THE CONCEPT OF MENTAL ILLNESS AND MENTAL HEALTH LAW IN NEW SOUTH WALES: A CRITICAL ARGUMENT

STEPHEN BOTTOMLEY*

I. INTRODUCTION

If one generalises a little, and judges by reference to recent Australian literature in the area of law and psychiatry, critical discussion about the concept of "mental illness" apparently fell out of style in the early 1980's.[1] This contrasts with the early 1970's, when "mental illness" occupied a central place in debates about mental health law reform, the power of psychiatry, and the role of lawyers in the civil commitment process.[2] For some, this change may have been due to a feeling that such discussion was doomed to be trapped in the crossfire of inter-professional warfare; or maybe it was thought that by the 1980's the topic had already been sufficiently covered.[3]

In spite of all this, this paper is concerned with the significance of the concept of mental illness for current developments in New South Wales mental health law. This is not because I wish to revitalise the polemics of the 1960's and 1970's, but because the legal-psychiatric debate about

*B.A., LL.B.(Macq.), LL.M.(N.S.W.), Lecturer, Faculty of Law, Australian National University. This article is based on a paper presented to the Fourteenth International Congress on Law and Mental Health, Montreal, June 1988.

1 This paper refers only to the law relating to civil committal. My partial impressions do not refer to the area of 'psychiatry and criminal law'.

2 See, for example, Erica Bates, *Models of Madness* (1977); Pat O'Shane, "N.S.W. Mental Health: An Insane Act" (1978) 3 *Legal Service Bulletin* 109. An overseas example is found in David Ingleby (ed.), *Critical Psychiatry: The Politics of Mental Health* (1980).

3 A less facetious explanation may be that in the intervening period the various critiques of psychiatry have shifted their focus from the concept of "mental illness" to the notion of social control as offering a better means of explicating the power of psychiatry. See Peter Miller, "Critiques of Psychiatry and Critical Sociologies of Madness" in P.Miller and N.Rose (eds.), *The Power of Psychiatry* (1986).

"mental illness" in N.S.W. is currently undergoing something of a renaissance, as lawyers, judges, psychiatrists, patients, and health workers engage in the on-going process of mental health law reform. As will be seen, this renaissance is clearly evidenced by the number of recent N.S.W. Supreme Court cases in which the definition and concept of mental illness has been considered. It is also seen in continuing dissatisfaction amongst psychiatric circles with the redefinition of the term "mentally ill person", proposed in the Mental Health Act 1983.[4] More recently, the Report of the Steering Committee on Mental Health [the Deveson Committee][5] has made recommendations concerning the legislative definition of mental illness which doubtless will fuel further debate.

This paper has two main aims: to examine those recent cases in order to critically assess what they demonstrate about the construction of the concept of mental illness, and secondly, to assess the nature of current and proposed changes to the statutory definition of mental illness. However, before examining these recent developments it is useful to canvass briefly some of the history of debates on the concept of mental illness in order to understand how this renewed discussion differs from earlier critiques.

A. EARLIER CRITIQUES OF "MENTAL ILLNESS"

In Australia, as in other jurisdictions, the critique of "mental illness" was expressed most forcefully and influentially by the anti-psychiatry movement. While it may be misleading to talk of the anti-psychiatry movement as a unified body of argument and critique, nevertheless the work of people such as Thomas Szasz and R.D. Laing, as well as that of the so-called radical psychiatrists, has tended to be grouped together under this heading.[6] I will outline what I see as the broadly common themes in many of these works, though in doing so I do not suggest that these writers have necessarily shared any unified purpose or perspective.

Critics of mainstream psychiatry in the 1960's and 1970's attacked, sought to undermine, or at least questioned what they saw as an illegitimate psychiatric hegemony. While, as Miller reminds us, these arguments had a number of different focuses (he suggests institutional, theoretical, juridical, and technological),[7] a central concern was a critique of the concept of mental illness. This critique employed both philosophical and sociological perspectives; the strategy seemed to be that by exposing the normative bases of this concept, psychiatry's privileged grip on those people labelled mentally ill could be prised open. As Miller

---

4 See discussion at notes 91-95 *infra.*

5 Steering Committee on Mental Health, *Report to the Minister for Health on the Mental Health Act 1983,* May 1988.

6 See, for example, Thomas Szasz, *Law, Liberty and Psychiatry* (1974), and *The Manufacture of Madness* (1971). Laing's work varied considerably in its emphasis, but his *The Politics of Experience* (1967), was most frequently cited. On "radical psychiatry" see Phil Brown, *Towards a Marxist Psychology* (1974).

7 Note 3 *supra,* 13.

puts it: "If we could only establish what madness is, then psychiatry's claims to pronounce on it and to treat it could be evaluated".[8]

In Australia it would be fair to say that much of this reassessment of the function of psychiatry, and the need for legal intervention, was prompted (or at least fuelled) by Szasz's writings. Szasz popularised a realisation that psychiatrists diagnose people and their conditions on the basis of social and professional norms. Mental illness, he argued, is a normative abstraction; his aim was to show that the phenomena which we call mental illness should be looked at afresh and, once removed from the category of illness, they should be regarded instead as expressions of individual struggles with "problems in living". This simple, moral ideal of personal liberty led to an equally simplistic and individualised solution that rested on the classical ideal of "contractual psychiatry"; i.e. a doctor-client relationship which would be "based on contract, freely entered into by both, and, in general freely terminable by both".[9] Szasz encouraged, within the ranks of psychiatry's critics, a civil-libertarian theme that was seen to lend some degree of political credibility to his arguments. As Sedgwick comments:

> The Szaszian case contains both the force and the fragility of any analysis of social evils undertaken from the standpoint of a single absolute moral principle . . . In this case – civil-libertarian individualism.[10]

Alongside the civil libertarian theme there was one further aspect of these critiques that needs emphasis. In looking at the concept of mental illness, attention was drawn not only to its content but also to its form. This led to questions such as how and why the concept of mental illness is used and produced. A noticeable feature was the critical attention which some of these writers directed towards the positivist method in psychiatric practice. Positivist methodology stresses a formal adherence to principles of objectivity, causality, and determinism in explaining phenomena. It:

(i) postulates a radical separation between "facts" and "values" (declaring only the former to be the subject matter of the professional investigator) and
(ii) suppresses the interactive relationship between the investigator and the "facts" on which he or she works.[11]

The positivist method, it was argued, is the foundation of "the" medical model of mental illness.[12] In its broader sense, the medical model was shown to foster explanations that promote the individual as the site of mental illness and proceed to treat that "condition" in an objectifying

---

8 *Id.*, 16.
9 Szasz, *The Manufacture of Madness,* note 6 *supra,* xxiii.
10 Peter Sedgwick, *PsychoPolitics* (1982), 154.
11 *Id.*, 23.
12 I qualify the term because in the literature there is a great degree of flexibility in the way it is used: see Bates, note 2 *supra.*

manner.[13] Mental illness (or its subcategorisations: neuroses, psychoses, etc.) could be seen not simply as a diagnostic entity, but also as a product of, and in that sense a description of, social relations in our society.[14]

Whatever their weaknesses, one of the strengths of these anti-psychiatric arguments was to make it clear that "mental illness is a social construction; psychiatry is a social institution, incorporating the values and demands of its surrounding society".[15] Though we may agree with Adlam and Rose that this revelation hardly amounts to an effective critique of psychiatry,[16] it did make possible a clearer elucidation of the nature of psychiatric work. Of course, in Australia none of these critiques led to the wholesale dismantling of the psychiatric profession or its practice. In part this is because "the Psychiatric establishment, pragmatic if not profound, has always taken enough cognizance of the reality of emotional disturbance to win people's attention".[17] A further reason, offered by Miller, is that historically critiques of psychiatry have actually been a "significant element" in "the process of modernisation and transformation" of psychiatry.[18]

B. THE RECENT CRITIQUE OF PSYCHIATRY IN N.S.W.

Anti-psychiatric thought in N.S.W. has, by and large, been subsumed within a legal critique of the public psychiatric system. It is a "legal" critique not because it has been expressed exclusively by lawyers – which it hasn't – but because it has relied on legal ideologies for its impact.[19] This is particularly true of the last five to ten years of mental health law reform which, in relation to involuntary civil commitments, have seen pilot legal representation projects, debates about the necessity and nature of legislative procedural safeguards against unwarranted civil commitment, and the formation of a publicly-funded Mental Health Advocacy Service.[20] A number of features of this period of reform need emphasis.

Firstly, there has been little in the way of conceptual analysis of core

---

13 In this broad sense, the "medical model" is both a method of investigation, and a philosophical framework – a distinction argued by Jules B. Gerard, "The Usefulness of the Medical Model to the Legal System" (1987) 39 *Rutgers Law Review* 377.

14 As Marx put it: "The same men who establish their social relations in conformity with their material productivity, produce also principles, ideas and categories in conformity with their social relations", in Marx and Engels, *Collected Works Vol. 6* (1976), 166.

15 Sedgwick, note 10 *supra*, 25.

16 D.Adlam and N.Rose, "The Politics of Psychiatry", in D.Adlam et al (eds), *Politics and Power Four: Law, Politics and Justice* (1981), 182.

17 Joel Kovel, "The American Mental Health Industry" in Ingleby, note 2 *supra*, 100.

18 Miller, note 3 *supra*, 13.

19 The "legal critique" has been expressed by both legal and medical professionals. It must be stressed, though, that there is no unified attitude towards reform of the public psychiatric system amongst the legal profession.

20 For the background to the M.H.A.S., see S.Rendalls, A.Owen and S.Bottomley, "Mental Health Law in NSW: Benevolence, Expediency Or Opportunity For Change?" (1984) 9 *Legal Service Bulletin* 268.

concepts such as "rights", "advocacy" and "mental illness" – they have, more often than not, been employed rhetorically rather than analytically. Secondly, and inter-linked with this, the process of legal reform has been pervaded by a civil libertarian, individualistic approach which is reminiscent of the undercurrents in Szasz's work. One of the main effects of this narrow view of civil liberties,[21] has been summed up nicely by Peter Sedgwick:

> [C]ivil-libertarians find themselves cast in the role of a permanent reforming opposition to the main structures of authority and decision in psychiatry . . . Their voice is essentially reactive.[22]

Thirdly, the arguments have tended to be conceptualised as an inter-professional dispute between psychiatrists and lawyers, each group seeking to make or maintain claims to an area of knowledge, both advocating the interests of the individual. The emphasis has been on a case-by-case approach, challenging specific instances of psychiatric judgement. The arenas in which these debates take place have, over time, become the inquiries, hearings, and cases conducted by magistrates (to determine initial involuntary committal), the Mental Health Review Tribunal (in relation to continued treatment of patients and forensic patients) and the Supreme Court of N.S.W.

One result of this concentration on a legal critique is that the positivist dimension of psychiatry has not been explicitly subjected to any ongoing analysis; neither, for that matter, have the positivist dimensions of the legal critique itself. The debate has been framed more narrowly, as I hope to show. Within these narrower parameters, the concept of mental illness has re-emerged as a significant issue – a focal point for the reorganisation of the interrelationship between law and psychiatry. However, the ostensible concern has not been with the form of the concept, but rather with its content. The sometimes slender theoretical insights made in earlier critiques have often been left aside. This can be illustrated by referring to some recent decisions of the N.S.W. Supreme Court.[23]

II. RECENT N.S.W. SUPREME COURT DECISIONS ON "MENTAL ILLNESS"

Since 1982 there has been a series of decisions on this issue. Although

---

21 For an argument about the limitations inherent in "civil liberties" arguments, see G.Zdenkowski and D.Brown, *The Prison Struggle: Changing Australia's Penal System* (1982), 38-39.

22 Sedgwick, note 8 *supra*, 217.

23 My focus on these cases should not be read as a preference for appellate cases as the "true" sources of law. Rather, it reflects the ready availability of Supreme Court decisions as opposed to those of magistrates. For an argument about the wide array of practices that constitute mental health law see S.Bottomley, "Mental Health Law Reform and Psychiatric Deinstitutionalisation: The Issues in New South Wales" (1987) 10 *Int Jnl of Law and Psychiatry* 369, 373.

each case has obviously involved a different set of facts, they have, for the most part, been decided by the same Judge, Mr Justice Powell.[24] The cases can loosely be divided into two groups: the first are what I will call the "section 18 cases", i.e. decisions under (the now inoperative) section 18 of the Mental Health Act 1958 which empowered a court to hear an application for the discharge of a person from a psychiatric facility where there is evidence that the person is not a "mentally ill person". This latter expression is "defined" in section 4 of the Act as follows:

> "Mentally ill person" means a person who owing to mental illness requires care, treatment or control for his own good or in the public interest, and is for the time being incapable of managing himself or his affairs and "mentally ill" has a corresponding meaning.

The second group of cases comprises the "section 38 cases", dealing with applications for property orders and the appointment of "committees" in relation to people who are "mentally ill and incapable of managing [their] own affairs".

I will begin by outlining the decisions and argument in some of these cases before pausing to make some suggestions about how they might be understood. In this light I will then go on to look at the definition of "mentally ill person" in the Mental Health Act 1983, and proposals for its amendment found in the Report of the Deveson Committee.

PY v. RJS and others, decided in 1982,[25] was a section 18 case. Powell J. held that "upon its proper construction" the section 4 definition of "mentally ill person" requires proof of three things: mental illness; the consequential requirement of care, treatment or control for the person's own good or in the public interest; and the further consequence "that he or she is, for the time being, incapable of managing himself or herself or his or her affairs".[26] In other words, for the purposes of the Act "mental illness" is a necessary but not a sufficient requirement to a formal finding that someone is a "mentally ill person". His Honour then went on to give further details about the particular requirements for establishing each of these three elements, but it is only the first (mental illness) that concerns me here. On this, Powell J. simply stated his finding, without expressly referring to any psychiatric evidence, that "the plaintiff is suffering from a mental illness, schizophrenia, which illness has manifested itself in the form of delusional experiences".[27]

Later in the same year came Mr Justice Powell's decision in *RAP v. AEP and another*[28] (a section 38 case). His Honour repeated the

---

24 Space does not allow every judgement handed down on this issue to be canvassed.
25 [1982] 2 NSWLR 700.
26 *Id.*, 701.
27 *Id.*, 702. In *CF v. TCML* [1983] 1 NSWLR 138, Powell J. repeated his views on the proper construction of the s.4 definition. Once again, His Honour went on to accept medical evidence that a person with delusions arising either from paranoid psychosis or paranoid schizophrenia was mentally ill.
28 [1982] 2 NSWLR 508.

familiar observation that the purported definition in section 4 of the Act was circular, and he went on to state that "where used in the Act the phrase [mental illness] refers to a mental illness in the classical sense of being a 'disease of the mind'".[29] By way of explanation, Powell J. argued that the juxtaposition of the term "mentally ill" in section 38 with the expression "mental infirmity arising from disease or age" in section 39 indicates that section 38 must be referring to "some form of psychiatric illness".[30] Powell J. backed up his argument by referring to the legislative precursor to section 38 of the 1958 Act, found in section 102 of the Lunacy Act 1898 N.S.W. In this latter section, reference was made to a person being of "unsound mind". His Honour referred to the interpretation of this expression which had been given in *Barnsley's Case* in 1775, in which it was stated that the expression was one "which all Persons must understand to be a Depravity of Reason, or want of it".[31] Hence, Powell J. concluded that where, as in *RAP v. AEP,* the defendant was suffering from senile dementia, he could not hold that she was a mentally ill person for the purposes of the Mental Health Act.

Some four months later Powell J. relied on this decision in another section 38 case (*DW v. JMW*[32]) to hold that Down's Syndrome was not a mental illness. He also elaborated on his previous reference to the phrase "disease of the mind":

> [T]he phrase . . . is now taken to have a very wide meaning, and such as to embrace "as well as all forms of physical or material change or deterioration, every recognisable disorder or derangement of the understanding whether or not its nature, in our present state of knowledge, is capable of explanation or determination".[33]

Schizophrenia, however, does fall within this vague description, as Powell J. confirmed in *McD. v. McD.*[34] In that case the issue was whether the defendant was "mentally infirm" (and thus an "incapable person" for the purposes of section 39) or "mentally ill". Powell J. considered a body of psychiatric evidence which expressed opinions both for and against the defendant. That evidence was apparently concerned with whether or not the defendant was presently suffering from a chronic schizophrenic illness. Powell J. resolved this conflicting evidence, in part by referring to the defendant's "somewhat eccentric mode of dress" and "her seeming indifference to the fate of these proceedings".[35] He concluded that she was suffering from schizophrenia, and that:

> at least until the condition has reached that advanced stage at which there is a marked deterioration in intellectual functions, a person suffering from schizophrenia must

---

29 *Id.,* 510.
30 *Ibid.*
31 *Barnsley's Case* (1745) 22 ER 489, cited *ibid.*
32 [1983] 1 NSWLR 61.
33 *Id.,* 66, citing Sir Owen Dixon, "A Legacy of Hadfield, M'Naghten and McClean" (1957) 31 *ALJ 255.* In *GPG v. ACF* [1983] 1 NSWLR 54, Powell J. similarly held that "X-linked mental retardation" was not a mental illness within the Act.
34 [1983] 3 NSWLR 81.
35 *Id.,* 86.

be regarded as one who is "mentally ill" rather than one who is "mentally infirm".[36]

His Honour subsequently reaffirmed the views on the meaning of "mental illness" which he had expressed on *PY v. JRS* and *RAP v. AEP,* in two further section 18 cases, deciding that alcoholism and anorexia nervosa are not mental illnesses for the purposes of the Act.[37] The latter decision was described by Powell J. as "inescapable" after he had referred to the evidence of an expert that "[a]lthough it is a serious mental condition . . . anorexia nervosa is not a psychotic illness".[38]

A. A PRELIMINARY EXPLANATION

Before going on to look at the final two cases in this analysis, it will be useful to suggest what I think underlies the cases considered so far. They might simply be summarised by saying that although the Court does not appear to be too certain about what mental illness is, it is prepared to be much more definite about what it isn't. However, I would go further than this, and suggest that the references to notions such as "disease of the mind" or "unsound mind" represent an appeal to an undefined, but (in Powell J's analysis) historically mandated *understanding* of what constitutes mental illness. The passage previously quoted from the judgement in *DW v. JMW*[39], for example, seems to rely on an "intuitive" base in defining the concept. I will develop this argument more fully after examining the two remaining cases. For the moment, however, I should stress that the (usually implicit) reliance on this "intuitive understanding" does not displace or usurp the role of psychiatric diagnoses in the mental health decision making forum. I will argue that the relationship between intuitive understandings and psychiatric opinion is much more complex than a simple either/or choice. Something of this complexity is apparent, for example, in the *RAP v. AEP* decision, noted previously, in which Powell J. explained his reference to "the classical sense of being a 'disease of the mind' "[40], by suggesting that he was looking for "some form of psychiatric illness".[41]

The final two cases to be considered in this brief chronology are perhaps the most significant for this argument. *CCR v. PS (No.2)*[42] was a "section

36 *Id.*, 85.
37 *CN v. Medical Superintendent of Rozelle Hospital,* unreported, Sup.Ct. of N.S.W., Powell J., 4 March 1986 (alcoholism not "mental illness"); *JAH v. Medical Superintendent of Rozelle Hospital,* unreported, Sup.Ct. of N.S.W., Powell J., 4 March 1986 (anorexia nervosa not "mental illness").
38 *JAH v. Medical Superintendent of Rozelle Hospital, id.*, 3-4.
39 Note 32 *supra.*
40 Note 28 *supra,* 510.
41 *Ibid.*
42 (1986) 6 NSWLR 622.

18 case"[43] involving a person with Alzheimer's Disease. The defendant (representing the hospital) opposed the application for the person's discharge, and argued that Powell J. had too narrowly interpreted the phrase "mental illness" in his previous judgements. In defining "mental illness" his Honour was invited to adopt the approach taken by Lawton L.J. in the 1974 House of Lords decision in *W v. L.*[44]

> The words are ordinary words of English language. They have no particular medical significance. They have no particular legal significance... Ordinary words of the English language should be construed in the way that ordinary sensible people would construe them. That being the right test, then I ask myself, what would the ordinary sensible person have said about the patient's condition in this case if he had been informed of his behaviour...[45]

Powell J.'s response to this invitation was that despite the "attractive" and "disarming simplicity" of this approach, he was constrained by local N.S.W. judicial and legislative history to conclude that:

> [f]or the purposes of the Mental Health Act 1958, a "mentally ill person" is to be regarded as one who, in the language of the old cases "although not having been so found, would be found a lunatic on inquisition".[46]

His Honour went on to stress that even though psychiatric opinion no longer drew a distinction between functional and organic psychoses,[47] he was bound to maintain "the distinction between the 'mentally ill person' and the 'incapable person' which the legislature has chosen to draw".[48] He concluded that a person diagnosed as having "senile dementia" (Alzheimer's type) was mentally infirm rather than mentally ill, adding that:

> [t]o many members of the medical profession... such a conclusion, based, as it is, upon distinctions which they would consider outmoded, and, discredited, is ridiculous.[49]

The final case in this analysis, *B v. Medical Superintendent of Macquarie Hospital,*[50] was a decision of the N.S.W. Court of Appeal concerning a decision originally given by Powell J. The appeal focused on the confusion

---

43 The case was complicated by the fact that the Mental Health Act 1983 had only been proclaimed in part. Section 139 of the 1983 Act is approximately the equivalent of s.18 of the 1958 Act, and continues the reference to "a mentally ill person". Powell J. held that at the time of the case both sections were in operation, though s.139 should prevail. He also held that since the definition of "mentally ill person" in the 1983 Act had not yet been proclaimed, the 1958 definition should be applied.

44 [1974] 1 QB 711.

45 *Ibid.*, 719 per Lawton L.J.

46 Note 38 *supra,* 637 (emphasis in original). The purpose of the early "inquisition" (or commission de lunatico inquirendo) was to establish whether a person was an "idiot" (or "natural fool") or a lunatic ("deprived of their understanding or reason by the act of God").

47 Functional mental disabilities were those which were regarded as having predominantly environmental or psychological etiologies; organic disabilities were traced to primarily biological factors.

48 Note 38 *supra,* 638.

49 *Id.*, at 639.

50 Unreported, Sup. Ct. of N.S.W. Ct. of Appeal, Kirby P., Priestly and McHugh JJ.A., 21 September 1987.

generated by the co-existence of the incompletely implemented Mental Health Act 1983, and the not yet fully repealed Mental Health Act 1958. In the original hearing, Powell J. had affirmed his earlier ruling in *CCR v. PS,* that section 139 of the 1983 Act had superseded section 18 of the 1958 Act, but that the operative definition of "mentally ill person" for these purposes was still found in section 4 of the 1958 Act.[51] The Court of Appeal ruled, however, that as a matter of statutory interpretation the definition of "mentally ill person" in the 1958 Act could not apply to the 1983 Act.[52] Now, since the definition in the 1983 Act had not been proclaimed, the question in the section 139 application was how the Court should define the expression "mentally ill person"? The answer given by Kirby P. was that:

> [t]he correct approach, in default of a special statutory definition (such as that provided by section 5 of the 1983 Act) is that the Court is driven back to the ordinary meaning of the phrase used. In giving that phrase meaning it would be proper to have regard to ordinary community understanding of what a "mentally ill person" is. In my view, statutory definitions, including those in the 1958 and 1983 Acts, could be used to give some guidance.[53]

Since this particular issue had not been argued during the case it was, said Kirby P., "undesirable that the Court should now venture such a definition".[54] He explained his reluctance by pointing out that:

> [a]s the changes in the definition of lunacy, insanity, unsoundness of mind and mental illness demonstrate, we are not dealing here with a simple or stable concept. It is one of a constantly changing and evolving content such as would render the automatic adoption of a definition in one statute for use in another later statute, quite unsafe.[55]

This judgment is interesting for what it reveals about the way in which the concept of mental illness is judicially conceived. The argument of Kirby P. is that if there is no statutory definition of the term "mentally ill person", then the court will fall back on unarticulated commonsense or "ordinary" meanings of the term. Note, though, that the legislation (in both its 1958 and 1983 forms) does not offer a definition of "mental illness". The relevant sections (4 and 5 respectively) define a "mentally ill person" by reference to (i) an attribute of the person: mental illness and (ii) some perceived consequential characteristics of the person (e.g., requirement of care, treatment or control, actual or possible serious bodily harm to self or others). Thus in *any* case, when it comes to attaching the meaning to the concept of "mental illness", the court will be unable to refer to a statutory definition, as the legislation is currently framed. In order to reach a decision whether a person should be committed, or whether a property order should be made, the court will inevitably import

51 Note 43 *supra.*
52 Note 50 *supra,* 15 per Kirby P.
53 *Id.,* 17 (emphasis added).
54 *Id.,* 18.
55 *Id.,* 15.

"community understandings" to give meaning to the term. This will not necessarily be done explicitly, and will often be diffused by reference to arguments about legislative history and judicial precedent, as in the judgement of Mr Justice Powell in *RAP v. AEP.* The use of commonsense understandings will thus normally be contained, to be brought out only in the exceptional case such as *B v. Medical Superintendent of Macquarie Hospital.*

B. ON COMMONSENSE UNDERSTANDINGS OF MENTAL ILLNESS

The idea that participants in the civil commitment process rely on commonsense or ordinary meanings of mental illness is not a new one. In the United States this point has been highlighted by Carol Warren's extensive study of mental health hearings in California[56] in which she observes that:

> [a]lthough the medical and legal frames may appear to conflict on the surface, there is an underlying commonsense and taken-for-granted perspective on mental illness.[57]

To explain this, Warren borrows the Greek notion of *topoi* (sing. *topos*) which De Sousa Santos explains as follows:

> No matter how precisely a norm is written, nor how carefully a legal concept is defined, there is always a background of uncertainty and probability which cannot be removed by any deductive or apodictic method. The only solution is to employ the inventive art . . . of finding points of view or "common places" (loci communes, topoi), which, being widely accepted, will help to fill the gaps, thus rendering the reasoning convincing and the conclusion acceptable.[58]

Warren uses this to argue that "psychiatric or legal models of madness merely add to, and do not cancel out, commonsense concepts".[59] Reliance on this *topos* of mental illness produces "a working consensus" between the medical and legal participants in court. Warren goes further and argues in favour of the use of commonsense perceptions, saying that they are "as legitimate as the use of unproven psychiatric or genetic theories, or contextually absurd legal assumptions concerning rationality, choice, and free will".[60]

In New South Wales a similar, though more restricted, argument has been made recently by Dr James Durham. He asserts the existence of "a common notion of what it means to be 'mad'. or 'insane', though with most people it is not analysed or articulated".[61] Whilst Durham does not advocate the use of this common notion in civil committal hearings, he does argue that:

---

56 Carol A.B.Warren, *The Court of Last Resort: Mental Illness and the Law* (1982).
57 *Id.*, 140.
58 B.de Sousa Santos, "The Law of the Oppressed: The Construction and Reproduction of Legality in Pasargada" (1977) 12 *Law and Society Review* 9, 15.
59 Note 56 *supra,* 139.
60 *Id.*, 213.
61 J.Durham, "The Gravely Inadequate Definition of a 'Mentally Ill Person' in the Mental Health Act (N.S.W.) 1983" (1988) 22 *Australian and New Zealand Journal of Psychiatry* 43, 56.

> [t]here is a certain sense of the term [mental illness] in which it denotes a category of conditions formally denoted by the terms "insanity", "madness", "unsound mind" or "lunacy" which does correspond to a widely-shared stable notion common to lawyers, physicians and lay persons. This narrower sense of the term is identical with that in which "mental illness" is accepted as . . . a necessary but not sufficient condition for "civil committal" . . .[62]

I want to look at two criticisms that can be made about these sorts of arguments. The first criticism – one recognised by Warren – is that a reliance on commonsense understandings runs counter to the mainstream view of legal reasoning and judicial decision making in Anglo-American legal thought. This is the view that holds that legal arguments and decisions are characterised by formalism and objectivism; law, in this view, is:

> a serious and coherent discipline; bounded by concepts such as "relevance" or "reasoning by analogy", and above all, to be practised by experts – those skilled in the art of "reasoned elaboration".[63]

Within this view it is acknowledged that sometimes "we might turn to other experts, the 'social scientists', who could offer objective and empirical answers to our instrumental questions",[64] but value neutrality, and the depiction of law as "separate from – and 'above' – politics, economics, culture or the values or preferences of judges"[65] remain as key components of this mainstream view. Now, as Warren points out, if commonsense criteria are seen to enter overtly into this process, they are likely to be perceived as "obstructions of justice" introducing arbitrariness and negating the separation of the law from "the world of everyday life".[66]

It may well be that concerns of this sort underlie the cautious and diffused approach of the N.S.W. Supreme Court which I noted earlier. However, I do not think that this criticism is all that significant. The mainstream Anglo-American view of legal reasoning has been subjected to a much wider, sustained critique on similar issues for many years – most recently from scholarship coming under the umbrella of Critical Legal Studies. As Kairys notes:

> While there is presently considerable dissatisfaction with the courts and their decisions from a variety of political perspectives, it is usually expressed in terms of this notion of deviation from the idealised model. Thus, the conservative criticism that courts have overstepped their bounds – going beyond or outside legal reasoning and the idealised process – is now commonplace . . .[67]

---

62 *Id.*, 43-44.

63 Alan Freeman, "The Politics of Truth: On Sugarman's 'Legality Ideology and the State'" (1986) *American Bar Foundation Research Journal* 829, 831.

64 *Ibid.*

65 D.Kairys "Introduction" in Kairys (ed.), *The Politics of Law: A Progressive Critique* (1982) 1.

66 Note 56 *supra*, 153-154. Further examples of this type of criticism are found in two responses to the *W v. L* decision, note 44 *supra:* J.Finch, "Mental Health (Amendment) Act 1975" (1976) *Modern Law Review* 70, 73; and B.Hoggett, *Mental Health Law* (2nd ed., 1984), 46.

67 Note 65 *supra*, 2-3.

The crucial flaw in this first criticism is its failure to pinpoint the social and political content of these so-called commonsense views – particularly those concerning "mental illness". This is the second criticism I will look at and one I will put more forcefully.

At a general level, there is no denying the social significance of commonsense views. Individuals rely on them in everyday life; commonsense views have "the crucial effect of simplifying experience to manageable proportions".[68] They provide an essentialist and pragmatic conception of the world:

> Common sense conceptions are intuitions but they ought not for being so described be understood as some mystically holistic apprehension of reality. They are fragmentary, incoherent beliefs and assumptions drawn from the communities within which individuals live . . . their truths are essentially practical in that they inform the practice of everyday life.[69]

These "truths" are drawn from a variety of resources: individual experience, experiences of others, and "extant theories of different types circulating in [the] wider social group";[70] they represent a merger of normative and empirical judgements.[71] In this regard, such views are both limited and limiting: "they close off and make unavailable certain options".[72]

As I suggested earlier, commonsense understandings about mental illness have a complex relationship with psychiatric thought. Mental illness is an inter-subjective construct – it cannot be explained in either wholly subjective or objective terms. It emerges from a socially produced network of meanings that draw upon a variety of resources, including personal experience. One of the principal resources in the formulation of views about "mental illness" continues to be the "psychiatric system".[73] Peter Miller and Nikolas Rose have highlighted the power of psychiatry in determining both the conception of particular problems as "psychiatric" in nature, and also the range of solutions that then seem possible; social relations, they argue, become "animated by psychiatric themes".[74] Indeed, as Miller points out, "the critique of the very concept of mental illness is one that has come predominantly from within psychiatry itself".[75] In other words, the "commonsense" understandings about what behaviours, attributes etc. should be grouped under the heading "mental illness" are

---

68 David E. Van Zandt, "Commonsense Reasoning, Social Change, and the Law" (1987) 81 *Northwestern University Law Review* 894, 914, citing Heise, *Understanding Events* (1979).

69 V.Kerruish, "Epistemology and General Legal Theory" in G.Wickham (ed.) *Social Theory and Legal Politics* (1987) 10.

70 Van Zandt, note 68 *supra*, 915.

71 *Id.*, 916 and see Santos, note 58 *supra*, 16.

72 Van Zandt, *id.*, 917.

73 Miller, note 3 *supra*, 15, describes the psychiatric system as "an ensemble of diverse theoretical categories, therapeutic practices, institutional sites, and legal codifications which are to a significant extent interdependent".

74 Miller and Rose, note 3 *supra*, 2.

75 Miller, note 3 *supra*, 24.

not *a priori* concepts, but are the product of the psychiatrically affected perceptions which percolate through to individuals in everyday life.

Judicial reliance on these understandings (whether express or implicit) is one means whereby their social status is reinforced. In order to fully explain this point, however, we need to step back, and locate this analysis within the broader context of contemporary legal thought. To do this I have borrowed – somewhat selectively – from recent work coming under the umbrella of American Critical Legal Studies (CLS).

CLS has highlighted the indeterminacy and contradictions embedded in liberal legal thought.[76] In his analytical review of CLS, Mark Kelman[77] identifies three key aspects of this indeterminacy/contradiction: the tension between rules-oriented and standards-oriented approaches to deciding disputes; the maintenance of a distinction between the subjective values and desires of individuals, and the objective nature of "universal facts"; and the simultaneous commitment to "intentionalist" views of human action (stressing individual free-will and moral self-responsibility) and determinist views (human action as "the expected outcome of existing structures").[78] This framework – especially the subjective/objective dichotomy[79] – is a useful way of explaining both the recent court decisions and also the existing and proposed amendments to the definition of "mentally ill person" in N.S.W. mental health legislation.

According to CLS arguments, mainstream Anglo-American (and, I suggest, Australian) legal thought demonstrates, in the final analysis, a preference for the view that value choices, beliefs, and morals are essentially individualistic and subjective. Furthermore, it prefers a view of legal and state action which facilitates people's diverse choices.[80] Of course at the same time the State must be able to justify its various interventions into the nominally private, subjective lives of individuals. This activity requires an appeal to what are regarded as externally verifiable objective facts,[81] since in the liberal view one could hardly justify state action solely by reference to competing "subjective" judgements. My argument is that recent mental health cases can be seen as instances in the resolution of the tension[82] between nominally subjective

---

76 The "liberal" label is vague. The aspects of liberalism which I see as relevant to the Australian context are those identified by Alan Hunt: liberalism argues for the separation of law from other varieties of social control, a "law as rules" perspective in which rules are presented as an objective and legitimate normative mechanism which can give determinant and predictable results. See "The Theory of Critical Legal Studies" (1986) 6 *Oxford Jnl of Legal Studies* 1, 4.

77 Mark Kelman, *A Guide to Critical Legal Studies* (1987) 3.

78 *Ibid.*

79 *Id.*, see generally chapter 2.

80 *Id,* 4.

81 See note 79 *supra.*

82 Martin Krygier argues against the "rhetorically overblown" use of the term "contradiction" in CLS work: "Critical Legal Studies and Social Theory – A Response to Alan Hunt" (1987) 7 *Oxford Jnl of Legal Studies* 26, 29.

and objective perspectives on the concept of mental illness.

The preceding cases present the decision about what constitutes mental illness as being the result of an essentially objective process. This form of presentation is necessary, according to CLS arguments, because these cases involve decisions about the validity of "public" intrusions into "private" lives. Thus, any subjective element in these cases must be de-emphasised. The formal value of psychiatry – both in and out of court – is that it offers an allegedly scientific and rationally-ordered set of opinions about what mental illness is (or isn't) and what should be done about it.[83] To this extent, psychiatry is a source of objective justification for these judicial decisions.[84] Of course, psychiatric opinion does not of itself settle the issue in every case, if only because there will often be conflicting psychiatric testimony presented by each party. Choices have to be made by judges and magistrates: will they accept any of the psychiatric evidence? If so, which particular evidence is to be accepted? My argument has been that in every case the choice will be informed, at least in part, by psychiatrically affected understandings of mental illness. Depending on the extent to which these understandings are overtly invoked to justify a particular decision, they may be imbued with a quasi-factual, universal status by being described as "commonsense", "ordinary" or "community" based. Again, the aim is to provide a more-or-less objective justification for the decision which is being made; by stressing its supposed communal foundation, the subjective aspect of the decision is de-emphasised. Implicit in this analysis, of course, is the realisation that there can never be a clear division between the subjective and objective aspects of the decision. Each inevitably informs the other.

A further point concerns the role of *legal thought* in this process. Kelman suggests that legal thought is one way of suppressing the tensions I have just described; legal thought allows us "to believe that we are 'solving' a case by applying settled or noncontroversial decision norms to 'facts' that are found without reference either to norms or to a subconscious urge to avoid thorny issues".[85] As an example, take Mr Justice Powell's judgement in *CCR v. PS (No.2)*[86] in which his Honour felt constrained by principles of statutory construction to distinguish between a "mentally ill person" and an "incapable person". He observed that:

> [w]hile such distinctions are retained by the legislature as the basis for determining whether or not a person may, or may not, lawfully be detained in a mental hospital . . . it is the duty of judges and magistrates – no matter how sympathetic to

83 For historical accounts of how this has come about see A.Scull, *Museums of Madness* (1979); and S.Garton, *Medicine and Madness* (1988).

84 Denise Russell provides a short and amusing critique of the claim to objectivity in "Who Is Mad?" (1982) 2 *Social Alternatives* 29.

85 Note 77 *supra,* 289.

86 Note 43 *supra.*

> the views of the medical profession they may be – to uphold, and to give effect to, such distinctions . . .[87]

Similarly, appeals to the rule of law, precedent, individual rights, the *parens patriae* and the police power justifications for civil commitment, are means of legitimating the balance that is struck in each case between psychiatrically informed individual understandings and professional psychiatric opinion.

III. CURRENT REFORMS AND PROPOSED AMENDMENTS

The continuing saga (already 15 years old)[88] of the amendment and repeal of the Mental Health Act 1958 surely reveals much about the role of legislation as a vehicle for politics, policy and posturing. At the end of 1988 over half of the provisions (including the major provisions dealing with involuntary committals) of the Mental Health Act 1983 were still not proclaimed. Consequently none of the cases I have discussed directly considered the definition of "mentally ill person" which is found in section 5 of the new Act. This new definition was intended to restrict the discretionary scope offered by section 4 of the 1958 Act: introducing the legislation into Parliament for the first time the Minister for Health said that "the proposed new law is framed deliberately in narrower terms than those that previously applied".[89] For these reasons the new definition was generally well received by those who were described in public debates at the time as civil libertarians.

Section 5(1) of the 1983 Act defines a "mentally ill person" as one who needs care, treatment or control either for his/her own protection or for the protection of others. The section lists nine criteria by which this assessment may be made; in general they refer to actual or reasonably anticipated acts involving "serious bodily harm". In eight of these categories the harm must be said to result from the person's "mental illness", although this term is not defined. Section 5(2) adds a qualification to the definition, providing that a person is not a "mentally ill person" (for the purposes of the Act) by reason only of their expressing particular political or religious opinions; their sexual preference, orientation or conduct; engaging in either immoral or illegal conduct; having a development disability of mind; or taking drugs.

The most noticeable difference between this definition and that found in the 1958 Act[90] is the emphasis which it places on verifiable objective facts[91] (e.g. evidence of serious bodily harm), which are intended to limit

---

87 *Id.*, 639.
88 For a short review, see Bottomley, "Changes to N.S.W. Mental Health Legislation: Some Reasons for a Rationalisation" (1984) 9 *Legal Service Bulletin* 23.
89 *N.S.W. Parliamentary Debates*, 1982, 2991.
90 See text accompanying note 24 *supra*.
91 Kelman, note 81 *supra*.

the ambit of psychiatric opinion in the civil commitment process. The 1983 definition more clearly reflects a liberal conviction that State sponsored intervention into the lives of mentally ill people must be justified by reference to "facts" which are knowable and generalisable. This shift in emphasis reflects the effectiveness, in N.S.W., of the civil libertarian legal critique of psychiatry's claims to objective and scientific judgements. The civil libertarian position is thus not as "radical" as some would have it; rather it is simply one position in the liberal philosophical spectrum, albeit one which takes a harder view about what type of "facts" should justify state action.

It is worth stressing, however, that the 1983 definition does not abandon a reliance on "interpersonally variable value judgements".[92] Predicting the likelihood of future dangerous conduct, assessing "the limits of normal social behaviour" (section 5(1)(b)(iv)), and in particular – defining "mental illness", are just some of the topics which are left to the combined efforts of psychiatrists, lawyers, magistrates and other involved in the mental health law process. These and the other vagaries of defining mental illness were a particular concern of the Deveson Committee. The Committee's Report[93], released in May 1988, discusses and proposes a series of recommendations concerning the inclusion of a definition of "mental illness" in the mental health legislation. The report argues that:

> [t]he approach of not statutorily defining mental illness leaves the decision about persons who may and may not be compulsorily detained to the medical profession; another consequence is that the term is artificially defined by the courts doing the best they can.[94]

To overcome this, the Committee was concerned to produce a definition which would give greater precision but at the same time would continue the more limited approach of the existing 1983 involuntary civil commitment provisions. The Report recommends that:

> [t]he definition [of mental illness] be based on symptoms and signs of major psychiatric disorders which would be recognised by virtually all psychiatrists as indicative of illnesses for which compulsory admission and/or treatment may be indicated.[95]

The proposed definition is limited "mainly to persons with psychiatric illnesses or major affective disorders (severe depression and manic depressive illness)".[96] These recommendations are supplemented by

---

92 *Ibid.*
93 See note 5 *supra.*
94 *Ibid.*
95 *Ibid.*
96 *Id.*, 29. The proposed definition of "mental illness" is: "a condition which affects the mental functioning of a person, either temporary or permanent, characterized by the presence of any one or more of the following:– (i) delusions; (ii) illusions; (iii) hallucinations; (iv) sustained or repeated irrational behaviour suggestive of delusions, illusions or hallucinations; (v) a severe and irrational disturbance of mood state".

another which suggests that "statements on the purpose of the legislation... be included in the body of the Mental Health Act 1983".[97]

In summary, these recommendations can be read as an attempt to de-emphasise the role of the judge or magistrate in defining mental illness, and to make the psychiatric basis of committal decisions more explicit. In other words they seek to re-assert a perception that those decisions should result from a rational procedure, by more clearly orienting them towards stated purposes, and by explicitly defining the criteria by which those purposes can be achieved.

IV. CONCLUSION

I will conclude by suggesting what I think is the appropriate response to the Deveson Committee's recommendations on the definition of "mental illness". I will do this in the light of the preceding analysis of the recent cases in this area.

There is, I think, an advantage in re-emphasising the formal role of psychiatric judgement in the civil commitment process. While one may agree with Warren that commonsense conceptions are at least as legitimate as "unproven psychiatric theories",[98] this should not lead to the conclusion that these conceptions should be given a free hand in that process. There is no denying, of course, that commonsense conceptions and understandings are integral to the legal process: "law is both a product of and a resource for the process of common sense reasoning of individuals in society".[99] But recognising this is quite different to celebrating the role of these perceptions in the legal process. As I have argued elsewhere, mental health law and practice develops through the two-way interaction of both law and psychiatry.[100] An express recognition of psychiatry's role in determinations of "mental illness" creates a greater potential for studying and, where necessary, criticising both psychiatry's impact on the civil commitment process, and legal responses to this.

By broadly agreeing with the Deveson Committee's recommendation on the definition of mental illness, I am not suggesting that the problem is simply one of definition – that we can get it "right" by being more precise in our criteria. Nor am I arguing that the ideals of rationality, certainty and objectivity in the civil commitment process are achievable. My argument

---

97 *Id.*, 39. The model for these statements would be ss 4, 5 and 6 of the Mental Health Act 1986, Victoria, which include express reference to "the intention of Parliament" that any powers, jurisdiction etc. conferred or imposed by the Act must be exercised so that mentally ill persons are given "the best possible care and treatment in the least restrictive environment", and "any restriction upon the liberty of patients ... is kept to the minimum necessary" (s.4(2)).

98 Note 60 *supra.*

99 Van Zandt, note 68 *supra,* 933-934.

100 Note 23 *supra.*

is a strategic one. Taken together, committal hearings, Supreme Court hearings etc. are one arena in which the production of the concept of mental illness is formalised and reinforced. Given the continuing statutory requirement of judicial/quasi-judicial input, there is something to be gained by requiring at least a nominal adherence to the privileged rhetoric of rationalism and objectivity, in order to make more explicit the part which professional ideologies (both medical and legal) play in mental health law and in the lives of the mentally ill.

POSTSCRIPT

After this article was submitted, the Mental Health Act 1990 was passed (receiving assent in June 1990). That Act replaces both the 1958 and the 1983 legislation. The new Act (*via* section 3 and Schedule 1) substantially adopts the recommendations of the Deveson Committee concerning the definition of mental illness. The differences between the definition in the Act and the Committee's Report do not affect the argument presented in the Conclusion of the article.