Pregnancy and acute mental illness

Mental Health Law Conference 2014
What we will cover

• This session will consider:
  – Early pregnancy and acute mental illness – in particular, termination of pregnancy
  – Late pregnancy and acute mental illness – in particular, labour and delivery
Early pregnancy and acute mental illness
Case example

• Alexis is 18 weeks pregnant. She is acutely mentally unwell, and is subject to an inpatient order under the MH (CAT) Act. She says that she doesn’t want the baby, and has made arrangements for an abortion. Alexis’ responsible clinician considers that she lacks capacity to make this decision. Alexis has asked that arrangements are made for her to attend the clinic for a termination of pregnancy.

• Do you do so?
The law on abortion in brief

• Abortion is unlawful in NZ unless one of the exceptions in the Crimes Act 1961 applies

• For a pregnancy of “not more than 20 weeks gestation” these include where the “continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health of the woman or girl” (section 187A(1)(a) of the Crimes Act 1961

• The above is the most commonly used ground for abortion in NZ, with 98% of all abortions authorised under this exception
The law on abortion in brief

• There is no specific legal test for what constitutes a “serious danger to …mental health”. This is a medical question for a certifying consultant to determine in each case (Right to Life New Zealand Inc v The Abortion Supervisory Committee [2012] NZSC 68)

• There is no power of the Abortion Supervisory Committee to challenge these clinical judgements, and the certifying consultant does not need to give reasons for the decision or to provide any specific diagnosis or its severity (The Abortion Supervisory Committee v Right to Life New Zealand Inc [2011] NZCA 246)
More than 20 weeks gestation

• For a pregnancy of “more than 20 weeks gestation”, the grounds for abortion are narrower – there are two exceptions set out in section 187A(3) of the Crimes Act 1961 being:
  – That it is “necessary to save the life of the woman or girl”; or
  – That it is “necessary to prevent serious permanent injury to her physical or mental health”
Process

- In terms of process, the Contraception, Sterilisation and Abortion Act 1977 specifies the following:
  - The woman must first consult her medical practitioner. If that practitioner believes one of the grounds for abortion exists, he or she refers the woman to two certifying consultants
  - The two consultants must both form an opinion (in good faith) that one of the grounds for abortion applies
  - If this is so, the consultants issue a certificate of authorisation for the abortion
  - The consultants must also offer the woman counselling
  - Once the certificate is issued, the abortion can be performed in a licensed institution, and the practitioner who performs the abortion must report that procedure to the Abortion Supervisory Committee
Consent

• All medical procedures must be done with the woman’s informed consent (plus the two certifying consultants’ authorisation in the case of abortion)
• Capacity = decision specific, and requires a person to be able to comprehend and retain the relevant treatment information, believe the information and weigh the information balancing the risks and needs.
• The fact that someone is subject to an inpatient order does not mean that she lacks capacity to consent to treatment
Lack of capacity

- Consent from a guardian/welfare guardian/Enduring Power of Attorney for Personal Care and Welfare
- Right 7(4)/doctrine of necessity usually applies, but probably inappropriate in the case of abortion.
- No cases on women suffering from mental illness, but there are cases on women with intellectual disability. In *Re H*, Judge Inglis held:

  “An abortion should not be carried out on a person whose intellectual disability impedes informed consent unless the directions of the Family Court have first been obtained in terms of the [PPPR Act]. Abortion is no less a “special case” than sterilisation. It is just as invasive and, like sterilisation, is irreversible”
Court orders

- A personal order under section 10 of the Protection of Personal and Property Rights Act 1988 (this requires the person to be wholly or partially lacking capacity); or
- An order from the High Court in exercise of its parens patriae jurisdiction
Legal, ethical and factual considerations

• The following legal principles are relevant:
  – That there be the least restrictive intervention possible in the life of the subject person, having regard to the degree of disability; and
  – That the Court must exercise its powers “in the promotion and protection of the welfare and best interests of [the subject person]”
Legal, ethical and factual considerations

- In deciding whether the procedure is in the best interests of the woman, the following considerations are relevant:
  - The woman’s understanding and preferences, if known;
  - The woman’s degree of impairment;
  - The prospect for improvement in her condition;
  - Any harm that will befall the woman if the procedure is not performed (including the ability of the woman to carry the pregnancy to full term, the ability of the woman to care for the child, and the mental and emotional impact of a potential adoption of the child once born);
  - Any harm that may befall the woman if the procedure is performed (including the emotional, mental and physical consequences of termination); and
  - Whether those suggesting the procedure are acting in good faith.
Legal, ethical and factual considerations

• Also relevant are the following four key ethical principles:
  – Autonomy, upholding the person’s independence insofar as this is possible;
  – Beneficence, trying determine what decision is most likely to be in the person’s best interests, taking into account all relevant factors;
  – Non-maleficence, the avoidance of doing harm (including not unduly depriving an individual of the opportunity to make her own reproductive decisions without sound reason); and
  – Assent, being the willingness or agreement of the person to the treatment (as compared to consent, which is assent coupled with the ability to legally authorise the treatment)
Back to Alexis

• Alexis is 18 weeks pregnant. She is acutely mentally unwell, and is subject to an inpatient order under the MH (CAT) Act. She says that she doesn’t want the baby, and has made arrangements for an abortion. Alexis’ responsible clinician considers that she lacks capacity to make this decision. Alexis has asked that arrangements are made for her to attend the clinic for a termination of pregnancy.

• Do you do so?
Back to Alexis

- Does Alexis have capacity to make this decision?
- If not, need to consider whether further steps are necessary to:
  - Make certifying consultants/clinicians performing the abortion aware of her lack of capacity
  - Consider whether court authorisation is required
Comments/Observations
Late pregnancy and acute mental illness
Case example

• Joan is 41 weeks pregnant. She has been subject to an inpatient order for most of her pregnancy. She presents with alleged ruptured membranes. It is not possible to examine her, but it does not appear that the membranes have ruptured. There are no signs she is in labour. She has had two children with no complications. Both children were recently removed from her care. CYF have an order to remove the baby once born.

• Joan is asked whether she would consent to being induced or to a caesarean if necessary. She refuses to give consent, saying that she “wants this baby to die”, and that she “never wanted it anyway”.
Case example

• The delivery team have asked to what extent they can intervene if it is considered necessary to induce labour and/or during labour, with respect to both the mother and the unborn child.
Thoughts?
What’s the key?
The answer is......
The law

- All competent persons have the right to refuse to undergo medical treatment (section 11 of the NZBORA)
- In NZ, a baby only becomes a person in the eyes of the law when the entire body of the baby has left the mother’s body (although the umbilical cord may still be attached); and the baby is alive (“the born alive rule”)
- What this means is that as a matter of law, there is no conflict between the rights of the mother and the unborn child - the mother’s autonomy and right to bodily integrity prevail
But....

- There is a tension between the woman’s autonomy and the desire to protect the interests of the child.
USA

- Supreme Court = woman’s right to privacy was not absolute (*Roe v Wade* 410 US113 (Tex, 1973)).
- In the wake of this ruling, the courts made orders overriding competent women’s refusals of medical treatment if their foetus was viable.
- By protecting the unborn child, the courts allowed the child’s interests to trump the mother’s rights of privacy, self-determination and bodily integrity.
USA

• But – see *Re AC 573 A 2d 1235* (DC App, 1990) where the District of Columbia’s Court of Appeals overruled a court-ordered caesarean section against the wishes of a competent, terminally ill 26 week pregnant woman. The Court of Appeals said that a foetus could surely not have rights superior to those of a person who has already been born.
England

- Generally – approach of the courts was that the court had no jurisdiction to place controls on the autonomy of pregnant women.
- But – in a couple of cases in the 1980s/early 1990s, the courts authorised a caesarean section overriding the woman’s protest.
- *St George’s Healthcare NHS Trust v S [1998]* – the Court of Appeal held that the compulsory caesarean section on a competent 36 week pregnant was a trespass to the person.
Canada

- *Winnipeg Child & Family Services (Northwest Area) v G* – Court of first instance ordered that a 5 month pregnant woman addicted to glue sniffing be detained for treatment to protect the unborn child.

- Court of Appeal, affirmed by the Supreme Court of Canada, held that the order proposed would introduce a radical change to the law of tort and would create conflicts between fundamental interests and rights.
Canada

- It held that “it would have an immediate and drastic impact on the lives of women as well as men who might find themselves incarcerated and treated against their will for conduct alleged to harm others”. It would interfere with the right to self-determination and bodily integrity.
• The born alive rule is current law
• But – there is also authority for the proposition that orders can be issued to protect the life, health and interests of a foetus e.g. *Re An Unborn Child*
Clear as mud?
Lack of capacity – in an emergency

- Person legally entitled to consent on behalf of woman – Enduring Power of Attorney for personal care and welfare/Guardian
- Doctrine of necessity. Leading English case - *Re F (Mental Patient Sterilisation)*, where the court said:
  - There must be necessity to act when it is not practicable to communicate with the person to whom treatment is being provided
  - The proposed action must be one that a reasonable person would take in the circumstances
  - It must be in the best interests of the patient
Lack of capacity – in an emergency

- Under Right 7(4) services may be provided if:
  - A person is not competent to make an informed choice and give informed consent AND
  - There is no person entitled to consent available AND:
    - The services to be provided are in the best interests of the incompetent person; and
    - Reasonable steps have been taken to ascertain the incompetent person’s views; and
    - Views of other suitable persons have been taken into account
Lack of capacity – non-urgent situation

• Application to the Family Court for a personal order authorising the procedure should be made under the Protection of Personal and Property Rights Act 1988
Case examples: *In the matter of V* (1997)

- As a consequence of her mental disorder V was “abnormally confused, with an overlay of delusion, in her feelings about her pregnancy and her unborn child”
- V was reported to be fearful about giving birth and how she would cope
- Clinicians treating V were concerned that if she went through a full labour her mental state was “likely to be seriously worsened” and this could “pose a risk to the safety of the baby” and so wanted V to deliver the baby by caesarean to avoid the risk
- V’s psychiatrist gave evidence that V was incapable of understanding the nature or foreseeing the consequences of decisions about birth procedures and did not have capacity to give effective consent to the caesarean, despite V “appearing to agree” that delivery by caesarean was best for herself and the baby
Case examples: *In the matter of V* (1997)

- The Court found that V lacked capacity and that in the circumstances, the caesarean was in her best interests.
- The Court issued an order that the baby be delivered by caesarean in accordance with section 10(1)(f) of the PPPR Act (i.e. that V be provided with medical advice or treatment of a kind specified in the order).

- The Family Court issued a personal order authorising a caesarean section for a woman subject to an inpatient order under the MH (CAT) Act.
- The woman had schizophrenia and was deemed unable to appreciate the effects of the disorder on her ability to exercise self-control in difficult situations. This created a risk that she would not consent to a caesarean if complications arose during labour and birth.
- A personal order was made to pre-emptively authorise the procedure.
• Joan is 41 weeks pregnant. She has been subject to an inpatient order for most of her pregnancy. She presents with alleged ruptured membranes. It is not possible to examine her, but it does not appear that the membranes have ruptured. There are no signs she is in labour. She has had two children with no complications. Both children were recently removed from her care. CYF have an order to remove the baby once born.

• Joan is asked whether she would consent to being induced or to a caesarean if necessary. She refuses to give consent, saying that she “wants this baby to die”, and that she “never wanted it anyway”.

• What happens now?
Joan – next steps

- Assessment of capacity by Responsible Clinician/Psychiatrist
- This should be well-documented in the Joan’s maternity record and mental health record
- If competent = can refuse treatment
- If not competent and no one entitled to consent on Joan’s behalf:
  - Doctrine of necessity/right 7(4)
  - Review maternity services records/discuss with staff whether she has expressed views about her pregnancy, labour or birth while competent
  - Consultation with family/people interested in her welfare including Mental Health
Joan – next steps

• Best interests not just confined to a consideration of the impact on Joan’s physical health. In this case, it may be that a caesarean would be in the best interests of Joan on the grounds that it would impact adversely on her mental health at the present time, or in the future, if once well/competent, she had to come to terms with the consequences of her (incompetent) decision to refuse a caesarean

• Ultimately, a matter of clinical judgement
Joan – next steps

- Maternity and Mental Health should put together a clear plan around Joan’s care leading up to labour; during labour; and after birth.
- The plan should address who will be there to support her during labour and after birth; how to work with Joan during labour and after the birth; and actions if certain possible scenarios arise (to the extent it is possible to anticipate these).
- The plan should address possible situations such as where Joan becomes distressed, aggressive and/or violent.
Questions/comments

“In an increasingly complex world, sometimes old questions require new answers.”