THIS IS AN OFFICIAL REPORT OF THE MENTAL HEALTH REVIEW TRIBUNAL PROCEEDINGS IN RELATION TO Ms S
AUTHORISED BY THE PRESIDENT OF THE TRIBUNAL ON 5 July 2017

Mental Health Review Tribunal

This is an edited version of the Tribunal's decision. The patient has been allocated a pseudonym for the purposes of this Official Report. This case was previously published as Tribunal Decision 1/99. For consistency, the same pseudonym of Ms S has been maintained.

MENTAL HEALTH REVIEW TRIBUNAL DECISION

CONCERNING: Ms S **MHRT NO: CXXXXX**

TRIBUNAL MEMBERS:

Helen Brennan	Lawyer member
Dr Leo Tsang	Psychiatrist member
Charlotte Leung	Member

APPLICATION FOR: s56 Review of Temporary Patient, *Mental Health Act 1990*

DATE AND PLACE OF HEARING: 20 April 1999, R Hospital

This matter initially came before the Tribunal on 20 April 1999 at R Hospital by way of an application under s56 of the Mental Health Act 1990 'the Act') for a four week extension of a temporary patient order in relation to Ms S. Ms S is of 17 years old, diagnosed with Anorexia Nervosa and who, at the time of presentation to the Tribunal, was in a critical medical condition. It was submitted by the Psychiatric Registrar, Dr D, that the medical team, led by Professor B, held grave concerns for Ms S. The medical team opined that an order under the Act would provide the optimum chance of saving Ms S's life, through a program of bed rest, abstaining from exercise and enforced nutritional replacements and supplementary feeding. It was hoped that once there had been some weight gain, and Ms S was out of immediate danger, she might then commence accepting treatment under the programme voluntarily. Dr D stated, that in her view, Ms S was a mentally ill person. The solicitor from the Mental Health Advocacy Service, Ms B, representing Ms S, submitted that Ms S was not a mentally ill person under the Act.

In December 1998, a Guardian had been appointed to Ms S under the *Guardianship Act 1987*. Although that order was current at the time of the hearing the medical treating team felt, that in the particular circumstances of this matter, Ms S should continue to be treated as an involuntary patient under the Act. Ms B submitted that the appropriate course, and her client's wish, was for Ms S to be treated under the Guardianship Order. It was acknowledged by all the parties present, including Ms B, that Ms S was in danger of serious harm to herself if she did not continue to receive treatment. It was Ms S's first presentation to the Tribunal.

In view of the complex legal and medical issues to be considered in reaching its decision, the Tribunal determined to adjourn the proceedings, under s271 of the Act, for one week to allow its further consideration. The matter was relisted on 27 April 1999. The Tribunal took into account the evidence given on 20 April 1999 and further evidence in relation to the continuing medical condition and behaviour of Ms S during the intervening week.

DETERMINATION

At the conclusion of proceedings the Tribunal determined that Ms S was a mentally ill person and ordered her continued detainment as a temporary patient under the Act, until 18 May 1999. The Tribunal, in the course of its determination, rejected the submission by Ms B, that continued treatment under the Guardianship Order and as an informal patient under MHA s12(2), would provide care of the least restrictive kind which was appropriate and reasonably available.

REASONS OF MRS HELEN BRENNAN, CHAIRPERSON

Anorexia Nervosa

The essential features of Anorexia Nervosa, as described in DSM-IV at p539, are:

> 'that the individual refuses to maintain a minimally normal body weight,. is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body. In addition, postmenarcheal females with this disorder are amenorrheic.' [1]

The first known description of this disorder was by Sir William Morton in 1689 when he referred to it as 'nervous atrophy', "a skeleton clothed in skin". It has also been described as "a pathological fear of becoming obese" or "a personality disorder manifested by extreme aversion to food, usually occurring in young women, resulting in life- threatening weight loss, considered an hysterical illness, but sometimes resembling or preceding a psychosis".

Background

Comprehensive background information in relation to Ms S, from the time of her initial admission, was given by Dr D. Ms S's initial presentation for deliberate weight loss was in 1996, at the age of 14, to N Hospital as an outpatient. At that time she weighed 57kg. In the period between March 1997 and December 1998, Ms S had six admissions to W hospital (including a period in the Specialist Adolescent Unit). These admissions were followed by short discharge periods during which time her weight fluctuated between 40.7 kg and 32kg. Her Body Mass Index (BMI) was consistently well below normal range. A person is at risk of being medically compromised with a BMI of less than 18. In August 1997, her BMI was 15. In July 1998, her weight was 32kg and she had a BMI of 13. In October 1998, she was once again admitted, this time following an overdose of Panadol. Ms S was depressed and dehydrated. Following discharge, Ms S attended the Outpatient Unit, until her readmission in December 1998 when investigations disclosed she was suffering from peripheral oedema, neutropenia and hyponatremia. An urgent re-feeding programme was commenced because of the seriousness of her condition. Ms S regularly indulged in behaviour to defeat the programme, such as waterloading, interfering with and pulling out her naso-gastric feeding tube, exercising and generally refusing to comply with the programme. In December 1998, a six month Guardianship Order was granted.

In early January 1999 Ms S absconded from W Hospital. When she was located she was admitted under the Guardianship Order to W Private Hospital under the care of Professor B. Evidence was give that Ms S was seriously ill upon that admission with a weight of 32kg. She was hypotensive, had bradycardia and was at risk of developing cardiac arrhythmia, which could prove fatal. During this period the Guardian was not consenting to the insertion of a naso-gastric or PEG stomach tube, but instead was negotiating with Ms S in respect to oral feeding. The treating team were of the opinion that supplementary tube feeding should be commenced immediately, for to wait until Ms S was medically compromised would put her life at extreme risk. Her weight dropped during this period to 28.3 kg and it was reported, in evidence, that she was described at that time in the notes of Professor B as the worst case of Anorexia Nervosa he had seen in 30 years. On 29 January 1999, the Guardianship Order was varied to override Ms S's 'objections to major and minor medical treatment for the treatment of Anorexia Nervosa'. Following consent by the Guardian to the insertion of a PEG tube this was inserted at R N Hospital in February 1999 and two days later she was admitted to R Hospital under the continuing care of Professor B and his team, where she remains an inpatient.

During her admission to R Hospital Ms S has consistently engaged in behaviour designed to thwart any effort by the treating team to increase her weight and stabilise her condition. This behaviour is usually secretive, but at times she is openly defiant, which was stated to be unusual in patients with this condition. The sustained and repeated behaviour described included interfering with, and removing, her naso-gastric tubes, interfering with her PEG tube by creating a blockage and cutting the tube, as well as allowing gastric contents to flow out of the tube into her bedding. She resisted bed-rest requirements, exercised and toyed with her food. She also promised to cooperate with the taking of oral supplements but later refused and waterloaded so that her weight would appear greater than it was. She was resistant to all efforts of the treating team to enable her to gain weight, despite being regularly counselled about the urgent need for weight gain to avoid medical complications that were putting her health and life at extreme risk. Her behaviour was based on her entrenched belief that

she was grossly overweight.

On 5 March 1999, whilst an informal patient under Guardianship, Ms S left R Hospital without formal discharge. At this time she was critically ill and had been advised that her condition was life threatening. The treating team and her parents were aware that there was a grave risk of her dying if she was not quickly returned to hospital. It was felt that her departure was the equivalent of a suicide attempt. Her father sought assistance from the media. The police were brought in to assist in the search. On 9 March 1999 she was returned to R Hospital with a weight of 26.5kg and a BMI of 10. Dr D stated, in evidence, that her BMI was believed to be the lowest ever recorded. She was in an emaciated condition and suffered from “re-feeding syndrome” which put her at risk of sudden cardiac death. She was transferred to the Endocrine Ward for intravenous replacement (phosphate, magnesium, thiamine) transfusions and one-to-one nursing. She was scheduled as a mentally ill person and a four week temporary patient order was made by a Magistrate under MHA s51 on 26 March 1999.

During the period of the one week adjournment by the Tribunal, Ms S's condition deteriorated. This deterioration followed the prior occasion when she had cut her PEG tube. Cutting that tube could be fatal, as complications could include perforation or blockage of the stomach from the stub of the tube and extreme risk of infection. It was stated, by Dr D, that it would be unlikely in the event of such complications for surgery to be undertaken to retrieve the stub of the tube as her condition was so poor she would be unlikely to survive surgery. The cutting of the tube occurred prior to a long weekend and fortuitously a gastro-intestinal Registrar was available to resite the tube rapidly, otherwise the evidence was that she could have died.

Proceedings

The Tribunal had before it in evidence the patient's hospital file, the Tribunal file from the adjourned hearing, a detailed history since first presentation of Ms S from Dr D, Registrar and Nursing Management Reports dated 20 April 1999 together with updated reports of Dr D. The Registrar's management report of 20 April detailed pathology tests showing irregularities. Immediate prognosis was classified as "poor". She was described as still grossly underweight with a weight of 31.2kg and a BMI of 13. She had had recent cardiac complications, was medically compromised and exhibiting recent behaviour sabotaging the treatment programme. The opinion of Dr D and the treating team was that early discharge would put Ms S at risk of death from cardiac, electrolyte and leucopoenic complications.

There was also a risk of suicide. Dr D commented further that, although it is unusual to have Anorexia Nervosa under the MHA, this was "an extremely difficult to treat case with high medical morbidity and repeated irrational behaviour".

The Tribunal noted, in its Form 2 report dated 24 March 1999, that Professor B had expressed the opinion that Ms S:

> "suffers from severe anorexia nervosa and has been in a life-threatened situation for over a month, but is incapable of accepting that she is seriously ill and has absconded from the hospital at great risk to herself. Her complete lack of insight into the seriousness of the disease constitutes a severe mental illness. If not treated adequately her continued behavioural disturbance will pose a severe risk to her life.”

He concluded:

> “Anorexia Nervosa constituting a mental illness and requiring remaining (sic) in hospital until she is physically and psychiatrically capable of looking after herself in a reasonable manner”.

In oral evidence to the Tribunal, Dr D stated that the diagnosis of Ms S was Anorexia Nervosa. There was no co-diagnosis. She was not diagnosed as psychotic though she was receiving haloperidol. It was submitted that there was evidence of disordered thinking as well as a severe disturbance of mood. Dr D emphasized that at that time, the priority of the treating team was upon improving Ms S’s medical condition in order to save her life and in-depth discussions or examinations of her mental state were

then not appropriate or possible. It was the view of the treating team that she was a mentally ill person requiring care, treatment and control for her own protection from serious harm, including the likelihood of death. Whilst there had been fluctuations in some of her symptoms and behaviour from time to time, Dr D submitted that consideration should be given to the continuing condition of Ms S in determining whether she was a mentally ill person under the MHA.

It was submitted that at times Ms S's behaviour and expressed beliefs demonstrated that she was suffering a severe disturbance of mood. Ms S's mood was described as fairly dysphoric and she was depressed to the extent that she had to be prescribed anti-depressant medication which had been cancelled due to her non compliance. She was currently felt to be a suicide risk, Ms S expressed to staff feelings of worthlessness on various occasions and being severely distressed, stating she was "not deserving of treatment", and felt "frustrated". Evidence was presented that these feelings were common depressive symptoms, though they were seen as secondary to Anorexia Nervosa. The consequence of these mood disturbances in Ms S culminated in behaviour detrimental to her welfare. Evidence was given of repeated irrational behaviour, which included, cutting her PEG tube when aware that to do so could put her life at risk, refusing nourishment and behaving deceptively to mask the fact she was not eating, and leaving the hospital when critically ill and in need of treatment. It was submitted that this behaviour indicated in Ms S the presence of a severe disturbance of mood.

The evidence of Professor B to the Magistrate was that Ms S has been:

> "in a life-threatening situation over the last month, but is incapable of accepting that she is seriously ill and has absconded from the hospital at great risk to herself. Her complete lack *of* insight into the seriousness of the disease constitutes a severe mental illness. If not treated adequately her continued behavioural disturbance will pose a serious risk to her life".

Dr D gave evidence to the Tribunal that Ms S was suffering from disordered thinking in that she held the firm and unshakeable belief, irrespective of compelling evidence to the contrary, that she was overweight and this belief, at times, reached delusional proportions. Ms S, while an articulate and intelligent young woman, seemed incapable of comprehending the extreme risks to her current and future well-being. She consistently and repeatedly carried out acts designed to stop any increase in her weight. It was brought to the attention of the Tribunal that despite Ms S being present when evidence was given to the Tribunal on 20 April that her behaviour was putting her life at risk and that unless her condition improved she could suffer cardiac failure, brain atrophy or death, Ms S nevertheless continued with her behaviour and during the following week made a further attempt to cut her PEG tube. Such behaviour was submitted as further evidence of her current state of ''seriously disorganised thinking.'' A further example of her complete lack of insight and disordered thinking was the evidence that after successful resuscitation, and when enforced feeding had been commenced only one hour before, Ms S asked Dr D when the feeding would stop as she would "gain too much weight".

Submissions by legal representative Ms B on behalf of Ms S

Ms B submitted that her client wished to be treated in R Hospital as an informal patient under a Guardianship Order. It was acknowledged by Ms B that there was no question that Ms S was in danger of serious harm to herself, but the question remained whether she was a mentally ill person under the Act. Ms B submitted that she was not a mentally ill person, as the hospital had failed to prove, to the required civil standard, that Ms S was a mentally ill person.

Ms B submitted that, based on prior authorities, Anorexia Nervosa was not a “mental illness” and as such Ms S was not a “mentally ill person” under the Act. She referred the Tribunal to the following references and authorities in support of her submission.

JAH v Medical Superintendent of Rozelle Hospital (Supreme Court of New South Wales s14 of 1986, Powell J) concerns an application for discharge of a patient, a young woman suffering from Anorexia Nervosa, under s18 of the Mental Health Act 1958 (MHA 1958). The facts of the case were not dissimilar to those of Ms S and evidence presented by Professor B, in that matter, was set out by Powell J and referred to by Ms B in the present hearing. Powell J referred to earlier decisions where he

had considered the meaning of "mental illness" under MHA1958 *(RAP v AEP* [1982] 2 NSWLR 508; *PY v RJS* [1982] 2 NSWLR 700; *CF v TCML* [1983] 1 NSWLR 138) and stated he would not repeat those views. Evidence in the matter included reference to the diagnostic criteria for Anorexia Nervosa, as given in the International Classification of Diseases - 9th edition World Health Organization (ICD) and in the Diagnostic and Statistical Manual - 3rd Edition (DSM Ill) for Anorexia Nervosa. In DSM Ill the essential criteria were:

(a) a significant state of under nutrition, together with physical consequences;
(b) brought about deliberately by the patient using a variety of weight losing behaviours;
(c) associated with a fear of being fat and an overvalued idea of being thin;
(d) in the absence of other physical or psychiatric illnesses that might account for the patient's symptoms.

Ms B particularly drew the Tribunal's attention to the reference to Anorexia Nervosa under (c) of the above criteria, in particular "an overvalued idea of being thin" and Professor B's evidence in that case that, "although it (Anorexia Nervosa) is a serious mental condition and may be life-threatening it is not a psychosis". Powell J stated:

> "[in the] light of this evidence and the views I have earlier expressed as to the meaning to be attributed to the phrase "mental illness" for the purposes of the Act ... the Plaintiff is not suffering from a 'mental illness' and that, accordingly, she is not a 'mentally ill person', for the purposes of the Act".

Ms B referred the Tribunal to an article[2] discussing legal and medical issues raised at a Grand Rounds presentation of a case of a woman who was seriously ill with Anorexia Nervosa. Ms B referred the Tribunal in particular to the statement of one of the presenters, Dr P Mitchell, who, in referring to the diagnostic criteria of Anorexia Nervosa stated:

> "Of these, the most pertinent to the current interpretation of 'mental illness' under the Mental Health Act 1958 in New South Wales is 'the pathological fear of becoming obese'. This belief, the central driving force behind anorexia nervosa, is an overvalued idea, not a delusion".

Ms B in submitting that Ms S was not a mentally ill person urged that the present Tribunal be guided by an earlier and similar matter before a prior Tribunal under the present Act (in the matter of Ms G (22 May 1996)). Similar submissions were put in that matter to the Tribunal by the legal representative, Mr W, on behalf of his client. The Tribunal stated in that matter:

> "the discussion turned on whether the level of denial of her condition constituted a delusion. The Tribunal was not satisfied on that point but felt there was a serious and imminent danger to Ms G's life precisely because of that level of denial".

The Tribunal felt that the "the most appropriate body to determine the matter was the Guardianship Board" and the matter was adjourned so that "the Board could determine the matter urgently without placing Ms G at the risk of dying".

Anorexia Nervosa and mental illness

The issue for the Tribunal to determine under the provisions of s56 MHA is whether Ms S is a mentally ill person under the Act, not whether Anorexia Nervosa is a mental illness under the Act.

The decision of Powell J in *JAH v Medical Superintendent of Rozelle Hospital* was that Anorexia Nervosa was not a mental illness and as a result the Plaintiff was not mentally ill under the MHA 1958. Section 4 MHA 1958 required three elements to be satisfied in determining whether a person was "a mentally ill person".

(a) "mentally ill person" means a person who owing to mental illness
(b) requires care, treatment or control for his own good or in the public interest and
(c) is for the time being incapable of managing himself or his affairs.

"Mentally ill" has a corresponding meaning. "Mental illness" was not defined under MHA 1958 and "mentally ill" was circular in definition.

When the statute is silent as to the definition of a word or a phrase it is for the courts to interpret the meaning of the statute. Powell J in *RAP v AEP*, in the absence of a definition of "mental illness" in MHA 1958, being unaware of "definitive judicial exposition" sought guidance from ss338 and 39 of the *Lunacy Act 1898* (which became the MHA 1958) and the distinction between "mental infirmity arising from disease or age" (ie "a disease of the brain") as opposed to "unsound mind, or depravity of reasons" (ie a disease of the mind in its classical sense). These categories originate from the historical distinction between "natural fools" [fatui naturales] and "lunatics" *[non compos mentis, sicut quidam sunt per lucida intervalla]* and the rights and obligations of the Crown in respect to persons and their property falling within each of these categories[3.] In *RAP v AEP* Powell J stated:

> "the word 'dementia denotes, not a condition attended by hallucinations or delusions such as are not uncommon in cases of schizophrenia, or by strong and irrational antipathies or fears such as are not uncommon in cases of psychosis, but rather, a condition evidencing deterioration in, or loss of, the intellectual faculties, which condition is commonly attended by confusion and disorientation reflecting a loss of memory". (p 510)

In other decisions, Powell J held that a person suffering from Down's Syndrome (*DW v JMW* [1983] 1 NSWLR 61), chronic alcoholism with war neurosis (*CN v Med Sup of Rozelle Hospital* (Supreme Court of NSW s13 of 1986), severe mental retardation (*RH v CAH* [1984] NSWLR 694), senile dementia ([1982] 2 NSWLR 508) was not mentally ill while a person with schizophrenia (*McD v McD* [1983] 3 NSWLR81) or entrenched delusions (*CF v TCML* [1983] 1 NSWLR 138) was mentally ill under MHA 1958.

In the Grand Rounds Presentation, referred to by Ms B, Dr P Mitchell mentioned the difficulties that had arisen following Powell J's rejection of Anorexia Nervosa as a mental illness. Whereas previously the young woman who was the subject of the presentation, had twice been detained involuntarily under MHA 1958, since the decision in *JAH v Medical Superintendent of Rozelle Hospital* it was not possible to detain her involuntarily under the Act "as currently interpreted". He referred to the central feature of Anorexia Nervosa as being the typical unwillingness of the patient to accept that she is .unwell or in need of treatment, and yet "this apparently diminished insight does not provide evidence of psychosis" under the then current interpretation.

> "The severely morbid clinical situation of this woman is uncommon, although when it does occur the clinician is presented with a dilemma, as anorexia nervosa has a significant mortality rate (up to 5% within 10 years of presentation)[4]… I would consider the current interpretation of "mental illness" in the NSW Act is too narrow. My concern is for other psychiatric illnesses in addition to anorexia nervosa. The failure to include a number of psychiatric illnesses under the provisions of the Act deprives some patients from appropriate medical care when they are in this uncommon, yet dangerous state of life-threatening illness".[5]

In *B v Medical Superintendent of Macquarie Hospital* (1987) 10 NSWLR 440 the Court of Appeal overruled the decision of Powell J in the matter of *CCR v PS & Anor* (no. 2) (1986) 6 NSWLR622 where as a result of the repeal of sections of MHA 1958 and the failure to proclaim sections of MHA1983 there was then no current statutory definition of "mentally ill person". Powell J decided that the definition of "mentally ill person" should be as under the repealed s4 of MHA 1958. The Court of Appeal held that His Honour was incorrect. The correct approach, in the absence of a special statutory definition, being that the Court "is driven back to the ordinary meaning of the phrase used" (at 449). Kirby P said:

> "by the language of s4, the definition of "mentally ill person" is confined to the 1958 Act. It cannot therefore apply to the 1983 Act, for it is a special statutory definition restricted by the language of the statute to operate in the statute in which it appears.
>
> 1. As 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;
> 2. This transfer would be particularly unacceptable in the circumstances of changes deliberately introduced by the 1983 Act. As the Preamble to, provisions of, and Second Reading Speech supporting the Bill for the 1983 Act demonstrate, the object of the new Act was to achieve significant reforms." (at 448)

Interpretation of the Mental Health Act 1990

Where a temporary patient is brought before the Tribunal under MHA s56, the Tribunal must, before any consideration of whether there is care of a less restrictive kind, determine under s57 whether or not the person is "a mentally ill person" under the Act. In the course of making its determination the Tribunal must enquire as to the administration of any medication to the patient and is to take into account the likely effect of such medication upon the patient's ability to communicate. It must then consider "such other information as may be placed before it" (s57(2)).

There is a clear duty upon the Tribunal in interpreting the meaning of a word or phrase under the Act to look at the words of the statute and give them their ordinary meaning. In *Cozens v Brutus* [1973] AC 854 Lord Reid stated:

> "The meaning of an ordinary word of the English language is not a question of law. The proper construction of a statute is a question of law. If the word is used in an unusual sense the Court will determine in other words what that unusual sense is ... It is for the tribunal which decides the case to consider, not as law but as fact, whether in the whole circumstances the words of the statute do or do not as a matter of ordinary usage of the English language cover or apply to the facts which have been proved. If it is alleged that the tribunal has reached a wrong decision then there can be a question of law but only of a limited character. The question would normally be whether their decision was unreasonable in the sense that no tribunal acquainted with the ordinary use of language could have reached that decision". (at 861)

The definition of "mentally ill person" in Schedule 1 of MHA reads "mentally ill person, for the purposes of this Act set out in section 8, means a person who satisfies the relevant criteria set out in Chapter 3". The relevant criteria are set out in section 9 of the Act. Certain limitations and exclusions to the definition are detailed in Section 11 whereby specified behaviours, conduct or beliefs do not, of themselves, establish mental illness. Section 9 MHA states:

> (1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care; treatment or control of the person is necessary:
>
> (a) for the person's own protection from serious harm, or
> (b) for the protection of others from serious harm.

In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

The definition of "mental illness", which is an essential element in determining whether a person is a "mentally ill person", is set out in Schedule 1 MHA:

"Mental illness means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

> (a) delusions,
>
> (b) hallucinations;
>
> (c) serious disorder of thought form,
>
> (d) a severe disturbance of mood,
>
> (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a) - (d).

In the absence of a statutory definition of “mental illness” under MHA 1958, in *JAH v Medical Superintendent of Rozelle Hospital,* Powell J relied upon recognised International Diagnostic Criteria that Anorexia Nervosa was not “a psychotic illness” but an “overvalued idea about the desirability of being thin”. Due to his interpretation of “mental illness” in the “classical sense” Powell J determined it was not a “mental illness”. Therefore the first essential element under MHA 1958 s4 had not been satisfied so the person was held not to be a mentally ill person under the 1958 Act. The decision of Powell J as to what constituted a “mental illness” under the 1958 Act continues to be influential in both legal and medical contexts. While the importance of the value of legal precedents in giving guidance when the statute is silent, or where the ordinary meaning of the statute is unclear, should not be underestimated, they must always be considered in the context of current legislation and the intention of Parliament in enacting such legislation.

In the current Act, nowhere other than the exclusion of "developmental disability" in s11, is there a requirement to establish a specific diagnosis to determine whether a person is or is not mentally ill. What is a "mental illness" under the definition in Schedule 1 is based upon the effect of specified symptoms or certain behaviours indicating the presence of one or more of such symptoms. This symptom, or symptoms, characterises a "condition", not necessarily a "mental condition", [6] that seriously impairs the mental functioning of a person.

Under the rules of statutory interpretation words and phrases are to be given their ordinary meaning. Under the MHA words are not given a "medical" meaning, but meanings given to them by "an ordinary lay person". International diagnostic criteria for various mental illnesses, as set out in publications such as Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or the World Health Organisation's International Classification of Diseases (ICD 10), cannot replace the ordinary meaning of the words in the statute.

There is a cautionary note in DSM-III:

> "the purpose of DSM-111 is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders. The use of this manual for non-clinical purposes, such as determination of legal responsibility, competency or insanity ... must be critically examined in each instance within the appropriate institutional context". (p12)

Thorpe LJ in *Vernon v Bosley* (No. 1) [1997] All ER 579 at 610-611 rejected the use of diagnostic manuals such as DSM-111-R and ICD-10 in personal injury litigation. His Honour referred to the fact that medical science was constantly expanding and evolving, and that:

> "developmental disorders of personality as opposed to mental illness seem to me to be unusually difficult to classify and define in the concrete terms within which physical illness can usually be defined".

He felt it clearly was the wrong test, that of:

> "picking up sufficient ticks within boxes in B, C, and D of the diagnostic criteria (in DSM-111-R) psychiatric illness is too complex and insufficiently concrete to be subjected to such a rigid analysis".

The caution raised in respect to the use of diagnostic criteria in a legal context, is no less relevant when viewed in the historical context of evolving medical science. Sing Lee [7], quoting Halmi [8] notes:

> "psychiatric diagnostic categories are constrained by history as well as biology ... psychobiological vulnerability factors that induced the development of irreversible starvation in medieval saints are similar to those inciting the emergence of anorexia nervosa and bulimia in twentieth century young women."

Historical research into eating disorders, for the period from 1500 to 1939 [9], provides substantial evidence of some of the characteristics seen in modem Anorexia Nervosa, such as "fear of fat", but there was no evidence of "body image distortion" (a criterion in DSM-111-R and ICD-10). They observed:

"There were, however, notable discontinuities. Over time, there was a changed explanation for fasting behaviour; its attribution to divine or supernatural intervention gave way to rational and medical theories during the process of secularisation. Of particular interest was the complete lack evidence of body-image distortion among the historical subjects. In contrast with present day anorexics, overactivity was rarely described ... the fasting objective varied from subject to subject and was never stated to be weight loss per se. Public exhibitionism was exploited, morally and materially, based on exorbitant claims of a capacity to survive without food; this stands in stark contrast with attempts by modern anorexics to convince onlookers of the adequacy, even the superfluity, of their intake."[10]

The changing nature of diagnostic criteria of Anorexia Nervosa, as with other psychiatric conditions, underlines the difficulty of adopting an approach based on such criteria. The problems of applying existing psychiatric classificatory systems in a judicial context for which they were not designed is aptly illustrated by Pathe and Mullen.[11] That is, however, not to say that such criteria are not relevant in assisting in the determination of what the medical profession considers to be a mental illness. It influences the views of the ordinary person of what is considered a mental illness. They must not become a straight jacket to the interpretation of the words of the statute, which must be given their ordinary meaning in the context of the "mischief" that Parliament sought to remedy by that legislation.

" 'Common sense' understandings about what behaviours, attributes etc. should be grouped under the heading "mental illness" are not a *priori* concepts, but are the product of the psychiatrically affected perceptions which percolate through to individuals in everyday life."[12]

In *Harry v The Mental Health Review Tribunal & Anor* (1994) 33 NSWLR 315 the Court of Appeal for the first time considered the provisions of the current Act. Kirby P stated:

"The Act should be given a purposive construction to ensure that, so far as possible its objects are achieved. Those objects include the facilitation of the care, treatment and control of persons who are mentally ill, or mentally disordered, in the least restrictive environment. See sections 4(1) and (2). In the modern approach to statutory construction, courts endeavour to avoid an unduly narrow interpretation of the words used by Parliament, particularly where a narrow approach would frustrate the achievement of the apparent objects of Parliament". (p321)

Mahony JA in that case, saw as one of the mischiefs that the Act sought to remedy, the "reconciliation of personal freedom and the need for treatment" and in considering exceptions to the general principle of the right to personal freedom stated:

"A person who needs treatment may not have the capacity to give consent to the treatment she needs. An hallucinating or potentially suicidal patient may need to be treated if she does not consent. In such cases the duty of the community to care for one who cannot care for herself may, in appropriate circumstances, have to take precedence over personal freedom… Diagnosis may often be difficult. If attended with doubt, respect for the person's personal freedom (or fear of the legal consequences) may result in treatment not being given when in fact it is needed. The present legislation was intended to provide means by which those who must make diagnoses, and would be liable in law if treatment was given when it was not justified, can form a calm judgement and do what is necessary in the patient's interest. Their judgement is to be scrutinised and, if proper, supported by the magistrate or the tribunal." (p 333)

The Intention of Parliament

In the second reading speech of the Mental Health Bill 1990 the Minister for Health, Mr Collins, stated that the Bill removed "the unnecessarily complex, legalistic and impractical aspects of the 1983 Act".[13] Mental illness is defined in the Bill on the basis of symptoms and signs:

"For the first time a definition of mental illness will be placed in this legislation. In the absence of such prescription in the Mental Health Act 1958 the courts have held that mental illness for the purposes of the Act means functional psychosis rather than organic psychosis. The difference between functional and organic psychosis is that the former has no demonstrable physical basis, whereas the latter has a physical cause. A patient with a psychotic illness is unable to evaluate external reality in some

spheres. The depressive illnesses and schizophrenia would formally have been placed unhesitatingly into the category of functional disorders. With more refined techniques of investigation, however, some specific biochemical abnormalities are being found to account for these illnesses, and the distinction between functional and organic psychosis has ceased to be meaningful. It has been replaced, therefore, by the new definition of mental illness. The relevant definition will be that which will be placed in the legislation rather than a court definition."[14]

and further referring to the symptoms characterising mental illness:

"The criterion of delusions refers to the absolute adherence of a person to a fixed irrational belief. This belief is not held by persons of the same racial, cultural or educational background, and is unshakeable by reasoning… Hallucinations are perceptions in any of the senses that are not caused by external stimuli … [In] serious disorder of thought form the main characteristic is loss of coherence with the person becoming incapable of communicating sensibly by following one idea logically with another. Severe disturbance of mood refers to a prolonged emotional state that is inappropriate given the circumstances of the person, and that is non-responsive to any event that would normally be expected to vary it."[15]

"Continuing condition" in MHA s9(2) is explained:

"It is not just the person's condition at the moment of any examination that has to be taken into account in deciding if he is, or remains, mentally ill. Fluctuations in the mental state of the person are to be taken into account. Should, at the specific time of the examination, the person not manifest one or more of the required symptoms of mental illness, but had done so in the recent past, he might meet the requirements of the definition".

Is Ms S a Mentally Ill Person under the Act?

In determining whether Ms S is a mentally ill person under the Act it is not necessary to determine whether Anorexia Nervosa is a mental illness. Categorisation of mental illness by diagnostic label was clearly not the intention of Parliament when enacting the legislation nor has it received judicial or quasi-judicial support since the enactment of the legislation.

It is not necessary for the Tribunal to consult medical texts or require further psychiatric evidence to determine whether the "overvalued idea" referred to in evidence is a "delusion", whether her belief having reached "delusional proportions" represents a psychosis or whether her symptoms of depression and seeming suicide attempts indicate a major depressive disorder. For the Tribunal to find that Ms S is a mentally ill person the Tribunal must be satisfied on the balance of probabilities that she is suffering from a mental illness, as defined in the Act, and owing to that illness, there are reasonable grounds for believing that care, treatment or control of her is necessary for her protection from serious harm. (There was no suggestion of harm to others in this matter.)

In considering the MHA Dictionary definition of "mental illness" in respect to Ms S the following observations may be made:

1. She suffers from a "condition", that condition being "Anorexia Nervosa". The definition does not require the condition to be a "mental" condition.
2. This condition must seriously impair, either temporarily or permanently, her mental functioning. Whilst there was little doubt that the Tribunal, or any observer, would have formed the view upon hearing the evidence and observing Ms S that her mental functioning was seriously impaired as a direct result of her condition, the definition requires evidence of symptoms present in the person that characterise the condition.
3. The onus of proof in relation to symptoms or behaviour indicating the presence of the specific symptoms is satisfied if one or more of the symptoms is established or sustained, or repeated irrational behaviour indicates the presence of any one or more of the symptoms.
4. There was a great deal of evidence before the Tribunal of irrational behaviour by Ms S (previously detailed) that was both sustained and repeated. This life-threatening behaviour was a feature of all her admissions and was based upon her false and irrational belief that she was obese despite all evidence to the contrary.

5. There was evidence before the Tribunal that Ms S was suffering both from a serious disorder of thought form and a severe disturbance of mood. Whilst these symptoms each have specific diagnostic criteria attached to them in the DSM-IV and ICD-10, the Tribunal is not required to tick boxes in each category to determine whether there are sufficient ticks or which symptoms fall within which category. It is sufficient for the Tribunal from the evidence presented to be satisfied that Ms S had, in the ordinary meaning of the words, one or more of the symptoms detailed.

   The rules of statutory interpretation require that where a statute is silent as to the definition of a word or a phrase one should not substitute an alternate definition. Rather, guidance can be had from determining what mischief Parliament sought to address and what the Legislators intended in the use of a specific word or phrase. In the second reading speech by the Minister for Health[16] a severe disturbance of mood" was said to relate to "a prolonged emotional state that is inappropriate given the circumstances of the person, and that is non-responsive to any event that would normally be expected to vary it."

6. The evidence was clear that Ms S held, and continues to hold, a belief that she is grossly overweight with deep conviction and, irrespective of the most compelling evidence to the contrary, she is unshakeable in this belief. In psychiatric terms such a belief may be described as "an overvalued idea" or "a belief of psychotic proportions", although not a delusion. However, the ordinary person seeing Ms S's emaciated body, and hearing evidence of her belief and sustained irrational behaviours to avoid weight gain, would consider her belief to be a delusion. In the words of the Minister, expressed in Parliament, the "criterion of delusions refers to the absolute adherence of a person to a fixed irrational belief. This belief is not held by persons of the same racial, cultural or educational background, and is unshakeable by reasoning". Ms S's belief in my view constitutes a delusion.

7. I am satisfied that, within the meaning of the Act, Ms S suffers from a condition that seriously impairs her mental functioning and that condition is characterised by the presence in her of delusions, a severe disturbance of mood and sustained and repeated irrational behaviour indicating the presence of these symptoms.

Treatment under the Guardianship Order

Ms B submitted that future treatment as an informal patient under the current Guardianship Order, under MHA s12(2), was of a less restrictive kind and was to be preferred to an order under the Mental Health Act, irrespective of whether or not the Tribunal found Ms S to be a mentally ill person.

When considering "other care" under s57 MHA it must not only be "less restrictive" but it must also be "appropriate" and "reasonably available". Evidence had been presented to the Tribunal by Dr D that when Ms S was previously undergoing treatment under the Guardianship Order the treating team experienced difficulty providing urgent emergency treatment because of delays in obtaining consent from her Guardian. Although the evidence was that the Guardian had since been replaced, this did not allay the medical staff's concerns that future delays in receiving consent or police assistance, in the event of Ms S absconding, might put Ms S's life at risk. It was submitted by Dr D that treatment as an involuntary patient would give the treating team the optimum opportunity to treat Ms S at this critical stage, in the hope that once the danger to her life was reduced and some weight gain had been achieved, she may then have developed sufficient insight to continue her treatment under the program as an informal patient under a Guardianship Order.

Determination

I am satisfied that Ms S is "a mentally ill person" under the Act and that she requires care, treatment and control for her own protection from serious harm. I am also satisfied that there is no other care of a less restrictive kind that in these circumstances is appropriate and reasonably available to Ms S and so order that she be detained as a temporary patient under MHA s57 until 18 May 1999.

REASONS OF DR LEO TSANG, PSYCHIATRIST MEMBER

I agree with the reasons of Mrs Helen Brennan, Chairperson.

REASONS OF MRS CHARLOTT LEUNG, MEMBER

I agree with the reasons of Mrs Helen Brennan, Chairperson.

ENDNOTES

1. *Diagnostic and Statistical Manual of Mental Disorders: DSM-iv* 4th ed. American Psychiatric Association, Washington D.C. 1994.
2. Mitchell PB, Parker GB, Dwyer JM (1988). "The law and a physically ill patient with anorexia nervosa: liberty versus paternalism". *Medical Journal of Australia 148(1) (p41-4 not italics)* p 41-4.
3. *Sydney Law Review* 4 [1962] p 48.
4. Later research puts the mortality rate from Anorexia Nervosa on a 20 year follow up as high as 15%.
5. Mitchell et al. op. cit. p 4.
6. Tribunal decision 1/92.
7. Lee S. Correspondence *British Journal of Psychiatry* 165 (1944) p 984
8. Ibid.
9. Parry-Jones W & B "Implications of Historical Evidence for the Classification of Eating Disorders" *British Journal of Psychiatry* 165 (1994) p 287.
10. Ibid.
11. Pathe & Mullen "The Dangerousness of the DSM-III-R" *Journal of Law & Medicine* Vol 1 July 1993 p 47.
12. S. Bottomley "The concept of Mental Illness and Mental Health Law in NSW" *University of NSW Law Journal* V12 (1989) p296.
13. Hansard NSW Legislative Assembly 22 March 1990, p 886.
14. Ibid. p888.
15. Ibid. p889.
16. Ibid.