NOTE: PURSUANT TO S 25 OF THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, ANY REPORT OF THIS PROCEEDING MUST COMPLY WITH SS 11B TO 11D OF THE FAMILY COURTS ACT 1980. FOR FURTHER INFORMATION, PLEASE SEE HTTP://WWW.JUSTICE.GOVT.NZ/COURTS/FAMILY-COURT/LEGISLATION/RESTRICTIONS-ON-PUBLICATIONS.

IN THE DISTRICT COURT
AT HAMILTON

FAM-2005-070-001041
[2016] NZFC 1898

IN THE MATTER OF	THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992
BETWEEN	WAIKATO DISTRICT HEALTH BOARD Applicant
AND	BS Person In Respect of Whom the Application Is Made

Hearing: 8 March 2016
(Heard at Henry Rongomau Bennett Centre)

Appearances: D Allan for the Patient
Dr A Steven - Responsible Clinician
I Wright - Second Health Professional

Judgment: 9 March 2016

RESERVE JUDGMENT OF JUDGE S D OTENE
[Application to extend a Compulsory Community Treatment Order]

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[1] This is an application to extend a Compulsory Community Treatment Order in respect of BS. The order was made initially in the District Court criminal jurisdiction on 8 September 2015. The order pursuant to s 34(1)(b)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 was that Mr S be treated as a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

[2] The application is contested by Mr S. During the course of the examination and through submissions from his counsel he made submissions which I distil as follows:

(a) There is nothing wrong with him and never has been and he rejects his diagnosis.

(b) He does not need to be on medication and there is no difference in his presentation behaviour or functioning when he is on medication as compared to when he is not medicated.

(c) He is a man of faith and considers that his religious beliefs are being held against him to justify the diagnosis of schizophrenia.

Legal issues

[3] The legal issue I need to determine is whether the criteria is met in terms of the legislation to extend the Compulsory Community Treatment Order currently in force. As it is the first extension, it would be for a period of time of six months, the timeframe mandated by s 29 of the Act. The criteria to make an extended Compulsory Treatment Order are as follows:

(a) That the two limbed test of mental disorder as set out in s 2 of the Act is met.

(b) That the order is necessary.

(c) That Mr S can be adequately treated in the community.

Test of mental disorder

[4] Section 2 of the Act sets out the test for mental disorder. In the interpretation section it says:

> 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;—

[5] In terms of the first limb of the s 2 test of mental disorder the Court has available to it reports prepared by Dr Stevens, the current Responsible Clinician and a report from Ian Wright, Occupational Therapist with the Assertive Community Treatment Team and Mr S's key worker in the community. During the course of the hearing I also heard from Dr Stevens and Mr Wright and they were cross-examined by counsel for Mr S.

[6] As set out in Dr Stevens' report of 23 February 2016, it is his opinion that Mr Smanifests an abnormal state of mind characterised by delusions and that such state of mind is intermittent. Dr Stevens' further evidence at hearing was that Mr S has a diagnosis of Schizophrenia. In the eight months during which Dr Stevens has been involved as Mr S's clinician he has not witnessed firsthand any symptoms of that illness. It is notable that during this time Mr S has been compliant with his medication. His diagnosis is based upon Mr S's clinical history in the various reports available to him and also Mr S's statements directly to Dr Stevens to the effect that he had been to Hell. Dr Stevens says such expression was made by Mr S in a literal rather [than] metaphorical sense and hence is a delusion. Dr Stevens acknowledges that Mr S is not experiencing delusional thoughts at present or indeed other negative effects of Schizophrenia.

[7] Mr S expanded upon his experience of going to Hell in the hearing by explaining that it is a religious experience whereby he was cut off from god which he

found to be torturous. As I have said Mr S disputes his diagnosis of schizophrenia and that he has an abnormal state of mind. Given that he raised diagnosis [as] an issue I indicated that I was prepared to adjourn the hearing to obtain a second opinion. Mr S elected not to have a second opinion so I decide the matter on the basis on the evidence available to me.

[8] Having regard to the evidence of Dr Stevens and also the previous psychiatric reports available on Mr S's file, I am satisfied that the diagnosis and abnormal state of mind is established thereby satisfying the first limb of the test. That Mr S is not currently experiencing delusions goes to Dr Stevens' opinion that the abnormal state of mind is intermittent rather than continuous, it does not mean there is no abnormality.

[9] In terms of the second limb of the test for mental disorder there needs to be a linkage between "abnormal state of mind" and behavioural factors. That is to say that "abnormal state of mind" must have a causative effect in terms of how a person behaves. The risk that Mr S is said to present arises within the context of his history of assaulting others when unwell. There is also said to have been accounts of Mr S running off when he was unwell and taking knives with him, although the evidence was not clear as to the specifics of those events.

[10] As I understand it there was no challenge to the proposition that Mr S had acted violently to others when unwell. Rather the issue is whether it is the "abnormal state of mind" that causes that violent behaviour. Dr Stevens and Mr Wright's direct personal experience of Mr S has only been over the recent period when he has been well and functioning well in the community. Dr Stevens at the hearing said that it was difficult to tell if the historic assaults are psychotically driven rather he relies upon reports that assaults have been committed whilst Mr S has been unwell.

[11] The documented clinical history for Mr S records assaultive behaviour by Mr S during periods of acute unwellness. For example on 11 June 2015 Dr Simone McLeavey a Consultant Psychiatrist for the Regional Forensic Psychiatric Service in Christchurch prepared a report on Mr S. That report refers to Mr S's

acknowledgment of past command hallucinations to assault others, although such commands were not present at that time. There is also reference in that report to Mr S becoming aggressive and abusive in the context of his criminal Court proceedings the prior week and an apparent decline in his mental health.

[12] The totality of the information available to the Court persuades me on the balance of probabilities that Mr S's abnormal state of mind is of such a degree that he poses a serious danger to the safety of others

Necessity

[13] Mr S is clear that he will not voluntarily continue medication if he is not subject to compulsory treatment. That is not surprising given that he does not accept that he has a mental illness. Without medication I am satisfied that there is a real risk that Mr S will become unwell. I am therefore satisfied that an order is necessary.

Adequately treated in the community

[14] Mr S is functioning well in the community and there is every intention for that to continue. I am satisfied therefore that he can be adequately treated in the community.

Order

[15] Being satisfied that the criteria is met to extend the compulsory community treatment order, I grant that extension for a period of six months.

S D Otene
Family Court Judge