Mental Disorder and Drink Drive Offences

The Author

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Introduction

Some people cannot provide a sample of breath, a specimen of blood or a sample of urine to order. Psychiatric signs or medical reasons can be behind this. Those convicted have been found to be more likely also to misuse alcohol or be alcohol dependent, as well as to have comorbid disorders such as misuse of other drugs, depressive illness and post-traumatic stress disorder (Lapham *et al*, 2001). Further, psychiatrists must be aware that individuals accused of a crime might have acted under the influence of a mental disorder (Gordon, 2004).

The article draws on the author's considerable experience of those psychiatric conditions that have satisfied the Court as reasons for Failure to Provide. He discusses the use of the documentation, and medical care in Custody.

Failure to provide a specimen of breath

This is a common problem. Apart from psychiatric considerations, poor performance is associated with breathing difficulty, as a result of cardiovascular, or respiratory disease.

It is worth enquiring from your clients about their physical health and medical treatments, as this could have a bearing on their psychological state and ability to comply with instructions. Psychiatric illness manifests with physical as well as psychological symptoms. (The converse is also true, e.g. physical illness such as hypothyroidism is commonly associated with depression and anxiety.) Medication commonly alters mental states.

Any psychiatric condition can be associated with panic attacks – although they may not *be a unique feature of the disorder. The term "Panic" comes from the god Pan, who*

would jump out and scare animals. Notable sufferers from panic attacks have included Charles Darwin who in 1872 gave an accurate and early account of his own experience. **(Appendix2)**

Panic attacks usually last for several minutes, but in some patients they can last for hours. Sufferers describe shortness of breath, tightness in the chest, and only being able to produce rapid, small-volume intakes of breath. This means that in breath testing they cannot provide the slow, steady breaths required by the machine. The anxiety builds to a peak in 10 min in most cases.

7-9% of the general population experiences them frequently, and most people will have some form of panic attack during their lifetime. Most go unrecognized. The causes can be rooted in panic disorder, depression, a mixture of anxiety and depression, Post Traumatic Stress Disorder, simple phobia, social phobia or claustrophobia. Panic attacks can be present in paranoid psychotic states as well as mania (elated mood). Stressful lives or significant events can lead to Adjustment Disorders which involve panic attacks as well as a mixture of psychological symptoms.

Clients, who do not know what to do when asked to give a breath test, may have problems of attentional bias, and studies demonstrate that severe anxiety disrupts information processing by the brain, and the task performance, (Macleod et al, 1992)

GP notes recording a history of panic attacks is desirable, and can support the likelihood that an attack took place during the EBM procedure. However, it is not essential, and the evidence from both witness statements and the client has been sufficient, even where there was no pre-existing condition.

Failure to provide a Blood Sample

Many of us, reasonably, have a fear of needles; however the benefits of giving a sample of blood or receiving a drug usually outweigh the mild discomfort. In the last 25 years, I have collected a number of anecdotal cases of needle phobia, from a heavyweight boxer to a coalminer with a crush fracture.

In a client with needle phobia, the decision making process becomes disrupted, and sufferers are unable to weigh up options and the possible outcomes or consequences of choices made. The phobic anxiety can be triggered by the mere thought of a needle, let alone the experience of actually piercing the skin. The client recognizes the irrationality and inappropriateness of this reaction, is embarrassed that people are watching and

this worsens the distress. All this can be so overwhelming that it leads to an inability to concentrate.

GP records show that some people fail to attend a consultation due to avoidant behaviour caused by proximity to needles or fear of an injection. However, the phobia is rarely recognized by GPs who may not appreciate that patients are avoidant, or how severely needles affect them. Patients' health consequently is put at risk. Nevertheless, a GP's letter supporting the diagnosis of needle phobia is invaluable when someone has failed to give a blood sample to the police.

In my experience as a Forensic Medical Examiner and Hospital Specialist, I have seen cases where the veins "shut down" or become narrowed due to anxiety. In one case, an experienced colleague was unable to collect a sample for analysis.

Failure to provide a specimen of urine

Anxiety often increases the urge to urinate. However it can make production impossible, especially during a panic attack. Medical conditions such as prostate disease, bladder infections, urethral disease, urinary retention and incontinence may also cause this.

Interviewing the Client

For many clients this is their first contact with a psychiatrist. The interview often establishes a long history of poor functioning and disability, and clear evidence of mental disorder that has gone unrecognized previously. It is not pleasant for clients to hear that they have a psychiatric illness. I prefer two assessments to check the consistency of the history over time.

The alcohol problems are sometimes a result of ongoing illness which explains abnormal drinking behavior. Subsequently treatment has led to moderation.

There is always a significant delay between assessment and trial during which significant medical notes may be collected. They are often useful in supporting the diagnosis and providing an addendum report. It is best to avoid hurriedly re-examining the client of the day of trial, only to find out that they have been receiving psychiatric treatment since the first assessment.

Psychiatric Management in Custody

If the arresting officer or Custody Sergeant suspects mental disorder in a detainee, they require a forensic medical examination. It is difficult for the Prosecution to challenge the diagnosis of a panic attack, if the client has not been assessed at that stage. Some experts will use the Audio/Video record to help establish the mental state; however, I find these tapes are of poor quality in the main, and not useful,

The acutely anxious patient will (temporarily) lack capacity and will not fulfil the requirements of the Mental Capacity Act 2007. They should not be charged until *capacity has returned, or an appropriate assessment has taken place.*

Witness Statements

The Expert will be looking for descriptions or evidence of the 4 main areas of anxiety symptoms **(Appendix 1)**.

Scrutiny of the arresting officer's witness statements, and the description of the client's demeanour on the MGDD/A have proven to be invaluable when deducing the mental state of the client. In some cases, their clear description of a distressed individual has satisfied me (and the Court) that the client was suffering from marked anxiety symptoms.

I view the assessments and diagnoses (or lack of) on the MG11 statements with caution. Examination of the quality of psychiatric assessments by Forensic Nurses and Medical Examiners is essential. Custody nurses do not have special skills in the assessment and diagnosis of mental disorder, and the psychiatric training of many *Forensic Medical Examiners is basic. Their unsupervised experience as a qualified* doctor is built upon rudimentary medical school training. This is reflected in how few are recognised under Section12 (2) of the MHA1983. The law does not view Forensic Nurses or Physicians as having Special Experience in the Diagnosis and Treatment of Mental Disorder **(Appendix 3)**.

Custody Record

The client may inform the Custody Sergeant of mental health problems on being booked in; however, I have observed detainees who are unable to complete the booking process because of intense distress or in some cases, intoxication.

The log may describe abnormalities of mental state. However, a lack of comments does not imply there was no disorder – Designated Detention Officers, gaolers and other Custody staff usually have no specific training in the assessment of the mental state.

GP Records

GP Records demonstrate pre-existing conditions. However most psychiatric illness goes undetected in the general population and there may not be evidence in the notes. Clients do suffer in silence, either because they are unaware that their symptoms are pathological, or tolerate their symptoms, or because of the stigma of consulting a doctor about mental health problems. Patients often view illness as a defect or weakness in the personality. Avoidance of feared situations is an embarrassment.

Panic-like symptoms occur in various medical conditions (hyperthyroidism, *phaeochromocytoma*, *seizures*, *cardiac arrhythmias*, *chronic obstructive pulmonary* disease). The patient will report a large number of physical symptoms and usually to a non-psychiatric physician, leading to misdiagnosis; generally because of the frequency with which these patients present in general medicine where there is a lack of awareness of this syndrome.

In Court

If the Legal Representative permits it, I sit behind him. This facilitates questioning of arresting officers specifically about the client's mental state. In some cases, I have found it useful (with the Legal Representative's consent) to offer suggestions for questioning of FMEs and Nurses with regard to their findings on the mental state examination.

Usually, listening to witnesses' description of the individual can provide a more colourful, and useful picture, compared to prepared statements, and can be referred to whilst giving expert evidence.

Client Aftercare

It is my practice, with the client's consent, to inform his GP of the examination. Undiagnosed conditions can be followed up, referred to local Psychiatric Services, and progress notes can be forwarded to the solicitor.

Summary

- There are well recognised mental disorders that lead to an inability to provide.
- FMEs and Custody nurses are not recognised as having special experience to assess mental health.
- Failure to provide should be followed up whilst in Custody, by a physical & psychiatric examination (as per Bolam/Bolitho) to exclude valid medical reasons.
- Witness statements can provide valuable information about the client's mental state.

- Legal representatives must provide experts with as much information as possible: Custody, and Medical Records, as well as witness statements, MGDD/A if they require a credible well argued report.

References

1. MacLeod, C. and Rutherford, E. (1992). Anxiety and the selective processing of emotional information. Mediating roles of awareness, trait and state variables and personal relevance of stimulus materials. *Behaviour Research and Therapy*, **30**, 479–91.
2. Gordon, H. (2004). Psychiatry, the law and death on the roads. Advances in Psychiatric Treatment **10**: 439-445
3. Lapham, S. C., Smith, E., C'de Baca, J., *et al* (2001) Prevalence of psychiatric disorders among persons convicted of driving while impaired. *Archives of General Psychiatry*, **58**, 943–949.

Appendix 1

Anxiety symptoms can be described in four areas:

1. Emotional (I am *frightened* of that large spider)
2. Cognitive (I am *thinking* of him crawling over my skin with his hairy legs, I *think* that I should to run away)
3. Physiological (physical symptoms - I am *breathing* too fast, my heart is *pounding*)
4. Behaviour (I am *running* away)

Symptoms

Rapid heart beat, pounding heart or palpitations , sweating, shaking visibly or inside, choking sensations or lump in throat, smothering or shortness of breath sensations, chest pain or discomfort, nausea, bloating, indigestion or abdominal discomfort, dizziness or unsteadiness, feeling light-headed, derealisation (feeling unreal or dreamy), depersonalisation (feeling outside yourself or like you don't exist), fear of losing control or going crazy, Paraesthesias (numbness or tingling sensations) in face, extremities or body, chills or hot flushes, skin losing colour, blushing or skin blotches, urgently needing to urinate or defecate, or an inability to do so.

Appendix 2 Charles Darwin (op cit.)

"The heart beats quickly and violently so that it palpitates and knocks against the ribs...the skin instantly becomes pale as during incipient faintness...under a sense of

great fear...in connection with the disturbed action of the heart, the breathing is hurried...one of the best marked symptoms is the trembling of all the muscles of the body."

Appendix 3 Mental Capacity Act 2007

A person lacks capacity if he is unable to make a decision for himself because of an impairment of, or a disturbance of functioning of his mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.

The Act provides a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time.

A person is unable to make a decision for himself if he is unable-

- To understand the information relevant to the decision,
- To retain that information,
- To use or weigh that information as part of the process of making the decision, or
- To communicate his decision (whether by talking, using sign language or any other means).

Explanations may be by using simple language, visual aids or any other means. Even if a person is can only retain information for a short period doesn't mean that he cannot make the decision.

The information should include foreseeable consequences of

- Deciding one way or another, or
- Failing to make the decision.

Appendix 4 Section 12, Subsection (2) Mental Health Act 1983

Special experience in the diagnosis and treatment of mental disorder. The Court of Appeal (1994) 31 B.M.L.R. 140 held, by a majority, that "special experience" is the sole criterion for approving a doctor and that having "special experience" requires examination of the doctor's current knowledge and skills in the diagnosis and treatment of mental disorder. The Health Authority has to consider the doctor's qualifications and experience and not his or her suitability for appointment.

Appendix 5 Forensic Nurse

They require completion of "Minor Injury and Illness" Course training to NMC level.

The course must be signed off by another Nurse Practitioner or Doctor. (If not the case, the patient should have been observed visually and not examined.). Reasons for not

calling FME when detainee unable to provide a specimen.

Appendix 6 Forensic Physician/Medical Examiner

Clarify Section 12 (2) approval. Clarify level of psychiatric training. Clarification of knowledge base with regard to mental disorder. Clarification of test of capacity.