The Disability Hearing: Evidential Issues —a Psychiatrist's View

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The aim of this paper is to summarize my clinical experience in the field of (acute/remand inpatient) forensic psychiatry in Auckland over the last 13 years as it relates to disability hearings. I will concentrate on the events leading up to the hearing, and the hearing itself. All will be from a very practical and clinical angle as it relates to pertinent medico-legal questions. It will also be a modified version of my multimedia presentation at the seminar itself, but it will not be a formal research treatise on the question of disability as such.

Introduction

The interested reader will want to consult the wording of the relevant Acts and sections mentioned at other places in this booklet. This includes the current legal definition of "mental disorder" within the meaning of the Mental Health Act (MHA) 1992, ie, s 2, p 4, and the "General rules relating to liability to assessment or treatment", as per s 4 of the same Act, p 6. Many other sections are indirectly relevant, and a working knowledge of the MHA would help to understand some of the intricacies of the Act in relation to the question of disability.

Part VII of the current Criminal Justice Act 1985 applies in relation to matters surrounding disability, with ss 108 to 116 being of particular relevance. Sections 121 to 123 CJA deal with matters related to the psychiatric report to the court, and is discussed in some detail in other parts of this booklet.

In relation to psychiatric matters, the currently most widely accepted classification in use in New Zealand and in most other parts of the world, is the *Diagnostic and Statistical Manual of Mental Disorders, DSM* IV, by the American Psychiatric Association (as editor and publisher), Washington DC. This book is readily available in medical bookstores in Auckland, and elsewhere.

There are other books and journals available which deal specifically with the question of disability within the meaning of the Act. It might help to contact your library, or bookshop. If you think we could be of help, please feel free to also ring us, phone 09-815 5150, (Mason Clinic), or 09-8497 789 (administration, management).

Pre-disability hearing

It is probably in the best interests of all parties concerned if any form of concern by anyone re the mental health of the alleged offender is (in the appropriate form) brought to the notice of someone who is deemed to be able to assist. This is a somewhat long-winded sentence, but it tries to wind its way through a number of important issues including confidentiality, freedom of information, and civil rights, just to name a few. It also takes

into account policies, and procedures (of the police, and others) of how to deal with alleged offenders. These matters frequently become clinically very relevant, especially if early statements and video-interviews done at the time, retrospectively raise the question of disability. At this stage, ie, right after the material time of the alleged events, the distinction between "insanity" and "disability" becomes quite foggy: "insanity" relates to the mental state at the time of the alleged offence, while "disability" relates to the mental state at the time of the hearing.

In my experience the police in Auckland have, in many if not most cases I later became involved with, been very interested to address the mental health of the alleged offender very early by contacting our court liaison staff in the various courts in Auckland, as well as other psychiatric services during and after hours, and weekends. Dropping charges, considering compulsory treatment orders, or other strategies appear sometimes appropriate to save the particular alleged and mentally unwell offender from going through the usual court procedure.

On other occasions, our court liaison service, both prior to and during the procedure itself will be in the position of trying to assist the alleged offender, as well as counsel and prosecution. The emphasis is on liaison, facilitating assessments, contacts, and preliminary opinions of how best to proceed from a court liaison/forensic psychiatry point of view. The important point is that court liaison is contacted, be that in person, by phone, fax or locator in the various courts. This includes occasions like court cases on Saturday mornings, and on selected days during statutory holidays (etc).

In my current role as psychiatrist in charge of the acute admission and remand unit called Kauri of the Mason Clinic, I screen, in discussion with court liaison, certifying medical practitioner, and often counsel, virtually all remand referrals for inpatient assessment pursuant to s 121(2)(b)(ii) CJA prior to actually coming in to the Mason Clinic. This is basically a daily exercise, and demand on our beds for seven male, and four female remandees virtually always outstrips supply. It often then becomes a clinical and medico-legal, and often political judgement between the competing demands of the general mental health system, the prisons and the courts. Be that as it may, sometimes you might find that not everyone to be assessed re disability needs to be in a hospital setting at least in the first instance. Nevertheless, I do recommend in the context of this seminar, that anybody to be considered re disability should ideally be assessed in hospital to exclude possible underlying psychiatric, neurological and other medical conditions which could conceivably contribute to a disturbed mental state. I am particularly worried about some of the effects of non prescribed and illicit drug abuse which can mimic a range of psychiatric and other conditions, and in fact can cause potentially dangerous medical emergencies. I also note that the potential for suicide during confusional states is often difficult to assess.

The above implies that disability can be a temporary state, can be fluctuating depending on the alleged offender's mental state, and does not necessarily require treatment in hospital. Language problems, cultural and ethical difficulties, a "poor fit" between counsel and the alleged offender is often equally important when it comes to assess matters like muteness, amnesia, "confusion", and malingering, to name a few of the more

common difficulties counsel will sometimes face. This is where inpatient assessment pursuant to s 121(2)(b)(ii) CJA becomes relevant.

I will deliberately bypass the legal requirements pursuant to s 121 CJA and concentrate on clinical matters relating to the inpatient assessment. Our extensive investigations concentrate on all of the requirements of s 121(2)(b)(ii) CJA, disability being one of them. You will thus in our inpatient court reports find comments which address the "wider picture", including comments on mental disorder (MHA), psychiatric disorder/illness (DSM IV), disability (CJA), insanity (Crimes Act), prognosis, dangerousness, and disposition (in the form of recommendation). I mention this here because a later legal finding of disability in my opinion also needs to be seen in the context of its possible consequences, and in relation to other options regarding s 115(1)(a) CJA, s 115(2) CJA, or the compulsory treatment orders. If, for example, an order pursuant to s 115(1)(a) CJA (as "special patient") is made, then the charges can be resurrected by the prosecution at a later time. At that time issues re insanity (or imprisonment) might become relevant, which the patient might not necessarily see as a reward for getting well, and then getting tried again. Some of our patients have over the years acquired their own "expert" knowledge through their own experience, and often prefer to malinger "not mentally disordered", in order to gain a finite prison sentence rather than a possibly extended or maybe infinite time of attention by various mental health services. The "soft option" of a "psych ticket" as sometimes in the past, is not necessarily the preferred option any more. This is one more reason why good liaison between counsel, police/prosecution and staff of forensic psychiatry services will go a long way towards evaluating the most appropriate way to assist individuals before the courts, who are deemed to suffer from a mental disorder to such an extent that they are judged to be under disability within the meaning of the Act.

The hearing

The legal requirements for the actual procedure are as per s 111 CJA. Two medical practitioners are required to provide an opinion in regard to disability, and the judge makes the final decision. This is where many psychiatrists see some irony in the fact that legal representatives are required to make findings concerning mental disorder or not, or being insane ie, the law-makers seemingly want the law to decide on medical matters, for example, who is mentally disordered. In contrast, most psychiatrists in my experience would probably think that their many years of training had something to do with assessing and deciding who might be mentally disordered or not.

Many questions remain to be decided prior to the actual hearing. Much has been discussed during the seminar March 31, 1995, and by others in this booklet. I refer to various interpretations of the criteria of being mentally disordered as per MHA, and the poor fit of this with current psychiatric classifications of mental disorders (DSM IV). Nevertheless, psychiatrists are required to offer an opinion on the extent of the mental disorder. This will hopefully be an occasion to clarify that not every mentally/psychiatrically disturbed individual/patient is necessarily under disability when seen in court.

It might also clarify the fact that psychiatrists often find it difficult to comment on whether the alleged offender is in a position to adequately communicate with counsel -

psychiatrists usually will want to comment if the defendant is in their opinion able to adequately communicate with them, ie, the interviewing and assessing psychiatrist.

Differences in outcome concerning s 115(1)(a) CJA, and s 115(2) CJA have been discussed by others before. Other options are also available, and will be discussed later in this booklet.

During all of the hearing, clinicians are well aware that the often adversarial nature of the hearing can destroy the frequently already tenuous therapeutic alliance between the assessing, and supposedly soon treating doctor giving evidence, and the remandee, soon presumably to be his/her patient. It is not necessarily a forte of paranoid patient, for example, to forget their doctor's comment about their abnormal state of mind, their bizarre delusions and behaviour, and their real/perceived danger to others. Counsel might also remember that what counsel says is not necessarily what their client hears. The discussion of dangerousness in court in front of the often angry remandee/patient sometimes later develops into many new aspects for the life of medical and legal (as well as other) individuals involved with a certain group of litigious remandees/patients in court. Again, good liaison with all parties involved can address many potential difficulties cognizant of legal considerations protecting the rights of the individual/accused. This also applies to the actual handing over to the remandee, of the actual report pursuant to s 122 CJA. Our service deals with more than 12 (male and female) stalkers with a history of a minimum of at least five years potentially dangerous compulsive following of others. Some have, and some will, in the future, most likely resort to serious violent acts towards others. Please liaise with us when your client's jealousy has propelled him/her to paranoid beliefs/behaviour. He/she might be somewhat irrational in his/her discussion with counsel, and disability might look at first sight to be the only issue. Nevertheless, often more is at stake, including the safety and well-being of medical and legal staff professionally involved with the remandee.

It is also advisable that comprehensive notes are kept by all parties involved. This is not thought to be a wise comment, but in view of the right of appeal pursuant to s 112 CJA against the finding of being mentally disordered, and disability, the question of bail could arise. Responsible handling of frequently complicated matters is often only possible if one can fall back on detailed notes, which have the potential to be acceptable to the court.

Post-script

Trying to assist many mentally disordered/psychiatrically ill alleged offenders during their way through the various remand stages can be like dancing on a moving carpet in the dark. During the hearing, medical terminology is often out of step with legal jargon. During the sentencing stage (or equivalent), the court is sometimes forced by the reality of the current non-availability of services for specific sub-groups of offenders, to think creatively. Individuals with an intellectual disability (or handicap or mental retardation) are one group of individuals who have caused some considerable concern to psychiatric services and the law. Nevertheless, the moving carpet is seemingly turning magic, and special facilities, and legislation might be available soon. This augurs well for the future, as does the ongoing dialogue (despite all philosophical, political and other differences) between the various levels and individuals of law and health providers.