizophrenia', 'bipolar disorder', 'head injury'*

Disorder of particular mental functions:

- *??? delusions, mood, perception, cognition ???*

Specific symptoms:

- *'manic relapse', 'pressured speech', 'disinhibition',*
- *'religiosity', 'grandiosity', 'auditory hallucinations'*

From this we can see the course of his disorder, a decline in social relationships, delusions, disorder of mood and a strained perception of reality, indicating that it likely suffices the first limb.

Basic criteria for compulsory psychiatric treatment under the MHA

'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 –

- Poses a serious danger to the health or safety of that person or of others; or
- Seriously diminishes the capacity of that person to take care of himself or herself.

*Abnormal state of mind is the first limb. It can be continuous or intermittent. And is specifically characterised…

KMD - psychiatrist in court gave a full background of the patient, possible causes of the disorder etc. they relate his past treatment and medications, his attitudes towards such treatment… they also touch on the social issues faced by KMD. They also say what harms might be suffered by *not* placing him under the Act - are these sufficiently severe consequences to meet the requirements of the second limb?

*terms used in the Act are not used by the psychiatrist here - so it must be determined whether this evidence actually fits the criteria. <u>They end up concluding that this does in fact relate to the descriptions in the Act.</u>

It is the task of the tribunal to *relate* the specific evidence they get to the definitions in the Act of the first limb.

Background to this classification of 'abnormal mental state'…

It is a difficult task to *objectively* identify *subjective* mental states…

This is *one* way in which psychiatry can break up the different aspects of mental state:

Psychiatric classification of disorders of particular mental functions (or mental states). **Disorders of:**

- Thought
  - delusions
  - thought processes [cognition]
- Perception
  - hallucinations
- mood (or affect)
  - elevated (manic)
  - depressed, anxious
- motivation (will, impulse, volition) - this aspect is controversial in NZ (brings the Q in of the difference between 'irresistible impulses and impulses not resisted')

Aubrey Lewis, in 'Health as a social concept', (1953) 4 Brit J Sociology 109

Mental illness is best defined in terms of:

"… evident disturbance of part-functions" of the mind, not in terms of disturbed social functioning alone.
"For illness to be inferred disorder of function must be detectable at a discrete or differentiated level."
"If non-conformity can be detected only in total behaviour, while all the particular psychological functions seem unimpaired, *health* will be presumed, not illness."

This is an attempt to distinguish actual disorders of the mind, from simply disorder behaviour
We follow this definition in NZ in the Act…

Aubrey Lewis… Defines: Disturbance of part-function of the mind:

- "is shown by the occurrence of, say, disturbed thinking, as in delusions, or disturbed perceptions, as in hallucinations, or disturbed emotional state, as in anxiety … or melancholia.
- "Deviant behaviour is pathological if [and only if] it is accompanied by a manifest disturbance of some such functions."

INTERNATIONAL APPROACHES…

Mental Health Act 2007 (NSW), section 4

'Mentally ill' means:
a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
(a) delusions
(b) hallucinations
(c) serious disorder of thought form
(d) a severe disturbance of mood
(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).

*Similar approach to NZ in NSW (perhaps a 'purer' approach)

Mental Health Act 1983 (UK)

As originally enacted in 1983: 'mental disorder' means:

- mental illness
- mental handicap
- severe mental handicap
- psychopathic disorder

As amended in 2007:
'mental disorder' means: 'any disorder or disability of the mind'

*UK doesn't define mental illness like we do… very broad, no guidance given (they don't require much justification to place someone under the Act - would also lead to more appeals of decisions)

<u>An Exercise: *Re FAH* (1999) NZFLR 615 (MHRT)</u>

Question: Does the evidence show that FAH has: 'An abnormal state of mind (whether of a continuous or an intermittent nature), characterised by… disorders	Evidence of the Responsible Clinician, Dr Norman, a clinical psychologist: - *FAH suffered from anorexia nervosa and bulimia, and engaged in periodic acts of serious self-harm* - *Her career as a teacher had been interrupted by her illness* - *Her capacity to think sometimes became seriously impaired due to cognitive distortions, associated with electrolytic imbalances in her body caused by her diet* - *These distortions were shown by FAH wanting to leave the hospital, even though she was so weak she was physically incapable of getting off her bed; and by her saying she wanted to remain alive, while proceeding to commit an act of serious self-harm, on the same day* - *FAH also presented a disorder of volition because her acts of self-harm arose out of an 'irresistible impulse', not just 'an impulse not resisted'. There was volitional impairment of such a degree that 'it overrides her capacity to make conscious decisions'.* FAH, applying for release from compulsion under the MHA, said: - She was always aware of her decision-making, and made conscious choices concerning her body - She had a right to make whatever choices she thought fit, including taking risks that put her life in danger

of … volition or cognition?'	- She was capable of making appropriate decisions, and could think logically and make rational decisions about her health and wellbeing - At no time were her thought processes other than fully rational. But: did FAH still present a disorder of **cognition** or **volition**? Although she is putting her body and life at risk, so do other people when they do dangerous activities. She can be involved in a rational conversation, although, they are clear chemical imbalances that lead her to have distortions in her thinking - are these to the point of a cognitive disorder? My thoughts… • Cognition = unable to understand her current state, leading her to think she could go home despite being physically incapable of doing so. • Volition = wanting to self-harm whilst also wanting to stay alive, i.e. it was an irresistible impulse demonstrating that she lacked volition to promote her own interests of staying alive. The Tribunal considered: **'In many respects [FAH's] thinking is unimpaired'.** • They decided that she did have a disorder of cognition • They concluded that it was a volitional disorder as she could not control impulses • Purposes of the MHA, i.e. saving someone's life, it is decided here that it is worth it. Second limb… is satisfied here, as her volition is impaired putting herself in danger, additionally, the way she is eating is also dangerous so that may have satisfied the second limb on its' own. **Robert Kendell, The Role of Diagnosis in Psychiatry (Blackwell, Oxford, 1975)** **A diagnosis is**: 'a cluster of symptoms with a characteristic time course': E.g., specific disorders of mental function plus a certain decline in social or occupational activity over a certain course of time **FAH* - she was previously a teacher and has lost her job as a result, shows a clear decline in occupational activity. i.e. a definite decline over a course.

Diagnostic Criteria for Schizophrenia: Summarised

- *Characteristic symptoms*
  - *Two (or more) of the following, each present for a significant time during a one month period:*
    - *delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour, or negative symptoms*
- *Significant decline in occupational or social functioning*
- *Duration: continuous signs of the disturbance for at least six months (unless successfully treated), including at least one month of the symptoms in A.*
- *Schizoaffective disorder and mood disorder with psychotic features have been ruled out.*
- *Not the direct effect of substance misuse or a general medical condition.*

Some diagnostic categories in DSM-V (the WHO manual defines disorders…)

- Premenstrual Dysphoric Disorder
- Separation Anxiety Disorder
- Social Anxiety Disorder (Social Phobia)
- Hoarding Disorder
- Insomnia Disorder
- Caffeine Withdrawal
- Cannabis Use Disorder
- Alcohol Use Disorder
- Tobacco Use Disorder

*these are classified as mental disorders that can be reimbursed for and recognised, but are they mental disorders requiring compulsory treatment?

Cautionary Statement for Forensic Use of DSM-5
https://doi.org/10.1176/appi.books.9780890425596.CautionaryStatement

- "… it is important to note that the definition of mental disorder included in **DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals**.
- "… DSM-5 may facilitate legal decision makers' understanding of the relevant characteristics of mental disorders, [but] … there is a risk that diagnostic information will be misused or misunderstood … because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis.
- "In most situations, the clinical diagnosis of a DSM-5 mental disorder … does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard."

*CLASH BETWEEN CLINICIANS AND THE LAW…

Primary Diagnosis of Patients under Community Treatment Orders in Otago in mid-2000s: N=259

Schizophrenic disorders	142	55%
Affective (mood) psychoses	67	26%
Schizoaffective disorder	14	5%
Paranoid states	5	2%
	= 88%	
Personality disorder	5	2%
Anorexia nervosa	4	1.5%
Alcoholic psychoses	4	1.5%
All Others	18	7%
	= 100%	

These stats show that people are put under the MHA *majority* for the major mental illness, not just the ones defined in the manual (the DSM-5 manual).

Continuing problems: *interpretation* of the terms in the list of disorders of mental function (eg, 'cognition', 'volition'. *Applying* those terms to the psychiatric evidence in light of the *social purposes** of the MHA and the many audiences to which it is addressed: patients, families, MH profs, judges, Police.

*protecting the patient's rights, protecting the public, helping the patient… many different purposes.

Query: Should we adopt a 'psychiatric', 'legal' or 'ordinary (or lay)' interpretation of the terms used in the list?

The Many Roles Played by Psychiatrists under the MHA
Arguably, they are the primary decision makers under the Act…

- *Certify patients for compulsory admission*
- *Conduct the compulsory psychiatric assessment*
- *Recommend a Compulsory Treatment Order to the Court*
- *Direct the patient's compulsory psychiatric treatment*
- *Decide between compulsory inpatient and outpatient care*
- *Discharge the patient when 'no longer mentally disordered'*
- *Sit as a member of the MHRT and examine the patient as part of its process.*
- *Their understanding of 'mental disorder'*
- *Is bound to be central to administration of the Act.*

Many decisions don't require the court, they are obliged to release patients etc. and a psychiatric member of a tribunal is always required - so they are part of every stage.

EXAMPLE - *RCH* CASE (Waitemata Health v AG appeal)

Issue?	He does not have a metal illness, but could be still be described as having an abnormal state of mind due to the threat he poses to the public… **Does RCH have an 'abnormal state of mind … characterised by delusions, or by disorders of mood or perception or volition or cognition'**
Evidence/ Facts	Some of the evidence put before the MHRT concerning RCH's history - Very disturbed childhood: abused and neglected, especially by his mother. - Severe childhood conduct disorder. - First contact with psychiatric services at 13 years; then at 20. Numerous convictions for violence or threats, especially against women: - Poured petrol over a woman and set her on fire - Convictions for conduct in prison: • E.g., threatening to kill prison counsellors who 'abandoned' him • None attracting an indeterminate sentence

	- Required to serve last sentence to the very last day: given no remission or parole. In the week before his final release from 13 years' continuous imprisonment he was certified under the MHA and transferred to a secure psychiatric hospital. Consistent diagnosis: severe personality disorder • Antisocial, borderline, and narcissistic traits, with sadistic features • Scores highly on recognised psychopathy checklist Acts of self-mutilation; 'anger and rage'; 'poor impulse control'; continuing threats of serious harm to counsellors who, he says, 'encourage' and then 'abandon' him. Occasional depression, sometimes severe, but not recently • Treated periodically with anti-depressants, but not in the last year • Has accepted medication for the depression, and engaged in psychotherapy Prof Mullen, a renowned forensic psychiatrist, said, at a previous tribunal hearing, that RCH's beliefs about a former counsellor should be considered 'delusions' within the meaning of an 'abnormal state of mind, due to the 'persistence', 'pervasiveness' and 'tenacity' of these beliefs. - he extended delusions to overinflated ideas… but then in 2000 no one was prepared to sat he had delusions… But, at a further tribunal hearing in 2000, clinicians currently treating RCH said: • Medication was not useful or effective for his condition • Some improvement had occurred from psychotherapy and behaviour modification • He had no current symptoms 'compatible with a mood or psychotic disorder' • There was no current evidence of 'delusions' • He had 'intense relationship needs' • These 'inevitably result in abandonment, fantasy, fixation and retribution' • He continued to pose a serious threat of harm to women • But he was not honest about his feelings, thoughts and plans • If released, he planned to go to australia
Relevant law/ considerations	**Some questions:** • What are the main issues as to whether RCH continues to have an 'abnormal state of mind' in the necessary sense? • Should the tribunal conclude that he meets the legal test? • Or should he be released from control under the MHA (when he is not currently charged with any crime, so cannot be imprisoned)? **The International Classification of Diseases (ICD)/(WHO) definition** 'Personality disorders' are: 'deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations'. **The diagnostic criteria for 'antisocial personality disorder' in DSM-5 refer to:** • Failure to conform to social norms, leading to repeated arrest • Aggressiveness, shown by repeated fights or assaults • Reckless disregard for others' safety • Lack of remorse, indifference to others' hurt • Plus: evidence of childhood conduct disorder before 15 years He fits these behaviours but is that sufficient to meet a disorder of cognition/ an abnormal state of mind…? **NOTE… Section 4's Exclusionary Rules** No person is to be civilly committed 'by reason only of' a. political, religious or cultural beliefs; or b. sexual preferences; or c. **criminal or delinquent behaviour**; or d. substance abuse; or e. intellectual disability. Are his actions just criminal or delinquent behaviour?