CHAPTER 1

The Complex Meaning of ‘Mental Disorder’

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1. Introduction

The legal criteria governing compulsory psychiatric treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) are mainly stated via a definition of ‘mental disorder’ in s 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; –
and ‘mentally disordered’, in relation to any such person, has a corresponding meaning.

These standards govern entry into and exit from compulsory mental health care.\(^1\) So a person may be certified by a doctor for compulsory assessment when there are ‘reasonable grounds to believe’ they are ‘mentally disordered’ in this sense; a judge may make a compulsory treatment order (CompTO) for a person who ‘is mentally disordered’; and a person may remain under compulsory treatment for as long as they meet this test. If they cease to meet it, they are entitled to immediate release.

This chapter considers the structure and meaning of this definition and the interpretive strategies adopted by courts and the Mental Health Review Tribunal (the Tribunal) when applying it in hard cases. The early part focuses on interpretation of the first limb of the definition, which specifies – in a distinct list – of disorders of mental function – the necessary characteristics of ‘an abnormal state of mind’.\(^2\) The formulation of this list reflects a particular theme in the

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philosophy of psychiatry expounded clearly by the great Australian psychiatrist, Aubrey Lewis, who worked at the Institute of Psychiatry in London in the mid-20th century. Lewis argued that mental disorder was best defined in terms of ‘evident disturbance of part-functions of the mind’.³

The chapter then turns to interpretive strategies used by courts and the Tribunal when applying the definition. Three main strategies are identified. The first emphasises the legal character of the definition, which is found in a statute passed by Parliament, after all, not in a textbook of clinical psychiatry or a diagnostic manual of the psychiatric profession. The definition is therefore open to the usual techniques of statutory interpretation used by lawyers, under which the meaning of open-textured terms is shaped by the apparent purposes and functions of the Act. The interpretation of the criteria for compulsion would then reflect the part those criteria play in the statutory scheme, and the consequences of placing a person under it, so the scope of the powers conferred over compulsory patients and the impact of those powers on patients’ rights would be highly relevant.

This legal approach relies on the fact that the MHA is addressed by Parliament not only to psychiatrists but to the whole community: to judges, Tribunal members, compulsory patients, their families, the Police, the staff of prisons – to all engaged with the compulsory treatment process. This fact should be recognised, alongside the central role played by psychiatrists in directing compulsory treatment, and might lead to an approach that occasionally generates different meanings for central terms in the definition than those commonly held within the psychiatric profession.

A second major interpretive strategy is based, however, on the fact that application of the civil commitment criteria is ‘heavily dependent’, as the Court of Appeal puts it, ‘on the assessment of clinicians’.⁴ This might be called the psychiatric approach. It puts great weight on specialist medical opinion concerning the meaning of technical terms in the definition – like delusions and disorders of mood and perception – when these are psychiatric terms of art. It relies on the fact that Parliament has deliberately given psychiatrists key roles under the Act, requiring them to apply the definition of ‘mental disorder’ directly to patients before them – in the certification process, for instance. Why would Parliament confer such functions on psychiatrists if their disciplinary knowledge were not critical?

A third interpretive approach is championed by the Tribunal. This focuses on the strength of the justifications for compulsory treatment in the individual case.⁵ Those justifications should be assessed in light of the limits imposed on

³ A Lewis ‘Health as a social concept’ (1953) 4 Brit J Sociology 109 at 118.
⁴ Above n 1 at [68].
patients' rights by the treatment contemplated. This approach favours the least restrictive intervention and the need for proportionality between interventions and impact on rights. The total arguments for and against compulsion are assessed in the particular case, and this can produce flexible – or 'dynamic' – interpretations of key terms, like 'disorder of cognition', or 'intermittent' disorder, when the criteria are applied.

Several interpretive strategies are therefore in play. This is not surprising. The definition of 'mental disorder' has a complex structure. It uses specialised terms, like 'disorder of perception', alongside words in common use, like 'danger' and 'health'. It is applied through a complex process – of certification, assessment, treatment and independent review. The Act is addressed to specialist and lay audiences. It performs several social functions: authorising and regulating emergency admission, assessment and compulsory treatment of individuals with serious mental disorders, and regulating their transfer from the criminal courts, and prisons, to psychiatric care. It is to be expected, in this context, that the application of the central gatekeeping concept can be controversial.

2. The structure of the definition of 'mental disorder'

Initially, the structure of the definition needs analysis to reveal the character of the interpretive task. The definition has two main parts, usually known as the first and second limbs. The first covers the abnormal state of mind. The second covers its consequences, which are listed in subclauses (a) and (b). These are sometimes called the severity or behavioural tests. All parts of the definition must be met (or, in the early stages of the process, there must be 'reasonable grounds to believe' they are met) for compulsory assessment or treatment to proceed.

The two limbs are stapled together because the person's mental state must be 'of such a degree that it' poses one or more of the consequences, in terms of serious dangers or seriously diminished capacity for self-care. There must be a nexus between the person's mental state and a specified consequence. That nexus will not always be established, even when both limbs are independently met, because there may be no clear link between the abnormal mental state, that satisfies the first limb, and the consequences, that satisfy the second. To give an example: a person who is in prison may become depressed, and be said to have a 'disorder of mood', and they may, on occasion, pose a serious risk of harm to others, through their violence. But there may be no clear link between their current disorder of mood and their occasional violence. So they may not be committable from prison to hospital under the Act.

As to the first limb, when considering whether a person's mental state is 'abnormal', the question is not whether their mental state is normal (or
customary) for them, but whether it is normal amongst members of the general community – a so-called 'objective' test. This abnormal mental state can either be 'continuous' or 'intermittent', reflecting the fact that mental disorders may follow a fluctuating course. This means a stipulated disorder need not be present at the moment the person is assessed, provided it was present in the past and a convincing prediction is made it will occur again. A discrete or one-off episode, on the other hand, that has resolved and may not recur – an episode of, say, drug-induced psychosis – would not continue to meet the statutory test.

At least intermittently, the person's state of mind must be 'characterised by' one of the disorders of psychological function on the list. This leaves open the possibility that some relatively severe conditions, that might be thought to need compulsory treatment, are not covered. That is one reason why some jurisdictions use only a bare term, like 'mental disorder'. It can cover a wide range of conditions, so there may be less danger of someone who urgently needs treatment falling through the cracks. There is the disadvantage that no clear meaning is provided for this central statutory term.

The New Zealand Act defines the abnormal state of mind in particular terms. It makes no specific reference to mental illness, or disease, or brain or personality. Nor does it directly employ the language of diagnostic manuals. There is no direct reference to schizophrenic, bipolar or depressive disorders, even if individuals given those diagnoses constitute the majority of those receiving compulsory treatment under the Act. The statute does not employ the diagnostic approach that grounds the classification of mental disorders in syndromes, or in 'a cluster of symptoms and signs with a characteristic time course'. Nevertheless, the major manifestations of most serious mental disorders, including delusions, hallucinations (a disorder of perception), disorders of thought form (or cognition), and markedly disturbed mood, are included on the list. So individuals diagnosed with most serious mental disorders are covered.

The next step is to establish a nexus between the person's mental state and (at least) one of the behavioural consequences in clauses (a) or (b). These are of five kinds, covering serious danger to the health or safety of the person concerned; serious danger to the health or safety of others; and seriously diminished capacity for self-care. The same evidence could satisfy more than one consequence. Self-harming behaviour could pose a serious danger to a person's health and safety, for instance. Or behaviour such as picking fights or wild driving could pose a serious danger both to the person and others.

The element of 'serious danger' is perhaps the most controversial. The Tribunal has consistently taken the position that, to apply this concept, the

6 Waitemata Health above n 1.
evidence concerning the patient's history and prognosis should be assessed on four main parameters: the nature of the harm involved (property damage as opposed to personal injuries, for instance); the magnitude, or gravity, of that harm; its imminence; and its frequency. In other words: what kind of harm; how grave; how soon; and how often? A wide range of evidence is relevant, some concerning matters 'intrinsic' to the patient, such as their mental state and motivations, and some 'extrinsic', such as the environment in which they will live and the degree of support and supervision they will receive.

In the result, three essential elements must be satisfied before the legal standard of 'mental disorder' is met. It must be possible to characterise the person's mental state in the necessary terms; one or more of the behavioural consequences must apply; and there must be a nexus between them.

**Collateral legal principles**

When making this judgement, further principles of the legislation apply. Section 4 lists exclusionary rules that prohibit civil commitment 'by reason only of' political, cultural or religious beliefs, sexual preferences, criminal or delinquent behaviour, substance abuse or intellectual disability. Those rules warn against ready assumptions in the assessment process. We should not assume, for example, that a person suffers from delusions, or a disorder of perception or cognition, simply because they manifest particular political, religious or cultural beliefs, or demonstrate unpopular sexual preferences. Nor should we assume a person exhibits a disorder of volition simply because they engage in repeated criminal behaviour or substance abuse.

Section 5 stresses that all those exercising powers under the Act – including the power of compulsory assessment – must show 'proper respect for the person's cultural and ethnic identity, language and religious or ethical beliefs'. This section – and s 7A – also stress the need for full family or whānau consultation concerning compulsory patients. We should not jump to the conclusion that a person is 'mentally disordered' without properly understanding that person's social environment and the belief systems of their cultural group.

Section 66 adds the principle that every patient under the Act has the right to receive appropriate treatment. This cautions against labelling a condition a 'mental disorder' for which there is no appropriate treatment, though not all conditions are fully treatable. Finally, s 27(3) states that a judge, before making a CompTO, must consider the order 'necessary' in all the circumstances. It may not be 'necessary' if the patient would accept informal treatment, a less
restrictive approach would suffice, or it would be futile or counter-productive to use compulsion.\footnote{See R Mullen ‘Personality disorder and the Mental Health Act’ this volume.}

3. The list of disorders of mental function

The most distinctive feature of the criteria is the exhaustive list of disorders of mental function that defines the content of an ‘abnormal state of mind’. The mental life of a compulsory patient must – at least intermittently – be ‘characterised by’ a disorder on that list. In addition, there is the negative injunction that a person cannot be civilly committed ‘by reason only of’ the factors listed in s 4. The same approach is taken in most jurisdictions in Australia, including Victoria\footnote{Mental Health Act 1986 (Vic), s 8(1A) (as amended in 1996).} and New South Wales.\footnote{Mental Health Act 2007 (NSW), s 4.} The Victorian Act, for instance, defines ‘mental illness’ as ‘a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory’, and contains equivalent exclusionary rules. Why this approach?

The views of Aubrey Lewis

Sir Aubrey Lewis is perhaps the person most responsible for this formulation. Lewis lived from 1900 to 1975. He was born and educated in Adelaide, but became the professor of psychiatry at the Institute of Psychiatry in London from 1946 to 1966. The authors of one work of medical history describe him as ‘the most influential post-war psychiatrist in the UK’.\footnote{K Angel, E Jones, M Neve (eds), European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s (Welcome Trust Centre for the History of Medicine at UCL, London, 2003) at 3.} He was, they say, a ‘formidable and sometimes intimidating figure’ with ‘a passion for intellectual rigour’ and ‘little patience with imprecision or poorly thought-out ideas'.\footnote{Id.} He was Jewish but schooled by the Christian Brothers. He read original texts in Greek, Latin, French, German, Italian and English and is said to have been ‘scrupulous in the use of language’.\footnote{Id. at 35.} To him, ‘the reification of universals was like a red flag to a bull’.\footnote{Id. at 38.} He preferred more precise particulars for descriptions of mental phenomena, for clarity of thought. He was particularly influenced, among his psychiatric predecessors, by the work of Karl Jaspers\footnote{K Jaspers, General Psychopathology (J Hoenig and M Hamilton trans., Manchester University Press, Manchester, 1963).} and Adolph Meyer.

In a famous article, ‘Health as a social concept’, published in 1953, Lewis
said mental illness is best defined in terms of 'evident disturbance of part-
functions' of the mind, not in terms of disturbed social functioning alone. He
wrote: 19

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.

Disturbance of part-functions of the mind is shown, he said: 20

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

This philosophy informs the approach to abnormal mental states taken in most
Australasian statutes: definition via a list of disorders of discrete mental func-
tions, combined with exclusionary rules suggesting a person is not to be civilly
committed by reason only of total behaviour, however socially unacceptable
(criminal or immoral behaviour, use of substances, sexual preferences, and so
on). Careful examination of the patient's mental state, especially via the clinical
interview, is designed to elucidate these disturbances in mental function, a
clinical technique elaborated by Lewis and colleagues at the Maudsley Hospital
in London that has become standard psychiatric practice.

As to the mental functions on such a list, Lewis wrote: 'There is, . . . at
present, general agreement about the importance of the following:— perception,
learning, thinking, remembering, feeling, emotion, motivation'. 21 But this 'list
of functions' is 'provisional', and 'The main objection might be that the list is
not exhaustive'. 22 'Motivation', Lewis said, 'is the least satisfying and probably
the most important' of the mental functions, 23 and 'The crucial difficulty arises
with psychopathic personality'. 24 Of this he said: 'until the category is further
defined and shown to be characterized by specific abnormality of psychological
functions, it will not be possible to consider those who fall within it to be
unhealthy, however deviant their social behaviour'. 25

Lewis was arguing that in psychiatry the careful assessment and description
of disturbance of particular functions of the mind is central to identification
of mental ill health, in the same way that assessment of disturbance in part-
functions of the body is central to the practice of physical medicine. Danger
to self or others, on the other hand, is a contingent, not a necessary, feature of
mental illness, so it is not the defining characteristic. Reliance on part-function
is the way to distinguish the mentally ill from the merely socially deviant, and
the way to reduce the risk of the political or social abuse of psychiatry. But
the list of disorders of mental function remains provisional and is bound to be
controversial at the margins. Disorders of motivation (or volition, or will) are
important, but problematic.26 And it will be difficult to characterise those with
personality disorders in terms of disorders on the list. Nevertheless, there is no
better way to distinguish mental illness from socially unacceptable behaviour.

Legal reception of this approach

This approach has never been adopted into the law of England. In the mid-
1970s, however, at the peak of Lewis’s intellectual influence, its adoption
was advocated by two English law reform committees: the Butler Committee
on Mentally Abnormal Offenders,27 in 1975, and a departmental committee
reviewing the MHA,28 in 1976. Their proposals subsequently found a home in
Australasia.

When these English committees addressed the definition of mental disorder,
they did so in a special legal context. They were addressing its meaning not
just for the purposes of treatment, or research, or determining the prevalence
of certain conditions in the population, as may have been Lewis’s primary
concerns. They were addressing the issue for the purposes of compulsory
treatment, and detention in hospital, even secure detention for lengthy periods.
The Butler Committee was a Committee on Mentally Abnormal Offenders,
and it addressed the definition of mental disorder in the context of proposing
reform of the ‘disease of the mind’ element in the insanity defence. For those
purposes, it favoured the following formulation:29

A mental illness is severe when it has one or more of the following characteristics:
- a) Lasting impairment of intellectual functions shown by failure of memory,
   orientation, comprehension and learning capacity;
- b) Lasting alteration of mood . . .

26 See the commentary on these terms in the Ministry’s Guidelines, above n 2; and C Ruthe
27 Department of Health and Social Security Report of the Committee on Mentally
   and 18.
28 Department of Health and Social Security, A Review of the Mental Health Act 1959
29 Above n 27 at [18.35]; and see Appendix 10.
c) Delusional beliefs...
d) Abnormal perceptions...
e) Thinking so disordered as to prevent reasonable appraisal of the patient's situation or reasonable communication with others.

Here we see the classical list of disorders of mental function, advocated for inclusion in the law. The Butler Committee favoured this approach because it thought causation (or aetiology) of mental disorders could not be used as the foundation for the definition, even if that would be ideal, because, in many cases, causation was unknown, or contested. It favoured it because it defined illness by reference to specific mental functions, at which the psychiatric assessment and evidence could be directed, clarifying the functions of psychiatrists in the legal process. It favoured it because the listed disorders marked the severity of the condition, or were characteristic of the so-called ‘psychoses’ but without the need to use that contentious term. And the Committee advocated this formulation because, in such cases, ‘there is an impairment of those mental functions upon which insight and understanding depend, and an inability to adapt to the ordinary demands of the social environment’, so the person ‘tends to confuse his morbid subjective experiences with reality’.30

In this last point, the Committee introduced an additional element especially relevant to compulsory treatment. It inferred a link between specific disorders of mental function and lack of insight (or understanding), and lack of responsibility for decisions, which can justify reliance on the insanity defence and its outcome: acquittal followed by compulsory treatment.

That kind of reasoning was carried into the civil commitment context by a government committee reviewing the English MHA in 1976. That committee again drew the inference that the presence of certain disorders of mental function – which should be listed – justified the relevant outcome: here, placing a person under the MHA. The committee’s aim, as Baroness Hale would later put it, was to list in the statute ‘those symptoms which might be thought to invalidate the patient’s own decision-making’,31 justifying the transfer of authority over treatment to others. Both these English committees therefore seem to have seen the list of severe symptoms as an implicit incapacity test, and perhaps today this thinking should be carried further by legislating an explicit incapacity test.32

These proposals were made in England in the mid-1970s: at the height of Lewis’s influence; in the wake of the US civil rights movement; at a time when the American Psychiatric Association was debating removal of homosexuality from the Diagnostic and Statistical Manual; when the International Covenant on

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30 Above n 27 at [18.33].
32 See J Skipworth ‘Should patients with capacity have the right to refuse treatment?’ this volume.
Civil and Political Rights was coming into force, in 1976, prohibiting arbitrary detention and promising a right for all detained persons to independent review. It was the era of the political abuse of psychiatry in the Soviet Union, it was the peak of the anti-psychiatry movement, and there was an intense focus on preventing discrimination and arbitrary use of state power.

This was the context in which proposals for a statutory list of disorders of mental function found a home in Australasia. The aims were: to provide a short legal definition of mental disorder consistent with the philosophy of psychiatry; to provide a clear focus for the psychiatric assessment and evidence; to link the definition to a principled justification for compulsory treatment; to reduce arbitrary decisions; to permit independent review of civil commitment decisions by non-psychiatrists, including the judiciary and members of review tribunals; and to reduce the potential for political or social abuse of psychiatry. This was to be achieved while serving the legitimate social purposes of a Mental Health Act.

4. The continuing difficulties

This approach is not a panacea, of course. Even when Parliament has endorsed this approach, there are still problems determining the range of disorders of mental function to include in the list and the precise language in which they should be expressed. The terms used then have to be applied to the endless varieties of psychological life. Even psychiatrists will sometimes disagree about their meaning or application, especially if the words used are not terms of art within psychiatry but are broader philosophical terms, like ‘cognition’ and ‘volition’ in the New Zealand list. Moreover, even if psychiatrists could agree on their meanings, the courts and the Tribunal must settle their interpretation, and that may differ from psychiatrists’ reading of the law.

A situation might even arise in which the same terms were given different meanings in different contexts or by the members of different professions – a pluralistic approach raising concerns about consistent application of the law. The operation of the MHA is characterised, after all, by the pervasive exercise of discretion, especially on the part of clinicians when performing their main statutory functions of certifying patients and then discharging them from the Act. Both these functions will often be performed long before the patient goes near a court or a tribunal. In constitutional theory, psychiatrists should follow the leading decisions of tribunals and courts on the meaning of statutory terms. In reality, clinicians work in sites and contexts that confer broad discretion, with very little supervision from the courts.

There are many problems, therefore, in constructing the statutory list and fixing a correct, consistent interpretive approach.
One example: the RCH case

The leading case in New Zealand on interpretation of 'mental disorder' – the RCH or Waitemata Health case33 – brought such difficulties to the fore. The main legal question in the case concerned the circumstances in which a compulsory patient was 'fit to be released' from compulsory status' and whether they must be released whenever they cease to be 'mentally disordered' in the statutory sense. But a collateral question was whether a man (RCH) should be considered 'mentally disordered' who had been gravely abused and neglected as a child and, as an adult, was said to have a severe personality disorder with occasional bouts of depression and self-harm.

RCH had spent 13 years continuously in prison under a series of finite sentences for crimes of violence against women and for threats to kill female prison counsellors who sought to assist him and whom he thought had encouraged and then unjustly abandoned him.34 If he was 'mentally disordered', he could be committed from prison to hospital at the very end of his sentence and be controlled indefinitely in secure conditions through the forensic system. Was that within the intention of the Act?

In the series of proceedings about RCH in courts and the Tribunal over the last 15 years or so, numerous points of interpretation arose. Did he have an intermittent disorder of mood, when he had not been treated for depression for more than a year, and when there was no clear link between this occasionally present disorder and the threats he posed to identifiable women? Were his 'pervasive thoughts of attachment to and desire to harm women who he perceives had wronged him',35 and his almost constant ruminations about killing a particular counsellor who had 'gone back on her word to him'36 erotomaniac 'delusions' or merely over-valued ideas?37 What did 'delusions' mean, in this context?38 Should it have the technical meaning it had within psychiatry, or some wider legal meaning? Would it cover over-valued ideas?

Moreover, did RCH have a disorder of cognition as a result of his ruminative thought processes? Or was the problem really abnormal thought content, which could not be properly described in terms on the list? What about his perceptions or views about women or the world? Did these reveal a 'disorder of perception' or would that be a dangerously broad use of the term?39 Should that concept extend only to hallucinations as it might be used in psychiatry? The danger was

33 Above n 1.
36 Ibid. at 7.
37 Above n 35.
38 Re RCH [2002] NZFLR 413 at [33] (NZMHRT).
that RCH's continuing confinement within the forensic system, as has occurred, was a political or social abuse of psychiatry, if he was committed solely due to his socially unacceptable views or behaviour not due to particular disorders of mental function on the list.40

This is an exceptionally difficult case, revealing firstly a dispute between psychiatrists about the proper assessment of RCH's mental life, the proper use of terminology within psychiatry ('delusions' versus 'over-valued ideas'), and the likely treatment prospects. Secondly, it reveals disputes about interpretation of the law: about the meaning of terms on the statutory list. Resolving that kind of dispute requires settling an interpretive theory. Then that theory has to be applied to fix the meaning of each term on the list. Those meanings must then be measured against the psychiatric evidence to reach a judgment in the particular case. All these complexities remain even when Parliament endorses a particular formulation of the list.

With regard to RCH's case, the outcome might be that if the phrase 'disorder of cognition' is not a term of art within psychiatry it can receive a general interpretation that is broad enough to cover this man's constant ruminations of causing harm to particular women, as the Tribunal subsequently found.41

5. Interpretive approaches in the courts and the Tribunal

The 'legal' approach

Faced with the demanding language and structure of the definition, the courts and the Tribunal have adopted three concurrent approaches to its interpretation in recent years. Their starting position has been that the definition and list of characteristics of an 'abnormal state of mind' are found in an Act of Parliament. The definition is therefore a legal one. Moreover, it was enacted for the specific purpose of authorising compulsory treatment. These factors must influence interpretation. So the Tribunal says:42 'While the mental disorder definition includes clinical content, it is in the final analysis, a legal definition'. It 'is not a clinical one describing illness, but serves as a legal gatekeeper by which the community determines who should be compulsorily treated and who should not'.43

The longtime convener of the Tribunal, Nigel Dunlop, writes:44 the issue is 'whether those with extended illnesses and conditions remain mentally

41 Above n 38.
42 Re MJ6 [2006] MHRT 06/090 at [8].
43 Re KMD [2004] MHRT 04/139 at [41].
44 Above n 5 at 232.
disordered in terms of the statutory definition. Clinicians play a crucial role in assessing patients, he says, but ‘the question still goes begging as to whether the clinicians’ opinions accord with the proper meaning of those terms in the s 2 definition’.45

Patients must be assessed for the purposes of the Act against the specific terms and mental phenomena of the statutory test. This is not expressed in the same terms as the diagnostic manuals, and some of its words may not be psychiatric terms of art. So the courts may give those words an ‘ordinary’ or general interpretation. This may generate a mismatch, on occasion, between the respective aims of the statute and those of the health professions. This is well understood. As the Tribunal put it in KMD, some cases highlight ‘the distinction between clinical and legal imperatives’.46

So clinicians may sometimes think the Tribunal (or a court) takes an overly narrow view of the range of persons who should be subject to the Act, to protect patients’ rights. Or, in other cases, clinicians might think it takes an overly broad view, perhaps to protect third parties, or prevent imprisonment, or reduce pressure on families – aims that the Tribunal considers within the purview of the Act.

The RCH case is described by the Tribunal as one ‘where clinical understandings of mental disorder have clashed with legal interpretation’.47 ‘In the final analysis’, writes Dunlop, ‘it is a policy question . . . whether or not any individual is mentally disordered in terms of the Act. . . . Rights issues . . . play a part in the interpretive process’; and the key question is whether compulsory treatment is consistent with the underlying purposes of the Act.48

The ‘psychiatric’ approach

Strangely, however, a purposive reading of the Act also supports the alternative, psychiatric approach to interpretation because, in constructing the statute, Parliament deliberately conferred key roles on psychiatrists. They must certify that a person is ‘mentally disordered’, triggering compulsory assessment. They assume the role of Responsible Clinician for a compulsory patient, directing compulsory treatment. They complete further certificates and the application to the Family Court for a CompTO during the assessment period, directly extending the period of compulsion. Then they make the case for the CompTO before the Court, and, if the order is made, they must conduct the periodic clinical reviews of the patient’s condition that are required.

45 Above n 5 at 227.
46 Above n 43 at [1].
47 Re RCH [2012] MHRT 12/039 at [71].
48 Above n 5 at 232.
At numerous steps in this process psychiatrists must independently decide whether compulsory patients continue to meet the ‘mental disorder’ definition or should be discharged. Section 35(1) states, for instance:

If, at any time during the currency of a compulsory treatment order, the responsible clinician considers that the patient is fit to be released from compulsory status, that clinician shall direct that the patient be released from that status forthwith.

It is deliberately part of the statutory scheme, therefore, that for compulsion to continue both the treating psychiatrist and review bodies must agree that the patient meets the statutory test. Parliament has conferred primary decision-making authority on psychiatrists alongside courts and the Tribunal. Moreover, a psychiatrist sits as a full member of the Tribunal and examines the patient whose discharge is being considered as a distinct aspect of that body’s process.49

There are therefore many indicators that Parliament intended the disciplinary knowledge of psychiatrists to count heavily in this process, and Parliament would hardly put psychiatrists at centre stage if it did not intend them to use their disciplinary expertise. Furthermore, it cannot be a coincidence that aspects of the mental disorder definition – terms like ‘delusions’ and ‘disorder of mood’ – constitute the chapter headings in classical textbooks of clinical psychopathology used by the psychiatric profession.50

So, Dunlop writes, ‘Surely . . . a meaningful interpretation and understanding of the Act will draw heavily on the constructs and insights of modern psychiatry’.51 In part, says the Tribunal, ‘the definition is clinically descriptive, particularly its first limb’,52 which ‘has detailed clinical content’.53 Therefore, ‘When the Tribunal hears cases, it takes considerable heed of the viewpoints of clinicians’.54 Furthermore, ‘The Tribunal itself contains its own clinical expertise insofar as that one of its members must always be a psychiatrist’, and in reaching its decisions ‘it will be assisted by the expertise of that psychiatrist’.55

The Tribunal has therefore held that specialised terms, like ‘delusions’, ‘mood’ and ‘perception’, should be given:56

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.

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49 See N Dunlop ‘The Mental Health Review Tribunal’ this volume.
50 See, e.g., the chapter headings of M Hamilton (rev ed) Fish’s Clinical Psychopathology (J Wright, Bristol, 1974).
51 Above n 5 at 227.
52 KMD above n 43 at [22].
53 Above n 5 at 225.
54 Re PJT [2009] MHRT 09/130 at [60].
55 Ibid. at [61].
56 Re IM [2002] NZMHRT 57/00 at [68].
because it might be inconvenient due to the circumstances . . . of a specific and unique case.

Compromise is therefore required between ‘legal’ and ‘psychiatric’ approaches to interpretation of the Act when both these approaches seem to fit Parliament’s intentions for the statutory scheme.

The Court of Appeal’s position in the Waitemata Health (or RCH) case

This need for compromise is implied in certain well-known sentences of the judgment of Elias CJ in Waitemata Health. The Chief Justice wrote:

The words used in the definition of mental disorder are words in ordinary use, although their application is heavily dependent upon the assessment of clinicians (italics added).

The first part of this sentence suggests that we need to give the words in the definition their ‘ordinary’ meaning, while the second emphasises the core role played by psychiatrists in applying the definition to individual patients. It is not easy to reconcile these aspects of the sentence. Nor is the first part fully convincing. Some of the terms used in the definition – ‘cognition’, ‘volition’, ‘disorder of perception’, notably – are hardly ‘words in ordinary use’. Nevertheless, the sentence as a whole accurately reflects the fact that while the MHA is addressed by Parliament to the whole community, for discrete social purposes, it gives psychiatrists – along with courts and the Tribunal – a central role in applying the criteria for compulsion. The Court seems to be saying both that there must be reliance on psychiatrists’ professional expertise and that psychiatrists must be conscious of the social and statutory functions they perform under the Act.

The Chief Justice notes the parallel decision-making processes established, when she says:

If at any time the responsible clinician or a judge is of the opinion that the patient is fit to be released from compulsory status, he or she must direct the patient’s release from that status (italics added).

She correctly identifies a cardinal feature of the MHA: that both psychiatric and legal actors must directly apply the legal criteria to compulsory patients to decide whether they should remain under the Act. Psychiatric and legal imperatives are therefore embedded side-by-side. Both are bound to influence interpretation.

57 Above n 1 at [68].
58 Id.
The ‘dynamic’ approach

A further ‘dynamic’ strategy of interpretation has been developed by the Tribunal. This approach is concerned with inter-relations between the definition’s parts and flexible interpretation of its terms. It permits the meaning of some terms to change in a subtle fashion depending on the strength of the justifications for compulsory treatment in the individual case.

This approach has two main implications. First, it means the strength of the evidence concerning one element of the definition (say, ‘serious danger’) can affect the meaning given to other terms (say, ‘disorder of cognition’). A dynamic or flexible reading is authorised. So, where compelling evidence exists about ‘serious danger’, the meaning of ‘disorder of cognition’ could expand. That term could cover grossly abnormal thought content, as well as thought process, to give effect to a primary purpose of the statute, protecting third parties, even if that is not how psychiatrists would tend to use that term. Arguably, the Tribunal has applied the term ‘disorder of cognition’ in this way in reviews of RCH’s case since 2001. Moreover, the same reasoning applies where the evidence shows a person presents very serious disorders of mental function of the relevant kind. Where that is so, the threat of less serious dangers could justify compulsory treatment.

The notion of ‘intermittent’ disorder is especially open to dynamic interpretation. So the question ‘How intermittent can the disorder be and still qualify?’ has no simple answer. The concept of intermittency is flexible. The word’s meaning depends on the likely consequences of the individual patient’s relapse, and therefore on the seriousness of the danger posed.

Secondly, following this approach means that many elements of the surrounding context can be factored into the reasoning: the patient’s past response to treatment; their current treatability; the actual treatment available; the availability of less restrictive alternatives; and the strength of opposition shown by patient or family to the treatment proposed. All these factors can affect the strength of the justifications for intervention and therefore the reading of the statutory terms.

This approach is a form of rights-driven interpretation, required by the NZBORA. The same kind of reasoning is used by courts to determine whether ‘justified limitations’ have been placed on a person’s human rights: the more compelling the justification for state intervention, the more readily can it be approved. This is a sophisticated, individualised approach. It seems to complement, not subvert, the ‘legal’ and ‘psychiatric’ approaches discussed above.

59 See Dunlop above n 5; Re KMD above n 43; Re JRS [2005] MHRT 05/087; Re PFB [2005] MHRT 05/124; Applicant 08/184 [2009] NZMHRT 22.
60 For example, in Re RCH [2002] NZFLR 413.
6. Conclusion

Where does this leave the meaning of ‘mental disorder’? It shows we need to take a dynamic and flexible approach to its interpretation and that several interpretive strategies must be used to determine the meaning of its different terms. A specialised reading should usually be given to psychiatric terms – notably to delusions, and disorders of mood and perception. In compelling cases, however, a somewhat less specialised reading may be given to words that are not psychiatric terms of art. This approach would permit more general interpretation – informed by good dictionary meanings perhaps – of the words cognition and volition.

Even these latter terms should usually be given a narrow meaning, however, to respect a person’s usual right to refuse treatment; to give full force to the philosophy expounded by Lewis that informs the list of disorders of mental function; and to apply the principle behind s 4’s exclusionary rules: that a person is not to be classified as ‘mentally disordered’ by reason only of their total behaviour, or socially unacceptable thought content, or persistent violence or substance abuse.

For ‘mental disorder’ to be found, there must be ‘evident disturbance of parts-functions of the mind’ within the legitimate meaning of the statutory list. This provides the best chance of drawing a principled line between the proper use of compulsory treatment and use of other mechanisms of social control, such as imprisonment. It should reduce the prospects of arbitrary detention. It provides the best way to avoid the political or social abuse of the health professions.