Does mental health and guardianship legislation in Western Australia (WA) protect elderly persons from human rights abuse, and ensure procedural and substantive justice?

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This thesis is presented for the degree of Doctor of Philosophy of The University of Western Australia

The work presented in this thesis was performed in the Law School

2016
Declaration

This is to certify that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma from any university and that, to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Signed

Name  Neville Francis Hills

Date    December 1, 2016
Abstract

This thesis addresses matters affecting the liberty, rights and welfare of older people in Western Australia (WA). Restriction of personal liberty to choose where to live, and who to associate with, is usually only permitted under criminal law, following legal processes. Mental health legislation also permits restraints on freedom of individuals, subject to legal oversight of the process.

Admission into an aged care facility may restrict a person’s liberty, if placed in a locked area which they cannot leave without staff assistance. Laws regulating these procedures should be fair, open to scrutiny, and meeting international standards of law and good practice.

In 2015 there were 16,350 Commonwealth funded aged care beds in 263 facilities in WA. Records indicating which of these facilities are locked always are not kept, although accreditation standards require attention to security and safety of residents. Over 50% of residents have dementia or related conditions, potentially affecting their decision-making capacity. The WA Public Guardian has sole decision-making responsibility for 1,383 individuals, not all of whom are in aged care, suggesting the majority are placed under informal arrangements. These informal admissions are not routinely monitored by any form of legal safeguarding or oversight. Some elderly people informally admitted to mental health facilities, also have no protection under mental health legislation, and no access to official advocates.

Informal detention in aged care, has received substantial examination overseas and in other states of Australia. In WA, authorities up to now have shown limited interest in the ethical and human rights aspects. The ‘Bournewood’ case in England provoked
substantial attention and litigation, but the lessons derived have not received attention in WA. Unlike the UK, there is no Human Rights Act in WA, nor any right of independent appeal to an international court. The fact that mental health care and legislation is a state responsibility, while aged care is under Commonwealth government control, creates a gap in ownership of this problem.

Laws regulating admission to psychiatric hospitals in WA, owe their origins to historical developments in English law and procedures, handed down in the colonial era. These have been modified in each jurisdiction with the passage of time and local influences. The extent of this divergence is examined in this thesis by two methods; a table of comparisons set out in chapter 3, and an opinion survey of psychiatrists in chapter 4, with further chapters discussing legal and practical issues.

Current views on capacity and consent are discussed, followed by consideration of risks with non-consenting detention in aged care, including elder abuse and potential harm. The thesis examined the position up to November 30, 1915 while the Mental Health Act 1996 (WA) was in operation. There are comments in chapter 8 on the Mental Health Act 2014 (WA) and its ability to address some of these matters. English reports indicate serious problems with the costly and burdensome legislation adopted in that country. The thesis concludes with suggested measures which may assist in remedying some of the reported defects in current law and practice, while avoiding unduly complex and ineffective legislation.
Acknowledgements

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Secondly, and not least I thank my wife Roberta, who has shown great patience and support in my many absences, both at home and away.

Thirdly, I acknowledge the contribution to my understanding of law and psychiatry which I have received over many years from patients, carers and fellow workers.

Assistance with editing from Ceridwen Clocherty was much appreciated.
Statement of candidate contribution

This thesis is entirely my own authorship.

The thesis is 90864 words in length, excluding footnotes, bibliography and appendices.
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Abbreviations

ACAT  Aged Care Assessment Team

CoOV  Council of Official Visitors

DoLS  Deprivation of Liberty Safeguards

ECHR  European Convention on Human Rights

ECtHR  European Court of Human Rights

HaDSCO  Health and Disability Service Complaints Office

HDWA  Health Department of WA

MHC (WA)  Mental Health Commission of Western Australia

MHRB (WA)  Mental Health Review Board of Western Australia

MHRT (UK)  Mental Health Review Tribunal (Termed the First-Tier Tribunal since 2008. The original term, MHRT will be retained throughout this thesis for consistency).

MHRT (WA)  MHRB (WA) (renamed in Mental Health Act 2014)

MHT (WA)  Mental Health Tribunal (WA 2015)

UK  United Kingdom

UWA  University of Western Australia

WA  Western Australia
1 Introduction and review of the field

1.1 Introduction

This chapter addresses the key topics which have been researched in this thesis and indicates their relevance to the unfolding document. The problem at stake is proposed, and an outline given of the legal, social and medical fields which are impacted when deprivation of liberty occurs in the context of medical care. This medical care may arise in psychiatric hospitals under mental health legislation or informally in aged care facilities. A complex matrix of legal, medical, social and government policies is outlined to set the scene for the legal avenues examined and the research approach pursued. The research aimed to expose the extent of problems, and suggest directions for future action, bearing in mind that experience elsewhere has highlighted the considerable difficulties involved.

1.2 What is the problem that this thesis addresses?

The ability to direct oneself and make decisions on personal health, lifestyle or financial matters is influenced by the capacity, to make those decisions free from undue or oppressive coercion, and advance the best interests of the person. Free personal choice, or autonomy, can be eroded by many influences which are part and parcel of the human condition, particularly health and social factors. With increased age, they come to assume even greater significance, and in some circumstances, can result in limitation or removal of the ability to make decisions. Elderly persons may experience limitation of their autonomy through a variety of social and cultural expectations, as well as illnesses and the effects of medical treatments or care. The matter of who makes these decisions, the person himself or others, is central to promoting autonomy and resolving conflict.¹

¹ Beauchamp T, Childress J, Principles of Biomedical Ethics, ((Oxford University Press 1994) 3, 120: The word *autonomy* derived from the Greek *autos* (“self”) and *nomos* (“rule,” “governance,” or “law”) was first used to refer to the self-rule or self-governance of Hellenic city-states.
Over the centuries all societies have developed a variety of systems of law and procedures, to ensure protection of the assets and interests of mentally incapacitated persons. A need to balance rights to autonomous decision-making, against the rights of other persons who may equally have legitimate interests to be protected, such as family members, carers and dependents has grown. As we live in a socially regulated society, personal autonomy is not unlimited and must consider a range of interests, some of which may give rise to conflict.

A key development in this field is the increased recognition of the rights of the disabled, including elderly persons with disabilities. This is reflected in the UNCRPD to which Australia is a signatory, and was an active partner in its formulation. In a reference to the impact of the UNCRPD, The Australian Law Reform Commission (ALRC) states:

> The CRPD reflects a “social” model of disability which describes disability in terms of the interaction between person’s disability and the external world.

### 1.3 Examples of a problem

To ground the research in real examples the following two cases illustrate potential problems in each jurisdiction. The first is provided with permission of a relative of the affected person. The second is an account of what is known in the United Kingdom as ‘The Bournewood case’, which has been widely reported.

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2. E.g. Statutum de Praerogativa Regis, Courts of Chancery, UK, etc.
4. ALRC Report 124, August 2014, 36, 2.4.
5. Ibid, 38 2.11.
1.3.1 Case 1: WA

A 94-year-old man alone at home in a rural WA town where he had lived and worked since the age of 12, became increasingly unwell and was admitted to the small general hospital in that town. The hospital was well regarded in the community, including by the patient who expressed a wish to remain there until he died.

An abdominal cancer was identified and he underwent two blood transfusions as well as receiving general nursing care and medications for pain relief. He was considered by an experienced family member (a nurse), to have some degree of confusion at times, although communication was clear and he remained aware of his situation. He developed abdominal swelling, which was said to cause some difficulty with nursing care, although lifting equipment and staff were available. He was satisfied with the care he received, and his constant wish was to spend his last days in his home town.

The hospital manager deemed him to be a bariatric or overweight patient, and insisted he was to be moved to any available nursing home, even to Perth if necessary. He stated it was hospital policy, and ‘my hands are tied’. No nursing home was available within the small town, and transfer was being firmly urged.

As admission to a nursing home requires approval from the Commonwealth Health Department, an assessment from the Aged Care Assessment Team (ACAT) was requested by the hospital. A sole nursing officer from a neighbouring town attended and completed the Commonwealth assessment forms approving his admission for high level nursing home care. Mercifully the patient passed away before any attempts could be made to transfer him. However, his family were placed under considerable stress at a critical time in his terminal illness.
A Freedom of Information request for a copy of the ACAT forms was submitted with the consent of his daughter. This revealed that the patient had signed the consent form for an assessment leading to admission to a nursing home, contrary to his family’s knowledge of his long-held wishes. No assessment of his capacity to consent, or his understanding of what he was being asked to sign was recorded. No friends or family members were invited to be present at the time of the assessment, although readily available.  

1.3.2 Case 2: England

A series of court cases of international significance commenced in England in 1995 regarding consent to hospitalisation and treatment, including who should make decisions for persons lacking mental capacity.  

The case concerned a male patient (L) at Bournewood hospital, who was born to older age parents in 1949. After apparently normal development for 30 months he failed to progress, being found to have severe learning disability and autism at the age of seven. He was admitted to Botleys Park Hospital at the age of 14, and his parents died in the 1960’s. He continued to live at the hospital for 30 years and was diagnosed as suffering from autism, intellectual handicap, possible mood disorder and temporal lobe epilepsy. In 1994 L left the hospital to be placed with a family under paid foster care arrangements. This included a requirement that he attended a day centre weekly and was subject to follow-up. He was

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7 A similar experience was recorded in the Staffordshire Hospitals Inquiry in England. The report noted: ‘Another family was positive that they were available to be present at the consenting process required for a procedure even though the consent form recorded them as “not available”. At the very least, insufficient effort must have been made to find them.’ Mid Staffordshire NHS Foundation Trust Public Inquiry, Francis R, QC.


9 Formerly known as Botleys Park hospital, the name has been again changed to North West Surrey Mental Health NHS Partnership Trust, possibly in view of the resulting opprobrium the name “Bournewood” has attracted.

10 Carers identified in reports as Mr. & Mrs. E.
reported to have improved both physically and socially in the local community. Three years later he was still on a trial basis with his carers and had not been discharged from the hospital.

In July 1997, an episode of disturbed behaviour at the day centre occurred, at which time his carers could not be contacted temporarily. He was taken to the emergency department of Bournewood hospital, where a duty psychiatrist saw him. It was decided to admit him to the Intensive Behaviour Management Unit (IBU). As he appeared not to resist admission, he was admitted informally under the customary *duty of care* policy.\(^1\) His consultant psychiatrist had been previously informed of increasing behaviour problems over several months. She considered compulsory admission under Section 3 of the Mental Health Act 1983, but as he appeared compliant he was admitted as an informal [voluntary] patient under section 131 (1).\(^2\)

The following day L was reported as …calm, had complied with all care needs and accepted the change without problem.\(^3\)

The escalating behaviour problems with self-harming acts and a possible mood disorder were said to suggest that serious issues needed to be addressed before he could return to the day centre. He was reported to find it ‘…increasingly difficult to cope with his environment and group’.\(^4\) The day centre insisted these had to be remedied before they would consider his return.\(^5\) This would have placed his community placement at risk of cancellation.

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11 The *Mental Health Act 1983* (UK) s131, has specific provisions for informal admission of patients.

12 *H.L. v. THE UNITED KINGDOM (Application no. 45508/99) JUDGMENT STRASBOURG 5 October 2004*: Having considered the drafting history of section 131 of the 1983 Act, Lord Goff concluded that section 131 applied to patients who consented as well as to those who, lacking the legal capacity to consent, did not manifest any objection. As to the basis upon which the hospital was entitled to treat informal patients admitted pursuant to section 131: “It was plainly the statutory intention that such patients would indeed be cared for, and receive such treatment for their condition as might be prescribed for them in their best interests. Moreover, the doctors in charge would, of course, owe a duty of care to such a patient in their care. Such treatment and care can, in my opinion, be justified on the basis of the common-law doctrine of necessity ...” (*In re. F (Mental Patient: Sterilisation)* [1990] 2 A.C. 1).


14 Ibid at 14.

15 The day centre was one catering to intellectually handicapped persons, and the appropriateness of this type of placement for an autistic individual seems not to have been examined. Many autistic persons commonly need a strictly structured and consistent routine, whereas intellectually handicapped benefit from change and stimulation. On the day in question his routine travel arrangements were unexpectedly changed due to an unfamiliar driver.
Concerns that may be perceived in the background were; which department, Social Services or Health, was responsible for funding his care in the community after three years’ placement, and whether the routines of a day centre for intellectually handicapped were suitable for an autistic man.

His carers were instructed not to visit until further advised, and no length of admission was nominated. The *no visiting* direction was said to be unit policy, in case L became unsettled and attempted to return home with the carers. Relationships with the paid carers broke down as they felt unable to support L at this critical time. They felt hospital staff were making it difficult for them to arrange his return home. As was subsequently confirmed in court, all his decisions were being made for him by the medical staff of the hospital, with no legal basis. The carers stated:

…as the days went by they kept fobbing us off and we began to think he would never come out of hospital again.\(^\text{16}\)

According to the first legal report following an application for a writ of habeas corpus and judicial review, Owen J commented:

Dr Manju, the clinical Director (Learning Disabilities) and Deputy Medical Director for the Trust, says that the Applicant’s best interests required, have continued to require and are likely for some time to require, in-patient treatment in order to prevent deterioration in his health.\(^\text{17}\)

… The case is put forward on behalf of the Applicant that he has been “detained” in hospital and, since he did not consent to detention, or for that matter to an informal admission, his detention and treatment have been unlawful.\(^\text{18}\)

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\(^{16}\) Communitycare.co.uk, HL learning difficulties case, online, 13 July 2006.

\(^{17}\) *L v Mental Health NHS Trust (1997) EWHC Admin 850* (9th October 1997), 5.

\(^{18}\) Ibid 6.
The fact, it is said, that he does not know he is detained is of no matter since, “a person can be imprisoned while he is asleep, while he is in a state of drunkenness, while he is unconscious and while he is a lunatic”: per Atkin LJ in Meering v Graham White Aviation Co. Ltd. [1919] 122 Law Times 44.\(^8\)

The case went on appeal to the House of Lords, which decided in favour of the Hospital and Government case. A major concern of the Lords was the daunting prospect, that every person in the United Kingdom who was detained in a hospital or care home without a legally based arrangement, could need to be detained under the Mental Health Act 1983 (UK):

In 1998, when the Court of Appeal gave a similar (though not identical) judgment, the Mental Health Act Commission (MHAC) undertook a survey which implied that at any one time there were some 22,000 compliant incapacitated hospital in-patients in England and Wales who would instead have to be detained formally under the 1983 Act and that each year there would be around 48,000 more formal admissions under the 1983 Act.\(^\)\(^9\)

An appeal by the carers to the ECtHR in Strasbourg resulted in a decision against the government position, the Judges finding breaches of Article 5 and Article 14 of the ECHR, which state.\(^\)\(^10\)

Article 5 (1) – Right to liberty and security.

Everyone has the right to liberty and security of the person. No-one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

… (e) The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind (emphasis added), alcoholics or drug addicts or vagrants.

Article 5 (4) - Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

\(^8\) Ibid 7.
Article 14 – Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, political or other opinion, national or social origin, association with a national minority, property, birth or other status.\(^2\)

As a consequence of the ECtHR result the British government was obliged to reconsider its position. The \textit{Mental Capacity Act 2005} (UK) had been intended to address concerns regarding persons lacking legal capacity, but it did not make provision for the type of deprivation of liberty in the Bournewood case. To remedy the position, a measure referred to as the DoLS was added to the \textit{Mental Health Act 2007} (UK), which was being revised at the time. While there has been general support for the \textit{Mental Capacity Act 2005} (UK), the DoLS have met with criticism from various quarters.

The level and breadth of criticism of the Deprivation of Liberty Safeguards, including from the judiciary, demonstrates that the legislation is not fit for purpose. Better implementation would not be sufficient to address the fundamental problems identified.\(^2\)

\subsection{1.4 Australian Federal and State jurisdictions}

Under the Australian system of government each state and territory has its own court hierarchy. The Commonwealth Government also has a court hierarchy which deals with national legislation as agreed under the Australian Constitution.\(^2\) Mental health and guardianship are not included under Commonwealth legislation and each state has its own individual approach, although there are generally common features. A gap appears to exist between the Commonwealth Government jurisdiction, and individual state and territory responsibilities for aged care. This leads to lack of clarity regarding responsibility, duplication, and a risk of abused persons falling between the two systems.\(^2\)

\begin{itemize}
\item \(^2\) ECHR, <http://www.echr.coe.int/Documents/Convention_ENG.pdf>.
\item \(^2\) House of Lords Post Legislative Scrutiny Chapter 3: \textit{The five core principles: Is the Act working as intended?} 32.
\item \(^2\) \textit{Commonwealth of Australia Constitution Act}, 1900.
\end{itemize}
1.4.1 Structure of government

There is an important political and administrative distinction between mental health law in Britain and Australia. The Westminster government has the major role in administration and responsibility for all English mental health legislation, and operation of the National Health Service (NHS) in England and Wales. English laws are based on the Mental Health Act 1983, amended in 2007. Scotland has its own legislation\(^{26}\) which has some common features, and Wales implements the English legislation via the Welsh National Assembly.\(^{27}\) Northern Ireland has its own parliament and mental health legislation.\(^{28}\) This research examines the position in England only.

Since the introduction of the Human Rights Act 1998 (UK), courts have a duty to consider Human Rights issues in judgement decisions and procedures, but are not bound. They are also obliged to give due attention to the European Convention on Human Rights (ECHR). If a UK court holds that the law conflicts with European law, a ‘declaration of incompatibility’ can be made. The Court can refer the matter back to the Westminster Parliament, thereby preserving parliamentary sovereignty.\(^{29}\) The first significant case in which this occurred involved a mental health matter, viz. the reversal of the burden of proof in MHRT’s.\(^{30}\)

While WA mental health law has many of the expected safeguards to protect the interests of elderly persons, this thesis established that there are gaps which collectively contribute to an inadequate system. On the other hand, the profusion of laws and safeguarding procedures in England appears excessive, and their effectiveness is questionable.\(^{31}\)

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\(^{26}\) Mental Health (care and treatment) (Scotland) Act 2003.

\(^{27}\) Wales has also introduced the Mental Health (Wales) Measure 2010, with additional provisions.

\(^{28}\) The Mental Health (Northern Ireland) Order 1986.

\(^{29}\) Jones R, Manual of Mental Health Law, 5-006, 3.

\(^{30}\) R (H) v Mental Health Review Tribunal for North and East London Region, [2002] QB 1, 9.

1.5 Admission to hospitals and aged care homes

Attention is paid in this research to persons who lack mental capacity to make their own decisions, who are received into, or placed in, psychiatric or aged care facilities. The topic of capacity to consent, has been extensively examined and in many cases re-formulated overseas. Serious consideration in Australia, especially WA, has emerged slowly.\textsuperscript{32}

Of special importance are those decisions made prior to hospitalisation or care home placement, which is a crucial tipping-point at which the wishes of the patient and family or medical authorities may conflict. Once admission has been made to a care home, the prospects of a return home are remote in some cases, and this underlines the importance of correct procedures. A widely-adopted principle underlying hospitalisation procedures has been that of the ‘least restrictive alternative’:

The ‘least restrictive option’ principle was raised explicitly in relation to care for dementia patients. Professor Jones referred to research “which showed that 60% or thereabouts of patients with dementia who were admitted to hospital were admitted from their home, but only 30% were discharged back to their home”. This raised the question of whether the least restrictive option in such cases—a return home, with support—was adequately and routinely considered, and the extent to which concerns regarding risk as well as resources were allowed to lead decision-making.\textsuperscript{33}

The World Health Organisation defined the \textit{least restrictive} principles in 1996, following the work of Wolfensberger on de-institutionalisation, and developments in special education and disability laws in the United States.\textsuperscript{34} Wolfensberger was particularly influential in WA disability services, and \textit{least restrictive} policies gained prominence in the \textit{Guardianship and Administration Act 1990} (WA).\textsuperscript{35} It was also a basic policy of the psychiatric services for the elderly in WA from 1980 onwards.

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\textsuperscript{33} House of Lords, Mental Capacity Act 2005 (UK), post legislative scrutiny, Select Committee of the MCA 2005, 102.

\textsuperscript{34} Appelbaum P, Least Restrictive Alternative Revisited: Olmstead’s Uncertain Mandate for Community Based Care, \textit{Law and Psychiatry}, Psychiatric Services, APA, October 1999, Vol 50, No 10, 1271.

\textsuperscript{35} \textit{Guardianship and Administration Act 1990} (WA), Part 2, S4, Principles.
The WHO 1996 principles stated:

1. **Items to be considered in the selection of least restrictive alternatives include:**
   a. the disorder involved;
   b. the available treatments;
   c. the person’s level of autonomy;
   d. the person’s acceptance and cooperation; and
   e. the potential that harm be caused to self or others;

2. Community-based treatment should be made available to qualifying patients;

3. Institution-based treatments should be provided in the least restrictive environment and treatments involving the use of physical (e.g. isolation rooms, camisoles) and chemical restraints, if at all necessary, should be contingent upon:
   a. sustained attempts to discuss alternatives with the patient;
   b. examination and prescription by an approved health care provider;
   c. the necessity to avoid immediate harm to self or others;
   d. regular observation;
   e. periodical reassessments of the need for restraint (e.g. every half hour for physical restraint);
   f. a strictly limited duration (e.g. 4 hours for physical restraint);
   g. documentation in patient’s medical file.\(^\text{36}\)

**Appelbaum stated:**

In its heyday in the 1970’s, the doctrine was viewed as a major tool for moving committed patients out of state mental hospitals and into community settings. As supported by a number of decisions in lower federal courts, the doctrine rested on the argument the state could not deprive persons of liberty to an extent unwarranted to meet its legitimate aims.\(^\text{37}\)

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\(^{37}\) Appelbaum above, 1271.
Appelbaum pointed out the pitfalls if adequate community care facilities did not exist, and the legal arguments concerned with requiring state governments to divert funding resources. He concluded:

Whatever else it may accomplish, the decision in Olmstead v. L.C. is unlikely to precipitate the widespread creation of community-based services for persons with mental disabilities.\textsuperscript{38}

Suggestions from the UK are that the ‘assumption of mental capacity principle’, and ‘least restrictive alternative’ doctrine, can be distorted and invoked by service providers to deny adequate care to some persons in need.\textsuperscript{39} The lesson is, that resources and cultural shifts must follow good legislative intentions, if significant social change is to result.

Mistreatment or indifference to a person’s autonomy, may lead to improper decision-making regarding care and treatment. An example could be the placement of a patient in a nursing home against their wishes, or without due regard to the health and social consequences of placement. If this action was undertaken to obtain access to the person’s home and assets, or simply to expedite discharge from a hospital service, then tortious liability or possibly criminal offences could arise. The wider topic of elder abuse is therefore potentially closely related, although it is not a prime consideration, to place reasonable limits on the scope of this research. What is important is that legal mechanisms designed to prevent such abuse are evaluated for their effectiveness.

Consideration has also been given to Federal Government responsibilities where the aged care residential sector is involved, through its vicarious liability as a provider of funding and services. Hamilton and Menezes have high-lighted the ‘perverse incentives’ embedded in the Commonwealth funding arrangements.\textsuperscript{40} While their paper addresses the financial

\textsuperscript{38} Ibid, 1272.
\textsuperscript{39} House of Lords Select Committee on the Mental Capacity Act 2005, Chapter 3: The five core principles: Is the Act working as intended? October-November 2013.


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incentives in patient selection, particular note should be taken of incentives which may maximise patient dependency to achieve a high score of the ACFI funding instrument.

More money is paid for those who need more help; residents rated as requiring high levels of assistance for activities of daily living are supplemented at au$108.92 a day. Those at medium levels receive au$78.62 a day, a difference of au$11,059.50 a year.\textsuperscript{41}

1.6 Psychiatrists and law

Mental health professionals have a particular responsibility to ensure that older people with mental health problems are involved to the maximum degree in decisions about their treatment and care, to safeguard their patients’ rights and to combat ageism and elder abuse.\textsuperscript{42}

Psychiatrists are crucially involved in many decisions which impact on the lives and health of patients. Involvement includes an obligation to look beyond the clinical issues and be actively attentive to many related social and legal matters. This requires a knowledge and respect for the laws applied by parliament, which impact on all elderly persons, especially those whose decision-making abilities are impaired by mental disorders.

Consistent with the above World Psychiatric Association (WPA), Section of Old Age Psychiatry Section statement, my research examines the legislation and protective procedures in Western Australia (WA), which apply to older people with mental illness and dementia, where decision-making capacity is believed to be impaired.

Two central issues have been examined; admission of older persons to State psychiatric hospitals, and Commonwealth funded residential aged care facilities in WA. Both may involve detention and a degree of deprivation of liberty with legal safeguards.

\textsuperscript{41} Low LF, Brodaty H, Aged-care funding creates dependency and lowers well-being of residents, The Conversation, September 22, 2015, accessed online.

The question is whether these safeguards are equal to the task, and whether they measure up by comparison with current practice in England.\textsuperscript{43} 

The right to make our own decisions, free from undue or oppressive coercion, including all forms of medical care and where one lives, is receiving increased legal attention in recent decades.\textsuperscript{44} The WPA, building on the 1977 Declaration of Hawaii, developed ethical guidelines for psychiatrists.\textsuperscript{45} These were promulgated at Madrid in 1996 and updated at subsequent General Assembly meetings in 1999, 2002, 2005 and 2011.\textsuperscript{46} Declaration 4 is particularly relevant:

4. When the patient is gravely disabled, incapacitated, and/or incompetent to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient’s will, unless withholding treatment would endanger the life of the patient and/or the life of others. Treatment must always be in the best interest of the patient.\textsuperscript{47}

*Treatment*, should be viewed in its widest sense and taken to include matters beyond the usual concept of medical or surgical treatments, to include dislocation from a person’s usual residence, forced social isolation and loss of autonomy, which can affect physical and mental health\textsuperscript{48}.

\textsuperscript{43} Comparison is made due to the similarity of legal systems and common origins, and the author’s experience as a psychiatrist in both countries.


\textsuperscript{45} Declaration of Hawaii issued by the WPA in 1977 and updated in 1983 in Vienna, was initiated because of political abuse of psychiatry in some countries in the seventies. Approved by the General Assembly of the World Psychiatric Association in Vienna, Austria, on 10th July 1983


\textsuperscript{47} WPA Section of Old Age Psychiatry, Accesssed online, June 30, 2014.

\textsuperscript{48} *Guardianship and Administration Act 1990* (WA), Part 1, s 3, “treatment” means any medical, surgical or related treatment or care that may lawfully be provided to a patient with the patient’s consent or the consent of any person authorised by law to consent on behalf of the patient, but does not include the procedures referred to in Division 3 of Part 5.
That treatment wishes of the patient and family must be considered has been legally confirmed in England in June 2014.\textsuperscript{49} It took an appeal to a court of law to insist on what should be routine hospital practice, and which most people would expect. Events in WA in recent years highlighted the extent to which rights regarding risk assessment and family/carer information sharing, needed to be reviewed in keeping with community expectations.\textsuperscript{50} The \textit{Mental Health Act 2014} (WA) addresses matters of consultation with the patient and significant carers, with extensive requirements covering all aspects of treatment and care.\textsuperscript{51}

Clinicians in old age psychiatry work routinely with families and carers, protecting the patient’s rights to privacy where necessary, and balancing the need for appropriate consultation with others. Family conferencing has been a regular element of clinical care from the outset, and has not required legal directions to do so.\textsuperscript{52} Whether formal legal enactments or compulsions ensure best practice in communication between health care staff and families and carers, is debatable.\textsuperscript{53}

Clarification of the circumstances and legal obligations when a clinician can over-rule a person’s wishes certainly supports good practice. Carefully worded official guidelines, published from time to time by the Chief Psychiatrist (CP), with support of the Minister, would more readily respond to changing circumstances than waiting on parliamentary revision of legislation. Thus, an English Supreme Court judge has cautioned against

\textsuperscript{49} \textit{R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Secretary of State for Health} [2014] EWCA Civ 822. The court found that the Article 8 rights of the Claimant, Mr Tracey’s, late wife were infringed when a ‘do not attempt CPR notice’ was placed in her records without consultation of the deceased. Accessed online, Lexology ACLA July 15, 2014.

\textsuperscript{50} In 2008 Erin Berg committed suicide in Mexico, having been recently treated at a Perth psychiatric hospital and discharged by the MHRB, with clinic follow-up plans. She refused to allow her family to be included in her care. They were highly critical of her management.

\textsuperscript{51} \textit{Mental Health Act 2014} (WA), Part 16 – 18.

\textsuperscript{52} Policy and procedure documentation in loose leaf form to permit updating, including a draft Charter of Residents’ Rights, were provided to each Old Age Psychiatry unit on establishment in 1985.

\textsuperscript{53} Hatzigeros J, (NSW Attorney-General), \textit{Legislation is not the key to human rights}, The Australian Opinion, December 12, 2008 (online).
expecting that resort to legal procedures will resolve complex medico-legal problems. Hale SJ stated recently: ‘Far better if they (conscientious professionals) have a clear idea of the legal principles and how to apply them in advance.’

This thesis considers whether there is adequate provision of protection for decision-making by older persons, and whether the legislative arrangements enacted by parliament in WA are effective, and fair.

Any adult or elderly patient with full decision-making capacity can make his or her decisions on health and lifestyle matters. These may include unwise decisions, including those which could result in the person’s own death. Education of health professionals, patients, families, carers, and the community at large is essential to ensure elderly persons’ rights and wishes are properly and legitimately protected.

Complex and emotive issues can arise when decision-making capacity is fully or partially impaired, and in those cases, clear legal guides are essential. In this regard, the Mental Capacity Act 2005 (UK) is considered a positive legal development in Britain. However the Deprivation of Liberty Safeguards (DoLS) introduced by the Mental Health Act 1997 (UK), have proved to be overly complex, expensive, and ineffective. The level of attention given to this area of health and social care has been applauded in some respects, and criticised in others. Recommendations suggested for WA should consider all aspects to provide a more balanced view.

56 House of Lords, Mental Capacity Act 2005: post-legislative scrutiny - Select Committee on the Mental Capacity Act 2005: We acknowledge the wide-spread support which the Act enjoys among stakeholders. It is described in unusually enthusiastic language. It is disappointing therefore that the implementation of the Act has yet to receive the same acclaim. (paragraph 103)
There are two principal areas, public law, and private law. Cane stated:

Private law might be defined as law regulating the relations of private persons, whether individuals, corporations, or unincorporated associations with one another. This definition suggests that public law concerns the activities of governmental agencies; it regulates relations between government agencies and private individuals on the one hand, and between different government agencies on the other. Further, just as private law defines what is meant by a ‘person’, so public law regulates the creation and organisation of governmental organisations.  

Private law concerns the fundamental human rights of all individuals, regardless of age, gender, or disability, to be treated fairly in dealings with each other. Tort law provides for the redress of a civil wrong through an award of damages. The person wronged may seek a writ against the wrongdoer, which writ then initiates legal proceedings. In legal terms the concepts of trespass and case are invoked. Fleming noted:

Trespass became the remedy for all forcible, direct and immediate injury, whether to the person, land or goods of the plaintiff; in short, against the kind of conduct most likely to cause breach of the peace by provoking retaliation.  

[Fleming continued.]

The discrimin between trespass and case was, therefore, whether the injury was a direct result of the defendant’s force, or was due merely to an omission or an act not immediately but only consequentially injurious to the plaintiff’s interests.

[And in addition.]

The trend of later development was to associate actions on the case with negligent harm and trespass with intentional wrongs.

\[60\] Above 15.  
\[61\] Above. 15.
In the context of this thesis, assault of an older person, which may include unlawful deprivation of liberty and negligent defaults in care, can amount to tortious behaviour. As such the person offended against may have an avenue to seek justice through legal action.

### 1.8 Common law

Common law refers to that law which has arisen in a country from accepted custom and practice rather than legislation. The Australian Law Dictionary describes four senses of the term:

- First, a system of law developed by the English courts through the principles of precedent and adopted in Commonwealth countries with a British heritage. In this sense, Australia is a ‘common law country’.
- Second, the law laid down by the common-law courts, in contrast to the rules of equity.
- Third, case law that is not enacted in a statute by parliament…
- Fourth, historically, the rules of law common to all people in England, as distinct from local or customary laws.

While Parliaments have the principal role in creating legislation, it has been the decisions of judges that have increasingly added another dimension, which is the common law. Where there is no statute law, clinicians must rely upon the common law, which may be unreliable in the absence of sound policies, and access to prompt legal advice.

Partington states:

> There are important sources of law other than Parliament. Under the British system of separation of powers, judges in the higher courts have power to make new rules of law. They do this through the development of rules of ‘common law’ – longstanding principles of law developed over the years, in some cases centuries, by the Judges. …The legitimacy for their law-making is found in other constitutional principles, in particular the separation of powers.

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62. From the Latin, tortus, a wrongful act or an infringement of a right.
Although the existence of nine major court hierarchies in Australia could suggest there are nine versions of the common law, this is not so. A case which refers to this position is *Lipohar v The Queen*, in which Kirby J, set out the basis of the position that there is only one common law in Australia.

KIRBY J: All that may be water under the bridge because at 1903 this Court was established, and certainly by now this Court is the sole voice on the statements of the common law for the whole of Australia. I understand that is the foundation for the theory that there is one common law for Australia that ultimately comes together in us, in this Court.65

WA clinicians rely upon their understanding of the common law in many situations, but the validity of this should be reconsidered in the light of the Bournewood case.66 Substantial changes to British law and procedures resulted from this case, including an upgrade of the CoP, and modifications to the *Mental Health Act 2007*, (UK).

Searching for a *gold standard*, and pre-judging the adequacy of WA law and procedures, solely by comparison with England would not be the best approach. There has been strong criticism of English laws by Brenda Hale and others, the legislation having been described as ‘labyrinthine’67, and ‘not fit for purpose’68. When to use the *Mental Health Act 2007* (UK) or the *Mental Capacity Act 2005* (UK), has necessitated advice to psychiatrists.69 Uncertainty amongst clinicians, as well as other health care workers such as care home and ambulance staff has also resulted.70

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68 House of Lords Select Committee on the Mental Capacity Act 2005, October-November 2013 stated: ‘The level and breadth of criticism of the Deprivation of Liberty Safeguards, including from the judiciary, demonstrates that the legislation is not fit for purpose. Better implementation would not be sufficient to address the fundamental problems identified’.
69 Royal College of Psychiatrists, Mental Capacity Act Update following *P v Cheshire West and P & Q v Surrey County Council Cases*, (Online).
1.9 Necessity

Clinicians dealing with persons lacking capacity to consent, have relied upon the common law of *necessity* to protect a person from harm, when approving detention in psychiatric facilities for the elderly and aged care nursing homes. This was stated by Ryan et al:

In general medicine, if someone has decision-making capacity and refuses (even life-saving) treatment after a considered decision then that is their right. However, when a person lacks decision-making capacity, and is unable to comprehend or weigh the information necessary to refuse treatment, then that person can be treated either with substituted consent or in their best interests.\(^71\)

However, the dilemma is epitomised in the title of the Lord Chancellor’s (UK) 1997 document, ‘Who decides?’\(^72\) In the case of serious decisions with potentially harmful outcomes for vulnerable adults, it may be inappropriate for medical professionals to assume authority to decide. The various items of legislation which limit some forms of surgery for example, place restrictions on procedures such as psychosurgery and sterilisation. Decisions involving placement into aged care or psychiatric treatment facilities may also have adverse outcomes, hence the need for rigorous legal oversight.

Health care personnel and carers may be appropriately concerned about the risks of liability to themselves or the hospital services, should harm befall a patient who absconds into bushland or busy traffic. This may be consistent with a ‘foreseeable risk’, mentioned in connection with a duty of care case, decided by the Victorian Supreme Court.

In attempting to solve this problem, it is of the utmost importance to define the precise nature of the duty involved in the tort of negligence in such a case. In our opinion, the duty is not simply one to take reasonable care in the abstract, but to take reasonable care not to injure a person whom it should reasonably have been foreseen may be injured by the act or neglect if such care is not taken. \(^73\)

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\(^{72}\) ‘Who Decides’, Making decisions on behalf of mentally incapacitated adults: Presented to Parliament by the Lord High Chancellor by Command of Her Majesty, (December 1997).

The foreseeable risk entailed in most decisions to admit an elderly person into a hospital or aged care facility may appear small, but if undertaken without due attention to their autonomy and expressed will and preferences, then a complaint may arise. If the foreseeable risk is of serious harm, the case for effective procedural safeguards should be supported even more strongly.

### 1.9.1 Human rights and international obligations

English and European authorities are obliged to observe human rights principles in areas including health care, but this obligation had not entered WA health policy in a statutory or legislated form until the references in the *Mental Health Act 2014* (WA). Australia has a Sydney based Australian Human Rights Commission (AHRC), established under the *Australian Human Rights Act 1986*. Relatively little attention was paid to mental health as a human rights issue in Australia until the Burdekin Inquiry, and the UNCRPD.

There is no *Human Rights Act* (WA), nor is there any apparent interest in obtaining one. The Charter of Mental Health Care Principles states:

> A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

### 1.10 Health and Mental Health Legislation

Public law which applies to relations between individuals and government agencies, is obliged to observe certain legal obligations in performance of these duties. The two main categories of public law are Australian Constitutional law and Administrative law.

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In the context of this thesis, Constitutional law governs arrangements under which the Commonwealth is responsible for Acts of Parliament related to aged care.\(^77\)

As Cane stated:

\[
\text{...because of the very great power which the government can wield over its citizens the law has traditionally imposed on government agencies special duties of procedural fairness which do not normally apply to dealings between private citizens.}^{78}
\]

In explaining the development of law in the modern world, Friedman refers to English common law thus:

The common law as developed in England, drew a sharp line between real property, (meaning basically land), and personal property (everything else).

...The ruling elite in England was a landed aristocracy. The law of property was in many ways, odd and irrational, but the basic emphasis on land and the main outlines of land law made sense for a society with such a social system.

...Similarly, the law of torts was not very important in England before 1800.\(^79\)

[He explains further,]

Even more fundamental than the distinction between realty and personal, moveables and immovable, is the distinction between procedure and substance. Rules of procedure are rules about rules: how to tell a good rule from a bad rule; how to go forward with a case; how to behave in the role of a judge, litigant, or lawyer. Rules of substance are rules of conduct. Law according to H.L.A Hart, is distinctive precisely because of this double stock of rules. Law is the union of primary rules (roughly substance) and secondary rules (roughly process).\(^80\)

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59 COMMONWEALTH OF AUSTRALIA CONSTITUTION ACT - SECT 51, gave power to legislate for invalid and old-age pensions. Subsequently amended to: (xxiiiA) the provision of maternity allowances, widows’ pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances;

77 Subsequently amended to:

78 Above, Cane 5.


80 Above, 49.
The title of this thesis refers to procedural and substantive justice, requiring clarification of these terms.

1.10.1 Procedural justice (fairness)

The Ombudsman of WA guidelines explain procedural fairness (natural justice) as follows:

Procedural fairness is concerned with the procedures used by a decision-maker, rather than the actual outcome reached. It requires a fair and proper procedure be used when making a decision. The Ombudsman considers it highly likely that a decision-maker who follows a fair procedure will reach a fair and correct decision.\(^81\)

A lecture on this topic by French CJ, set out his view of the importance and relevance of the topic of procedural justice, using the term fairness rather than justice.

Despite incidents of legislative exclusion, procedural fairness is alive and well today in Australia. There is little doubt that the norms of procedural fairness reach well beyond the confines of the courtroom in judicial proceedings or judicial review of administrative decisions. They are important societal values applicable to any form of official decision-making which can affect individual interests. I do not think it too bold to say that the notion of procedural fairness would be widely regarded within the Australian community as indispensable to justice. If the notion of a ‘fair go’ means anything in this context, it must mean that before a decision is made affecting a person’s interests, they should have a right to be heard by an impartial decision-maker.\(^82\)

This thesis considered WA and Commonwealth legislation, to observe whether, in comparison with their English equivalents, they can be said to be ‘world best practice’.\(^83\)

1.10.2 Substantive justice

Substantive justice implies that real and tangible results ensue from legal proceedings, as opposed to theoretical or impractical outcomes. This requires a clear basis in substantive

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laws which define what an individual can expect from examination and compliance with those laws, passed by parliament and enacted in legislation.

In this thesis, I considered whether the substantive laws affecting elderly persons in WA, provide a fair and equitable framework, jointly operating between government and individuals, for managing the relationships between elderly persons, carers or family members and government agencies.

1.10.3 Legal issues of relevance to WA

Although WA and English mental health and guardianship laws and procedures have a common historical source, through time and the passage of colonial and post-colonial influences, these have diverged significantly. While WA appears to have pursued an economical and simplified course, this may be at the expense of procedural fairness and human rights.84

A complication is that the Australian Commonwealth Government is tasked with providing aged care services, including special dementia care residential facilities, while mental health service provision is a WA State responsibility.85 As described by Lacey, there is a “gap” between the two government instrumentalities.86 Confusion with which service is involved with the patient and family has also been criticised by carers.87


85 The Senate (Australia), Community Affairs References Committee, Care and management of younger and older persons with dementia and behavioural and psychiatric symptoms of dementia (BPSD). http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Dementia/Report/index. The Senate report gives details of some of the areas of overlap between Federal and State government responsibility and complex funding agreements, particularly those in Tasmania related to the Alzheimers Nursing Home (ADARDS Tasmania).


87 MHC, Consultation Summary Report: The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025; ‘Strong feedback was provided by respondents regarding the need for improved system integration and navigation.’
This thesis identifies selected points of difference, to determine whether elderly persons in WA are adequately protected from abuse of their human rights, and are able to obtain procedural fairness in health and residential care decision-making. A comparison between the two jurisdictions in England and WA must allow for differing international treaty obligations and political structures. WA is not obliged to observe decisions of the European Court of Human Rights (ECtHR), which apply in England. Although these decisions may be mentioned in Australian court judgements, they do not carry the same influence as they do in the United Kingdom, a member State of the European Union. In the case of Kracke v Mental Health Review Board, the Charter of Patient Rights set out in Victorian mental health legislation, was compared with that in several overseas countries.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) presents new challenges not yet fully appreciated worldwide, let alone in WA.

88 While Australia has agreed to be bound by these major international human rights treaties, they do not form part of Australia’s domestic law unless the treaties have been specifically incorporated into Australian law through legislation. Some provisions of a treaty may however already exist in national legislation. For instance, many of the provisions contained in the Convention on the Rights of People with Disabilities are mirrored in Australian law through the Disability Discrimination Act 1992 (Cth). Human Rights Commission, <https://www.humanrights.gov.au/human-rights-explained-fact-sheet-australia-and-human-rights-treaties>.

89 Kracke v Mental Health Review Board & Ors (General) [2009] VCAT 646 (23 April 2009).

Two areas of special interest will be examined in this thesis. These are:

a) Older persons admitted to psychiatric hospitals as detained patients under the *Mental Health Act 1996* (WA), and those admitted as ‘voluntary’ patients to these hospitals, who may or may not have capacity to consent to admission and treatment.\(^91\)

b) Older persons admitted to commonwealth government aged care homes and detained in locked areas, without specific legal oversight of their circumstances. In this regard the *Aged Care Act 1997* (Commonwealth), and procedures involving clinical decisions which result in aged care admissions, such as ACAT assessments are reviewed.\(^92\)

Detention of any person against their will is a matter taken very seriously by the law.\(^93\) The need to provide some lawful detention requires careful thought and monitoring to avoid abuses, while at the same time meeting new challenges. The well documented rise in the number of persons suffering from dementia is a relatively recent development. This has brought detention and restrictive practices in health care into closer scrutiny.

The Australian Law Reform Commission (ALRC) has referred to restrictive practices stating:

> The term ‘restrictive practices’ refers to the use of interventions that have the effect of restricting the rights or freedom of movement of a person in order to protect them. Serious concerns have been expressed about inappropriate and under-regulated use of restrictive practices in a range of settings in Australia.\(^94\)

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91 In WA, a ‘voluntary’ patient is one who is not compulsorily admitted under the *Mental Health Act 1996* (WA). Such patients are not mentioned within the text of the Act. This is in contrast with the position in England where such patients are termed ‘informal’, and are specifically mentioned in the *Mental Health Act 2007* (England). An ‘informal’ patient may not necessarily be ‘voluntary’.

92 Aged Care Assessment Teams, as they are known in WA or ACAS in Victoria.

93 Victorian Law Reform Commission (VLRC), *Guardianship: Final Report*, Report No 24, (February 2012), Chapter 15.12; ‘Liberty is one of the most important values protected by common law.’

Legal proceedings in England regarding psychiatric care and medical decisions are very precisely controlled, with great attention to proper conformity with the law, both English and European.

Commenting on the growth of legislation, Brenda Hale SCJ has said:

So now the mental health law community has to grapple with two pieces of legislation, three Codes of Practice, and a multitude of case law both in the UK and Strasbourg. Oh, and with different Codes and regulations in England and Wales. … No wonder the books are getting fatter. But I continue to ask myself, what is all this law for?\(^\text{95}\)

This legal precision comes at a substantial cost of resources in time, personnel, and money. This was exemplified in the case of \textit{R v Ashworth Hospital} where five judges of the House of Lords, after a series of earlier court hearings, deliberated at great length producing a 42-page judgement about seclusion, but only arrived at the following concluding sentence,

Sooner or later, consensus must be reached upon the proper place of seclusion within our mental hospitals. This issue has been a running sore for far too long.\(^\text{96}\)

The judgement in \textit{R v Ashworth Hospital} covered a range of important issues in mental health law including the legal standing of the Codes of Practice. Bingham LJ stated:

It is in my view plain that the Code does not have the binding effect which a statutory provision or a statutory instrument would have. It is what it purports to be, guidance and not instruction. But the matters relied on by Mr Munjaz show that the guidance should be given great weight. It is not instruction, but it is much more than mere advice which an addressee is free to follow or not as it chooses. It is guidance which any hospital should consider with great care, and from which it should depart only if it has cogent reasons for doing so.\(^\text{97}\)

A high level of judicial scrutiny to administration and routine clinical care involving coercion and compulsory treatment, is invaluable. The \textit{R v Ashworth Hospital} case, along with many others in English mental health legal decisions, demonstrated the importance of

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\(^{96}\) \textit{Regina v. Ashworth Hospital Authority} (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz (FC) (Respondent).

\(^{97}\) Ibid, 21.
medical decision-making being consistent with legal standards. The British psychiatrist, Stafford Clarke stated:

It is important to recognise that in all aspects of the relationship between psychiatry and the law, it is in fact the law which calls the tune. The law defines the basis of the relationship, and is by definition the final arbiter in all interpretations of medico-legal problems.98

Law is more than positivistic examination of legal documents; the moral and ethical elements behind what parliament has directed, require a minimum standard of behaviour from those in authority, including all health professionals. Good practice and humanitarian considerations cannot be easily codified and guaranteed, unless the culture of society and the professions is open and accepting.

A House of Lords Select Committee observed:

A fundamental change of attitudes among professionals is needed in order to move from protection and paternalism to enablement and empowerment. Professionals need to be aware of their responsibilities under the Act, just as families need to be aware of their rights under it.99

The Royal Colleges of Psychiatry in Australia and England, as well as the Australian Medical Board, and the Australian and British Medical Associations, provide detailed codes of good conduct expected from medical practitioners. These codes need to be reinforced by sound legislation, education for health professionals on ethics and law, and ensured access to justice for patients. An obligation is placed on the respective authorities to see that the

99 House of Lords, Post legislative scrutiny, Select Committee on the Mental Capacity Act 2005 (UK 2014), Chapter 3, 108.
best clinical and legal practices are observed, consistent with socially approved, legal and morally valid principles.\textsuperscript{100}

Jurisprudence in mental health law in WA is relatively sparse, and should be noted with concern. In their review of tribunal practices in Australia, Carney et al commented:

\ldots there is little Australian jurisprudence in the mental health field, no doubt owing in part to the fact that no Bill of Rights has been adopted in national law, and only Victoria and the ACT have very recently adopted charters of rights and responsibilities.\textsuperscript{101}

An effective yet economical remedy should be sought if this paucity occurs as a consequence of inadequate access to legal proceedings, or lack of professional concern for human rights of elderly persons.

A survey, discussed in Chapter 4, suggests that WA clinicians are sometimes unclear about legal matters, and have limited access to prompt legal assistance. There is no shortage of judicial and academic talent in WA, as there are four university law schools and many eminent jurists.\textsuperscript{102} It may be that for reasons of inadequate access to justice, limited resourcing of legal aid, and failure to identify systemic ethical problems in care, serious matters have been overlooked.\textsuperscript{103} This can have an impact on service delivery, and undermine recognition of the quality care provided by many conscientious care workers and professionals.

\textsuperscript{100} Organisation for Economic and Cultural Development (OECD), \textit{Reducing the risk of policy failure: challenges for regulatory compliance}, 2000, 7. Accessed online www.oecd.org. A key determinant of government effectiveness is how well regulatory systems achieve their policy objectives. Rapid increases in regulation and government formalities in most OECD countries since the 1970s have produced impressive gains in some areas of economic and social well-being, but too often the results of regulation have been disappointing. Dramatic regulatory failures tend to produce calls for more regulation, with little assessment of the underlying reasons for failure.


\textsuperscript{102} University of WA, Murdoch University, Edith Cowan University and Notre Dame Catholic University.

\textsuperscript{103} Martin W, CJ of WA has commented on the lack of interpreters for indigenous people charged with serious offences, resulting in miscarriages of justice and incarceration. <ABC News online, September 27, 2015>.
Problems in provision of adequate and accessible aged care services can impact social and policy matters in the wider community, including families and carers of elderly persons.  

Failures in decision-making regarding patient care can result in errors, contributing to adverse incidents, and resulting litigation costs. Jeremy Bentham described the unsatisfactory nature of English law in the 19th century which he saw as unduly complex, expensive and unjust:

Great is the assistance which this plan of depredation receives from the darkness in which the whole system of procedure is involved by the thick cloud of technicalities.

Critical reports on some English hospitals from the Care Quality Commission (CQC), suggest that an overly controlling, bureaucratic and legalistic system has not guaranteed high quality outcomes, particularly when cost pressures affect patient care and staffing.

The Mid-Staffordshire Hospitals Report (Francis), noted the dire consequences of neglected standards of patient care. The cost of inquiries, such as the 2013 Francis Report, can run into millions of pounds. This represents money that, could have been directed in the first place to ensure quality care through adequate numbers of well trained staff, a deficiency

104 Australian Government Media initiative, Mindframe: The highest age-specific suicide rate for males in 2013 was observed in the 85+ age group (38.3 per 100,000). This rate was considerably higher than the age-specific suicide rate observed in all other age groups, with the next highest age-specific suicide rate being in the 45-49 and 50-54-year age groups (23.9 per 100,000 respectively) and the 80-84-year age group (22.2 per 100,000).

105 NHS Trust fined £500,000 following murder of care home worker by patient inappropriately placed, <Daily Mail Australia>, online access December 2, 2015.


107 Mental Health Act Annual Report 2011/2012, © Care Quality Commission 2013, <http://www.cqc.org.uk>. This report indicates a steady rise in the number of compulsory admissions and that 4% of detentions had been found to be incorrectly documented, amounting to unlawful detention. Patients are being affected by reductions in staff numbers. For example, MHA Commissioners raised concerns in 77 visits that a lack of staff prevented patients taking escorted leave.

108 Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust, Final report, <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report>. ‘The Inquiry Chairman, Robert Francis QC, concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care’.

109 The inquiry ran for a year between 2010 and 2011, and took evidence from more than 160 witnesses over 139 days, at a cost of £13m.
recognised in the report.\textsuperscript{110} The adverse impact on staff morale and service provision whilst lengthy inquiries are conducted, should also be considered.

Economy of resources and effort may be achieved at the expense of human rights and freedom of elderly persons, particularly those lacking mental capacity. When matters go badly wrong professionally and legally, the cost of putting them in order can be extreme, thereby denying funds to avoid the next potential mishap.\textsuperscript{111} Briggs, an English orthopaedic surgeon, has mounted a campaign urging a ‘Get it Right First Time’ approach to surgical cases, with a view to restraining excessive costs.\textsuperscript{112}

Excessive costs, if not producing genuine protection and justice, may deprive other areas of essential funding and resources. Unnecessary detention may increase overall health care costs, or result in diversion to even more costly alternatives such as emergency departments or prisons.\textsuperscript{113} Detailed cost benefit analysis is a highly complex field in public health, and is mentioned to assert the need for accurate evaluation of the outcomes of new initiatives, including legislation expected to redirect behaviour of health care workers.\textsuperscript{114}

In the UK, confusion has emerged over which Act should be used in some situations, resulting in further court cases and legal arguments. As an example, the \textit{Mental Capacity Act 2005} (UK) was erroneously used by the police to transport a woman to a psychiatric hospital

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\textsuperscript{110} Mid-Staffordshire report above, 77,78.
\textsuperscript{111} NHS Trust fined £500,000 following murder of care home worker by patient inappropriately placed, <Daily Mail Australia, online>, December 2, 2015.
\textsuperscript{112} Prof Briggs T, \textit{Getting it Right First Time: Improving the Quality of Orthopaedic Care in the National Health Service}, http://www.gettingitrightfirsttime.com/downloads/briggsreporta4_fin.pdf. Briggs points out; ‘The NHS budget is £110 billion of which musculoskeletal accounts for £10 billion, the third most expensive speciality after mental health and cardiac. Potential liabilities for NHS malpractice currently stand at £15.5 billion. Last year almost £1 billion was paid out by the NHS Litigation Authority. This is unsustainable’.
\end{flushleft}
against her wishes.\textsuperscript{115} In another case the DoLS were incorrectly engaged by a local authority to prevent a father taking his son back home after a period of local authority respite care.\textsuperscript{116}

A House of Lords Joint Select Committee on the \textit{Mental Capacity Act 2005}, produced an extremely critical report with firm recommendations for change. The intention is to support the concepts but improve the overall implementation and monitoring.\textsuperscript{117} The \textit{Mental Capacity Act 2005} (UK) and DoLS have required substantial staff training for all local authorities and health services to minimise misuse.\textsuperscript{118}

Legal proceedings in WA applied to guardianship and mental health care, are less formal, usually brief, and provided at no cost to applicants. Informality is recognised as a positive feature, ensuring patients and relatives are as comfortable as possible, and ensuring decisions taken are fairly negotiated and understood. In this way, a large degree of socially desirable mediation can be obtained. Hearings are directed at achieving the best negotiated settlements where there may be uncertainty and conflict. The effectiveness and fairness of these arrangements is nevertheless in need of rigorous evaluation.

\textbf{1.10.4 What is already known on this subject that is relevant to WA?}

While the subject matter of this thesis is expanding in Europe and other States of Australia, there has been little published research in WA by clinicians, concerning issues of mental health law, mental capacity, and elderly persons. Only one publication by a Western Australian psychiatrist has been located which examined the legal and human rights perspectives of capacity and treatment, in this case regarding alcohol caused psychiatric

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\textsuperscript{115} \textit{R (Sessay) v South London and Maudsley NHS Foundation Trust} (2001) EWHC 2617 (QB).
\textsuperscript{116} \textit{LB Hillingdon v Stephen Neary} (2011) EWHC 413 (COP).
\textsuperscript{117} House of Lords, Mental Capacity Act 2005, Post Legislative Scrutiny, Report of session 2013-4.
\textsuperscript{118} Law Commission Report 222 (UK) \textit{Consultation paper on MCA and DOLS}, 2015.
\end{flushleft}
problems. Another is a paper by clinicians in the Health Department of WA (HDWA), including the Chief Psychiatrist (CP). The paper examined information on legal and human rights provided to patients regarding provisions of the Community Treatment Orders (CTO’s). It questioned whether patients on community treatment orders were adequately informed of their rights. The research indicated insufficient provision of information, only partially meeting the rights of patients.

Rolfe has written on the case for reconsidering and changing our approach to having specific mental health legislation.

1.10.5 Neville Barber: civil commitment and review

A PhD thesis by Barber examined the historical origins of mental health law, and the role of review bodies regarding civil commitment of the mentally ill in various jurisdictions. As the first President of the Mental Health Review Board (MHRB) in WA, he was uniquely placed to review the interface between the law and psychiatric practice. His report addressed the legal and jurisprudential aspects of civil commitment and indicated the different forms which reviews took, following visits to several other countries and within Australia. Having drawn attention to the limited attention given to the subject, he stated as a hypothesis:

…this lack of critical attention and analysis has meant that the establishment of review bodies has given rise to, and indeed was borne out of, unreasonable expectations from both within the legal paradigm and outside of it.

This is a most relevant observation in view of a substantial increase in the role of the MHRB, renamed the Mental Health Tribunal (MHT) in the Mental Health Act 2014 (WA).

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119 Restifo S, A review of the concepts, terminologies, and dilemmas in the assessment of decisional capacity: a focus on alcoholism, Australasian Psychiatry, July 24, 2013.
121 Above, 42.
122 Rolfe T, 1st Winter Sunshine Symposium, Australian College of Mental Health Nurses (WA), (2009).
1.10.6 UWA research theses

Examination of catalogues of law PhD theses in WA Universities, disclosed none that addressed the situation of elderly persons with an acquired lack of decision-making capacity. This research is original in subject matter, and examines medico-legal matters not previously canvassed in WA. In view of optimistic government expectation of benefits from changes in the Mental Health Act 2014 (WA), it also forms a building block for further studies.\textsuperscript{124}

1.10.7 Elder abuse

Clare et al have undertaken research into the broad subject of abuse of elderly persons in WA, including physical, financial, and sexual abuse.\textsuperscript{125} In some cases this can amount to criminal behaviour. It is not intended to address these topics in detail, unless related to a point under discussion. This thesis is mainly directed at what may be termed administrative and clinical care abuses, which involve decision-making during interaction with health services. Kingsley described as social abuse that which is imposed by a social system which;

condones negative stereotypes and ageist attitudes towards the elderly; which excuses harassment of older people, which condones discrimination against seniors, and which accepts a bureaucratic system of social inequity that fails to meet the needs of the elderly.\textsuperscript{126}

Inappropriate or unnecessary admission to acute care hospitals may place an elderly person at increased risk of harm including physical injury and death.

\textsuperscript{124} Minister for Mental Health, Media statements, \textit{A new era dawns for mental health}, https://www.mediastatements.wa.gov.au/Pages/Barnett/2014/10/.

\textsuperscript{125} Clare M, Blundell B, Clare J, Examination of the extent of elder abuse in Western Australia, Crime Research Centre, UWA, April 2011.

Older people who become acutely unwell in Residential Aged Care Facilities (RACF) are a considerable proportion of ED presentations. A number of studies have found that for certain disorders or conditions, effective treatment does not necessitate presentation to ED from the RACF. For example, those with acute infections treated in their residence have similar or better survival rates and fewer complications compared to those transferred to hospital for treatment, even accounting for severity.\textsuperscript{127}

Admission to residential aged care facilities also has the potential to pose a health risk for some individuals.\textsuperscript{128} Domiciliary assessment at an early stage is a long-standing policy of aged care practice, to avoid hazardous hospitalisation where possible. As Lefroy stated:

The nature of elderly people’s disabilities demands attention in their homes; although members of the team are hospital-based, they cannot ignore what happens in the community.\textsuperscript{129}

Inadequate provision of community based alternatives to hospital and aged care admissions, may create a risk of harm for which health services and governments could be held responsible through vicarious liability.\textsuperscript{130} A joint hospital and community approach can best involve the family and carers, as well as allowing the aged person a familiar environment in which to make decisions that can have consequences. Lefroy, investigated several patients approved for transfer to a nursing home while in an acute hospital, and stated:

\ldots alternative arrangements \textendash admission to a hostel, to a special dementia unit or to a facility for further rehabilitation \textendash would have been preferable for a significant number of patients. But discharge had been arranged in order to avoid bed-blocking.\textsuperscript{131}

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\textsuperscript{127} Hoy S, Aged Care Emergency Institute, Model of Care, 22 June 2015, accessed online at http://www.ecinsw.com.au/  
\textsuperscript{128} Chapter 6.1-4.  
\textsuperscript{130} Dictionary of Australian Law (Oxford University Press 2010) 601; Legal liability for the tortious act of another: Generally, the liability of an employer for the act of an employee. Also see this thesis Chapter 6.3.1.  
\textsuperscript{131} Lefroy, above 2005, 111. 
\end{flushleft}
1.10.8 Psychiatric practice in WA

Mental health and guardianship law in WA has evolved from its origins in English common law and legislation. A significant name in WA psychiatry was Belfast born Dr Sydney Montgomery (1870 – 1916). A number of mostly British born or trained psychiatrists followed him in later years. Other influences on policy and treatment in psychiatry have been introduced from North American and European experience. Many WA psychiatrists were heavily influenced by immigrant professionals from overseas countries including England, or had undergone their training in overseas countries.

Connell has written:

There is a problem about intellectual work in settler-colonial societies, like Australia, that deeply affects social science. The problem was named “The Cultural Cringe” by the Australian critic Arthur Phillips, in a pungent article published in 1950 by the new literary magazine Meanjin. Phillips diagnosed “a disease of the Australian mind”, an assumption of inferiority vis-a-vis England, a deep dependence on imported judgments and tastes.

As Australia emerged from colonial influences directed from England, differences in law and practice arose in their statutory and common law jurisdictions. Despite considerable geographic, political, and cultural movement away from seeing England as the ‘mother country’, there is a continuing trend to look towards England for solutions to service provision in WA.

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132 Arguably the most significant name in the early years of WA psychiatry, Dr Sydney Montgomery, was born in Belfast in 1870 and graduated in medicine in 1894. He joined the staff of the Nottingham City Asylum before appointment to the Fremantle Asylum. He was later largely responsible for the building and operations of the Claremont Hospital for the Insane, and the introduction of the Western Australian Lunacy Act in 1903.


134 My own views were greatly influenced by British psychiatrists working in Perth such as Ian Pierce-James, one of the first psychiatrists to work at Royal Perth Hospital whilst employed at Heathcote Hospital.

In April 2012, the Mental Health Commission received a paper to initiate discussion on the establishment of an Independent Mental Health Advocacy Service from the international mental health advisors, Gregor Henderson Ltd. In July 2012, the Mental Health Commission provided an update and described the need for further consultations with people living with mental illness.\(^{136}\)

While such transfer of ideas may be commendable, assessment of the success or otherwise of new procedures is required before adoption. The official history of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) records as follows:

> While there is no consensus on this matter, from the interviews conducted with leading psychiatrists in compiling this book and from other sources, a widely-held view emerged that Australasian psychiatry is distinguished by being eclectic. It borrows the best features from foreign models and adapts them to Australian and New Zealand society producing a mixture of organic and psychotherapeutic models suitable for societies with perhaps fewer sharp social divisions than elsewhere.\(^{137}\)

Planning for the replacement of Swanbourne Hospital in 1981 considered developments in England and Europe, but rejected a number from the NHS deemed lacking in progressive thinking.\(^{138}\) Not repeating the mistakes of others is an important lesson in history, equally applicable to mental health practices and legislation.

### 1.10.9 Legislation and procedures to protect the interests of the elderly

Prior to the *Mental Health Act 1996* (WA), which introduced a system of oversight by the MHRB and other provisions, proceedings by which a person detained in a psychiatric hospital could appeal against detention were limited to a writ of habeas corpus or application to the Board of Visitors.\(^{139,140,141}\)

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\(^{139}\) *Mental Health Act 1996* (WA), Part 6, Division 1, S 125 – 155.

\(^{140}\) Dictionary of Australian Law (Oxford University Press 2010) 279: The writ of habeas corpus ad subjiciendum is a prerogative writ requiring a person who has detained another person in custody to produce the prisoner before a court or judge, generally for the purpose of determining whether the detention is legal.

\(^{141}\) Above, Part II, 18, (d).
A 1954 Royal Commission in England examined the law and procedures affecting the mentally ill and handicapped. The Mental Health Act 1959 (UK) was the product of this review. As the legal procedures for admission were redirected from the primarily legal to a social/medical basis, a balancing judicial element was included, to offer a review of detention after the fact. This led to the establishment of the Mental Health Review Tribunal (MHRT) in 1959, and has been affirmed in following revisions of the mental health laws. WA did not introduce a comparable review system until almost four decades later. The effectiveness or fairness of this review system has not been independently reviewed in WA. The last MHRB Annual Report was published in 2012.

Tribunal systems to review compulsory detention and treatment feature in Australian and British mental health legislation and procedures. One of the earliest critical reviews of MHRT’s in the UK was that of Peay in 1983. Peay dealt with patients detained at Special Hospitals, consequently her book has limited application to this research. The material was relevant in supporting a good case for researching the patients’ experience of tribunals, rather than only academic or professional opinions. The 1959 provisions were viewed in comparison with those of the 1983 Act. Even in a maximum-security hospital environment, patients expressed a degree of satisfaction with the tribunal system.

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143 Mental Health Act 1996 (WA), Part 6 Mental Health Review Board.
146 English Special Hospitals include Broadmoor, Rampton and Ashworth Hospitals. WA forensic patients are under separate legislation and procedures which have not been included in this thesis. See, Criminal Law (Mentally Impaired Accused) Act 1996.
Points of positive comment noted by Peay were:

Patients noted that the tribunals were less formal and they believed that more care was taken in reviewing their cases. Also mentioned as positive features were the opportunity to see the reports and attend throughout the hearing, as well as being able to question the RMO.

…Moreover, patients especially welcomed the tribunal clerks’ reassurances and the tribunals’ efforts to make them feel at ease.\footnote{Peay n above, 42.}

It is relevant to note the lack of comparable legal procedures affording fairness and protection, which apply under the \textit{Mentally Impaired Accused Act 1996} (WA), which has a similar function to the English legislation dealing with mentally ill offenders detained in Special Hospitals.\footnote{\textit{Mentally Impaired Accused Act 1996} (WA). Detained patients under this Act are not seen at hearings conducted ‘on the papers’. Legal representation is exceptional. The Chief Justice, along with psychiatrists and others, has expressed concern over the system.}

\section*{1.10.10 Literature}

Apart from a small number of academic and official reports, formal literature originating in WA about legal and mental capacity, natural justice and human rights has been very limited in number and scope. As the field is changing rapidly, internet and journal sources are especially valuable. Textbooks provide reference material useful in understanding progress towards changes that have been introduced and court decisions. However, there are no WA authored textbooks on local mental health law, and those available from other States of Australia, tend to be East coast oriented with limited reference to WA. The Chief Psychiatrist published a Clinicians Practice Guide of 288 pages relevant to the \textit{Mental Health Act 2014} (WA), in late 2015.\footnote{MHC (WA) <http://www.mentalhealth.wa.gov.au/mentalhealth_changes/mh_act2014/mh_professional_resources.aspx>.}

A publication by Fennell et al, published by the Law Society runs to 369 pages. In the foreword, Lucy Moncrieff-Scott, President of the Law Society describes the position when she commenced in 1979, a situation which has similarities to that which applies today in WA:

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I first represented a client at a Mental Health Review Tribunal in 1979, when the relevant law was the Mental Health Act 1959; there were no second opinion doctors, Mental Health Act Commission, or care Quality Commission, and of course no Human Rights Act. The concepts of patient rights, mental health survivors and patient advocacy were more or less unheard of, and non-means tested aftercare for detained patients had not yet come in.

Tribunal reports could be, and frequently were, withheld from patient applicants in their entirety, so they were often outside the door for much of the hearing, whether or not they were represented. There was no requirement for the medical member to outline his or her conversation with the applicant at the pre-hearing interview, and as it was not necessary for tribunals to give detailed reasons, the prospect of challenging a decision was really very low indeed.

Well, those days have long gone and the law and society, now recognise the extreme vulnerability of people who are not only mentally disordered, but also detained or deprived of their liberty. But it is not enough to have good laws, they also need to be understood if the rights of the individual are to be properly protected (emphasis added).\footnote{Fennell P, Letts P, Wilson J, \textit{Mental Health Tribunals, Law Policy and Practice} (The Law Society London 2013), xi.}```
Moncrieff-Scott’s observations are significant regarding the late introduction of the training program on the *Mental Health Act 2014* (WA). It is one step to state the law in fine detail, but another to ensure it is understood, resourced, accepted into the service culture and implemented.

The most substantial and regularly updated references to mental health law in the UK are authored by Richard Jones. The eleventh edition of his Mental Health Act Manual runs to 1036 pages, including details of case law, legislation and codes of practice.\(^{153}\)

1.11 Guardianship

Guardianship can mean different things in different countries and jurisdictions, as well as to different people in the same jurisdiction. Essentially guardianship is a form of substituted decision-making, where it has been determined that an individual lacks the capacity to make legally valid decisions, and the responsibility for making decisions has been handed to another individual or authority. More recently the concepts of substituted decision-making have been challenged in favour of supported decision-making.\(^{154}\)

South Australia has proposed a ‘Stepped Model of Supported and Substitute Decision Making’.\(^{155}\) Guardianship has attracted considerable opprobrium, largely due to abuse by authorities in Eastern Europe.\(^{156}\) Criticism of substituted decision-making has arisen from other quarters in England, as well as in Australia for a variety of reasons.\(^{157}\)

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\(^{156}\) *Stanev v Bulgaria* Application No. 16760/06 ECHR. Accessed online HUDOC.

1.11.1 Guardianship in England

The *parens patriae* function of the crown in the Middle Ages was carried out by the Court of Protection (CoP).\(^\text{158}\) The *Commissioners in Lunacy Act 1842* (UK) made provision for these functions at first, and later Masters in Lunacy were appointed to make their own decisions under the *Lunacy Act 1891* (UK). After a period as an Office in Lunacy of the Supreme Court from 1925, it was renamed the CoP in 1947, but continued to deal only with property and affairs of mentally ill persons.

Until the introduction of the Mental Capacity Act (2005), the former CoP was a relatively minor administrative body, an office of the Supreme Court. It was solely responsible for matters of patient property and affairs. The CoP has a newly enhanced role in protecting the interests of persons with absent or diminished capacity from a variety of causes. It is now a superior court of record with the ‘same powers, rights, privileges and authority as the High Court’.\(^\text{159}\)

Guardianship was, until recently, associated with the provisions of the *Mental Health Act 1983* (UK), Section 7. It had not been used extensively and reports demonstrate a continuing decline, although with regional variations.\(^\text{160}\) The introduction of the *Mental Capacity Act 2005* and the DoLS, have had a significant impact and guardianship has been little used in recent years; only 966 cases were open for the whole of England in 2005.\(^\text{161}\) In 2011/2012 the figure had fallen to 331 although the rate of decline was slower than previously.\(^\text{162}\) The new procedures in place under the *Mental Capacity Act 2005* (UK) and the DoLS are believed to be responsible.

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\(^\text{158}\) ALRC Report 114, *Family Violence – a national response*, (2010) 4.56: The Supreme Court of each state and territory has a very wide power to make orders to protect the welfare of children, known as the *parens patriae* (‘parent of the country’) jurisdiction, the underlying premise of which is that the children in question have no other, or no other suitable, guardian. When the jurisdiction of the English Court of Chancery became vested in the Supreme Courts of the states and territories, the *parens patriae* jurisdiction was included as part of the inherent jurisdiction of the court.


\(^\text{160}\) Health and Social Care Information Centre (UK), *Guardianship under the Mental Health Act 1983*, 18 Sept. 2012.

\(^\text{161}\) The Information Centre, Guardianship under the Mental Health Act 1983, 26 August, 2005, online Portal.

\(^\text{162}\) Health and Social Care Information Centre, Local Authority Personal Social Services Statistics, Guardianship Under the Mental Health Act 1983, England, 2012,
1.11.2 Guardianship in Australia

Carney and Tait termed guardianship and tribunals in Australia an ‘experiment’. On the whole they were supportive of the process, having described the historical development, the rise of a disability rights thrust and the growth of tribunals with lay members. They noted shortcomings in WA, quoting the 2005 Annual report of the MHRB as follows:

‘In some cases, no member of the treating team with up-to-date information about the patient’s progress and current situation is available at the hearing to provide information needed by Board members in order to make an informed decision about the patient’s involuntary status. (MHRB (WA), 2006:10).’ This was a state of affairs that the Annual Report went on to note was likely due to the under-resourced state of many health service agencies in Western Australia.  

1.11.3 Guardianship in Western Australian

In common with other Australian States, WA has long had a system for substituted decision-making, through recourse to the declaratory powers of the Supreme Court, and the statutory powers of the Public Trustee. This arrangement applied only to property matters, while serious personal health or care questions, could require a Supreme Court decision. The need to apply to the Supreme Court could apply to many relatively minor or undisputed matters and was costly.

The WA Government established a review of the Mental Health Act 1962 (WA) in 1980, undertaken by three committees, one of which proposed new Guardianship and Administration provisions. Two committees dealt with the revision of laws in respect of civil and offender patients. The Mental Health Act 1981 (WA) was passed by parliament but never proclaimed. The Guardianship and Administration Act 1990 (WA) was eventually put

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164 Carney above, 100.
165 Supreme Court Act 1935 (WA) - S 25, *Rules of law upon certain points*, (9), Public Trustee Act 1941 (WA).
into operation through the State Administrative Tribunal (SAT). The functions of guardians were set out with specific reference to the *Family Court Act 1997* (WA).

45. Authority of plenary guardian

(1) Subject to section 43(3), where a person is appointed as a plenary guardian, or two or more persons are appointed as joint guardians, he or they have all of the functions in respect of the person of the represented person that are, under the Family Court Act 1997, vested in a person in whose favour has been made –

(a) a specific issues order which confers responsibility for the long term care, welfare and development of a child; and

(b) a specific issues order which confers responsibility for the day to day care, welfare and development of a child,

As if the represented person were a child lacking in mature understanding (emphasis added), but a plenary guardian does not, and joint plenary guardians do not, have the right to chastise or punish a represented person.\(^{165}\)

While the provisions of the *Guardianship and Administration Act* (1990) WA were intended to ensure that decision-making for persons lacking mental capacity was brought under regulatory control, it warrants periodic examination to ensure that it remains on a par with best practice both within Australia and internationally. A review of the *Guardianship and Administration Act 1996* (WA), was opened in 2013 by the Attorney-General.

### 1.12 Protection of human rights and freedom from abusive procedures

One of the most effective means of ensuring protection from injustice is encouragement of research and education, and a general study of ethics and sociology of health care. This approach can examine currently held justifications for treatments and detention. Not only are the interests of the affected persons and carers of great importance, but community perceptions of the performance of governments can be adverse, in the wake of repeated scandals and evidence of waste and poor performance. This may be damaging to the reputation and stability of a government.

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\(^{165}\) *Guardianship and Administration Act 1990* (WA), Division 2, 45 (1).
A former WA Premier, in an essay on the WA government and political upheavals of the 1990s stated:

Ultimately, however, it is up to Parliament and the public to ensure that government is for and about the public interest rather than an arena within which private interests battle for their share of power and revenue. That requires a free and open political system and an active and informed citizenry.\textsuperscript{168}

International obligations must also be given due weight, ensuring basic standards of human rights, and that Australia can speak without fear of criticism when commenting on human rights abuses in other countries. Australia has been rightly criticised by Amnesty International over the high rates of imprisonment of young indigenous persons.\textsuperscript{169}

Much of the incentive to develop systems of human rights protection arose after WW11, as a reaction to the abuses which occurred under Nazi influence in Germany. Psychiatry was demonstrated to have played a central role in following political agendas such as forced sterilisation, unethical research practices and killing of individuals deemed unable to contribute to the welfare of the State, due to mental illness or disability.\textsuperscript{170} With passage of time and distance from Europe, some of the heat may have appeared to dissipate. Case reports from the ECtHR, and organisations such as the Hungarian based Mental Disability Advocacy Centre (MDAC), indicate serious misuse of psychiatry and guardianship continues, particularly in Eastern Europe.\textsuperscript{171} Consensus and international agreements can encourage continuing vigilance in this area, as no country or state can consider itself immune from the risk of a slide into unethical behaviour, if not by governments intentionally, then by individuals out of control.\textsuperscript{172}

\begin{itemize}
\item \textsuperscript{168} Gallop G, \textit{A State of Reform}, (Helm Wood, 1998), 95.
\item \textsuperscript{169} Amnesty International Report, \textit{A brighter tomorrow: Keeping Indigenous kids in the community and out of detention in Australia}, www.amnesty.org.au, June 2, 2015.
\item \textsuperscript{170} Burns T, \textit{Our Necessary Shadow}, (Allen Lane 2013), 201.
\item \textsuperscript{171} Stanev v Bulgaria Application No. 16760/06 ECHR. Accessed online HUDOC.
\item \textsuperscript{172} E.g. Dr Harry Bailey, Deep Sleep, Chelmsford Hospital, Townsville Hospital. See Rubinstein W & H, \textit{Menders of the Mind}, Chapter 12, (Oxford University Press Australia 1996).
\end{itemize}
Governments and some outspoken advocates of their particular points of view, may have a tendency to see legislative measures as a simple solution to complex human and social issues. Media driven responses urging changes to laws, may result in superficial and inadequately researched solutions. The success of legislative measures is very dependent upon the resources and expertise applied to a problem, rather than solely through an Act of Parliament.\textsuperscript{173} Disappointment with the performance of some legal measures such as Violence Restraining Orders (VROs), and Anti-Social Behaviour Orders (ASBOs – UK), illustrates that resources and culture changes must be applied, as well as law, to achieve significant results. Unjustified expectations of achieving changes in human behaviour simply through legislation can be disappointing and costly. According to Hatzistergos, a former NSW Attorney-General:

As tantalising as they sound, charters and bills, with their soaring values and protections enforced through adversarial litigation, do not present the best way forward on human rights.\textsuperscript{174}

For many reasons, it is essential that resources put into the introduction and operation of legal procedures, result in effective outcomes without undue waste. Programs which do not advance the effectiveness of service delivery, may detract from quality services and funding, adding litigation, and delivering little benefit to the community.\textsuperscript{175} Measures which governments take to address community concerns, need to be cost effective, based on quality research, and demonstrated to consistently produce the expected results.\textsuperscript{176}

\begin{footnotesize}
\begin{itemize}
  \item[173] Consultation Summary Report: The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: \textit{The consultation process to inform the development of the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025}. The Plan has been comprehensive, involving over 2,300 individuals and organisations. Item 35, Legislative measures received the least amount of support in the consultation forums and comments primarily suggested that a greater emphasis on prevention and early intervention would have a greater impact than legislation.
  \item[174] Hatzistergos J, Legislation is not the key to human rights, \textit{The Australian}, Opinion, 12 December 2008.
  \item[175] The Inebriates Act 1912 (WA) was an example where good intentions had negligible influence on alcohol consumption or the protection of long-term alcohol affected persons. The abolition of the Statute, however, in the absence of replacement care provisions, led to a serious health and mortality problem amongst this group. (Personal observations as member and chairman of the Convicted Inebriates Advisory Board).
  \item[176] Jorm A, Is ‘headspace’ really improving young people’s mental health? \textit{The Conversation}, online, August 26, 2015.
\end{itemize}
\end{footnotesize}
Current reports of mental health care in England and WA, suggest an expensive and overly prescriptive approach does not necessarily deliver better patient outcomes, nor is the community reassured or protected. The WA government enacted the *Mental Health Act 2014* (WA) which received support and criticism from politicians, community, and health professionals.\(^{177}\) Political confidence and community expectations are at a high level, and it remains to be seen if this can be sustained in practice.\(^{178}\)

### 1.13 Consequences of failing to address problems in mental health law

Over the period of history of English mental health legislation there has been a tendency to swing from legalism to medicalisation in the management of the mentally ill.\(^{179}\) The earliest laws passed were intended to address widespread public fear of being illegally or unfairly committed to a ‘madhouse’ indefinitely and for nefarious reasons.\(^{180}\) As a result statutory legal provisions were paramount at one time, while the medical role was largely confined to providing treatment for physical disorders. With the growth of treatment options in mental illness the psychiatric role grew, and brought greater awareness of social and psychological factors. Legislation changed to reflect this perception, and then back again in the face of concerns about the ability of psychiatry to ensure protection of civil liberty and community safety. Fear of psychosurgery and scandals associated with unfettered exercise of some psychiatric treatments, compounded the issue.\(^{181}\) I considered in this thesis whether the review procedures in WA may be too informal, and lack the crucial “equality of arms” essential to any healthy democracy.\(^{182}\)

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182. Equality of arms involves giving each party the reasonable possibility to present its cause, in those conditions that will not put this party in disadvantage against its opponent.
1.14 Cost of checks and balances

The cost of a high level of scrutiny are considerable and should be assessed against the results obtained. Budget austerity measures under review in England have examined increased use of mediation and less formal procedures to achieve a better result with economy\textsuperscript{183}. Severe budgetary reduction applies to all UK government departments including Legal Aid, which currently has an annual expenditure of over £2,100 million, down from a peak of £2,414 million in 2003-4. Of this expense total, £38,632 million is for all mental health cases in 2009-10, a figure which had already been reducing. Reduction in legal aid may be counter-productive if other consequences are increased use of prisons, and formal hospital admissions, a position described by Penrose in 1939 and recently supported in European research.\textsuperscript{184,185}

1.15 Research aims

This thesis examined mental health and guardianship legislation affecting the aged population in WA, comparing this with legislation and protection available in the United Kingdom, and commenting on its effectiveness.

1.15.1 Objectives

1: To provide documentation of the historical emergence of English and Western Australian mental health legislation, regarding persons for whom decisions are made sometimes without their consent or knowledge. These developments in law have been compared with contemporaneous events in society, including events that represented change in public and professional attitudes and knowledge. A ‘time-line’ presentation was

employed, to illustrate the connectivity of contemporary social factors and world events, with changes in the approach to managing mental illness.  

2: A basis for comparison was made by tabling of legal safeguards, intended to provide protection for persons lacking capacity. English and Western Australian legislation is set out to illustrate the common features, as well as those which distinguish the two. 

3: The opinion of clinicians in the two countries was surveyed on the value and effectiveness of current legislation and practice. 

1.16 Parameters and limitations

The research was confined to WA and English law and procedures, except where necessary to illustrate alternative approaches or research. Legislation and procedures under consideration were those applicable to civil cases only. The subject of criminal law was not reviewed.

Although this thesis focuses on the Mental Health Act 1996 (WA), the Mental Health Act 2014 (WA), became operational on November 30, 2015 necessitating additional examination.

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186 This time-line was presented in a lecture to the Australian and New Zealand History of Medicine Society conference in Brisbane, July 2011.
187 The table was presented as a poster at the 15th International Congress, The Hague, September 2011
188 Chapter 3, 153.
189 Mentally Impaired Accused Act 1996 (WA)
190 The Mental Health Act 1996 (WA) applied at the time this research was conducted.
1.16.1 Intellectual disability

Reporting of mental health case law in England relates frequently to persons with intellectual disability from birth. This group is not considered comprehensively in this study. WA psychiatrists have relatively little service provider contact with intellectually disabled persons, unless they are also mentally ill.¹⁹¹ This contrasts with the position in England.

1.16.2 Mental illness or disorder

Persons over 65 years of age, with mental illness or acquired brain disabilities which may result in impaired decision-making capacity, are subjects of this research. Dementia and other forms of mental illness such as delirium, late-onset schizophrenia, and mood disorders, can temporarily, or in the longer term, limit decision-making capacity. Physical illnesses associated with age and illness such as delirium, can affect decision-making capacity, and such disabilities may be temporary or fluctuating.¹⁹²

1.16.3 Place of detention for care or treatment

Circumstances of elderly persons have been considered whether living at home, in residential care facilities or hospitals. The study was not limited to psychiatric hospitals or treatment. This reflects the approach taken in the UK where persons who lack decision-making capacity and are in residential care, may come within the operation of the Mental Capacity Act 2005 (UK), or, when indicated, under the Mental Health Act 2007 (UK). The DoLS within the Mental Health Act 2007 (UK) apply equally to private hospitals, aged care homes and Local Authorities. The provisions of the Human Rights Act 1998 (UK) apply to the courts, all local authorities and NHS Trusts and Hospitals.

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¹⁹¹ Disability Services Commission WA has responsibility for this group.
¹⁹² Delirium is a physical health illness, characterised by fluctuating mental state with “lucid intervals”.
This thesis considered laws and procedures which apply to persons, over 65 years of age, within the responsibility of old age psychiatry services, including geriatric medical and residential aged care. Comparison is offered with the position of elderly persons in a region of England, (Norfolk, Suffolk, and Cambridgeshire). This region was selected as convenient for sampling, because the author’s work experience indicated the presenting clinical issues and demographics are comparable.\textsuperscript{193} The full range of mental illnesses can occur in old age, and many persons with dementia present with serious psychiatric conditions besides cognitive and behavioural disorders.\textsuperscript{194}

1.17 Survey of psychiatrists in WA and England

An opinion survey of psychiatrists was conducted to expand the background material of this comparison, between aged care law and practice in WA and England. The psychiatrists included in this study were a small ‘convenience sample’, and may not be representative of a larger sample.\textsuperscript{195} The aim was to survey psychiatrists managing reasonably similar clinical and social presentations in the two countries. Consultants in Older Persons Psychiatry currently working in WA, and a selected area of England, were approached and 24 agreed to participate in an online survey using Survey Monkey. Although numbers were small, their views on key topics suggested some important differences between the two countries.\textsuperscript{196}

\textsuperscript{193} I was employed in the Norfolk/Suffolk region over 12 months in 2000 -2001 as a locum consultant psychiatrist.

\textsuperscript{194} Alzheimer’s original case concerned a 61-year-old woman with paranoid delusions, who went on to develop the same brain pathology as seen in ‘senile dementia’.

\textsuperscript{195} Dorland’s Illustrated Medical Dictionary: a type of nonprobability sample in which the population selected is easily accessible to the researcher; available subjects are simply entered into the study without any attempt at randomization.

\textsuperscript{196} Individual interviews were planned initially but proved impractical requiring considerable time and expense in England.
1.18 International issues

The Australian government is constitutionally responsible for international treaties and agreements, and specific matters within its limited powers under the Australian Constitution. State mental health laws and procedures are retained exclusively by each State or Territory. There are no Australian federal mental health laws or mental health hospitals. In 2010 the Australian government appointed a Minister for Mental Health and Ageing.

1.19 Methodology

The research problem was a legal, medical, and sociological one requiring approaches from several directions. The plan adopted was to outline the historical development of systems of law and protection in psychiatry, noting where these have originated, and how the current situation in WA has emerged. Examination of historical references on the origins of mental health laws was supported by additional research at the Royal College of Psychiatrists library in London, and University Law libraries in Cambridge and Norwich.

Attendance at Conferences in Australia and Europe added to the background, ensuring as far as possible current trends in mental health policy were observed. Poster or oral presentations were made at five conferences. Current issues in UK mental capacity legislation and practices were noted at mental health law update courses, and reading online case reports and journals.

Research included reviews of relevant WA Mental Health Legislation, including historical documents, Hansard and the Guardianship and Administration Act 1990 (WA).

197 The Australian Constitution Act, 1901.
198 Hon. Mark Butler appointed in 2010.
199 Details of courses, conferences and lectures etc. are included in Appendix, 388.
Personal experience and visits to UK MHRT’s, the WA MHRB hearings, and SAT (WA), assisted comparison of procedures and policies.\textsuperscript{200}

Elder abuse emerged more clearly during the research as a significant issue in Australian legal and clinical practice. This led to a phone interview with Prof Wendy Lacey from Adelaide, and subsequently a meeting with the Public Advocate for South Australia, Dr John Brayley. Research in WA indicating serious concerns regarding the subject of Elder Abuse, has pointed to the need for legislative reforms as well as greater inter-agency liaison.\textsuperscript{201}

1.20 Significance of this research

The limited amount of original research publications in this subject arising in WA, means this thesis makes a significant contribution to scholarship, and should form a basis for further academic research and education.

1.21 Conclusion

There are several key themes throughout this thesis which have been outlined in this chapter.

- Raising awareness of unlawful detention of elderly persons in psychiatric or aged care facilities.\textsuperscript{202}
- Provision of psychiatric scholarship in the areas of law and treatment of elderly persons with impaired decision-making capacity.
- Review of legislation intended to provide protection against unlawful detention.
- Promotion of educational and quality improvements to assist clinicians and the wider health care workforce in meeting changing community expectations.

\textsuperscript{200} I was a member of the MHRB (WA) from 2004 – 2010.
\textsuperscript{201} Clare M, Blundell B, Clare J, \textit{Examination of the extent of elder abuse in Western Australia}, Crime Research Centre, UWA, April 2011.
\textsuperscript{202} Unlawful detention may not necessarily imply malicious or criminal behaviour of the part of care staff. It may result from the absence of alternatives including effective legal procedures to ensure that any detention is in the best interests of the person and is proportionate to the risks otherwise posed.
• The problem under examination was set out in this chapter, including two case examples regarding individuals with impaired decision-making capacity.

• Borrowing on experience and the opinions of clinicians surveyed in WA and England, this thesis questions current legislation and procedures.

• The methodologies employed, together with the limits that have been imposed on the scope of the research have been outlined.

• Some essential legal concepts have been explained briefly and current protective provisions outlined.

Chapter 2 will document some of the historical connections between English mental health laws, and those which now apply in Western Australia.
2 History of mental health law

The Australian legal tradition cannot be understood without an appreciation of the idea of law as it was developed through some seven centuries in Britain prior to the settlement of Australia, and the various institutions through which that idea of law was, and still is, expressed.¹⁰³

The historical origins of mental health law in England, and the extent to which they have developed differently in WA, are discussed in this chapter.²⁰⁴ A key question is whether that divergence has achieved the aims of mental health law, by providing protection and care to patients and the community. A detailed ontological account of the historical development of law in Britain and Australia is not presented, being outside the remit of this research. This chapter demonstrates selected points of commonality with English law, and how written accounts of the history of psychiatry, as with other accounts of world events and periods of change, bear critical examination.

2.1 Early steps in development of protective laws

Concern for the physical and mental welfare of mentally disordered persons evolved slowly. The earliest relevant provisions related mainly to the protection of estates and property. Perceptions of mental illness as something associated with the devil or evil influences meant sufferers were liable to be condemned rather than supported.²⁰⁵ The following fictional passage refers to patients being admitted to Bethlehem Hospital (Bedlam) around the Thirteenth Century, as imagined by a former chaplain to that establishment:

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¹⁰³ Parkinson P, Tradition and Change in Australian Law, (Thomson Reuters 2013), 5th.ed, [1.20].
²⁰⁴ A condensed version of this chapter was presented orally to the Annual Meeting of the Australian and New Zealand History of Medicine Society, Brisbane, 14 July 2011.
²⁰⁵ Read J, Models of Madness, (Routledge 2013), Chapter, Gods and Devils, 10.
A clanking of chains, and the swish of a whip, volleys of virulent abuse and appalling blasphemy, peals of ribald laughter from a roystering mob, and the threats of the spearmen to the mud-slingers—such perhaps may have been the scene when the patients from the Stone House, Charing Cross, passed into an institution for ever associated with the keeping and healing of the diseased in brain or nerve.\textsuperscript{206}

More humane attitudes and regulation of mental health management, were introduced in England in the eighteenth century to control the expansion and operation of what were, at first, mainly privately run ‘madhouses’, referred to as ‘the trade in lunacy’\textsuperscript{207}. Later the many town or county asylums, bridewells\textsuperscript{208} and prisons came under scrutiny, including some with charitable origins such as Bethlehem, (Bedlam) Hospital in London.\textsuperscript{209}

Concerns about ill-treatment and corruption were transferred to the British colonies, including WA. The Colonial government at first, and subsequently the WA State government, was primarily responsible for provision of all services of this nature. The Australian Federal Government was not significantly involved in the mental health area until 1992.\textsuperscript{210} Thus legal attention to persons detained in mental hospitals remained a subject entirely for State or Territory government legislation. This mostly affected persons detained and treated against their wishes for the protection of themselves, and other persons or property. More recently, in line with developments overseas, legislation has embraced broader sociological and philosophical issues such as autonomy and human rights.\textsuperscript{211}

\textsuperscript{206} O’Donoghue EG, \textit{The Story of Bethlehem Hospital from its foundation in 1247}, (T Fisher Unwin 1914). VII 65.

\textsuperscript{207} Bedlam above, n, 198,65.

\textsuperscript{208} Bridewell- a prison, lock-up or police cell.


\textsuperscript{211} \textit{Mental Health Act 2014} (WA), Charter of Mental Health Care Principles. Sched. 1, 392.
Carney has stated:

Most Western countries have moved away from a strict ‘medical model’ towards a ‘legal model’, which imposes specific criteria for civil commitment, and seeks to ensure the procedural fairness of such decision making through a process of independent review. While jurisdictions vary in relation to the particular criteria adopted, they generally reflect an attempt to balance the individual’s right to liberty with the state’s duty to act in the best interests of people who are not capable of caring for themselves (known as the ‘parens patriae’ power).

The ageing population has generated new responses in medical and social care in the form of special facilities such as nursing homes, hostels, and aged care services in Britain as well as in Australia. The need to detain and protect some individuals in aged care facilities has led to and increased focus on legal rights and protections, formerly thought only relevant to psychiatric hospitals in both countries.

2.2 English and WA history

A study of history is not only a backward-looking exercise of purely academic interest, but serves an essential purpose for future developments. Cook quoting Cardozo stated:

[H]istory, in illuminating the past, illuminates the present, and in illuminating the present, illuminates the future.

[Cook continued:]

Of course, we should not regard English law as superior to our own. But to suggest—as some do—that because Australia has become a fully independent member of the international community, it must turn its back on its legal and political ancestry, is to argue for intellectual and legal impoverishment.

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The foregoing statement supports the case for comparisons between England and WA as made in this thesis, to ensure that lessons can be learned from the experience of the former, while acknowledging that WA should not adopt policies which may be impractical or unsuitable for local conditions.

At settlement of WA in 1829 initial British authority was vested in the Governor, James Stirling.\textsuperscript{216} As Russell has recorded:

\begin{quote}
…when Captain James Stirling sailed from England on 8th February 1829, he brought with him no formal Commission, but merely a set of instructions to him as Lieutenant-Governor which had been issued by Sir George Murray, the Secretary of State for the Colonies…\textsuperscript{217}
\end{quote}

Psychiatric practice and mental health legislation adopted policies copied from Europe, and England in particular.\textsuperscript{218} The importance of understanding the historical and political background to events in each country must be accepted, to avoid a slavish imitation, overlooking deficiencies in either system.

\section*{2.3 Law defined}

Law: An authoritative system of religious or secular norms, written or unwritten, which can govern a society, can empower or discipline its members, and can be enforced by sanctions.\textsuperscript{219}

Attempting to define what law is, can descend into a confusion of philosophy, sociology, jurisprudence, and morality based in abstract concepts, which may bypass consideration of practical applications and impact on individuals. As in psychiatry and medicine generally, the fact that there are many theoretical positions underlines that no one position holds true in every situation.

\textsuperscript{216} Russell E, \textit{A History of the Law in Western Australia and Its Development from 1829 to 1979}, (University of Western Australia Press 1980), Chapter 1 Introductory, 3.
\textsuperscript{217} Russell E, \textit{A History of the Law in Western Australia and its Development from 1829 to 1879}, (University of Western Australia Press 1980), 8.
\textsuperscript{218} \textit{Victoriae Regina No. 9. 1871}. First WA mental health legislation.
Paton stated:

…controversy absorbs much of the energy that should be spent in pursuing the subject itself. Modern jurisprudence trenches on the fields of the social sciences and of philosophy; it digs into the historical past and attempts to create the symmetry of a garden out of the luxuriant chaos of conflicting legal systems.\textsuperscript{220}

Philosophical and jurisprudential debates as to what is law have raged over many centuries. Partington approached this topic differently by asking ‘what is the role of law?’\textsuperscript{221} He referred to the popular concept of law as order, but found this unsatisfactory as:

There is no single concept of order, but rather a variety of orders in relation to which law may play a role. These include: Public order; Political order; Social order; Economic order; International order and Moral order.\textsuperscript{222}

Each of these various forms of order is related to cultural, social, political, and economic ideologies. The history of psychiatry is closely linked to all the foregoing factors, as are the various measures for management of the mentally ill, which are not isolated from events and developments in the wider society. Law has its origins in the need of even the earliest human communities to introduce order and some form of control over the behaviour of individuals in society. At first, what was termed natural law was the major philosophical position held by eminent thinkers such as Aristotle and Cicero. Paton has stated:

Dominating all the doctrines of natural law is the thought that law is an essential foundation for the life of man in society and that it is based on the needs of man as a reasonable being and not on the arbitrary whim of a ruler.\textsuperscript{223}

\begin{itemize}
\item \textsuperscript{221} Partington M, \textit{Introduction to the English Legal System}, (Oxford University Press 2013-2014) 2, 8.
\item \textsuperscript{222} Above n 212.
\item \textsuperscript{223} Paton, GW, \textit{A Textbook of Jurisprudence}, (Oxford Clarendon Press 1972) 100.
\end{itemize}
Paton also explained how the natural law and positive law differ:224

Natural law is not directive in the same sense as positive law: The former provides the ultimate end, the latter directs a certain course of action after considering all the circumstances here and now. Natural law binds the conscience: positive law binds because of a sanction, though if it is just it will also bind the conscience.225

Subsequent philosophical and religious influences affected the interpretations of what was considered natural law by introducing concepts of deities, and Christian thinking related to beliefs in a single God. In reference to the origin of the King’s ecclesiastical power, Sir Matthew Hale stated:

That the power of ecclesiastical order is not derived from the crown, neither is it so conceived to be, but so much as is not superstitious is derived from Christ. Hence it is that the powers of order are not in themselves, nor as to the efficacy of them, confined to any diocese or precinct.226

In the Seventeenth century, Grotius (1583 – 1645) expressed views on the rational and social aspects of man. He was especially affected by international events and wars for which he sought answers in recognition of mutual rights.

Hobbes (1588-1679) was greatly upset by the events of the Civil War in England and sought ways to ensure peace by appealing to a case for a rational and positivist view of law. At the conclusion, he wrote:

And thus I have brought to an end my Discourse of Civil and Ecclesiastical Government, occasioned by the disorders of the present time, without partiality, without application, and without other design than to set before men’s eyes the mutual relation between protection and obedience; of which the condition of human nature, and the laws divine, both natural and positive, require an inviolable observation.227

224 Natural Law: In jurisprudence, a related group of theories, including the DIVINE LAW of Aquinas and the further –developed enlightenment theories of Locke, Hobbes and Hume, which saw human law as subject to a higher moral law that exists naturally and is immanent (innate in God or nature and inherently abiding) as foundational principles. Australian Law Dictionary (Oxford University Press 2010) 396.
225 Sir Matthew Hale’s The Prerogatives of the King, Yale DEC (Ed.) Selden Society, 1976, Chapter XV 145.
His principal book, Leviathan, was described effusively by Oakeshott as: ‘... the greatest, perhaps the sole, masterpiece of political philosophy written in the English language’.

2.4 Natural rights

In the eighteenth century, the role of religion came increasingly under question in respect of its relationship with law. The Protestant revolutions against the Roman church and the French revolution encouraged individualism and freedom of choice. The emergence of scientific knowledge and a new spirit of open inquiry challenged the old order and moved in the direction of positive promotion of certain basic human rights. In America dissatisfaction with rule from Britain sparked the Virginia Declaration. This document included significant reference to the natural rights of man, concepts central to thought in subsequent similarly expressive international documents, including the Universal Declaration of Human Rights (UDHR) adopted by the UN General Assembly on 10 December 1948.

There are risks in natural law as Paton stated:

It remains true that one disadvantage of any theory of higher law is that it is subject to abuse – thus the Nazis employed the higher law theory to undermine the position of certain classes of the community. Is there a theory, however, which cannot be misused?

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228 Oxford Encyclopedia of World History, Scientific Revolution, 596: The 17th Century was an age of intellectual activity marked by great progress in science. Unbiased enquiry, shrinking from no conclusion merely because it was unorthodox and testing all conclusions by experiment and observation characterised the work of leading scientists.

229 A call for American independence from Britain, the Virginia Declaration of Rights was drafted by George Mason in May 1776, and amended by Thomas Ludwell Lee and the Virginia Convention. Thomas Jefferson drew heavily from this document when he drafted the Declaration of Independence one month later. Mason wrote that “all men are born equally free and independant [sic], and have certain inherent natural rights...among which are the Enjoyment of Life and Liberty, with the Means of acquiring and possessing Property, and pursuing [sic] and obtaining Happiness and Safety.” This uniquely influential document was also used by James Madison in drawing up the Bill of Rights (1789) and the Marquis de Lafayette in drafting the French Declaration of the Rights of Man (1789). Library of Congress online access. American Treasures of the library of Congress.

The common law is the name given to the legal tradition which evolved in England after the Norman Conquest, and which has become one of the major world legal traditions. Most states use legal traditions which, either in whole or part, have been borrowed from elsewhere; they rely on what have been called legal transplants. The common law, however, did not originate in such a process of cultural diffusion; it was an indigenous English legal tradition, though it has been considerably influenced by the other major Western European tradition, the Roman law (or ‘civil law’) tradition.²³¹

The indigenous common law developed historically as a means of resolving disputes and can be traced back to a code of written law promoted by King Aethelbert of Kent about AD 603. There were several other forms of customary laws such as those of manors, chiefs and churchmen which applied to individuals. In the reign of Henry II (1154-1189) certain laws were documented and known as the ‘King’s law’. These were termed ‘common law’ because they applied to everyone, and the authority was obtained from the King who appointed his judges to resolve disputes. Other senses of common law emerged as law grew on a case by case basis whereby precedent decisions came to have a bearing on subsequent decision-making. This contributed to the perception of common law as ‘judge-made law’.²³²

²³² Constitutional Foundation Centenary, *Key Issue 7: The Role of Judges*. <https://www.law.unimelb.edu.au/files/dmfile/FACT7-41.DOC>. ‘The common law is judge made law. It has been developed by the courts. It continues to be adapted to meet new situations and changing circumstances.’
2.6 Statute law

The place of statutes in our legal system has evolved with historical events and growth of the parliamentary systems of government. The invention of printing and acquisition of books and libraries as written documents on law were major related factors. Devereaux has commented:

It may come as something of a surprise to learn, however, that it was not until the end of the eighteenth century that systematic provision was at last made to ensure that some justices of the peace actually received complete copies of the statutes of the realm in regular and systematic fashion.233

Lemmings observed:

… by 1700 concepts, processes rules and definitions established by the common law courts had become second nature to many aspects of everyday life and administration in English society, especially local government, productive relations, inheritance, and property ownership generally.

Yet some of these legal customs were challenged and completely overturned by legislation over the next century, and in this period, acts of parliament were passed in unprecedented numbers as permanent parliamentary sessions became an established feature of government from 1689.234 While at first much of the attention was devoted to matters of criminal law, the civil law grew in complexity and scope, described as a ‘continuous organic process’.235

The reception and application of English law into colonial Australia, was modified by local conditions and decisions of magistrates such that from an early stage, the law commenced to acquire its own unique forms.

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234 Above n 225, Lemmings D, 1,2.
235 Above n 225, 13.
As indicated by Kercher:

Many recent studies of British colonial laws have concluded that, particularly in the early years, the law used in the colonies was markedly different from that in England. Early colonial judges in America and Australia, for instance, bent harsh English debt recovery laws, for instance, by allowing instalment orders, payment in chickens, wheat or other produce, making work orders instead of ordering payment in money, and so on.\(^{236}\)

From the earliest periods of colonisation of Australia, the received laws of England were modified and adjusted to local circumstances. Thus, considerable differences in mental health laws originated at the outset of colonisation, and the variations in each country and State reflect differing social and political influences.

Various sources of authority to impose controls on behaviour have evolved over the millennia, influenced by tradition, culture, religion or superstitions, political, social, and scientific developments. How those with mental illness or loss of legal capacity are both managed and assisted in our society, calls into play a complex network of legal, medical, psychological, and social factors, at times with conflicting aims and priorities.

### 2.7 Psychiatry and law

Medical practitioners have a long history of association with mental disorders in their description, identification, and suggested remedies, but the profession of psychiatry emerged as a distinct entity only in the 19th Century. Medically trained persons were commonly appointed to attend to illnesses or injuries in a variety of communal settings such as ships, prisons, and workhouses. With the establishment of asylums many medical practitioners were appointed in overall charge as medical superintendents, at first mostly with little or no formal psychiatric training.\(^{237}\)

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\(^{236}\) Above n 225, Kercher B, 10, 230.

\(^{237}\) In WA, until 1967, the Superintendent of Claremont Hospital held no psychiatric qualifications.
In 1809 the German neurologist Reil (1759-1813) coined the term psychiatry from the Greek psyche and iatros for medicine. In Germany, psychiatry was viewed as *medicine of the mind*. Well-known names in psychiatry worldwide such as Freud, Kraepelin and Alzheimer were neurologists by training, and the blurred boundaries between brain and mind persist in modern debates and clinical practice.\(^{238}\)

Psychiatry has a unique and longstanding link with law, in contrast with much of medicine as a profession. This is a result of the special place which psychiatry holds in society, whereby its medically qualified practitioners, in certain circumstances, can be held responsible for confinement and protection of its citizens. This protection can take the form of safeguarding the community from harm by persons unable to control their behaviour, and preventing self-harm. While the community expects such protections to be effective and humane, there is an understandable fear of improper detention of the sane, which continues to this day.\(^{239}\)

From the time of Magna Carta and the need to curb the actions of the Monarch, to twenty-first century development of international law, the role of law has been to provide a mechanism of social control acceptable to all parties. It is not a vehicle for effecting outcomes but a vehicle by which disagreements can be resolved and formally adhered to by individuals and authorities. Therein lies much of the dissatisfaction often expressed both by victims of crime and executive governments, both of whom can place unrealistic expectations upon the role of legislation. The capacity of law to resolve intransigent

\(^{238}\) Lipowski Z. Psychiatry: mindless of brainless, both or neither? *Canadian Journal of Psychiatry*, 1989, April; 34, (3):249-254:

\(^{239}\) WA Parliament Hansard, 27 February 2014, Petition: “We, the undersigned, say that the new Mental Health Bill 2013 currently before the Legislative Assembly lacks of awareness of the real possibility of citizens being misdiagnosed as having a mental illness when they are NOT mentally ill. It is a terrifying and damaging experience to be treated involuntarily for mental illness in error. Citizens who have been misdiagnosed can be imprisoned without trial and given “treatments” which themselves are hazardous and traumatic”.

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difficulties can be an asset when used wisely, but in dealing with human behaviour and emotions, absolute satisfaction may inevitably be elusive.

Edmond Cahn, professor of Law at New York University School of Law, opens his chapter on Justice and Power with a quotation from the English poet WH Auden:

Yet law abiding scholars write;

Law is neither wrong not right,

Law is only crimes

Punished by places and by times…

[Cahn continues:]

In the beginning, there were those who believed that law was only the will of the dominant deity, and in our own era there are those who believe that law is only the will of the dominant ruling class. The question whether the difference between these beliefs constitutes a net advance may be interesting, but for immediate purposes it is less important than the fact that the two agree in defining law as a manifestation of applied power.

2.8 Litigation and mental health

Much of the litigation in mental health disputes arises from the relative imbalance in positions of power, between patients and health professionals. An important role of mental health law in these circumstances is to ensure an ‘equality of arms’, by which the patient can defend him or herself against authority or being forced to accept decisions with which one does not agree.

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240 Cahn, E, *The Sense of Injustice, An Anthropocentric View of Law*, New York University Press, 1949.3. Cahn states, p134, In the Union of South Africa there are some judges who read the law through bifocal spectacles, the upper lens being reserved for men of the white race. What is in store for such men can be found in Canto XXI of Dante’s Inferno.

241 Ibid.

242 In terms of European law, equality of arms involves giving each part the reasonable possibility to present its cause, in those conditions that will not put this part in disadvantage against its opponent. International Journal of Law and Jurisprudence Online Semiannually Publication published by Union of Jurists of Romania and Universul Juridic Publishing House e-ISSN 2246-9435.
Mental health law represents the application of power by parliament, operationalised by the executive government and its appointees/delegates in the psychiatric and public welfare workforce. This activity is monitored by judicial elements in the form of tribunals and courts. Each of these elements is critical to achieving a balanced outcome which is acceptable to society. The exercise of power, bribes, party politics or corruption can produce outcomes that are either beneficial or evil, even though technically legal. This was the case in Germany under a Nazi government in a position of power to pass unethical enabling legislation, which authorised mass killing and sterilisation of persons, diagnosed by psychiatrists as having mental disorders such as schizophrenia.\textsuperscript{243} The eminent British psychiatrist Burns, refers to the role of psychiatry in this unhappy period as follows:

Psychiatry has been severely (and rightly) criticised for being too willing to knuckle under to social and political pressure. Its collusion in the extermination of the mentally ill and mentally handicapped under the Nazis is a lasting stain. Similarly, so the use of bogus diagnoses such as ‘sluggish schizophrenia’ to detain political dissidents in the former Soviet Union …They accuse us of serving the interests of the pharmaceutical company shareholders before our patients.\textsuperscript{244}

The corruption of psychiatry in Germany and The USSR may stand out, but abuses can arise close to home yet appear less readily recognised.\textsuperscript{245} The study of history, law, philosophy, and ethics as well as sociology, can help to expose the flawed logic and hazards of past errors, both medical and political.\textsuperscript{246}

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\item[244] Burns T, \textit{Our Necessary Shadow}, (2013), Allen Lane, xlvi.
\item[246] Dionysius, (30 – 7 BC), \textit{History is philosophy from examples}, Oxford Dictionary of Quotations, 246.
\end{footnotes}
\end{footnotesize}
2.9 Early written laws

Long before there was any form of systematic care or treatment for persons with mental disorders, the care of their possessions and freedoms was addressed by legal documents, and was a matter of financial importance to the ruler and good governance at the time.\textsuperscript{247}

In WA, as in many countries around the world, the common law can be traced back at least as far as these historic documents. Their value therefore is not simply that of ancient documentation of rights, but in the fact that a continuous evolutionary line can be traced back through legal judgements and policies which support the concepts represented.\textsuperscript{248}

2.10 Magna Carta

Few people are unaware of Magna Carta even if they have never read about it nor thought about its history and relevance. The essentials of the original Magna Carta are now retained in only three chapters. As stated by Lord Neuberger, it was largely repealed in 1863 by the Statute Law Revision Act leaving only chapters1, 9 and 29 intact. Of these the most relevant to this thesis is chapter 29, which he quotes in the 1354 version:

No man of what estate or condition that he be, shall be put out of land or tenement, nor taken, nor imprisoned, nor disinherited, nor put to death, without being brought in answer by due process of law. Due process of law is of course shorthand for the ‘lawful judgment of his peers or by the law of the land. To no-one will we sell or deny or delay right or justice.’ As Chief Justice Coke, a former Treasurer of this Inn and the great early 17th century common lawyer, put it, (this) was a declaratory statement of the Common law.\textsuperscript{249}

The customary manner of dealing with mentally disturbed people at the time was incarceration or exclusion from society in various ways. One can recognise deprivation of liberty, as a link with modern day psychiatric or aged care confinement in asylums,

\textsuperscript{247} For example; Magna Carta and De Praerogativa Regis.
\textsuperscript{248} The manuscript held by the Australian Parliament is one of four surviving originals of the 1297 Inspeximus issue of Magna Carta and was sent to the Sheriff of Surrey, Robert de Glamorgan, to be proclaimed in the county court.
\textsuperscript{249} Lord Neuberger, (Chair Magna Carta Trust), Speech given October 17, 2011.
psychiatric hospitals, and aged care homes. The home page of the Australian Government website related to Magna Carta states:

As a statute of the realm from 1297, Magna Carta officially became part of British law, to be referred to, interpreted, and quoted in the courts and in parliaments of Britain and of countries that have adopted British law, including Australia.\textsuperscript{250} Documents such as Magna Carta have been modified over centuries by successive parliaments, such that little remains intact. In current British law, it appears to have little more than a symbolic value, and has proved of no help in recent cases where protestors objected to certain police tactics.\textsuperscript{251} However, the British Prime Minister described Magna Carta as a ‘British value’ and promoted its significance in 2015, the 800\textsuperscript{th} year of its origin. In an address in Washington DC, Hale SCJ made positive references to the shared elements of Magna Carta between England and the USA, drawing attention to one of the clauses which indicated the importance attached to scholarship in law:

\begin{quote}
We will not make justices, constables, sheriffs, or bailiffs save as such as know the law of kingdom and mean to observe it well.\textsuperscript{252}
\end{quote}

\subsection*{2.11 Habeas corpus}

‘Lat – a writ used to secure the liberty of a person improperly detained or to enable a person who has legal custody of a minor to obtain a child in the wrongful custody of another.’\textsuperscript{253} This measure could require a hospital to release a patient from detention, so that the legality of the act could be ascertained by a court. Although of ancient origin, it formed part of the writ issued in 1997 regarding the Bournewood case in England.\textsuperscript{254}

\begin{flushright}
\textsuperscript{251} Kettleing, the restriction of protestors to a confined area in a city by police.
\textsuperscript{252} Hale J, Supreme Court Historical Society Annual Lecture 2015, Washington DC. Online access.
\textsuperscript{253} Australian Encyclopaedic Legal Dictionary, LexisNexis online access.
\end{flushright}
2.12 Historiography

In the Trevelyan Lectures entitled “What is History?” Carr explored not only the factual origins of history, but also its social and political basis.\(^\text{255}\) He asserted:

> The function of the historian is neither to love the past nor to emancipate himself from the past, but to master and understand it as the key to the understanding of the present.\(^\text{256}\)

[He continued:]

> Before you study the historian, study his historical and social environment. The historian, being an individual, is also a product of history and of society; and it is in this twofold light that the student of history must learn to regard him.\(^\text{257}\)

The name of Pinel is irrevocably attached to his role in removing the chains of his patients and one could be forgiven for thinking this was the extent of his reforms.\(^\text{258}\) However, as is explained in the Translator’s Preface:

> The 1809 Treatise is a landmark work in the study of the mind. In these pages Pinel can be seen grappling with the enduring issues of insanity and their interactions with his time. He had to accommodate, on the one hand, contributions on the issue of insanity stretching back to the Greeks, while at the same time disengaging from the claims of other authorities such as the Church when it came to dealing with pathological piety or religious delusions, for instance; and he had to negotiate these issues at a time of unparalleled social upheaval.\(^\text{259}\)

It is important to recognise the social and economic times in which he worked. This interplay of the current economic and political environment with mental illness and its contemporary management, underpins any appreciation of history in the evolution of psychiatry.

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\(^{256}\) Ibid 29.

\(^{257}\) Ibid, 54.


\(^{259}\) Ibid, Preface.
Pinel’s Treatise illustrated the breadth of his interests, including use of the term, ‘polypharmacie’, and his attention to detailed quantifying and categorisation of disorders, so that they might be better understood and managed. Although seen as a great liberator of the mentally ill, he was also very authoritarian and not opposed to the use of the strait-jacket when necessary.\textsuperscript{260} His status as the person responsible for removing the shackles of mentally ill patients at the Bicetre, Paris in 1792 has been challenged by Weiner, according to Fennell.\textsuperscript{261} The well-known painting of the unshackling of a patient, overseen by Pinel, includes his assistant Pussin in the act. However, it is asserted by Fennell that the removal of shackles took place two years after Pinel left the Bicetre. Nevertheless, Fennell attributes the importance given to Pinel, as stated by Weiner, being his influence upon the attitudes of French Society and encouraging them to perceive the ‘mad’ as sick and capable of cure. Whatever the outcome of the ‘who did what and when’ debate, a reading of Pinel’s Treatise conveys his advanced thinking on mental disorders. It is also relevant to consider the revolutionary political changes occurring contemporaneously.\textsuperscript{262}

One of the foremost English writers on the history of psychiatry was Kathleen Jones, a social worker and historian\textsuperscript{263}. Historical references such as those of Jones, demonstrate that the main cause for concern in society, leading to passage of mental health laws, was the fear of assaults and crimes by the mentally disordered. The need to ensure that poor-relief was not inappropriately given to those not entitled to it, such as malingerers, and people from outside the responsible parish, was also an issue. Jones documented the growth of interest in the care of the insane, and the initial ‘experiments’ in providing alternatives to conventional incarceration in prisons.

\textsuperscript{260} Pinel above, n 250.
\textsuperscript{262} Philippe Pinel, born 1745 – died 1826; The French Revolutionary period approximately 1789 – 1804.
The absence of suitable places for the care of such individuals was plainly aggravated by the social changes of the industrial era. Private establishments or ‘madhouses’ bred both corruption and the need for legal reforms. Jones documented the rise in Parliamentary reforms, and the emergence of psychiatry as a profession exclusively within the medical field. Subsequent volumes have brought the information up to date, covering the asylum growth era and the developments afterwards up to 1993.

Authors such as Scull have portrayed the problems of the mentally ill as due to the influence of psychiatry and the medical profession, while others such as Kathleen Jones have seen it as a cyclical event gravitating between excessive legalism and medicalisation of socially induced behaviour patterns.

Criticism of accounts written by medical authors has suggested that such writings were self-serving and overlooked sociological and cultural aspects. Andrew Scull wrote:

> It should come as no surprise that psychiatrists have been unusually attentive to the need to police their own history: often writing it themselves; bestowing praise and whatever expert authority they can muster on writers who write accounts they find congenial; and evincing violent hostility to historians whose work presents the history of psychiatry in a less than flattering light.\(^\text{264}\)

Scull writes from the perspective of a sociologist with an exhaustive historical focus. His areas of interest are listed by him as ‘Historical, Psychiatry, Medicine, Social Control, Professions, (and) Theory.’\(^\text{265}\) He is no less scathing, however, of the efforts of the English social worker and historian Kathleen Jones. He accuses Jones of a “[n]aive Whiggish perspective which sees the doctors as the purveyors of scientific enlightenment”.

\(^{264}\) Scull A, *The Most Solitary of Afflictions, Madness and Society in Britain, 1700-1900*, (Yale University Press, 1993).

In doing so, he conveys his own anti-medical bias, evident from his literary style and targeted focus on the failure of psychiatry to address many of the ills of mankind, particularly in former times.\textsuperscript{266}

Scull dismisses consideration that psychiatry has a medical footing, and illness is irrelevant to his theme that sociological insights should have primacy.\textsuperscript{267} His book describes ‘the mad’ throughout as a mainly homogeneous aggregate of humanity, failing to account for those whose disabilities were the result of disorders present at birth, or acquired by injury, disease, or intoxication etc. He refers to early writings by doctors as a “spate of books purporting to be medical treatises on insanity”.\textsuperscript{268}

Scull’s views are significant in illustrating the social and cultural dimensions of ‘Madness’ and the growth of institutional responses to problems. The era he examines was one when professional psychiatry was at its infancy, as also were other branches of medicine. The value of his approach lies in alerting us to the risk of enthusiasms for expensive and populist answers to complex medical, psychological and socio-cultural issues. Important as the sociological viewpoints are, he too is in error, ignoring the reality of medical diseases in the genesis of many, but not all, mental disorders.

Burns mentions the importance of Scull’s account of the American psychiatrist Henry Cotton, whose unscientific theories led to thousands of patients being subjected to needless surgery for removal of sources of ‘sepsis’.\textsuperscript{269}

\textsuperscript{266} Scull A: The Most Solitary of Afflictions, Madness and Society in Britain, 1700-1900, Yale University Press, 1993, ‘-- - a thin veneer of continuing medical attention to the miseries of the mad’ 393.

\textsuperscript{267} Above n 258, ‘Psychiatrists and other social control experts for that matter, negotiate reality on behalf of the rest of society. Theirs is pre-eminently a moral enterprise, involved with the creation and application of social meanings to particular segments of everyday life. Just like physicians, they may be said to be engaged “in the creation of illness as a social state which a human being may assume”.’

\textsuperscript{268} Scull, above n258, 206.

\textsuperscript{269} Burns T. Our Necessary Shadow, (2013), Allen Lane, 195-6.
Scull drew attention to the fact that psychiatry at the time ignored and suppressed a major critical report, a feature of several scandals which followed, including some within Australia.\textsuperscript{270} 271

Critically important as sociological insights are to understanding the emergence of psychiatry as a profession, they are complementary to many other insights from other fields of scientific and literary endeavour. These include the study of law and the responses to medical and sociological elements of the whole subject of mental disorders. Important as healthy debate and argument may be, if the result is to sink the sufferers under the weight of political and public indifference, and even greater stigmatisation, then great harm can result.

One book which could fit the picture painted by Scull of self-serving psychiatric writing, is that of the late Director of WA Mental Health Services (MHS), Ellis.\textsuperscript{272} He wrote a history of MHS, commencing with the arrival of the first surgeon in 1831, which described gradual progression with scant attention to the scandals, Royal Commissions, or political and professional in-fighting which also occurred. He also ignored the role of general hospital psychiatric units which were not under his administration. Nevertheless, it is useful as a record of past efforts and his contribution should be appreciated.

The English psychiatrist Thomas Bewley, has written on the History of the Royal College of Psychiatrists, providing an account of the origins of the formal structure of psychiatry, and the social and political factors leading to the evolution of this branch of the medical profession.\textsuperscript{273} It also offers an authoritative and fair account of some of the early asylum scandals and controversies.

\textsuperscript{270} Above 261, re Scull, \textit{Madhouse} (2005), 197.
\textsuperscript{271} Rubinstein WD, and Hilary L, \textit{Menders of the Mind}, 1996, Oxford University Press, 193. (The RANZCP was unable to respond at the time due to threats of legal action.)
\textsuperscript{272} Ellis AS, \textit{Eloquent Testimony}, (UWA Press, 1983).
\textsuperscript{273} Bewley T, \textit{Madness to Mental Illness}, (RCPsych Publications 2008).
Any discussion of the history of psychiatric thought must include reference to Thomas Szasz, an American psychiatrist who opposed any form of psychiatric intervention that involved coercion. He was most well-known for the expression, ‘The Myth of Mental Illness’, one of his book titles in which he argued for no interference by the State under any circumstances. The corollary to this was that persons, who chose not to follow his advice and came into conflict with the law, would be dealt with by the legal system. This represented his extreme political conservatism and his place as a private practitioner in the American health care scene.

The status of Thomas Szasz, and others who have been influenced by his writing, is potentially a formula for continuing mistreatment and inability to recognise human rights abuses. Szasz failed to distinguish genuine reforms and progress from false and erroneous positions of which there have been many.²⁷⁴ Few psychiatrists would claim exclusive ownership of the field as Szasz implies when he stated, ‘Today the role of the physician as curer of the soul is uncontested’.²⁷⁵ Denying there is an entity that can deprive humans of essential characteristics of rational, emotional, and cognitive functions, because of disorders or malfunctions of the brain, does nothing to advance knowledge or care. Regardless of any later criticism of his writings, he provoked attention and thought regarding the position he took.²⁷⁶

²⁷⁴ Edward Shorter: *The Psychiatrist* May 2011 35, 183-184. ‘Books such as Szasz’s delegitimised psychiatry in the eyes of much of the population, and drove desperately ill individuals away from such treatments as electroconvulsive therapy that could have been life-saving’.


²⁷⁶ Edward Shorter: *The Psychiatrist* May 2011 35, 183-184. ‘Books such as Szasz’s delegitimised psychiatry in the eyes of much of the population, and drove desperately ill individuals away from such treatments as electroconvulsive therapy that could have been life-saving’.
During the 1960-1970 period a swing against orthodox psychiatric thinking developed, much of it in keeping with the liberation philosophies of that era. One of the most influential during this time was Ronald Laing, a Scottish born psychiatrist. Although viewed as an anti-psychiatrist by many, he evinced a more balanced view of the role of psychiatry and medicine in tackling the problems of the mentally disordered. 277 He was noted for introducing more reflective approaches to psychosis, including promoting efforts to understand the meaning of a psychosis for the individual. Laing asked the question that remains unanswered in the literature; if psychiatrists did not exist, someone would have to be designated by society to carry out their functions.

The ‘need’ for this removal, seclusion and treatment service is not manufactured by psychiatrists. There is a consumer demand. As long as there is, some group will be appointed to meet it. Such intervention may not always be controlled by doctors. It is difficult to imagine our society without such a service, run under the control of the medical profession or not. 278

The foregoing view was echoed recently by Prof Nikolas Rose who stated:

Doctors get a bit of a raw deal in critiques of medicalisation, they are not just naive fools, especially psychiatrists who are often placed in circumstances where most of us who are not psychiatrists would not want to be, dealing with problems we don’t know how to deal with, and trying to find their way through very complicated situations. 279

Laing has been described by Burns as, ‘… probably the most eloquent and charismatic of all the anti-psychiatrists’. 280 Laing drew attention to the possibility of comprehending what patients were experiencing in a psychosis, rather than simply dismissing it as a form of pathology. Sadly, he declined in health and his behaviour, including excessive drinking, later offended many who were initially supportive.

279 Rose N, (talk I attended at Nottingham University 2014).
The extent to which psychiatrists should be expected to address the range of social, cultural, and psychological topics, thought by some politicians and the media to come under the ever-widening umbrella of ‘mental health’, warrants further thought.\textsuperscript{281}

More explicitly critical accounts of the emergence of psychiatry can be found within authors antithetically opposed to the role of psychiatry.\textsuperscript{282} Read, a psychologist, describes the hope that was raised during ‘The Enlightenment’, and a scientific approach to mental illness:

\begin{quote}
… that correct categorisation would lead to the discovery of physiological causes. Actually those rare instances where physiological origins of madness have been found – such as the effects of advanced syphilis – have been the cause rather than the result, of a new classification. The Enlightenment’s many attempts to find the imagined true categories of ‘mental illness’ led to no useful advances in physiological explanations. Meanwhile the violent treatments continued.\textsuperscript{283}
\end{quote}

Read and others have a point in drawing attention to the defects in a purely medical view of mental disorders, but their bias may blind them to their equally limited view. Exaggerated use of emotive terms such as ‘madness’, and an apparent unwillingness to recognise the power of their own retrospective and re-interpretive view of history, limits the influence of the messages they have promoted. Clinical psychology has a great deal to offer, but effective therapies, commitment and cooperation are required from all health professions rather than polemical in-fighting.\textsuperscript{284}

\textbf{2.13 Australian authors}

Some professional historians and writers from the social science fields may also focus on areas relevant to their own experiences and interests, at the expense of significant alternative perspectives on history. As an example, a journal article by MacKinnon and Coleborne on

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\textsuperscript{281} Davis LJ, Chapter 10, Obsession, in \textit{Against Health}, Metzl J, Kirkland A, Eds.130. ‘In the end, simplistic and reductionist explanations of complex medical phenomena will always be against health.’
\textsuperscript{282} Read J, Dillon J, (Eds.) \textit{Models of Madness}, (Routledge 2013),
\textsuperscript{283} Read and Dillon, ibid, 15.
\textsuperscript{284} In 1964 only one part-time psychologist and no social workers attended Claremont Hospital, housing at the time over 1500 patients. The changes wrought in the early stages were largely the result of medical and nursing contributions.
\end{flushright}
deinstitutionalisation in Australia and New Zealand asserted that ‘In practice the two strands of deinstitutionalisation have focused on the mentally ill first and the intellectually and physically disabled second’.\textsuperscript{285} However, they are writing from the perspectives of the East coast of Australia. In WA, the opposite course was followed with the intellectually handicapped field leading the way.

The causes of this differing position in WA were local administrative and social factors heavily influenced by an event involving criminal behaviour.\textsuperscript{286} Other elements in the differing position were that three of the senior MHS medical staff had personal experience of intellectual disability. Without this important local knowledge, it is too easy to attribute changes in public policy to events with which the historian is most familiar in his or her experience.

Equally incorrect is to assume that what happens in one part of Australia applies equally everywhere in the nation. Perth is as far removed in distance from Sydney as London is from Moscow or Athens, and each State government largely determines its own legislation and policies. WA still carries a strong secessionist attitude which reached its peak in the 1934 formal request to the British Government ‘to be restored to its former status as a separate self-governing colony in the British Empire’.\textsuperscript{287} WA Mental Health Services previously had an independent approach, mindful of experience elsewhere in Australia and overseas.\textsuperscript{288}


\textsuperscript{286} Earl D, Conference Paper: Reviewing Dr. Benn July 13, 2010; Online at http://davegearl.com/ A UWA mathematics academic in WA, Benn, became seriously depressed at the birth of his intellectually disabled son, and fearing institutional care murdered the boy. Sentenced to death in 1964, this was later commuted to 10 years’ imprisonment.

\textsuperscript{287} The Secession Referendum Act, 1932, and the Secession Act 1934. The case of the people of Western Australia in support of their desire to withdraw from the Commonwealth of Australia established under the Commonwealth of Australia Constitution Act (Imperial), and that Western Australia be restored to its former status as a separate self-governing colony in the British Empire, Published under Parliamentary and statutory authority, Perth 1934.

\textsuperscript{288} Cocks E, Fox c, Brogan M. Lee M, Under blue skies: the social construction of intellectual disability in Western Australia, (Optima Press 1996) 5. Burton quotes Guy Hamilton, late Medical Director of Disability Services stating, ‘...the Nullarbor prevented the traditionalists then running services in the Eastern States from interfering in what was being done in Perth.'
This is less in evidence since the involvement of the Federal Government through a series of National Mental Health Plans, commencing in 1992. State and Federal ministers for mental health meet regularly and some harmonisation with differing laws and standards is emerging.

2.14 Growth of mental health services in Australia

John Bostock wrote of the Australian psychiatric hospital scene in 1951:

There are more beds in mental hospitals than in general hospitals. In spite of modern methods of treatment, the influx of those needing psychological attention outstrips the capacity for cure. Our society faces a gigantic problem. In our search for the solution we need to face the realities of history. (My emphasis)

The same could be said today, despite changes in treatment of which Bostock would have had limited fore-knowledge. The use of mental hospital beds has changed dramatically, as has the range of health professionals involved in care, and the financial provisions from government. In 1955 the Stoller and Arscott Report to the Federal Government provided a contemporary statistical basis for estimating the requirements for mental hospital bed provision based on a figure of 4 per 1000 of the population. If that provision had been retained in WA the total number of hospital beds would be approximately 10,000 in 2015; the total in 2015 is nearer to 700. Of interest from a legal and rights perspective, is the transition from State based mental health legislation applying to detention for treatment and care, to aged care facilities with greater informality and lessened attention to the reality of detention. Thus historical materials can illustrate the extent of change, irrespective of value judgements as to benefits or costs in the process.

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293 Despite this substantial change, the MHC Mental Health Plan 2015-2015, refers to past service delivery models as ‘inefficient’.
Reference materials on the history of psychiatry, leads to the conclusion that it is important to identify author bias or perspectives, from the polemical stances adopted by some writers. The historiography of mental health practice over the centuries is voluminous, expanding and controversial. Frequently the experiences, gender, cultural and occupational interests of the author impinge upon the content and views expressed, and this must be given due weight.

As Carr has stated:

> The belief in a hard core of historical facts existing objectively and independently of the interpretation of the historian is a preposterous fallacy, but one which it is very hard to eradicate.  

2.15 Patients and carers as authors

Patient and carer authors are mentioned to emphasise the importance of new movements including wider community participation in policy and service delivery. These are proving very significant in promoting changes to policies world-wide, and which are increasingly open to public scrutiny. Patients are termed ‘experts by experience’, ‘survivors of psychiatry’ and ‘consumers’, and their views are formally sought in official documents of the Department of Health UK and the RANZCP.

The historiography of mental health law evokes objective and subjective areas with considerable potential for opposing points of view. Most of what we believe to be true about the history of developments in mental health practices has been passed down to us by historians and practitioners. But it is only in more recent times that the experiences of patients have gained a fairer hearing. The voice of patients was only infrequently heard indirectly, through accounts of history and on occasions in fiction.

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One particularly telling 19th century account is that of Perceval, quoted recently by the Care Quality Commission (CQC) and titled, ‘Placed among strangers’.

Instead of my understanding being addressed and enlightened, and my path being made as clear and plain as possible, in consideration of my confusion, I was committed … to unknown and untried hands; and I was placed amongst strangers, without introduction, explanation or exhortation. Instead of great scrupulousness being observed in depriving me of my liberty or privilege, and of the exercise of so much choice and judgment as might be conceded to me with safety – on the just ground, that for the safety of society my most valuable rights were already taken away – on every occasion, in every dispute, in every argument, the assumed premise immediately acted upon was that I was to yield, my desires were to be set aside, my few remaining privileges to be infringed upon for the convenience of others. Yet I was in a state of mind not likely to acknowledge even the justice of my confinement … and jealous of any further invasion of my natural and social rights; but this was a matter that never entered into their consideration. John Perceval (1840) 296

The ‘Alleged Lunatics’ Friends Society was active in the quest for improved legal provisions in early mental health legislation in Britain, as a counter to the asylums and private madhouses then in operation. They employed writs of habeas corpus and contested cases of confinement, coming to the attention of the Law Amendment Society.297 This influence can be noted in the weight given to legalistic procedures in Victorian era legislation, conveyed at settlement to WA.298

296 CQC Tenth Biennial Report, Placed Among Strangers, 24, 2001–2003, London. Perceval was the son of the only British Prime Minister to have been assassinated. He went on to establish the, ‘Alleged Lunatics’ Friends Society’, a forerunner to the patient self-advocacy movement which has gained in strength in recent years, particularly through the ‘Hearing Voices’ movement, MIND, and other related organisations.


298 Victoriae Regina No. 9, 1871. Note that Justices of the Peace received a medical report which they approved before a person could be admitted to the asylum.
A landmark publication illustrating the concerns of families and carers was the book ‘Sans Everything’ by Barbara Robb. She detailed the degrading influences of psychiatric hospital routines in the care of an elderly friend in Friern Barnet Hospital. Her account, and the attendant public outcry led to significant government and professional attention.  

With the growth of education and media opportunities the position is changing, and even celebrity figures are no longer reluctant to give an account of their personal lives. An example of recently emerging carer publicity and media interest, was the account on film of the last days in the life of Iris Murdoch, who experienced a severe dementia illness portrayed by a major film. The contribution of accounts from very high profile individuals suffering from Alzheimer’s disease has contributed enormously to wider community appreciation of this condition, and its consequences for carers, communities and governments. Communities are more likely to take serious interest in changes to mental health legislation and participate in evolutionary developments.

### 2.16 A melded approach to history

Inevitably, as a psychiatrist, my own selection bias would intrude regarding which topics have been chosen. The reader should draw their own conclusions, extracting for themselves a sense of change, and hopefully progress, from the observations offered.

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299 AEGIS (Aid to the Elderly in Government Institutions) was a pressure group set up by Barbara Robb (d 1975) to campaign about the treatment of elderly people in the psychiatric and geriatric wards of British hospitals, following her personal involvement in the case of Amy Gibbs, a patient at Friern Barnet Hospital. AEGIS was founded in November 1965, and the publication of *Sans Everything: a case to answer* (Nelson, London, 1967) by Robb led to government debates and the setting up of Committees of Inquiry into the conditions at several hospitals in Great Britain.

300 Eyre, R, *Iris*, film shown in 2001 re the novelist Iris Murdoch.

It may also offer an opportunity to see where we stand today in the ontological sequence of
events, and avoid errors no less great than those associated with the great asylum building
enterprises, criticised by Foucault as ‘The Age of the Great Confinement’.\(^\text{302}\)

However Foucault has been criticised for appearing to mis-interpret historical events to suit
his arcane arguments.\(^\text{303}\) Interventions such as cold showers, blisters, dental extractions and
other later intrusive surgical interventions, have to be viewed alongside contemporary
political and social perspectives.\(^\text{304}\) A melded time-line approach was developed in a
presentation to the Australian and New Zealand Society for the History of Medicine, to
attempt to capture the parallel development of thought and movements in psychiatry,
matching contemporaneous events in society.\(^\text{305}\)

\section*{2.17 The role of prevention}

Although the saying, ‘an ounce of prevention is worth a pound of cure’ is popular, it can also
become a catch cry for simplistic fixes of complex social issues. Some initiatives promoted
for psychiatric disorders in old age including dementia, recognise the value of fundamental
life-style changes, offering promise. They can herald a move away from drug or medically
directed care, towards addressing issues of social inclusion and healthy activity.\(^\text{306}\)

\begin{footnotes}
\footnoteref{303} Malament B, (Ed) \textit{After the Reformation}, (MUP 1980), Midelfort H, Madness and Civilisation in Early
Modern Europe: A Reappraisal of Michel Foucault, 256.
\footnoteref{304} Ibid. Underdown D, ‘…Foucoult invites misinterpretation… Recent research has shown the dangers of
extrapolating from an idea, as Foucoult does, without sufficient attention to chronological or regional
differences’, 256.
\footnoteref{305} Presented as a lecture with slides at the Australian and New Zealand History of Medicine Society
Conference, Brisbane 2011.
\footnoteref{306} Almeida O, Yeap B, Hankey G, Golledge J, Flicker L, Association of Depression with Sexual Activity and
Daily Activities: A Community Study of Octogenarian Men, \textit{American Journal of Geriatric Psychiatry},
\end{footnotes}
Early intervention for younger people has been extensively promoted in Australia. This matches the call of the early asylum superintendents, who complained that many patients arrived too late for hope of cure.

Asylums had been opened with the promise that they would offer cure, but the reality proved very different. Year after year in his annual reports the Superintendent was to write such sentences as “of the 421 lunatics resident at the end of the year only 18 can be considered curable, and probably several of these may not realise the hope of recovery now entertained” (1869).

Study of history can illustrate cycles of enthusiasm and defeat which have continued to mark progress in mental health care. This should act as a caution against erroneous measures that have popular support, but may lack best practice identification of unequivocal benefit. Debate as to the value of early intervention in psychosis continues, but relates to how best to provide effective services, rather than pointing to some break-through in treatment of mental illness. Another example is the introduction of coercive Community Treatment Orders (CTOs), which are reported by some researchers as little or no better than treatment as usual. A relevant research paper concludes:

In well-coordinated mental health services, the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients’ personal liberty.

The steps which led to the introduction of CTOs in England have been well set out by Fennell. Understanding the historical and political influences which led to this coercive community legislation is essential to appreciating recent developments in WA contained in

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308 Crammer J, Asylum History, (Gaskell 1990), 61.
309 Jorm A, Is ‘headspace’ really improving young people’s mental health? The Conversation, online, August 26, 2015.
the Mental Health Act 2014 (WA). If the use of CTOs is significantly modified, or abandoned, history will record yet another coercive intervention in mental health law that, at first light, appeared to offer promise.

Although Fennell perhaps unfairly attributes unworthy motives to the actions of psychiatrists, the practice had developed under the Mental Health Act 1959 (UK) whereby patients could be discharged from hospital, and yet continue to receive treatment in the community which they would otherwise not accept. Patients could be discharged on ‘conditional leave’, and required to attend the hospital for reviews at set times. This was referred to as ‘the long leash’ and was criticised by the Mental Health Act Commission as unlawful.\(^{313}\) However they saw the development of this practice as ‘a substitute for a community care order, as had been suggested by BASW in 1976.\(^{314}\)

The UK government commissioned a report in October 1998 proposing a revised approach to mental health legislation, chaired by Prof Genevra Richardson. The Report was in favour of having no specific mental health legislation, and instead, one based on the presence or absence of mental capacity.\(^ {315}\) Two serious events involving mentally ill patients aroused great public reaction and this approach was shelved.\(^ {316}\) A more coercive position was adopted regarding new legislation, and CTO’s were introduced into clinical practice.

\(^{313}\) Mental Health Act Commission (UK), First Biennial Report, 1983-1985, 8.12 (d).
\(^{314}\) Ibid, 8.12 (b).
\(^{316}\) Both cases were debatable grounds for introducing community treatment orders. As Fennell points out the first concerned a patient who had taken his medication, while from my reading of the second the problem was one of failure to ensure a safe and effective clinical handover of a patient with a history of seriously aggressive behaviour.
The lesson for WA in this historical account of mental health legislation, is that new proposals may be adopted, without ensuring the promise was confirmed by research and experience. Jorm has criticised the performance of the heavily promoted *headspace* mental health program for young people in Australia stating:

> Like many mental health reforms, *headspace* centres are based on good ideas with an appealing logic. And the *headspace* concept has been effectively promoted to politicians who may be very pleased to announce a new centre in their electorate. But once such an initiative is rolled out nationally, it becomes very difficult then to take an alternative approach, even if the data eventually turn out to be unconvincing. Real reform of Australia’s mental health care system is long overdue and keenly awaited by the sector. But if the community is to benefit, there needs to be piloting of reforms and rigorous evaluation before, rather than after, any national roll-out.

2.18 Legislation

2.18.1 Mental health law in England

Mental Health has been heavily dependent on the prevailing views of the causes of such conditions, and whose responsibility it was to address the care and management of those affected. This has changed over time, as has the ability, or inability to modify or ameliorate such conditions. The historical references emphasised in the historiography vary with the focus and interests of the authors. Thus, while many works relate to prominent medical personnel involved, others indicate the legal, parliamentary, and social origins of what was often a very hard fought political struggle against fear, expense, ignorance and prevailing alternative priorities.

The earliest documented application of law to insanity appears to have commenced with attention to the estates of ‘idiots or natural fools’, although there may well have been earlier undocumented laws. The Statute of the King’s Prerogative, established in 1324 was designed to ensure the continuation and safety of an estate. The terms of this statute have plain
reference to mental conditions present from birth and those which arose later in life. The interest of the King stemmed from not only an obligation to protect the estate from loss and ensure maintenance of the affected person, but as it would revert to the crown in the case of a felon, there was an additional incentive to ensure its preservation. As felons were at risk of execution and/or confiscation of an estate, the interaction of mental illness and crime was of concern to the king from the earliest times.

Subsequent attention to the insane is found in the Poor Laws regarding beggars, some of whom were unable to work because of age or incapacity. This legislation obliged the local community or ‘hundred’ to maintain these persons within their boundaries and to make provision for them.

The Court of King’s Wards established by Henry VIII in 1540 applied to idiots and lunatics until 1661. Under Queen Elizabeth I the Poor Law Acts of 1598 and 1601 required parishes to address the needs of those unable to manage for themselves. This Act continued to operate until 1834.

*The Vagrancy Act 1774* contained a reference to:

…persons of little or no estates, who, by lunacy, or otherwise, are furiously mad and dangerous to be permitted to go abroad…’ Section 20 of the Act allowed two or more Justices of the Peace to authorise the insane to be apprehended and ‘…kept safely locked up in some secure Place as such Justices shall appoint; and (if such justices find it necessary) to be there chained…’

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319 Statute of Cambridge, 12 Richard 2 c.7 1388.
320 27 Henry VIII c.46.
Jones pointed out that certification was by two magistrates without medical or legal training, and that until the passage of *The Medical Registration Act 1858*, medical practitioners could be variously qualified apothecaries, herbalists, homeopaths, divines, physicians, and barber-surgeons etc.\(^{322}\)

### 2.19 Madhouses and asylums

The absence of any suitable place, other than the person’s own home for the care and restraint of the insane, led to the provision of privately run profit making homes or “madhouses”. A series of scandals related to poor care and illegal detention led to demands for regulation. *The Madhouses Act 1744* was intended to address the concerns, but according to Bewley:

\[\ldots\] the Act was not effective as anyone could get a licence to open an asylum. The Royal College of Physicians of London received reports of abuses but could do little.\(^{323}\)

In the 17\(^{th}\) and early 18\(^{th}\) century many insane persons were also confined in prisons, bridewells or poorhouses. The unsatisfactory nature of this practice in turn led to the use of rate funded or charitable asylums or hospitals in the hope of relief. A Select Committee of the House of Commons in 1763 proposed a Bill to regulate practice but this was not passed. In 1773 another Bill was passed by the House of Commons but this was turned down by the Lords. Not until 1774 did a Bill achieve status as an Act and limited regulation and inspection procedures were introduced. Concerns regarding the management of paupers and criminals continued with a focus on the risks to the public and non-insane prisoners.

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\(^{322}\) Ibid, 29.

The County Asylums Act 1808 referred to this concern stating in the preamble:

Whereas the practice of confining such lunatics and other insane persons as are chargeable to their respective parishes in Gaols, Houses of Correction, Poor Houses, and Houses of Industry, is highly dangerous and inconvenient…it is expedient that further Provision should be made for the Care and Maintenance of such Persons, and for the erecting (sic) proper Houses for their Reception.  

As far as the legislators were concerned, the safe operation of prisons and poorhouses was a priority. A Bill proposed in 1816 included the inspection of what were termed “single lunatics”, some of whom were of upper class connection and whose care was considered no business of governments. The House of Lords initially opposed such legislation.

The Madhouses Act 1828 set out to address the ‘Care and Treatment of Insane Persons in England’. This followed a series of scandals arousing public concern as well as the results of the Select Parliamentary Committees of 1815-1816. Where new or revised legislation resulted, this was as a consequence of significant public concern and community pressure for Parliament to act.

Legislation usually followed a considerable time after parliamentary select committee reports, the most important of which were those involving Lord Ashley the 7th Earl of Shaftesbury. Lord Ashley was involved in several major inquiries and committees related to social reforms. These included diverse social concerns including the slave trade, child slavery and factory conditions. Very early in his parliamentary career he was involved in the passage of the County Asylums Act 1828 and the Madhouse Acts 1828 and later the Lunacy Act 1845. As chairman of the Lunacy Commission from 1834 his name has been associated with the major reforms of the Victorian era.

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324 Kathleen Jones, above 312.
325 This position was repeated in WA when the governor of Fremantle prison petitioned London for approval to build an asylum, because of the number of insane prisoners being sent out, and the occurrence of attacks on warders. An asylum was built at Fremantle by the prisoners in 1865.
Scull refers to the trajectory taken by lunacy reform in nineteenth century England

... as the product of historically specific and closely interrelated changes in that society’s political, economic, and social structure; and of the associated shifts in the intellectual and cultural horizons of the English bourgeoisie.\textsuperscript{326}

\textbf{2.20 Examples of significant English mental health legislation}

Noting that WA was only proclaimed a colony in 1829, the dates of English legislation are of interest. Political and social upheavals which wracked the English homeland, would have been known to the early settlers, and this information would have guided measures in WA. Appendix 11.2. Table 1 illustrates selected examples of legislation enacted in England to meet emerging concerns of the day, with examples of corresponding WA legislative developments.\textsuperscript{327}

\textbf{2.21 Australian mental health legislation}

\textbf{2.21.1 Indigenous people}

The initial management of the Australian continent by the British government was to regard it as “terra nullius” or uninhabited land. The concepts of international law in existence at the time, permitted this focus primarily on the perceived tribal hunter gatherer behaviours, then considered insufficient to establish ownership of land under any “natural law”.\textsuperscript{328} This position held in Australia until 1992.\textsuperscript{329}

\textsuperscript{326} A Scull, \textit{The Most Solitary of Afflictions, Madness and Society in Britain, 1700-1900}, Yale University Press, 1993.

\textsuperscript{327} Table 1, 390.

\textsuperscript{328} Parkinson P, \textit{Tradition and change in Australian Law}, (Thomson Reuters 2013), 5\textsuperscript{th} Ed, p127 refers to a publication by E de Vattel, the Law of Nations, 1758 which supported this view.

\textsuperscript{329} \textit{Mabo v Queensland (No 2)}, High Court of Australia.
2.21.2 Customary Indigenous or Aboriginal law

Considerable debate surrounds even the terms used to discuss law in Australian aboriginal society. A report by the NSW Attorney-General’s department states:

3.14 There is no generally accepted definition of what constitutes Aboriginal customary law, not least because, it is almost impossible to describe comprehensively. There is secrecy surrounding many of the laws, some of which are “sacred and not to be spoken about to anyone”, except the members of the relevant tribal group. Tribal laws differ from community to community. Information obtained from one Aboriginal tribe would not include information about the laws of another tribe as they would not be permitted to speak about those other laws. A universal definition cannot be formulated by generalising from a sample description.330

The Australian Law Reform Commission (ALRC) report commenting on the character of aboriginal customary law stated:

Rules of behaviour were thought of as inscribed in social relations and in features of the landscape. These rules dealt with many aspects of life, and included responsibilities of various kinds for land and for objects and ideas associated with land, complex structures of kinship and family groupings, patterns and rules of marriage and child care, and procedures for the conduct and resolution of disputes. This variety was stressed by Dr Diane Bell, who commented that customary laws need to be seen as:

…both a body of rules backed by sanctions and as a set of dispute resolution mechanisms. At a more informal level it was also a series of accepted behaviours which allowed daily social life to proceed. The formal rules are backed by sanctions and are clearly articulated in terms of what one should do and why. These shade into more informal areas of behavioural controls which may never be clearly stated, but which are the stuff of interpersonal relationships, the self-regulating patterns of interaction.331

As the role of law in any community is to provide a measure of social control, it is reasonable to accept that aboriginal customs permitted a degree of negotiation and mediation. It would appear highly likely that some form of consideration was given to managing mental disorders, within local groups and mediated by elders.

Vicary and Westerman have indicated the complexity of issues which affect perceptions of mental disorders amongst indigenous Australian people. The gulf of differences between Western ideas on mental health and aboriginal concepts is substantial. Any defects in justice affect both indigenous and non-indigenous persons, the former even more adversely.

2.22 Colonial Australian laws

2.22.1 Charter of Justice 13 October 1823 (UK)

This Charter from King George IV created the Supreme Court of New South Wales and Van Diemen’s Land. Provisions included the power to appoint:

Guardians and Keepers of the persons and estates of natural fools and such as are or shall be deprived of their understanding or reason by act of God so as to be unable to govern themselves and their Estates which we hereby authorise the said Court to hear and determine by inspection of the person…

Although a settlement was established at Albany in the South of WA in 1826 WA was not declared a colony officially until 1829. The Charter does, however, include a reference to The Island of New Holland indicating awareness that there was a larger land mass yet to be considered.

2.22.2 The Australian Courts Act

The legal status of laws in the early days of Australia was complicated by the fact of penal settlement in all States, except South Australia which had never accepted convicts. The Australian Courts Act 1828 sought to remedy the position by declaring that English law was applied from the date of settlement.

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332 David Vicary & Tracy Westerman (2004) That’s just the way he is’: Some implications of Aboriginal mental health beliefs, *Australian e-Journal for the Advancement of Mental Health*, 3:3, 103-112

333 ABS Snapshot at 30 June, 2015, WA. ‘At 30 June 2015: Aboriginal and Torres Strait Islanders comprised 38% (2,113 prisoners) of the adult prisoner population. The Aboriginal and Torres Strait Islander age standardised imprisonment rate was 17 times the non-Indigenous age standardised imprisonment rate.’ <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2015~Main%20Features~Western%20Australia~24>.

All laws and statutes in force within the realm of England at the time of the passing of this Act (not being inconsistent herewith, or with any charter or letters patent or order in council which may be issued in pursuance hereof), shall be applied in the administration of justice in the courts of New South Wales and Van Diemen’s Land respectively, so far as the same can be applied within the said colonies.335

2.22.3 Colonial Laws Validity Act: 1.17, 1865 (UK)

The commencement date for English law in WA was retrospectively set at 1 June 1829.336 However, despite the Australian Courts Act 1828, uncertainties continued resulting in the need to pass the Colonial Laws Validity Act. This arose because of doubts as to the validity of Australian laws which were inconsistent with, or repugnant to, English common or statute law. The English Westminster Parliament enacted legislation to ensure that colonial legislatures were bound by such Imperial laws as were extended to them or applied by paramount force.337 The laws affected were mainly concerned with shipping and broad colonial matters which applied throughout the British Empire. Doubts persisted, however, as to the status of Australian laws in situations where the British Parliament could still pass laws applicable to Australia under what was termed paramount force. Australian parliaments would be unable to alter or oppose such laws raising doubts as to its status as an independent country. To address this issue to some extent, the States passed legislation of their own which either confirmed or deleted certain redundant UK statutes applicable therein.338

335 Australian Courts Act 1828, 9 Geo 4 c 83.
336 Interpretation Act 1918 (WA). 43. For the purpose of determining the applicability or otherwise within the State of any Act of the Parliament of the United Kingdom, the State shall be deemed to have been established on the first day of June, One thousand eight hundred and twenty-nine.
338 WA Law Reform Commission recommended repeal of Imperial Acts in Project 75 in 1994. This is still before parliament, as the Obsolete Legislation Repeal Bill 2015 Part 3, Repeal of Imperial Acts.
2.22.4 Court of Civil Judicature Act 1832 (UK)\textsuperscript{339}

This document, hand written by His Excellency, Captain James Stirling, confirmed the constitution by King George IV of the Legislative Council ‘for the Government of His Majesty’s Settlements in WA on the Western Coast of New Holland’. It refers to the Court of Civil Judicature with powers to make Laws and establish courts.

The Court was also empowered to appoint:

Guardians and Keepers of the Persons and Estates of Natural Fools, and of such as are or shall be deprived of their reason by the Act of God … And to hear and determine questions of Idiocy and Lunacy, by a jury of Twenty-Four good and lawful men, the opinion of the majority of whom shall be taken and received as the verdict of the said jury.\textsuperscript{340}

2.22.5 The first Western Australian (Colonial) Mental Health Act

\begin{quote}
Victoriae Regina No. 9. 1871.
\end{quote}

An Act to Provide for the safe Custody of, and the Prevention of Crimes by, persons dangerously insane.\textsuperscript{341}

WA briefly became self-governing with its first Parliament of 1891. Up to that time the colony had been managed by the Legislative Council. With Federation on January 1, 1901 WA ceased to be a colony, becoming an independent State of the Commonwealth of Australia.

2.23 Conclusion

The history of mental health law cannot proceed in isolation from the multi-factorial influences that have been brought to bear over millennia of civilized development. Primitive emotions have persisted throughout history and surface even today, alternately seeking to excuse or blame the individual for behaviours which transgress societal norms and values. A particularly violent and inexplicable crime arouses much the same reaction

\textsuperscript{340} Ibid.
\textsuperscript{341} R \textit{Victoriae Regina No. 9. 1871}, The Statutes of Western Australia, Vol 1, 1832 – 1882, JCH James, Ed. (Spottiswoode and Co, 1896).
today as that which occurred in previous centuries. Thus, a table of changes to law statutes and procedures cannot be viewed in isolation as purely historical data. These accumulative changes have grown on the substrate of underlying and, at times, conflicting influences. Unless this can be appreciated in a broad-brush socio-political perspective, it is impossible to grasp the significance of a single piece of legislation, or its place in offering a remedy for the matter in question.

It is not appropriate to take a single-track view of mental health law, as if solely a subject for lawyers and courts, psychiatrists, and psychologists. It is intertwined with many professions and disciplines including historians, sociologists, criminologists, anthropologists, politicians, and economists to name but a few.

The complexity and variety of legal and non-legal contributions to an understanding of the subject has been illustrated. Divergent views of the history of psychiatry, like many other historical reviews, are heavily influenced by the personal, and sometimes unconscious, perceptions of their authors. What seemed at first to be a simple matter of documenting an itemised account of past events proved to be challenging. Even more so when many factors regarding the historian and the subject are controversial and subject to differing interpretations. The historiography of mental health law invokes many objective and subjective areas with potential for opposing points of view. Both the history and the historians are worthy subjects for examination. Most of what we believe to be true about the history of developments in mental health practices has been passed down to us by historians and practitioners. The historical literature embodies more than just facts and ‘black letter law’, as it includes interpretations and opinions of the authors themselves. The historical, political, social, cultural and gender positions of the author may be as relevant as their authoritative statements. It is therefore important to look beyond the historical literature not only for facts, but also for bias and contradictory or oppositional viewpoints.
Legislation and procedures designed to protect the interests of the elderly should be judged both on their own merits, and against the yardstick of other jurisdictions. The common historical origin of WA legislation has been illustrated, while subsequent chapters will portray the divergence which has occurred.

The level of activity in legislative changes in the two jurisdictions, England and WA, is of special interest. The first modern review of mental health law in WA took place around 1960 resulting in the Mental Health Act 1962. The Mental Health Act 1981 (WA) was passed in 1981, but never proclaimed. The Mental Health Act 1996 (WA) was intended to be reviewed after five years. This took place in 2003, and recommendations were made but not followed up until 2011. The cover artwork of the published document on the review of the 1996 Act by Holman, titled, The Way Forward, featured two tortoises, implying ponderously slow activity. This tardiness may be of some merit, if genuine and cautious progress results.

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3 International comparisons, WA vs. England

This chapter addresses some key distinctions between mental health legislation and procedures, in WA compared with England. Comparisons have been made with the Mental Health Act 1996 (WA), as the Mental Health Act 2014 (WA), was not in operation until 30 November 2015. The relevance of identifying differences between international standards in this field, is to be found in the statement of the WA Minister for Mental Health related to the WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025.

Combining research, evidence, expert opinion, world’s best practice (my emphasis) and some of the latest planning tools, we are now able to estimate the optimal mix of services required for our growing population over the next ten years.343

What constitutes ‘world’s best practice’ is difficult to identify, as there are many parameters which could be relevant. A thorough examination of the practices, as well as an appreciation of the results of policies and procedures is required, with due regard to costs and benefits. The phrase, ‘world’s best practice’ is rarely defined and considered by some as simply a management ‘buzz-word’, and by others to refer to practice based on evidence-based outcomes.344 The term also implies a universally agreed fixed standard of excellence which is non-existent in mental health practice. Feek, writing on the use of language has commented on the adverse effects of too readily adopting buzz words, without full examination of their contexts and usefulness.345

344 Cornwall A, Development in Practice, Vol 17, Issue 4-5, 2007. Buzzwords get their ‘buzz’ from being in-words, words that define what is in vogue.
345 Ibid, Feek W, ‘Why are ‘best practice’ and its natural extensions of ‘replication’ and ‘going to scale’ bad for progress on development issues? I would suggest the following reasons. They imply uniformity, when we need greater diversity: diversity matching the number of contexts – an almost infinite number. They have the strong possibility of disempowering people and organisations: those who are doing great stuff in their contexts see something rated as the best which they know will not work in their situations, and they wonder why they do not get the recognition they feel they deserve. They bias the suggested required action towards the large agencies, international agencies, and away from the small, local organisations.
Comparison between WA and England alone, was made because of differences in legislation between the several governments that comprise the UK. While some of these are more in form and terminology than content or intention, since devolution by the Westminster government there have been significant changes in mental health law in each of the jurisdictions. For example, Zigmond has cited significant points of difference between the *Mental Health (Care and Treatment) (Scotland) Act 2007*, and the *Mental Health Act 2007* for England and Wales. 346 These related to differing opinions on incapacity, advance directives, compulsion exceeding 28 days and roles and responsibilities of professional groups.

The Welsh National Assembly has separate delegated mental health legislation, which is essentially based on that of England. 347 Scottish mental health law has its own history and vocabulary as well as differences in practice, although there are common features in principle and intent. 348 The parliament of Northern Ireland has its own *Mental Health (Northern Ireland) Order 2004*. 349 As the clinical and legal background to this research has been based on English law, and as previous chapters have illustrated the essentially English origins of WA law, reference will be mainly confined to England.

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347 *Mental Health Act 2007* (England and Wales).
348 *Mental Health Care and Treatment Act* (Scotland) 2003.
3.1 Legal systems and procedures

WA inherited its mental health and related laws from the Westminster parliament in England. There are many similarities in practice and procedures, due not only to transmission of legal rules and concepts, but also the significant number of psychiatrists, lawyers, and administrators in WA with experience of British law and health services.

WA has its own State Constitution initially handed down directly from the colonial authorities in England.\textsuperscript{350} Hanks states:

Each of the States has its own formal constitutional document, entitled a Constitution Act, whose origins lie in United Kingdom legislation (the inescapable mark of colonial status). However, these original imperial documents have been replaced by local legislation and, in general, they are subject to amendment or repeal by the State parliaments in the same way as other more mundane, legislation.\textsuperscript{351}

The Constitution Act 1889 (WA) has the long title, ‘An Act to confer a Constitution on Western Australia, and to grant a Civil List to Her Majesty’. This Act established a parliament in place of the previous Legislative Council, and legislation covering many matters comprising electoral procedures, the judiciary and legal provisions, financial arrangements and miscellaneous.\textsuperscript{352} The accumulated WA statutes proceed with all forms of legislation necessary for a growing community, and are based on legislation in the UK as well as that of other States.

3.1.1 Development of a Federation

WA was proclaimed a British settlement in 1829, the only two colonial divisions at first being New South Wales and WA, previously known as New Holland. During 1855-1859 the other States were granted constitutions.

\begin{thebibliography}{99}
\bibitem{} \textsuperscript{350} The Constitution Act 1889, (WA).
\bibitem{} \textsuperscript{351} Hanks P, \textit{Australian Constitutional Law Materials and Commentary} (Butterworths 1994) 9.
\bibitem{} \textsuperscript{352} Constitution Act 1889, \textit{The Statutes of Western Australia}, Vol. II, 1883-1892, Ed. JCH James, (Spottiswood and Co. New Street London 1896), 373.
\end{thebibliography}
WA did not have its own constitution until 1890, when responsible government was granted by Westminster. In 1901 WA joined the Commonwealth of Australia in a federation, although late in doing so and with some reluctance.\textsuperscript{353} There is no national mental health legislation, each State Government being responsible for its own legislation and legal procedures. Hanks states the position of State and Commonwealth constitutions adopted at federation as follows,

\ldots the mixture of restrictive and flexible procedures for amending State Constitution Acts is acknowledged in s 106 of the Commonwealth Constitution, which declares that, ‘[t]he Constitution of each State of the Commonwealth shall, subject to this Constitution, continue as at the establishment of the Commonwealth until altered in accordance with the Constitution of each State.’\textsuperscript{354}

After Federation in 1901 the Commonwealth government assumed responsibility for a range of administrative and political matters including international agreements and treaties. Mental health services in each State were not affected and continued as before, with each State responsible for its own arrangements.

Since the introduction of the first National Mental Health Plan, agreed by all heads of the State governments in 2003, there has been a move towards more centralised policy and planning formulae for all the States. However, individual State legislation and funding remained in place and differences in policies and procedures have persisted in each State.

There is no equivalent to the National Health Scheme (NHS) in the UK, with its centralised management by the Westminster Parliament. The Commonwealth Government obtained power to legislate on specified matters under Section 51 of the Constitution of Australia, but certain State powers were ceded to the Commonwealth. Where the States enact legislation

\textsuperscript{353} Common\textit{wealth of Australia Constitution Act 1900} stated, ‘It shall be lawful for the Queen, with the advice of the Privy Council, to declare by proclamation that, on and after a day therein appointed, not being later than one year after the passing of this Act, the people of New South Wales, Victoria, South Australia, Queensland and Tasmania, and also, of Western Australia if Her Majesty is satisfied that the people of Western Australia have agreed thereto, (my emphasis added) shall be united in a Federal Commonwealth under the name of the Commonwealth of Australia’.

\textsuperscript{354} Above n341, 9.
related to those Commonwealth powers, they are ineffective if in conflict with the Commonwealth legislation. This is provided for under Covering clause 5 and section 109 of the Constitution which asserts that the federal law will prevail.

COMMONWEALTH OF AUSTRALIA CONSTITUTION ACT - SECT 109, Inconsistency of laws. When a law of a State is inconsistent with a law of the Commonwealth, the latter shall prevail, and the former shall, to the extent of the inconsistency, be invalid.  

The Commonwealth assumed responsibility for a range of additional services including aged pensions under Sec. 51 (xxiii) of the Australian Constitution. This led incrementally to involvement with national health and aged care systems throughout the whole country, including Medicare and general practitioner services.

3.1.2 Common law

Both England and Australia are common law countries. As stated by Partington:

England is a ‘common law’ country. This means that many of the principal doctrines of law have been established, not by Parliament, but through cases determined in the higher courts. Many examples of judicial law-making can be given;

- the fundamental law of contract, on which much economic activity is based;
- the law of negligence, which relates (among other matters) to dealing with the aftermath of accidents and other forms of injury; and
- the development of the principles of judicial review, which is the basis on which judicial control of the administrative arm of government is achieved.

Statutory interpretation. Courts play a crucial role in the interpretation of the statutes that Parliament has enacted.

Procedural law. Courts also make important contributions to, the development of procedures that the courts follow.  

In each country that observes the principles of common law, the judiciary has a central role in determining the character and public perception of the law over time and circumstances.

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Thus, although Parliament decides what the law will be, the courts and judicial processes add influences from society, resources, practice, and procedures, resulting in gradual change in form, if not in principle or intent. Consequently, the common law in England differs from that in Australia, not only because of the differences in enacted legislation from the respective Parliaments, but because of differences in interpretation and local application.

Countries which follow the common law, borrow and exchange from each other, resulting in modifications based on judicial statements attached to case law decisions. Particularly in the UK, the procedures of Judicial Review directly affect the practice of health clinicians because of case by case decisions.

Judgements by superior courts in WA provide precedents which are relevant in following cases. WA mental health case law by comparison, is extremely limited in number and scope. In the case of MHRB hearings which proceed to SAT (WA) or to the Supreme Court, the findings are binding on later hearings.

3.2 WA and English legislation compared

The WA approach to mental health law had its origins in English legislation and common law of that country during colonial and post-colonial eras. The Mental Health Act 1996 (WA), provided the basic legal requirements for compulsory treatment of psychiatric illnesses consistent with international practices until November 30, 2015. It was consistent with Winterwerp criteria in requiring medical evidence of the presence of a mental illness, and with the European Convention on Human Rights (ECHR), as far as requiring a judicial process to review compulsory detention.

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357 Winterwerp v Netherlands, (1979-1980) 2 EHRR 387
358 ECHR, Art. 5.4.
However, the Mental Health Act 1996 (WA) and the MHRB procedures differ considerably from the Mental Health Act 2007 (UK), and hearings of the MHRT, despite apparent similarities in name.

The following lists some areas of difference in tribunal procedures and mental health legislation current in 2012-2015.
### 3.3 Comparison list; England and Western Australia

#### Table of selected differences

<table>
<thead>
<tr>
<th>Subject area considered</th>
<th>England</th>
<th>Western Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of authority to detain</td>
<td><em>Mental Health Act 2007 (UK)</em></td>
<td><em>Mental Health Act 1996</em></td>
</tr>
<tr>
<td>Authority to detain delegated to</td>
<td>NHS Hospital managers</td>
<td>Registered psychiatrist</td>
</tr>
<tr>
<td>Referral for assessment by</td>
<td>Two medical (Sec 12) + AMHP</td>
<td>One medical, or AMHP</td>
</tr>
<tr>
<td>Maximum detention unless reviewed</td>
<td>Sec. 2: &lt;28 Days; Sec 3 &lt;6 months</td>
<td>Initial 24 hours, then 28 days</td>
</tr>
<tr>
<td>Tribunal administration</td>
<td>HM Courts and Tribunals Service</td>
<td>Minister for Mental Health</td>
</tr>
<tr>
<td>Burden of proof at tribunal</td>
<td>Onus on detaining authority</td>
<td>Onus on patient (in practice)</td>
</tr>
<tr>
<td>Time to earliest independent review</td>
<td>At any time (Manager’s hearings)</td>
<td>No equivalent</td>
</tr>
<tr>
<td>Time to first tribunal hearing</td>
<td>Sec 2 &lt;28 days; Sec 3 &lt;6 months</td>
<td>As soon as practicable</td>
</tr>
<tr>
<td>Time to subsequent reviews</td>
<td>Sec 3 – 6 months from last review</td>
<td>Within 28 days of last review</td>
</tr>
<tr>
<td>Independent second opinion</td>
<td>Yes, CQC appointed</td>
<td>Yes, same service/hospital</td>
</tr>
<tr>
<td>Compulsory medication review</td>
<td>Yes, CQC SOAD</td>
<td>No statutory requirement</td>
</tr>
<tr>
<td>Time to first automatic review</td>
<td>Sec. 2 - within 28 days</td>
<td>As soon as practicable</td>
</tr>
<tr>
<td>Nearest relative tribunal notification</td>
<td>Statutory under Mental Health Act</td>
<td>Not required under MH Act</td>
</tr>
<tr>
<td>Nearest relative discharge power</td>
<td>Yes, unless barring certificate</td>
<td>No statutory powers</td>
</tr>
<tr>
<td>Number of hearings per day</td>
<td>1 – 4</td>
<td>Commonly 8 - 10 allocated</td>
</tr>
<tr>
<td>Time per hearing</td>
<td>2-4 hours</td>
<td>30 – 60 minutes</td>
</tr>
<tr>
<td>Tribunal access to reports</td>
<td>Not less than one day</td>
<td>Less than 30 – 60 minutes</td>
</tr>
<tr>
<td>Tribunal psychiatrist examination</td>
<td>Yes (prior to hearing)</td>
<td>None</td>
</tr>
<tr>
<td>Patient access to tribunal reports</td>
<td>Usually in advance</td>
<td>Variable, frequently at hearing</td>
</tr>
<tr>
<td>Legal representation at tribunal</td>
<td>Customary</td>
<td>Not common, 16% of hearings</td>
</tr>
<tr>
<td>Accredited mental health lawyer</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Patient/lawyer access to clinical files</td>
<td>Yes</td>
<td>Variable, often at hearing</td>
</tr>
<tr>
<td>Notification of hearing to nearest relative</td>
<td>Mandatory</td>
<td>Not mandatory</td>
</tr>
<tr>
<td>Psychiatrist at tribunal hearings</td>
<td>Customary</td>
<td>Variable</td>
</tr>
<tr>
<td>Social worker in attendance</td>
<td>Customary</td>
<td>Rare</td>
</tr>
<tr>
<td>Social work report provided</td>
<td>Statutory requirement</td>
<td>Not a requirement</td>
</tr>
<tr>
<td>Nursing staff/case manager present</td>
<td>Requirement</td>
<td>Variable, not requirement</td>
</tr>
<tr>
<td>Community staff at inpatient hearings</td>
<td>Common</td>
<td>Rare</td>
</tr>
<tr>
<td>Family or carer in attendance</td>
<td>Common</td>
<td>Encouraged / not common</td>
</tr>
<tr>
<td>Written reasons for decision available</td>
<td>Yes, automatic</td>
<td>At patient/lawyer request</td>
</tr>
</tbody>
</table>
### Table 3.4

<table>
<thead>
<tr>
<th>Subject area considered</th>
<th>England</th>
<th>Western Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons written up at hearing</td>
<td>Yes</td>
<td>No (only if requested)</td>
</tr>
<tr>
<td>Appeals to higher courts</td>
<td>Common</td>
<td>Not common</td>
</tr>
<tr>
<td>Clerk to the tribunal</td>
<td>Usual</td>
<td>None at hearings</td>
</tr>
<tr>
<td>Venue</td>
<td>Board/meeting rooms</td>
<td>Meeting rooms/wards,</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>Enacted 2005</td>
<td>None</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>Enacted 2007</td>
<td>None</td>
</tr>
<tr>
<td>Human Rights Act</td>
<td>Enacted 1998</td>
<td>None</td>
</tr>
<tr>
<td>Personal Guardianship under MHAct</td>
<td>Infrequent use</td>
<td>Used frequently</td>
</tr>
<tr>
<td>Administrator appointed</td>
<td>Court of Protection</td>
<td>Used frequently</td>
</tr>
<tr>
<td>Appeals to Court of Protection</td>
<td>Court of record 2005</td>
<td>SAT (WA)</td>
</tr>
<tr>
<td>Official solicitor</td>
<td>Yes</td>
<td>No equivalent role</td>
</tr>
<tr>
<td>Independent Public Advocate</td>
<td>Public Defender Service</td>
<td>Public Advocate</td>
</tr>
<tr>
<td>Independent Mental Health Advocate</td>
<td>Yes</td>
<td>CoOV, Detained patients</td>
</tr>
<tr>
<td>Mandatory psychiatrist training (MH law)</td>
<td>Yes</td>
<td>Not mandatory</td>
</tr>
</tbody>
</table>

### 3.4 Comments on a selection of items from the above comparison list of mental health law and procedures in England and WA

The following observations are based on personal experience as a psychiatrist working in a variety of clinical settings in Australia and England, since 1961. This has been supplemented by study for the LLM at Northumbria University, attending tribunal hearings in England both as the responsible clinician and as an observer, and psychiatrist member of the WA MHRB from 2005 to 2012. Comments pertain to the *Mental Health Act 1996* (WA) which applied until November 30, 2015.

#### 3.4.1 Source of authority to detain

**3.4.1.1 England**

Section 1 of the *National Health Service Act 2006* (UK) was amended in 2012, as part of the changes which were introduced in the *Health and Social Care Act 2012* (UK). The new section 1 firmly places various duties on the Secretary of State (Health).
Secretary of State’s duty to promote comprehensive health service

(1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement-

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of physical and mental illness.

(2) For that purpose, the Secretary of State must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act.

(3) The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England.\textsuperscript{360}

Authority to detain patients is derived from parliament through the \textit{Mental Health Act 2007} (UK). The Act provides for assessment prior to admission, admission for assessment under Division 2, for admission and treatment under Division 3, and other matters. The \textit{Mental Health Act 2007} (UK) is not entirely new legislation, but was formed by amendment of the \textit{Mental Health Act 1983} (UK).

Admission for assessment.

(1) A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as “an application for admission for assessment”) made in accordance with subsections (2) and (3).\textsuperscript{361}

Admission for treatment.

(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as “an application for admission for treatment”) made in accordance with this section.\textsuperscript{362}

This legislation provides for a staged process leading to detention in Hospital, with emphasis on the triumvirate of an authorised mental health professional (AMHP) who usually initiates the \textit{sectioning} of the patient, a psychiatrist with Section 12 approval to make a referral, and

\textsuperscript{360} Health and Social Care Act 2012 (UK) Part 1, 1.
\textsuperscript{361} Mental Health Act 1983 (UK), <legislation.gov.uk>, accessed March 25, 2014.
\textsuperscript{362} Ibid.
another Section 12 approved medical practitioner, preferably with prior knowledge of the patient, such as their general practitioner or another psychiatrist.\textsuperscript{363} The intention of the 1975 review by the Labour Government was to add balancing social and legal components to decisions to detain patients for treatment, rather than a wholly medical perspective, which is achieved to a degree through the role of the AMHP.\textsuperscript{364}

3.4.1.2 WA

Authority to detain patients in hospital is derived from the WA Parliament through the 

*Mental Health Act 1996 (WA)* stated as,

An Act to provide for the care, treatment, and protection of persons who have mental illnesses, and for related purposes.\textsuperscript{365}

Within Part 2 – Administrative provisions, there are 10 functions of the Minister stated.\textsuperscript{366} The Minister is required to promote, ensure and encourage a range of necessary mental health and welfare services, but unlike the English legislation, the word ‘must’ is not used.\textsuperscript{367} The Act defines roles of the Chief Psychiatrist and other professional personnel, the authorisation of designated hospitals as ‘authorised hospitals’, and the meaning of mental illness etc.

3.4.2 *Delegation of Authority to detain*

3.4.2.1 England

In respect of mental health obligations these are carried through by the relevant legislation for which the Secretary of State is responsible. This includes the *Mental Health Act 2007*, (UK), which placed the delegated responsibility for detained patients with the appropriate

\textsuperscript{363} Section 12 approval requires mandatory attendance at an approved day course on mental health law, and must be renewed every 5 years, every year for those psychiatrists over 65.


\textsuperscript{365} Mental Health Act 1996 (WA), 1.

\textsuperscript{366} Above, 7.

\textsuperscript{367} The *Mental Health Act 2014* (WA) omits any reference to the duty of the Minister for Mental Health.
NHS organisations. This responsibility is carried by the NHS Trusts and their Hospital managers, with input from the Care Commissioning Groups (CCG).

Each NHS Trust appoints Hospital Managers who carry out statutory obligations under the *Mental Health Act 2007* (UK). These obligations include ensuring that correct legal procedures are observed, ensuring documentation is accurate and conducting Managers’ hearings into appeals against detention. There is no equivalent role in WA.

3.4.2.2 WA

The source of authority to detain patients for assessment and treatment is the *Mental Health Act 1996* (WA). Only certain psychiatric hospitals, or defined wards of general hospitals, are designated as “authorised hospitals”, and patients may be detained therein on the orders of psychiatrists employed by those hospitals, or in some cases on the order of a magistrate or judge.

3.4.3 Referral for assessment by:

3.4.3.1 England

A social worker, or other mental health professional with appropriate qualifications, employed by the Local Authority, is termed the Approved Mental Health Professional (AMHP). The AMHP may make an application for medical assessment, if there are grounds for believing that a person is suffering from a mental illness, and that hospital admission may be required. Medical assessments are carried out by two doctors, one of whom, if possible, should be known to the patient, and both holding Section 12 authority, as evidence of training in the Mental Health Act. Psychiatrists will be section 12 approved, usually a

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368 Jones, Above n357, 4-283.
369 *Mental Health Act 1996* (WA), Part 1.3. While a private hospital can be authorised, none are at present designated, although several contracted to the Health Department to provide acute services, are authorised.
370 Statutory responsibility for approving doctors under Section 12(2) of the Mental Health Act 1983 in England is delegated to Strategic Health Authorities Each maintains a register of s12(2) approved practitioners working in their area and authorizes approval, re-approval and removal from the register.
consultant or senior registrar. They must examine the patient, often together and within fixed time limits, accurately completing the documentation. The psychiatrist is legally required to ensure a bed can be found, and the patient admitted to hospital if that is necessary. Examinations can be undertaken at home, police stations or a ‘place of safety’ designated as such. Doctors undertaking ‘domiciliary visits’ can claim a special payment for each visit. A claim for payment by the Local Social Services Authority can be raised by the assessing doctor, where a Mental Health Act assessment is requested.

The nearest relative may apply to an AMHP from the Local Authority, to initiate the medical assessments mentioned above. The person designated the nearest relative is precisely defined in the Mental Health Act, and for Section 3 admissions they must also consent to the admission. Where the nearest relative objects to the patient’s admission, the psychiatrist must enter what is known as a barring certificate. This results in an automatic referral to the MHRT.

If the nearest relative is felt to be unsuitable or is objected to by the patient, an application can be made to the County Court to have the person ‘displaced’, and another nearest relative or person can be appointed. Failure to seek the correct nearest relative’s consent can result in a significant legal challenge. Complications may arise when the patient does not accept the nearest relative, who may, for example, be an abusing partner or parent.

3.4.3.2 Definitions

Until the Mental Health Act 1983 (UK) was amended by the Mental Health Act 2007 the definition of mental illness or disorder was extremely complex, resulting in a great deal of preoccupation with, and litigation around, which named type of disorder was present.

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371 The nearest relative is strictly defined and incorrect procedures can be legally challenged.
372 Mental Health Act 1997 (UK) Sec 25.
373 Jones R, Above n357, 4-078.
As amended by the 2007 Act the term ‘mental illness’ has been dropped, and a very broad term, ‘mental disorder’ now used. Part 1-(1) of the Mental Health Act 1997 (UK) states, ‘Mental disorder means any disorder or disability of the mind; and, mentally disordered’ shall be construed accordingly”.\(^\text{374}\) According to Jones:

The definition of mental disorder, as substituted by the 2007 Act, is consistent with the interpretation that the European Court of Human Rights has given to the phrase “persons of unsound mind” in art.5(1) (e) of the ECHR.\(^\text{375}\)

The Act goes on to state, (2A):

But a person with learning disability shall not be considered by reason of that disability to be-

(a) suffering from mental disorder for the purposes of the provisions mentioned in subsection (2B) below, unless that disability is associated with abnormally aggressive or seriously irresponsible behaviour on his part.

Previously under the *Mental Health Act 1959* (UK), mentally handicapped persons were classified as ‘severe subnormality’ and ‘subnormality’. Psychopathic disorder was also included as a category and this has now been dropped.

### 3.4.3.3 WA

The patient may be referred by one ‘authorised medical practitioner’, or an ‘approved mental health practitioner’, to a psychiatrist at an approved hospital or other suitable place for examination. The *Mental Health Act 1996* (WA) states:

The Chief Psychiatrist may, by order published in the Gazette:

Designate any medical practitioner (my emphasis) as an authorised medical practitioner for the purposes of section 77; and

Revoke a person’s designation as an authorised medical practitioner.

The Chief Psychiatrist is not to designate a medical practitioner under subsection (1) unless he or she is satisfied that the practitioner has the skills and experience necessary for the effective performance of the functions of an authorised medical practitioner under section 77.\(^\text{376}\)

\(^{374}\) Ibid, 16.

\(^{375}\) Ibid, 1-021.

\(^{376}\) *Mental Health Act 1996* (WA), 18. (1).
The Health Department agreed that all medical practitioners registered with the Medical Board of WA, now the Australian Health Practitioners Registration Agency (Medical Board), would be automatically designated as authorised medical practitioners.

Referral procedures provide a lower level of professional scrutiny and independence, in the process of initial assessment and referral to an authorised hospital. The emphasis in England is weighted towards a high degree of scrutiny prior to detention. It may be that the historical scarcity of community psychiatric resources and the geography of WA is an influence.

There are no statutory provisions in the *Mental Health Act 1996* (WA) by which a carer or relative can request an assessment or referral to a psychiatrist. This contrasts with the preceding *Mental Health Act 1962* (WA), which included provision for an application to be made to a Justice of the Peace (JP).\(^{377}\) The JP was required to obtain a medical report following his personal examination, and supporting ‘opinion that the person is suffering from mental disorder’.\(^{378}\) Provision of this kind was helpful in a jurisdiction with remote populations and few community psychiatrists, as mentioned previously. JPs were rarely trained or experienced in mental health matters.

A similar provision enabled a police officer to make an application to the JP for an order that the person be apprehended, examined by a medical practitioner, and similarly referred to an approved hospital.\(^{379}\) There is no corresponding provision in the *Mental Health Act 1996* (WA). However, a referrer, (medical practitioner or AMHP), could request police assistance by completion of a ‘transport order’.\(^{380}\)

\(^{377}\) Ibid 29. (1).

\(^{378}\) Ibid 29.2.

\(^{379}\) Ibid 31 (1)

\(^{380}\) *Mental Health Act 1996* (WA), 34. (1), (2), 35. (1) (2) (3) (4).
The grounds for referral under the *Mental Health Act 1996* (WA) are that a medical practitioner or an AMHP ‘suspects on reasonable grounds that a person should be made an involuntary patient’. The patient is said to be *received* into the approved hospital but not *admitted* until examined by the psychiatrist, whose examination must be completed within 24 hours.

The Mental Health Commission (MHC) public information website states:

> Involuntary patients are those people who have been placed by a psychiatrist on an involuntary order under the Act.  

Unlike the position in England, there is no reference in the *Mental Health Act 1996* (WA) to voluntary or informal patients. There is an indirect reference under Division 2, the responsibilities of the Chief Psychiatrist, who is required to ‘monitor the standards of care provided throughout the State’.  

It is solely the treating psychiatrist’s decision whether to detain the patient under the Mental Health Act. Consequently, at MHRB hearings the psychiatrist is placed in a position of direct confrontation with the patient. This may create a difficult therapeutic dilemma, as he/she may be alone in representing the sometimes unexpressed and uncorroborated interests and concerns of others, who are not present at the hearing. Nevertheless, it may be expected that he will argue for continuation of detention, contrary to the wishes of the patient. In my experience of WA tribunal hearings, attendance by family or carers was not common, but extremely helpful when it did arise.

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381 Ibid, s 29, (1), (2).
383 *Mental Health Act 1996* (WA), Division 2, sec 9 (2).
384 Ibid, s 37 (1).
Where a patient with capacity expressly refuses permission for the carer or family members to attend, this is upheld, which may result in conflict. Similar difficulties have been experienced in England dealing with attempted suicide patients in police custody.\(^{385}\)

One of the leading psychiatrists in England, who regularly conducts training in many aspects of mental health law has stated:

> Don’t ever represent the detaining authority. It is far easier and better to be a humble witness giving your medical opinion, rather than to be the person who is locking the patient up.\(^{386}\)

A suggestion has been made that legal hearings are a waste of clinician time and resources, but this is not a generally accepted or expressed view.\(^{387}\) Most psychiatrists and medical staff participate constructively where possible, but this is made difficult by circumstances such as remoteness of locations or unavailability for various reasons and limited resources.\(^{388}\)

Video and telephone linkages are used where appropriate. On occasions, where events have overtaken the timing of the hearing, the treating psychiatrist may indicate willingness to convert the admission to a voluntary one, or apply other measures such as a CTO.

Hospital budgets have no specific allocation to cover duties associated with implementation of the mental health legislation and procedures. The Health Department, MHC and hospital management appear to remain distant. Ideally, they should be involved in ensuring that the patient’s and carer’s interests are properly upheld, at the same time providing sufficient resources and support to staff.


\(^{387}\) Prof Skerritt P. Spokesperson for the AMA: *The West Australian*, Jan 3, 2013; Page: 17. ‘And these changes come at a cost — I use the word cost in its literal meaning because every revision of the Mental Health Act has more restrictions on the application of compulsory detention of people with a mental illness. All of these restrictions cost money with increased use of expensive tribunals to review the detention of patients.’

\(^{388}\) WA is the second largest State or province in the world after Siberia and covers 2,532,400 sq. Km.
Whereas consultant psychiatrists in England almost invariably have a personal secretary to assist with clerical duties and reports etc., this is the exception in WA. There are no designated Mental Health Act Administrator positions in WA hospitals; attention to Mental Health Act records and procedures is carried out by medical records clerks, usually in addition to their other duties.

The Mental Health Act Administrator post in England is a specific and responsible designated NHS or private hospital post. The job description for this position at St Andrew’s Hospital, Northampton runs to two pages of detailed requirements. This includes security of documents, scrutiny of statutory documents, ensuring statutory time frames are met, issuing service users rights notifications, notification of nearest relative etc., ensuring that responsible clinicians (usually psychiatrists) provide reports on time, educational duties and so on.389

In Northern Ireland, the detaining authority (NHS Health Trust) is represented by legal practitioners, thereby relieving the psychiatrist from acting as both treating clinician and detaining authority.390 This is not normally the case in England as, in most cases, the psychiatrist is expected to carry out this role. A 2008 report of a survey of psychiatrists has drawn attention to the problems which this raises, and the need for NHS Trusts to review their practice regarding legal representation.

Consultants generally had a low level of knowledge and understanding of their responsibilities as representatives, which increased since appointment and with experience of MHRT’s. They thought it appropriate that they continue representing the detaining authority in most cases, but recognised training needs.391

390 Nimmagadda S, Jones C, Consultant psychiatrists’ knowledge of their role as representatives of the responsible authority at mental health review tribunals, The Psychiatrist, Sep. 2008, 2.
Until recently all authorised hospitals were in the Perth metropolitan area, and patients were sent by Royal Flying Doctor Service aircraft, or ambulances over very long distances. Under Section 35 of the *Mental Health Act 1996* (WA), a ‘transport order’ authorises the person to be taken to an authorised hospital for examination. The person is ‘received’ but not ‘admitted’ until examined by a psychiatrist and may be in this initial state for no more than seven days, while an acute psychiatric bed was made available.\(^{392}\)

Mental health legislation in WA addresses the issue of authority for detention or deprivation of liberty, by defining in the *Mental Health Act 1996* (WA) the circumstances under which persons identified as having a mental illness may be made an ‘involuntary patient’ by a psychiatrist.\(^{393}\) The legislation requires the psychiatrist to consider whether a CTO can be applied.\(^{394}\) \(^{395}\)

The long title of the *Mental Health Act 1996* (WA) is, ‘An Act to provide for the care, treatment, and protection of persons who have mental illnesses, and for related purposes’.

The Objects of the Act are stated as follows,

To ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity;

To ensure the proper protection of patients as well as the public; and

To minimise the adverse effects of mental illness on family life.\(^{396}\)

\(^{392}\) According to newspaper reports, this provision has enabled some patients to be detained in Perth general hospital emergency departments for several days while awaiting a bed in an authorised hospital.

\(^{393}\) Mental Health Act 1996 (WA) Part 3, Division 1, 43 (2).


\(^{395}\) In no other branch of medicine is a doctor obliged by law to consider an alternative form of treatment. This is quite different to the issue of informing the patient of available treatment options to which the patient may give consent. See Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland), [2015] UKSC 11. Chapter 5, 234.

\(^{396}\) Above, MHAct, 6.
Responsibility for detaining the patient is that of the examining psychiatrist at the authorised hospital, as he/she must decide to apply involuntary status to the patient, admit them as a voluntary patient, or make a CTO, or discharge them from hospital. There is no equivalent role or function to that of the Hospital Managers in England. Thus, the first independent legal review is by the MHRB, possibly up to 6 weeks later.  

3.4.3.4 Definitions

Mental illness is defined in the Mental Health Act 1996 (WA) thus;

4. (1) For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgement or behaviour to a significant extent.

(2) However, a person does not have a mental illness by reason only of one or more of the following, that is, the person –

(a) holds, or refuses to hold, a particular religious, philosophical, or political belief or opinion;
(b) is sexually promiscuous, or has a particular sexual preference;
(c) engages in immoral or indecent conduct;
(d) has an intellectual disability;
(e) takes drugs or alcohol;
(f) demonstrates anti-social behaviour.

An involuntary patient is defined as,

… a person who is for the time being the subject of –

An order under section 43(2) (a), 49(3)(a), 50 or 70(1) for detention of the person in an authorised hospital as an involuntary patient; or a community treatment order.

There is no statutory definition of a ‘voluntary patient’, although the Chief Psychiatrist (CP) produced a pamphlet for patient guidance.

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397 Ibid Part 3, Division 2, 138. (2) ‘The review is to be carried out as soon as is practicable after the initial order is made, and in any event not later than 8 weeks after that time.’
398 Mental Health Act 1996 (WA), Part 1, 4.
399 Ibid, 3.
3.4.3.5 An alternative experience in New South Wales (NSW)

During 1978-1979 I was psychiatrist-superintendent to Kenmore hospital at Goulburn in NSW. At that time, compulsorily admitted patients would be seen by a visiting magistrate who held court at the hospital on a weekly basis. The psychiatrist would be required to outline the diagnosis and clinical reasons for detaining the patient, and an estimate of how long compulsory detention would be necessary for treatment.

Patients were almost invariably represented by local lawyers, and the magistrate would grant a fixed period after which the patient would be no longer formally detained unless an extension was requested, or he/she was discharged from the legal provisions. If the psychiatrist requested an extension, another court hearing would be held before the expiry date of the magistrate’s order, usually only one or two weeks later. Patients also have access to the MHRT.400

It was my view that this system had advantages. The magistrate was independently doing what he was trained to do, while the psychiatrist was better able to work cooperatively with the patient towards an acceptable result at the next hearing. Having an independent magistrate attending from outside the hospital, together with the external legal aid offered, appeared very positive, in marked contrast to the practice in WA under the Mental Health Act 1962 (WA). Patients could appeal to the Board of Visitors (BoV) under the Mental Health Act 1962 (WA), but this did not include any legally qualified members until the Mental Health Act 1996 (WA) was introduced. The role of the BoV was criticised by Bennett in 1976. After pointing out the obvious importance of an independent and objective method of review, he recounted interviews with two long serving Board members:

400 Mental Health Act 2007 (NSW), Section 34-39.
At the time of an interview with her the then Chairman of the Board of Visitors; a member of that Board for the past eleven years, both did not know how many psychiatrists were on the staff at Graylands Hospital and yet had never once so wished to question a psychiatrist’s opinion with respect to a complaint as to exercise the power conferred by section 18 (4), by consulting another psychiatrist from outside the hospital. For the past eleven years, the Board of Visitors has acceded, even in its position as a complaints tribunal, to the recommendations of psychiatrists.401

Under the 1962 Mental Health Act (WA), there were no provisions for legal involvement at any stage, except where the person had been referred by a Justice of the Peace.402 Until the Mental Health Act 1996 (WA), psychiatrists, and indeed all mental health staff, had very little exposure to any professional legal advocacy or regulatory practices. Although this would have been remedied in the Mental Health Act 1981 (WA), the Act was never proclaimed. This cultural and educational position may have contributed to the perception amongst some clinicians, that legal proceedings were an unnecessary additional burden.

It should not, however, be assumed that patient welfare and rights were previously overlooked. For instance, in 1984 all the new inpatient units for the elderly were provided with detailed policy and procedure manuals, which embodied among other things principles of normalisation, least restrictive practice, and dignity of risk, as well as regular reviews. These were introduced into practice by the management team, but were never legally tested or recognised by Health Department administration.

3.4.4 Maximum detention unless reviewed

3.4.4.1 England

Patients who are compulsorily admitted to a psychiatric hospital in England are said to have been ‘sectioned’; their admission having been effected under a Section of the Mental Health Act 2007 (UK).

401 Bennett M, The administration and operation of the laws relating to the care and treatment of mentally disordered persons in Western Australia, UWA Honours thesis, (1976)
402 Mental Health Act 1962 (WA), 30.
Patients admitted under Section 2 may be detained under that provision for a maximum of 28 days, which cannot be renewed, being an admission for assessment. It cannot therefore be applied to patients recently discharged and well known to the service, in which case a Section 3 order is made. Patients admitted under Section 3 are admitted for treatment, and can be detained for up to six months before renewal of the order.

3.4.4.2 WA

Patients are ‘received, but not admitted’, to an authorised psychiatric hospital until seen by a psychiatrist, which must occur within 24 hours of reception. There may be not more than seven days from the time of referral before the person arrives at the hospital under a transport order.\textsuperscript{403}

Only a qualified psychiatrist may confirm the admission as required by the legislation. This gave rise to one of the few mental health cases to reach the Supreme Court of WA. A hospital doctor who had been accepted as a psychiatrist for many years under the Western Australian Medical Board procedures, admitted a patient after the National Medical Registration Board took effect. As he was then briefly not qualified as a psychiatrist a complaint was lodged, which had repercussions in SAT and the Supreme Court, as well as being raised in Parliament.\textsuperscript{404}

\begin{flushleft}
\textsuperscript{403} \textit{Mental Health Act 1996} (WA) Part 3, Div. 1, 35, (3).
\end{flushleft}

\begin{flushleft}
\textsuperscript{404} \textit{RD v MHRB} [2013] WASAT 80.
\end{flushleft}
3.4.5 Tribunal administration

3.4.5.1 England

The administrative position in England is very different to that in WA, regarding legal independence and responsibility for legal oversight and management of the Mental Health Act 2007 (UK). The MHRT is placed with HM Courts and Tribunal Service, under the Ministry for Justice.

Her Majesty’s Courts and Tribunals Service was created on 1 April 2011. It brings together Her Majesty’s Courts Service and the Tribunals Service into one integrated agency providing support for the administration of justice in courts and tribunals.

HM Courts and Tribunals Service is an agency of the Ministry of Justice. It uniquely operates as a partnership between the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals as set out in our Framework Document.

The agency is responsible for the administration of the criminal, civil and family courts and tribunals in England and Wales and non-devolved tribunals in Scotland and Northern Ireland. It provides for a fair, efficient and effective justice system delivered by an independent judiciary.\(^\text{405}\)

3.4.5.2 WA

The administration of the Mental Health Act 1996 (WA) is the responsibility of the Minister for Health, initially delegated to the Commissioner for Health in the HDWA and subsequently to the Minister for Mental Health. Civil tribunals in WA, except for the MHRB, were amalgamated into a single body within the Department of the Attorney General in 2005. This amalgamated body is designated SAT (WA), and has responsibility matters as varied as town planning, guardianship, and occupational registration bodies etc. The clerical administration of MHRB hearings was carried out within the Department of the Attorney-General through SAT, but funded by the HDWA until 2012.

\(^{405}\) HM Courts & Tribunals Service (UK), Annual Report and Accounts 2012-13.
Appeals from the MHRB decisions to SAT can be made on matters of law or as a fresh review, and further appeals from SAT are possible to the Supreme Court if leave is granted. Appeals to SAT or the Supreme Court are relatively uncommon. A search of the SAT decisions database in respect of the *Mental Health Act 1996* (WA) for the 10 years from 2005 - 2015, produced only 50 cases.\(^{406}\)

The MHRB is responsible to the Minister for Mental Health.\(^{407}\) This matter was raised in my submission on the *Mental Health Bill 2012* (WA).

I am particularly concerned that the opportunity has not been taken to ensure the independence of the tribunal by placing it within the State Administrative Tribunals system. While I appreciate that other WA tribunals have no particular problem with this type of arrangement, it is important to remember that we are dealing first and foremost with the liberty of the person. This is not a tribunal on tradesmen, racing or gaming, it is a matter of the freedom, life and welfare of individual citizens. It must therefore be managed with the greatest attention to fairness, natural justice and correct legal procedures. In carrying out these tasks on behalf of the government there should be clear separation of the quasi-judicial role pertaining to detention against a person’s will, and the executive roles of the Minister and the Mental Health Commission. While health professionals and governments may view compulsory admission, detention and treatment as beneficially directed, the legal case for such intrusive measures must be cast iron.

The late Tom Bingham, a former Lord Chief Justice of England and Wales and Law Lord wrote a paraphrase of AV Dicey’s meaning of ‘the rule of law’ in which he stated;

> Dicey’s thinking was clear. If anyone - you or I – is to be penalised, it must not be for breaking some rule dreamt up by an ingenious minister or official in order to convict us. It must be for a proven breach of the established law of the land. And it must be a breach established before the ordinary courts of the land, not a tribunal of members picked to do the government’s bidding, lacking the independence and impartiality which are expected of judges.

It is important to recognize that psychiatrists have an almost unique role in health care in that they can force patients to accept their treatments against their wishes. Apart from a few public health situations no other medical staff can do this. As a consequence, it is critical that this role is carried out with the strictest attention.


‘The Mental Health Review Board (the Board) is an independent quasi-judicial review body established under Part 6 of the Mental Health Act 1996 (the Act) which commenced operation in November 1997. Members of the Board are required to be either legal practitioners, psychiatrists or persons who are neither legal practitioners nor psychiatrists, who are known as community members, and are appointed by the Governor, on recommendation of the Minister: section 126’.
to natural justice, fairness and legal requirements. Any defect in procedures opens the psychiatric profession to justifiable criticism. In my view the proposed mental health tribunal should be firmly located within the legal and justice realms. I appreciate the decision has been made not to do this but I must state my clear concerns. The compulsory detention of any person affects their fundamental human rights to liberty and is not only a health or social welfare matter, despite the best intentions of governments and service providers.  

The WA Attorney-General website for public information provides the following details:

Courts in Western Australia are administered by the Department of the Attorney General through the Court and Tribunal Services division. The judiciary presides over the courts and delivers justice to the community through sentencing in criminal cases and rulings in civil cases. The judiciary - which includes all judges and magistrates - is the third, independent arm of government. Court and Tribunal Services supports the judiciary by providing administration and resources.

Court and Tribunal Services’ mission, in partnership with the judiciary, is to ‘provide a court system which is responsive to community needs for access to justice’. It facilitates speedy and affordable court and tribunal processes that also recognise the independence of the judiciary.

State Administrative Tribunal (WA):

The State Administrative Tribunal (SAT) in WA deals with a broad range of administrative, commercial and personal matters. These matters span human rights, vocational regulation, commercial and civil disputes, and development and resources issues.

The Tribunal is the primary place for the review of decisions made by Government agencies, public officials and local governments. It also makes a wide variety of original decisions.

MHRB information can be found on the MHC website as follows:

The Mental Health Review Board is an independent quasi-judicial review body established under Part 6 of the Mental Health Act 1996 which commenced operation in November 1997. Members of the Board are required to be either legal practitioners, psychiatrists or persons who are neither legal practitioners nor psychiatrists, who are known as community members, and are appointed by the Governor, on recommendation of the Minister for Mental Health.

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The Mental Health Review Board’s primary statutory role is to review involuntary patients, in accordance with the Mental Health Act. Involuntary patients are those people who have been placed by a psychiatrist on an involuntary order under the Act.\footnote{http://www.mentalhealth.wa.gov.au/engagement/mental_health_review_board_copy1.aspx}.

### 3.4.5.3 Separation of powers

The WA Constitution Centre, established to provide general information and education on the State government, notes that the concept of ‘separation of powers’ is an important principle.

In Australia, the power to make and manage federal law is divided between three groups: The Parliament, the Executive and the Judiciary. This division is known as ‘separation of powers’ and is an important principle in Australia’s system of governance.

History has shown that checks on the use of power, such as this, are important for preventing misuse of power. Separation of powers avoids a monopoly of power by any one group. Each group works within its area of responsibility and also keeps a check on the actions of the other groups.\footnote{http://www.constitutionalcentre.wa.gov.au/ForSchools/Backgroundinformation/WhatisDemocracy/Pages/Separationofpowers.aspx}.

Nevertheless, it appears to be given little attention in WA government administration, legislation, and procedures, and is not formally included in the WA Constitution Act.

For any constitution, issues of separation of the powers of government loom large. There is no separation of the powers of the executive and judicial arms of the WA Government expressed in the Constitution Act or any other constitutional instrument. (In fact such a constitutionally entrenched separation of Commonwealth government powers is recognised not expressly, but by necessary implication from the text and structure of the Commonwealth Constitution – this is the Boilermakers doctrine which, although subject to certain qualifications, remains the law of Australia.\footnote{Constitution Centre of Western Australia, Constitutional and legal perspectives, 2. <http://www.constitutionalcentre.wa.gov.au/ResearchAndSeminarPapers>}.)

In 2015 the position of Chief Psychiatrist (CP), previously located within the Health Department, was transferred into the MHC. The CP is appointed by the Minister for Mental Health under the \textit{Health Legislation Administration Act 1984}. 
The WA Health Department continues to have responsibility day to day management of psychiatric hospitals and services in the community. The MHC role is one of policy and development, commissioning of services and allocation of funding.\textsuperscript{414}

The WA Parliament website information states:

The system of government in WA is that of a parliamentary democracy based on the rule of law. More than 250 years ago, a famous French philosopher, the Baron de Montesquieu, published a book The Spirit of the Laws (1748). In the book he claimed that liberty existed in England because of the way in which the system of government was organised. He recognised three branches of government: namely the legislature; executive; and judiciary. Each branch checked each other to prevent any person or arm becoming too powerful. Western Australia’s constitution does not exactly follow the ideas set down by Montesquieu as there are, in reality, overlaps. Viewing the three branches of government does assist in understanding how the government is structured.\textsuperscript{415}

The position where the Minister for Mental Health is responsible for executive action in the provision of services, as well as being responsible for legal oversight of individual rights and freedoms, would very likely be unacceptable in England today. In a review of the structure of administrative law in the UK Ingman detailed several defects in the tribunals system, one of which relates to perception of independence:

\begin{quote}
(c) Many tribunals decided disputes to which the government minister who appointed the members of the tribunal was a party. This made it difficult for a tribunal to achieve the appearance of impartiality, even though there may have been no evidence of bias in fact towards a minister’s case.\textsuperscript{416}
\end{quote}

Partington states:

\begin{quote}
…the power of the judiciary depends on the doctrine of the separation of powers, that to prevent dictatorial powers from being asserted there must be checks and balances in the Constitution. The independence of the judiciary is at the heart of this separation. The judges have the primary task of ensuring adherence by ministers and other agents of the state to the principles of the rule of law.
\end{quote}

\textsuperscript{414} President’s report, \textit{MHRB Annual Report, 2011-2012}. ‘The other significant change was that on the 30th June 2012 the Department of the Attorney-General ceased to be responsible for the supply of administrative support to the Board. That responsibility now vests in the MHC’.


\textsuperscript{416} Ingman T, \textit{The English Legal Process} 13\textsuperscript{th} Ed. 2011, 115, (accessed online 18 August 2015).
…one consequence of the passing of the Constitutional Reform Act 2005 is that, for the first time, statutory recognition is given to the importance of judicial independence and the need for the Lord Chancellor and other ministers not to seek to influence (other than by argument in court) the judiciary.\textsuperscript{417}

Customary practice in several areas has allowed a blurring of powers and independence in WA.

Although the functions of government in Western Australia can conveniently be classified into legislative, executive, and judicial, there is no formal constitutional separation of these powers as there is, for instance, in the constitution of the United States.\textsuperscript{418}

Judges in other States of Australia have expressed concerns about the status of the judiciary in Australian society. The Chief justice of the Northern Territory stated recently, ‘As we all know, the strength of our democracy rests in maintaining the balance of power between the executive, the legislature and the judiciary’.\textsuperscript{419} A highly regarded former Queensland judge has delivered telling criticism of the encroachment of political influences into the system of justice in that State.\textsuperscript{420}

A major driver in change in WA Health and ministerial responsibilities has been the ‘purchaser-provider split’, a management model adopted in WA with little assessment of its utility. A paper by Ryan et al has questioned the motivation behind government enthusiasm for this model.\textsuperscript{421}

\textsuperscript{418} Above, n 411.
\textsuperscript{421} Ryan, Neal and Parker, Rachel and Brown, Kerry (2000) Purchaser-Provider Split in A Traditional Public Service Environment: Three Case Studies of Managing Change. \textit{Public Policy and Administration Journal} 9(1): pp. 206-221. <http://eprints.qut.edu.au/archive/00004824>. Rather than providing a clearer focus on the responsibility of individuals, relationships between purchasers and providers often become confused, especially when the purchaser also carried out a regulatory function. In this way, the purchaser was involved in setting the rules for agency activities including regulating the behaviour of providers. Far from removing ‘self-interest’ from public sector activity as a consequence of purchaser-provider split, the regulator/purchaser could protect its’ own sphere of interest, while pressuring the provider to conform to unrealistic performance standards (emphasis added).
3.4.6 Burden and standard of proof at tribunal

3.4.6.1 England

The burden of proof rested with the psychiatric patient to demonstrate that he/she no longer needed to be detained until 2002. The position was reversed by the case of *R (H) v Mental Health Review Tribunal for North and East London Region*. The case was important not only for the decision, but because it was the first case in which the government position was overturned by the ECtHR, which required a change in English law and procedures. The explanatory note attached to the Remedial Order not only explains the significance of this step, but also the serious regard the UK government is required to hold, in respect of observance of the *Human Rights Act* (2008) (UK), where incompatibility with the ECHR is found to be present.

The Remedial Order states:

In the case of The Queen on the application of H v Mental Health Review Tribunal North & East London Region (Secretary of State for Health Intervening) (4 April 2001) the Court made a declaration under section 4 of the Human Rights Act 1998 that—

“Sections 72(1) and 73(1) of the Mental Health Act 1983 are incompatible with Articles 5(1) and 5(4) of the European Convention of Human Rights in that, for the Mental Health Review Tribunal to be obliged to order a patient’s discharge, the burden is placed upon the patient to prove that the criteria justifying his detention in hospital for treatment no longer exist; and that Articles 5(1) and 5(4) require the Tribunal to be positively satisfied that all the criteria justifying the patient’s detention in hospital for treatment continue to exist before refusing a patient’s discharge.”

In order to remove the incompatibility, the Order amends sections 72(1) and 73(1) of the 1983 Act to provide that a Mental Health Review Tribunal shall direct the discharge of a patient if they are not satisfied that the criteria justifying his detention in hospital for treatment continue to exist. The Order also makes a consequential amendment to subsection (2) of section 73 of the 1983 Act.

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424 Ibid.
A paper by Cooper and Davis examined the existence of a burden of proof in MHRT cases in the UK. They indicated that:

Whereas it is well established that in an adversarial system the burden of proof in a case will always rest with the party bringing the action, the position in an inquisitorial system is far less clear.

3.4.6.2 WA

In MHRB hearings the patient experiences many subtle disadvantages, which collectively appear to place the burden on the patient, to prove to the Board that continued detention is no longer required. These include lack of legal representation, limited or late access to reports, delays in conducting hearings and limited personal support arrangements from social workers, family, or the Council of Official Visitors (CoOV). Where the lack of community facilities is a significant factor preventing discharge from hospital, the patient is at times seriously disadvantaged.

The burden of proof issue in WA must also be considered from the aspect of whose responsibility it should be, to establish the need for continuing detention or an order under the Mental Health Act 1996 (WA). The impression gained while a member of the MHRB was, that some clinicians expected the Board to support continued detention or restriction, without sufficient effort at making an adequate legal case. This was demonstrated on many occasions by inadequate preparation, documentation, or representation by the treating team of clinicians. These are resource, education, and service delivery matters, more properly the responsibility of the MHC and the Minister. They are less amenable to legislative correction.

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426 Ibid, 5.
3.4.6.3 Standard of proof

As tribunal hearings are required to be inquisitorial in nature, rather than adversarial, the role of the various parties appears in need of further clarification. The accepted standard of proof is on the balance of probabilities, rather than beyond reasonable doubt as in criminal cases. Tribunals are not required to adhere to strict rules of evidence, yet on the other hand their title, composition, and role in determinations over liberty, suggests they are at least court-like structures.

The standard of proof in tribunal cases in Australia has been influenced by what has been termed the Briginshaw principle or test, following a prominent High Court case. As has been indicated in an article by De Plevitz, concerning the anti-discrimination tribunals:

> Ever since the case of the lift-driver who accused the New South Wales Commissioner for Main Roads of sexually harassing her, Australian anti-discrimination tribunals have demanded that complainants prove their case to the ‘Briginshaw standard of proof’.

> In fact, ‘standard’ is a misnomer as in the common law there are only two standards of proof: beyond a reasonable doubt for criminal cases, and on the balance of probabilities for civil. As anti-discrimination complaints raise civil issues, the appropriate standard is the balance of probabilities, though what that term means is by no means clear.

De Plevitz examined the place of the Briginshaw principle in several areas, one of which is, ‘Where the Outcome of the Decision may be Irreversible’. Under this heading she considered Loss of Liberty, and referred to a 1987 Queensland MHRT case, that of Schafferius, a Security Hospital patient.

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427 Briginshaw v Briginshaw (1938) 60 CLR 336.
429 Ibid, 316.
The *Mental Health Act 1996* (WA) Schedule dealing with the MHRB states:

7. Board to avoid technicalities

The board is to act according to equity, good conscience, and the substantial merits of the case without regard to technicalities and legal forms.

8. Board not bound by the rules of evidence

The Board is not bound by the rules of evidence but may inform itself on any matter as it thinks fit.  

While this may appear to favour informality and less intimidating procedures, there may also be an impression that fundamental legal standards and expectations of fairness are given less attention by everyone involved. Patients appreciate the informality and opportunity to put their case, but support for tribunals can be weakened if respect for minimum standards of the rule of law are not maintained.

### 3.4.7 Time to earliest independent review

#### 3.4.7.1 WA Mental Health patients

Under the Mental Health Act 1996 (WA) 43(1-4), involuntary patient status requiring detention in a hospital is applied where the psychiatrist makes an order in writing:

(2) The psychiatrist may if he or she believes that, having regard to section 26, the person should be made an involuntary patient, either –

(a) order in writing that the person —

(i) be detained in an authorised hospital as an involuntary patient; and

(ii) be admitted for that purpose;

or

(b) make a community treatment order in respect of the person.  

Thereafter the initial period of detention can be authorised for up to 28 days unless changed by an order that the person is no longer an involuntary patient, or is placed on a community treatment order. In effect this appears to allow longer periods of detention under the authority

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430 *Mental Health Act 1996*, Schedule 2, 103.
431 *Mental Health Act 1996*, Part 3, Division 1, 43. (2).
of one person, the psychiatrist, on mental health grounds, which may appear less stringently monitored by any judicial review than applies to criminals or terrorists. The earliest independent review quasi-judicial review is that of the MHRB, which could be delayed up to six weeks.

Recent reports of patients detained for many days in general hospital emergency departments in Perth, suggest that some mentally ill persons are being held in circumstances which are unacceptable from several perspectives.\textsuperscript{432} As strict observance is expected from a legal perspective, in a war zone dealing with terrorists, the detention of mentally ill persons should be equally carefully implemented.\textsuperscript{433}

3.4.7.2 Detention of persons under criminal law in WA

Detention or compulsory treatment against a person’s expressed wishes must always be regarded as a serious step for authorities to take, regardless of the best of intentions. In the criminal law persons taken into custody have specified rights which must be observed by the detaining authority. Under the \textit{Criminal Investigation Act 2006} (WA) an arresting police officer can detain a suspect for a ‘reasonable period’, but not more than 6 hours unless authorised by a senior officer. This is not renewable and application must be made to a magistrate who can authorise a further 8 hours’ detention.

\begin{itemize}
  \item A magistrate may authorise the detention of the suspect for a further period of not more than 8 hours if the magistrate is satisfied that detention of the suspect for the further period is justified.
  \item An application may be made, and an authorisation may be given, under subsection (6) on more than one occasion.
  \item If it is decided to charge an arrested suspect with an offence and the suspect is not released unconditionally, the officer who has custody of the suspect must ensure the suspect is charged as soon as practicable and is dealt with —
\end{itemize}


\textsuperscript{393} \textit{Mohammed & Ors v Secretary of State for Defence}, [2015] EWCA Cw 843. The UK Appeal court declared British armed forces in Afghanistan, were in breach of Afghan law and Article 5 of the ECHR, by detaining a suspected Taliban commander for longer than the 96 hours permitted by ISAF policy.
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(a) under the Bail Act 1982 section 6; or

(b) under the Mental Health Act 1996 section 196.434

3.4.7.3 Federal Government counter-terrorism laws

Under Australian Federal Government law intended to deal with suspected terrorists, there are provisions which provide some limits on detention, although these have been perceived as inadequate by the Human Rights Commission.

The Anti-Terrorism Act (No.2) 2005 (Cwth) established Preventative Detention Orders (‘PDOs’) under division 105 of the Criminal Code. Like control orders, PDOs represent a fundamental departure from the long-held principle that a person should not be detained without trial.

There are two types of PDOs:

An initial PDO permits detention for up to 24 hours and can be granted by a senior member of the AFP on application by another AFP officer.

A continued PDO may be made after an initial PDO has been granted and allows detention to continue for another 24 hours. A continued PDO must be made by a federal judge or federal magistrate, acting in his or her personal capacity.435

There have also been new provisions added under the Crimes Act.

4.1 Police powers to detain and question terrorist suspects

In 2004, the Anti-Terrorism Act 2004 (Cth) introduced special powers for the Australian Federal Police (‘AFP’) to question terrorism suspects without charge into Part 1C, Division 2 of Crimes Act 1914 (Cth) (‘the Crimes Act’). These powers mean that upon arrest for a terrorism offence a person can be detained without charge for the purpose of investigating whether the person committed the terrorism offence for which he or she was arrested and/or another terrorism offence that an investigating official reasonably suspects the person committed.

Under ss 23CA (4) of the Crimes Act a person can only be detained for four hours, unless a magistrate extends the period of detention under s 23DA. Under s 23 DA (7) the magistrate cannot extend the period of detention for more than 20 hours. Therefore, the maximum period of time that a person can be detained for questioning is 24 hours. 436

The importance of this topic is that delays in transfer to hospitals, and compliance with legal requirements, may be largely service and resource allocation issues not simply resolved by changes to legislation alone.

434 Criminal Investigation Act 2006 (WA) 140.
436 Ibid, 4.1.
3.4.7.4 England

The NHS Hospital Trust Managers are required to conduct a formal hearing as soon as possible after a request is received from a patient, who asks to be released from his detention. The Managers delegate this role to Trust members with experience in mental health matters, and a tribunal of three members can be convened very early in the patient’s admission. A detailed psychiatric report must be presented and attendance at the hearing is expected. It does at least provide an opportunity to re-assess the need for compulsory treatment, although if undertaken too soon it may not allow adequate time for the patient to stabilise and for staff to appraise the situation constructively.

Patients admitted for Assessment (Sec 2), and not under a Home Office Restriction Order may make an application to the MHRT within 14 days of admission.

3.4.7.5 WA

There is no equivalent to the Hospital Managers’ hearing. The earliest review following admission is by the hospital psychiatrist alone, which must be completed within 24 hours. A member of the CoOV can assist detained patients, but not voluntary patients. A hospital social worker may become involved at this stage, although they have no formal or statutory role in relation to decisions under the Mental Health Act 1996 (WA).

While the Mental Health Act 1996 (WA) stipulates that, there must be an initial MHRB review of the patient’s detention order, the timing of this has been imprecise. The Mental Health Act 1996 (WA) states: ‘The review is to be carried out as soon as is practicable after the initial order is made, and in any event, not later than 8 weeks after that time.’ In practice reviews have usually not been scheduled by the MHRB staff earlier than 6 weeks after admission, or two weeks in the case of children.

437 Mental Health Act 1996 (WA), Part 6, Division 2, 138 (2).
Efforts are being made to ensure earlier and more frequent hearings, pending the implementation of the *Mental Health Act 2014* (WA). The small number of psychiatrists who are on the MHRB panel creates some practical limitations, although steps have been taken to address this situation.

### 3.4.8 Independent second opinion

#### 3.4.8.1 England

Patients can request a second opinion. This is managed by the CQC, which maintains and funds a panel of psychiatrists, termed the Second Opinion Appointed Doctors (SOAD). They are involved in several areas of review including mandatory medication reviews, opinions for electro-convulsive therapy for non-consenting patients, and consenting patients under 18. Second opinions are provided free of charge to the patient, readily available, independent and of high quality. In this sense, they can be viewed as a useful form of peer review for the treating psychiatrist.

#### 3.4.8.2 WA

A second opinion may be requested, but is commonly provided by a psychiatrist from the same hospital or service. A private second opinion for inpatients must be paid for by the patient and this occurs only occasionally. Community patients can obtain a second opinion funded by Medicare, although depending on private insurance cover there may be a gap paid by the patient.
Hospitals have no additional or reserved budget provision for second opinions, and these can prove difficult to obtain, not only in rural and remote settings, but also in metropolitan and regional areas, due to a shortage of psychiatrists in WA.\textsuperscript{438}

A paper by Dawson et al provides a useful comparison between the SOAD system in England and a version applied in New Zealand.\textsuperscript{439} His discussion illustrates some of the practical issues, including the ‘no appeal’ rule applied in the UK, which gives some authority and finality to the decisions. They also mention the value of the UK program being managed by an independent national authority viz. the Care Quality Commission (CQC).\textsuperscript{440}

\subsection*{3.4.9 Compulsory medication review}

\subsubsection*{3.4.9.1 England}

Patients may be given medication for their mental disorder either by consent, or compulsorily after a second opinion. The patient’s consent must be confirmed and the details recorded. If the patient is detained under the \textit{Mental Health Act 2007} (UK), a second opinion must be obtained if the treatment continues longer than three months from commencement.

Where a patient is given medication under Sec 3 for treatment, it must be reviewed by a SOAD appointed by the CQC. This review is automatic, and requires close review of all drugs prescribed, not just those used in psychiatric treatment. All medications must be listed, including those for medical conditions, according to the British National Formulary names, with precise dosages and frequency.

\textsuperscript{438} Australian Medical Workforce Advisory Committee (1999), \textit{The Specialist Psychiatry Workforce In Australia}, AMWAC Report 1999.7, Sydney: Per 100,000 populations there were 10.6 psychiatrists and an estimated SPR of 1.9.\textsuperscript{455} AIHW 1997 data indicated that States/Territories with psychiatrists per 100,000 population ratios below that for Australia as a whole were the Australian Capital Territory (7.4), Western Australia (7.2) and Queensland (8.8), while health department data indicated the ratio for the Northern Territory was also below average at 5.3. States with above average SPRs were Victoria (13.4) and South Australia (12.1).


If exceptional dosage regimes are prescribed, the reasons must be stated. The hospital medication charts are inspected by the independent psychiatrist on the tribunal.

3.4.9.2 WA

No independent automatic review of medication is required by law at any stage. Medications may be reviewed at a MHRB hearing, but this is not a statutory requirement, and complete medication charts are not routinely made available. Patients attended almost invariably with only their current clinical ward notes, but little or no information on previous admissions and medication. When it appeared that a patient may have been heavily sedated and having difficulty following proceedings, occasionally deferral was necessary.

Where patients complained of side effects of medication, it was not possible in the time allocated to provide a review of whether alternatives were being fully considered, and the medication history. An independent second opinion option is indicated, rather than the tribunal attempting to provide a detailed review in unsatisfactory conditions.

It should be noted, however, that the \textit{Mental Health Act 2014} (WA) has introduced the expectation that tribunals will review the treatment plan drawn up by the hospital or clinic treating team.

394 Things to which tribunal must have regard

(1) In making a decision on a review under this Division in respect of an involuntary patient, the Tribunal must have regard to these things ---

(d) the involuntary patient’s treatment, support and discharge plan;\textsuperscript{441}

These, and the several other \textit{things to which a tribunal must have regard}, amount, in effect, to authorising continued detention rather than a full review. If not addressed suitably, the several defects in the existing arrangements for tribunals will not meet government or

\textsuperscript{441} \textit{Mental Health Act 2014} (WA), Part 21, Div. 3 s 394 (d).
community expectations. A similar position applied in England during discussions on the Mental Health Bill 2004 (UK). According to Fennell:

Initially the Government expressed determination to proceed with the 2004 Bill, but later it opted to introduce an amending measure rather than a comprehensive new statute. One of the main reasons for this appears to have been concern that the Mental Health Tribunal would be unable to carry out the new task proposed for it of authorising rather than reviewing detention.\footnote{Fennell P, Letts P, Wilson J, \textit{Mental Health Tribunals; Law Policy and Practice}, (The Law Society 2013).}

Carney stated in 2011:

Government action in the form of significantly increased funding for MHT’s and associated services, not some anodyne call for tribunals to do better with what they already have, is what is required.\footnote{Carney T, Tait D, Perry J, et al, \textit{Australian Mental Health Tribunals}, (Themeis Press, 2011) 316.}

3.4.10 Nearest relative tribunal notification

3.4.10.1 England

The statutory requirement to notify the nearest relative is a serious matter which can give rise to litigation if not managed correctly. It is the responsibility of the AMHP, usually in the course of arranging an assessment and admission. The Nearest Relative is carefully defined in the Mental Health Act 2007 (UK).

3.4.10.2 WA

The Mental Health Act 1996 (WA) has no specific requirement to notify family or carers if a patient is admitted voluntarily or involuntarily. There is no legally defined nearest relative like the provisions of the Mental Health Act 2007 (UK). Well established clinical guidelines and practices in Older Adult units have encouraged close liaison with carers, which can best be achieved as unit policy, and subjected to quality and accreditation reviews.
3.4.11 Nearest relative discharge power

3.4.11.1 England

The nearest relative may request that a patient be discharged. If the psychiatrist does not agree to this, a ‘barring certificate’ must be issued, and this action triggers an automatic appeal to the MHRT. This is a key element of the English legislation as it ensures an appeal can be made on behalf of the patient who may lack capacity to consent.

The Bournewood case arose from a situation where the patient’s only representatives, his paid carers of 3 years’ duration, could not obtain his discharge or even access to see him, as he was not under the Mental Health Act 1983 (UK). In effect this meant he had no access to any legal means by which his detention could be challenged, and it was largely this fact that resulted in the successful appeal to the ECtHR.444

3.4.11.2 WA

There are no nearest relative legal provisions within the Mental Health Act 1996 (WA) that are equivalent to the UK legislation. An application may be made to the MHRB by the patient, Official Visitor, or any other person who the Board may feel is appropriate.445 There is an extensive list of persons defined under the Guardianship and Administration Act 1990 (WA) who may apply to be appointed as a guardian.446

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445 Mental Health Act 1996 (WA), part 6, Division 2, s 142 (2).
446 Guardianship and Administration Act 1990, Part 1, s3, ‘nearest relative’.
3.4.12 Number of tribunal hearings per day

3.4.12.1 England

Experience suggests that 2 to 4 is the average number of hearings per day, although twice I observed only one hearing was held on the day. Where hearings are held entirely ‘on the papers’, up to 10 may be conducted in one day.\(^\text{447}\)

At one hearing the decision was made to adjourn until the following week, so that the patient could be reviewed after weekend leave. This type of response has been criticised by an academic lawyer and tribunal member John Horne, as leaving too much basic clinical decision-making to the tribunal.\(^\text{448}\) My view as a clinician was that the proliferation of mandated reviews, such as risk assessment meetings, care planning approach (CPA) meetings and tribunals, seriously reduced the amount of time, priority and resources allocated to ward assessments or case conferences. Multidisciplinary ward rounds were very difficult to convene due to various staff issues. These appeared less evident when a tribunal was held.

3.4.12.2 WA

As tribunal member, I experienced a range of experiences with listings. For example, where the main authorised hospital was concerned, there could be up to 10 cases set down for one day. Not all allocated cases would proceed to a hearing as, at times, the patient was found to have been discharged, or made a voluntary patient just prior to the hearing. At other times, where a considerable amount of metropolitan travelling was concerned, there might be only five or six hearings at a variety of clinic and hospital locations.

Tribunal hearings were also conducted by video link with remote areas, although some locations such as Bunbury, Albany, or Geraldton, possessing good community infrastructure and population base, could not reasonably be described as remote. There are very remote locations where attendance promptly by a full tribunal would be impractical at present. For example, the most northerly inpatient psychiatric facility was at Broome, a distance of 2240 Km from Perth. Video link hearings were generally useful as staff and patients have become accustomed to this medium for regular health and family consultations. This format was especially necessary in the case of indigenous patients who might be at remote centres several thousand kilometres away. Where the psychiatrist was based at another centre a considerable distance away, it was possible to hold three-way video hearings.

3.4.13 Average time per hearing

3.4.13.1 England

Hearings are frequently lengthy, running to several hours each. Due to the recent financial constraints efforts are under way to deal with some uncontested cases ‘on the papers’. Tribunal hearings may now exceptionally be heard and broadcast via video-link where public access is permitted, if the patient requests this.449

Video link tribunal hearings are not regularly conducted in England at this time, although the subject has been raised in view of the need for greater economy. While distance is not such an issue compared with WA, the logistical problem of holding hearings in some locations in England requires consideration, particularly when sometimes 12-15 participants may attend.

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449 Re Ian Brady (2012) MHLO 19 (FTT) Notice to the media; ‘The Tribunal made the following order which contains information for the General Public.1. The Hearing is listed for Monday 9th July 2012 with a time estimate of 8 days.2. The Tribunal will convene at Ashworth Hospital and the proceedings will be relayed by Close Circuit Television to the Civil Justice Centre Manchester where members of the General Public (including the media) will be able to observe the proceedings’.
Special forensic hospitals such as Broadmoor, Rampton and Ashworth are often a considerable distance from carer’s homes. The Court of Protection makes use of video links for hearings where required as do some magistrates’ courts.

3.4.13.2 WA

Given the high number of hearings per day in WA, the time per case was inevitably limited, although exceptions occurred. Cases were allocated one hour each, comprising 30 minutes to read reports and patient files, then 30 minutes for the hearing.\footnote{Carney T, Tait D, Perry J, et al, Australian Mental Health Tribunals, (Themis Press, 2011) 309.} If the patient was legally represented, which was not always known prior to the hearing, more time could be allocated. However, with the number of hearings per day, and necessity of travel between venues, time was limited to avoid inconveniencing patients, carers and staff waiting elsewhere.

3.4.14 Legal representation

3.4.14.1 England

It is the norm for patients to be legally represented at tribunals and higher courts, unless declined by the patient. Under the current budget restraints there has been a move to apply some modifications.\footnote{Ministry of Justice (UK), Chris Grayling, Reform of the Courts and Tribunals, Press release 28 March 2014.} Concern has been expressed that if unrepresented patients are needlessly detained, the overall cost to the Treasury will increase. As all departments of government in the UK are required to meet stringent budget reductions, some changes are inevitable. Lawyers in the UK undertaking mental health tribunals are required to be specifically trained, and are paid under an extremely complex formula. They are also likely
to belong to private group practices with special expertise in mental health law. Membership of the Law Society Mental Health Panel is a requirement.

3.4.14.2 WA

In my experience, there were relatively few occasions when patients were legally represented at MHRB hearings, although there has been some recent improvement. Figures illustrate that 16% of patients were represented by the Mental Health Law Centre in 2014-2015. The goal is to lift this to 25%.452

3.4.15 Access to reports by tribunal members

3.4.15.1 England

The provision of reports is set out in detail in the Mental Health Act 1983, and the Code of Conduct.453 In my experience, the Mental Health Act Administrator ensured that a report was provided in good time to be forwarded to the Tribunal. Not providing a detailed typed report was not an option. If there were persistent problems in this area the Medical Director and the NHS Trust responsible would quickly become involved, as the matter could incur litigation.

Reports must be made available to the tribunal well in advance, and are normally able to be studied by the members at least 24 hours ahead of the hearing. The role of the Mental Health Act Administrators is crucial to ensuring compliance, emphasising that there are clerical resourcing issues in addition to legal provisions to be met.

453 Jones R, Mental Health Act Manual, (Sweet and Maxwell 2008) 4-311.
3.4.15.2 WA

In WA, most psychiatrists provide written reports of a high standard, but some are of variable quality. At times these have been written by a junior doctor, and signed by both the consultant psychiatrist and the medical officer. The reports may, however, fail to address the key legal criteria, and until 2013 very little official guidance had been offered.\footnote{In 2013 one of the MHRB psychiatrists voluntarily drafted guidelines to assist psychiatrists preparing reports. These are now being informally revised for the Mental Health Act 2014 (WA).} Many reports were in the style of a case summary rather than one intended for a legal hearing. On numerous occasions the reports were not available, were compiled by nursing staff or medical officers, and were brief statements of only the most recent events.

The MHRB is required by the Act to consider:

> In making a determination upon a review, the Board is to have regard primarily to the psychiatric condition of the person concerned and is to consider the medical and psychiatric history and the social circumstances of the person.\footnote{Mental Health Act 1996 (WA), Division 2, 137.}

Although some patients may object to the Board referring to past admissions etc., this is a requirement and good clinical practice. A well conducted tribunal hearing can be an opportunity for assisting patients and carers to recognise how their behaviour and presentation in society, is affecting their prospects of discharge and recovery.

Supporting patients to recognise the triggers which lead to admission, and the steps needed for recovery can be of therapeutic benefit if explained fairly and thoroughly.\footnote{Wexler D, University of Arizona Legal Studies, Discussion paper, 13-51’, October 2013, 693, (online), Development of Therapeutic jurisprudence; ‘My interest was not so much in law and therapy as it was in law as therapy, and that in fact is the common thread that ran through the pieces, by myself and others, that most attracted my attention.’}

Where previous historical information may be unsubstantiated, the quality of submitted reports unreliable, the opportunity to carefully examine parties or consider information in depth lacking, then poor clinical outcomes are more likely.
As invariably reports were only made available to the Board members at the time of the hearing, little time could be spent on discussion and reviews of clinical files in depth.

3.4.16 Tribunal psychiatrist’s examination

3.4.16.1 England

A requirement of the Mental Health Act 2007 (UK) is that the tribunal psychiatrist must examine the patient, and interview staff prior to the hearing.\(^\text{457}\) This is usually done a day before, or on the morning of the hearing. The tribunal psychiatrist then reports his findings to the other members prior to the hearing. The situation in which the medical member is both a fact-finder and decision-maker, led to criticism if the medical report was presented to the tribunal members alone, at the pre-hearing stage. This was held to be contrary to natural justice, as the patient or his representative was not able to learn all that was said to the tribunal members. Practice now requires that the patient’s lawyer attends the briefing of the tribunal by the psychiatrist member prior to commencement of the hearing.\(^\text{458}\)

3.4.16.2 WA

In WA, the Board psychiatrist does not examine the patient in a formal clinical assessment at any stage, and indeed time would not permit this to occur. In that sense, unlike the position in England, the hearings cannot be said to amount to an independent psychiatric opinion, or any form of peer review. The role of the MHRB psychiatrist is usually limited to interpreting psychiatric terminology, explaining treatment plans and drawing attention to relevant matters in the history, responses to treatment etc.


\(^{458}\) Perkins E, Decision-making in Mental Health Review Tribunals, (Policy Studies Institute 2003), Notes, 51.
While an effort can be made to review previous history and treatment responses etc. where possible, time constraints do not permit proper professional psychiatric examination. This fact is often misperceived by patients and carers who may anticipate a more thorough review of all issues.

3.4.17 Patient access to reports provided to the tribunal

3.4.17.1 England

The position in England is that reports must be made available to the patient and his or her representative in advance. This is a legal requirement which can be subjected to litigation if not managed correctly.\(^{459}\)

3.4.17.2 WA

Patients in WA were frequently not presented with a copy of their report until the commencement of the hearing, in which case there was a delay while this was arranged. When it was evident that the patient did not comprehend the report it then had to be read to him or explained by staff at the hearing. Clearly this gave the patient little or no opportunity to prepare his case or consult with independent persons.

Because commonly the tribunal did not receive a copy of the reports until just before the hearing commenced, it was not unusual for the patient’s lawyer to be in a similar situation. This meant there was little opportunity for the lawyer to consider the report, discuss with the patient how best to proceed, or obtain further opinions if required.

\(^{459}\) *CB v Sussex County Council* (2010) UKUT 413 (AAC).
3.4.18 Consultant psychiatrist in attendance

3.4.18.1 England

Psychiatrists in England would rarely fail to attend the tribunal, if not in person, then represented by a senior medical clinician attending who was familiar with the patient.

3.4.18.2 WA

The WA MHRB hearings were usually attended by the treating psychiatrist, either in person or by phone/video-link. However, this was not always the case, sometimes for good reason, but at other times simply as he/she was not available on that day.\textsuperscript{460} Particularly for outpatients on a CTO, this could present a major difficulty, and hearings had to be rescheduled. Employed patients on a CTO had to take time away from their workplaces as hearings were only held in working hours.

3.4.19 Social worker in attendance

3.4.19.1 England

As the social services and health services are quite separate, it is common for a community based social worker to attend inpatient hearings. It may also be relevant where the social worker is an AMHP, and directly involved with the legal proceedings prior to admission. If the service has a hospital based social worker, that person may also attend, although not all hospitals have social workers on staff.

\textsuperscript{460} The abolition of psychiatrist-superintendents at hospitals and clinics, has meant that often no alternative responsible clinician was made available.
WA hospitals and community based mental health services have social workers who case manage the social aspects of a patient’s care. They are not involved in the legal aspects of admission, and it is rare for a social work report to be provided at hospital hearings, either separately or as an adjunct to the medical report. It is more likely to occur in community clinics where the social worker may be the ‘key worker’ for a patient.

3.4.20 Social work reports

3.4.20.1 England

Social workers in England are legally required to provide a report:

If the patient is detained in hospital as an in-patient, then the Responsible Authority must send a statement that contains or has attached: 1. Statement of Information about the Patient 2. Clinician’s Report 3. In-Patient Nursing Report 4. Social Circumstances Report.\textsuperscript{461}

3.4.20.2 WA

As indicated above, social workers rarely attend MHRB hearings nor do they provide reports unless specifically requested. Attendance by social workers is, however, more usual in Older Adult psychiatry units. This may be because established practice is for the initial assessment to be conducted by the psychiatrist jointly with the social worker or a community nurse. The social worker may have visited earlier with a community mental health nurse, and will have consulted with family/carers. A detailed report for the treating team is provided. Psychiatrists are expected to address social issues in their report to the MHRB, as it is a requirement to include the social circumstances in their considerations.\textsuperscript{462}


\textsuperscript{462} \textit{Mental Health Act 1996} (WA), Part 6 Div. 2, 137.
3.4.21 **Nursing staff/case manager in attendance**

3.4.21.1 **England**

Nursing staff attending tribunal hearings were usually senior and well trained in the role of the tribunal and how to present their professional opinions. Nursing opinions regarding patients are specifically recognised in the tribunal requirements.\(^{463}\)

3.4.21.2 **WA**

Attendance by nursing or other professional staff at MHRB hearings was extremely variable. In some hospital and clinic hearings, nursing staff could provide essential up to date information. At other times, they attended to escort the patient to the room, and left without contributing. Some nurses seemed to have a limited understanding of the purpose of the hearing, or how they could contribute. Agency staff with limited knowledge of the patient, the opinions of other staff or family were of limited help. Nurses with good training and hospital or clinic support, assisted the patient with encouragement throughout, while maintaining a professional appreciation of the situation.

3.4.22 **Community staff for inpatient hearings**

3.4.22.1 **England**

It is not unusual for the community based social worker and/or nurse to attend hearings for hospital inpatients and fully participate. The community staff are well informed on family and carer issues, and provide valuable assistance to the patient and treating team when planning discharge. This is a complex process with legal and funding arrangements which require specialised attention.\(^{464}\)

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\(^{463}\) Practice Direction, First-tier Tribunal, Health Education and Social Care Chamber, Statements and reports in mental health cases, Nursing Report – Inpatients, 13 (a-n) 5.

\(^{464}\) Local Authority housing, pensions, and home supports as examples. This may involve complex determinations as to whether Local Authority or Health Services funding is required.
Community based nursing staff and/or case managers very rarely attend inpatient hearings. It is much more common in the case of patients seen at clinics or via video-links when the patient is on a CTO.

### 3.4.23 Written reasons for decision available

#### 3.4.23.1 England

The usual practice is for the tribunal members to convene privately at the conclusion of the hearing, shortly after the decision has been delivered. The legal member will then draft a statement of reasons which is agreed by all the members.

#### 3.4.23.2 WA

As reasons are infrequently requested by patients, it is customary for the legal member to wait until a request is received before drafting a response. The reasons set out the legal issues at stake, an appraisal of whether these have been considered by the tribunal and agreement reached that they had been met. The reasons are circulated by email to the two other members who may reply by return, or alternatively a telephone conference can be arranged if further discussion is needed. Often these are not well phrased to be readily understood by patients, although meeting legal requirements.

### 3.4.24 Clerk to the tribunal

#### 3.4.24.1 England

Clerical support for tribunals is regarded seriously. The usual arrangement is that a tribunal clerk attends to many practical issues related to the hearing. This can include ensuring files are delivered and collected, reassuring the patient and explaining the procedures, managing the venue site, seating arrangements and liaising with attending staff and family members.
Although the hearings are intended to be informal, there are rules of procedure and conduct to be observed. For example, if attending purely as an observer, one is not permitted to make any written notes during the hearing. The tribunal clerk attended to these and other matters, ensuring a semi-formal protocol was observed. Of special concern was to ensure that family members were made welcome and comfortable.

The value of clerical assistance at tribunals was supported in a Churchill fellowship report on UK practice by a chairman of the Victorian MHRB:

Having said that, there is no doubt that Victorian Board members receive less direct administrative support at hearings than the members of all overseas tribunals and courts that I observed. In these jurisdictions, significant importance is attached to facilitating a wider range of administrative support provided by their staff for members at hearings with the use of clerks, in some cases legally qualified. In my view, this also enhances in a very positive way the public perception of the status and importance of the role of the members and the decision-making work they undertake. This in turn can have a positive effect in reducing the stigma attached to mental illness. This is particularly the case in England and Wales where tribunal members are treated as members of the judiciary, with access to the same continuing education and training programs as court judiciary.⁴⁶⁵

3.4.24.2 WA

No tribunal clerks attend hearings. A tribunal member collected a case containing the tribunal files and recording equipment for that day’s hearings, from the Perth city office first thing on the morning of the hearings. These were transported by the member to the hearing location and returned on completion. On arrival at the hearing room the members arranged the seating in some cases, prepared the sound recording equipment and located the clinical files from the ward or clerical staff. This would be the only time available to read reports and case notes. Members called for the patient to be brought to the hearing, and invited the family and representatives to the room.

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3.4.25 Hearings Venue

3.4.25.1 England

The venue for hearings was usually a hospital board room or special meeting room. These were generally spacious and provided adequate seating for all parties. The matter of the venue is important as it should, where possible, support the perception of the independence of the tribunal.\(^\text{466}\)

3.4.25.2 WA

Only one location in WA was set aside specifically for tribunal hearings. This was a very small room within the administration section of Graylands hospital. Locations elsewhere included occupational therapy areas, staff conference rooms, inpatient ward locations and outpatient clinic rooms. Holding the hearing on the ward in the case of very disturbed patients would be reasonable on occasions. On other occasions, it appeared to be mainly for staff convenience.

The position was even more unsatisfactory in the case of the forensic inpatient unit, where discharged patients on a CTO, were required to attend the inpatient ward for their hearings.\(^\text{467}\) Consequently, few patients attended and were effectively denied the opportunity to challenge their CTO. While this did not apply to any elderly patients in my experience, with the increasing incidence of aged forensic patients entering the judicial and mental health systems, this may arise as an issue in future.

\(^{466}\) CQC, (UK). Patients experiences of the First-tier Tribunal (Mental Health), Online: ‘Some respondents also reported problems with the AJTC and CQC Patients’ experiences of the First-tier Tribunal (Mental Health) 5 hearing room itself, saying that the environment was intimidating because they felt crowded. They also reported a lack of private spaces in the waiting areas in which to speak with their lawyers or the people there to support them.’

\(^{467}\) Frankland Unit, Graylands Hospital WA.
3.4.26 Mental Capacity Act 2005 (MCA)

3.4.26.1 England

The Mental Capacity Act 2005 (UK) is an item of English legislation of far reaching importance, and has received intensive government and public scrutiny over several decades.

Jones stated:

The Mental Capacity Act 2005 is a measure which is likely to touch the lives of everyone because, at some point, all adults will probably be affected by a lack of capacity to make decisions relating to their everyday lives, either personally, or through contact with people who are unable to make decisions for themselves.468

3.4.26.2 WA

There is no equivalent to the Mental Capacity Act 2005 (UK), and understood to be no discussion of any proposals in this matter. Thus, the issues raised in this thesis, i.e. the informal and arguably unlawful detention of non-consenting adults in hospitals and aged care homes, has been given relatively little consideration in WA.

The presence of mental capacity to consent or refuse treatment is briefly mentioned in the Mental Health Act 1996 (WA) as follows;

96 Capacity to give informed consent

A patient is incapable of giving informed consent unless he or she is capable of understanding –

(a) the things that are required by this Division to be communicated to him or her;

(b) the matters involved in the decision; and

(c) the effect of giving consent.469

Persons lacking capacity are treated in hospitals and aged care facilities under the common-law duty of care, or under the provisions of the Guardianship and Administration Act 1996.470

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469 Mental Health Act 1996 (WA), part 5 Div. 2 96.
470 Civil Liability Act 2002 (WA) Div.2. Duty of care 5B.
Duty of care is the legal obligation to avoid causing harm to another person, which only arises where it is reasonably foreseeable in a particular situation that the other person would be harmed by one’s action without the exercise of reasonable care. Duty of care refers not only to the actions of a worker, but also to advice the worker may give or fail to give.\textsuperscript{471}

Persons with mental illness or brain diseases such as dementia can be admitted to approved psychiatric hospitals under the \textit{Mental Health Act 1996} (WA), or informally under common law. An ‘authorised hospital’ is one which has been designated as such under the \textit{Mental Health Act 1996} (WA) for the reception and treatment of patients with mental illness. Mental illness is defined under the Act as;

\begin{quote}
(1) For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgement or behaviour to a significant extent.\textsuperscript{472}
\end{quote}

Intellectual disability is not, by itself, considered a mental illness within the \textit{Mental Health Act 1996} (WA) under any conditions. Patients who are intellectually disabled may only be admitted to a psychiatric hospital under the \textit{Mental Health Act 1996} (WA) if they suffer from a mental illness as defined above. Separation of the intellectually handicapped from psychiatry commenced in the early 1960 period in WA and was completed by 1982.

In its submission to The House of Commons Joint Committee on the Draft Mental Health Bill 2004 Mencap, a leading UK learning disability charity made the following point:

\begin{quote}
A learning disability is not a mental illness. Mencap believes that it is fundamentally wrong for someone with a learning disability to come under mental health legislation unless they also have a mental illness.\textsuperscript{473}
\end{quote}

The case for this separation was argued unsuccessfully by Mencap in the UK in 2004; however, intellectual handicap remains firmly in the hands of members of the Royal College of Psychiatrists.

\textsuperscript{471} Elder Abuse Protocol, APEA (WA) 2006, 12.
\textsuperscript{472} \textit{Mental Health Act 1996} (WA) Part 1, S 4 (1).
There are a very high number of mental health legal cases in the UK where intellectual handicap is the sole or principal medical diagnosis. Whether the separation in WA has been entirely beneficial may be argued, as it may be that the relatively small number of persons with dual diagnosis, have limited access to specialised services. They may also be at risk from non-specialist use of psychotropic drugs and inappropriate methods of care without sufficient clinical and legal safeguards. However, the argument for a social, rather than a medical model of care is more convincing.

In her PhD thesis Foley drew attention to the fact that Ellis, the Director of MHS, initiated the change to a non- psychiatrist.

In 1966 Ellis, who had been appointed Director of the MHS in 1964, separated it into two sections, Mental Health, and Mental Deficiency, and reorganised its structure to provide for the establishment of rehabilitation and community facilities. To head the new MDD he chose a physician rather than a psychiatrist, Dr Guy Hamilton, who had a special interest in individuals with intellectual disabilities in Claremont Hospital. Hamilton’s aim was to replace the medical model of treatment with a developmental model and provide appropriate support services in the community.  

The ‘social training’ model of care developed by Guy Hamilton, proved to be a most successful one, and removed much of the stigma of mental illness from hundreds of people in WA. Knowledge of the history of learning disability in WA is important in explaining the contrasting position in England. Under the care policies in England, disability is still seen very much as a medical field rather than a purely social training one. People with a learning disability in England are commonly detained under the Mental Health Act 1997 (UK) and treated by psychiatrists.

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3.4.27 Deprivation of liberty safeguards (DoLS)

3.4.27.1 England

As outlined in chapter 1, the detention of a voluntary patient at a psychiatric hospital in England led to an adverse finding against the British Government by the ECtHR.\textsuperscript{476} The government was in the process of introducing the \textit{Mental Health Act 2007} (UK) at the time, and decided to amend the new mental health legislation by adding a totally new concept by way of response. The new legislation, known as the DoLS, has proved enormously controversial. Jones has described it as follows:

\ldots a procedure has been created that is hugely complex, voluminous, badly drafted, overly bureaucratic and difficult to understand, and yet provides mentally incapacitated people with minimum safeguards. If that were not enough, the nature of the relationship between the MHA and the MCA in so far as it relates to the detention of patients is far from clear. This is not surprising given that the two Acts had differing sponsoring Government departments and pursue different policy agendas, one being capacity based and the other focusing on risk.\textsuperscript{477}

3.4.27.2 WA

There is no Mental Capacity Act in WA, nor does it appear that one is under consideration. The \textit{Mental Health Act 2014} (WA) introduced the expanded focus of capacity into WA mental health legislation, and a much greater level of attention to legal and professional aspects of capacity should be expected in future.\textsuperscript{478}

\textsuperscript{476} \textit{HL v United Kingdom}, ECtHR, Application no. 45508/99, 5 October 2004.
\textsuperscript{477} Jones R, \textit{Mental Health Act Manual}, (Sweet and Maxwell 2008), v.
\textsuperscript{478} ALRC, \textit{Equality, Capacity and Disability in Commonwealth Laws} (DP 81)10.66. ‘New mental health legislation in Tasmania and Victoria has changed the focus of criteria for the involuntary detention and treatment from the risk of harm to a person’s capacity to consent to treatment; and there are active mental health reviews and legislative initiatives in other jurisdictions.’
3.5 Conclusion

This chapter tabled many topics in mental health law which are common to practice in WA and England, with the aim of identifying contrasting positions in each. Most notable differences can be identified in respect of:

1. Delegation of authority to detain.
2. Tribunal administration.
3. Second opinion.
4. Compulsory medication review.
5. Patient access to tribunal reports.
6. Legal representation at tribunals.
7. Attendance and reporting by professional staff at tribunals.
8. Clerical assistance to tribunal.

Although based on the Mental Health Act 1996 (WA), many of these anomalies will remain despite the Mental Health Act 2014 being made operational on November 30, 2015. In some other areas discussed in the chapter, the fundamental issues have not been altered, additional unfunded obligations added and expectations in the community raised.

The comments listed here are based on my personal observations. To obtain a broader range of opinions, a sample survey was carried out including specialist older adult psychiatrists in England and WA. The survey of psychiatrists in Chapter 4 revisited some of these issues, with the addition of questions on residential aged care.
4 Survey of psychiatrists: Introduction

As I have been employed in older adult psychiatry services in each country, I have a personal perspective on the subject matter of this thesis. To reduce a perception of bias, a survey was conducted to establish whether other psychiatrists have opinions which may support or disagree with my views.

Background experience, which could be helpful in providing an information base to research, can also present difficulties. What has been termed ‘theoretical sensitivity’ refers to the ‘personal quality of the researcher. It indicates an awareness of the subtleties of meaning of data’.\textsuperscript{479} Sources of this sensitivity include literature, professional experience and personal experience. However, as stated by Strauss and Corbin, ‘this kind of experience can also block you from seeing things that have become routine or obvious’.\textsuperscript{480}

The survey participants were consultants in older adult psychiatry in WA, and another group from an area of England with which I was also familiar, Norfolk, Suffolk and Cambridgeshire. From my experience of working as a clinician in England and WA, I considered the clinical presentations of patients in each location were comparable, and would present clinicians with similar challenges. Any differences that might emerge were expected to relate to the participants’ views of the legal and administrative arrangements, which they could deploy in patient care.

As the number of clinicians in each location was very small the research was based on a ‘convenience sample’.\textsuperscript{481} There are, however, problems with convenience sampling.

\textsuperscript{479} Strauss A, Corbin J, Basics of Qualitative Research, (Sage publications, 1990)3, 41.
\textsuperscript{480} Ibid, 42.
\textsuperscript{481} Chapter 1.25, ref. 189.
As stated by Best:

The great advantage of convenience sampling is its convenience… it is inexpensive, it is easy and it is by far the most common way to study social problems. The disadvantage with convenience samples, of course, is that it is hard to know whether they reflect the population.\(^482\)

The WA sample was based on members of the Faculty of Psychiatry of Old Age, who could be expected to have well informed opinions on mental health law and procedures affecting the elderly. The role of private practice in WA, and the existence of some psychiatric facilities which do not use the compulsory provisions of the *Mental Health Act 1996* (WA), meant some practitioners have limited experience of the full range of legal provisions.

Conversely in England there is relatively little private practice, and all consultant psychiatrists can be assumed to have considerable experience of mental health law.

As I am not employed within the public service in any capacity, I had no current staff/supervisor relationships with any participants. A Survey-Monkey online format was chosen, which provided secure transmission through a paid subscription service. Each participant was forwarded an email requesting assistance with the survey, and provided with a Participant Information Form and a Participant Consent Form as required by the UWA ethics approval process.\(^483\) They were asked to read both forms before commencing the task. In each email a web-link was included which was generated securely by Survey Monkey. On clicking this link, they were then presented with the on-line survey.

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\(^{483}\) See pages 393, 394, 395.
The research was reported to conform to the NHMRC National Statement on Ethical Conduct in Human Research (2007). Initial approval was granted by the UWA Ethics Committee on 14 November, 2012. A revised Ethics Committee approval to reflect change to an on-line format was granted on August 2, 2013.\footnote{Appendix copy of approval.} 

4.1 Consent

As it was an essential component of the ethics approval process that participants consented and were fully informed of the background to the research, an online system to obtain consent was included. The survey included 28 questions on a range of topics in mental health law and procedure, which it was anticipated would elicit valid opinions in confidence.\footnote{Appendix, Consent form and letters.}

The results obtained online showed that all persons who completed the survey had consented. No personal or service identifying details were recorded other than the country of location of each participant. No-one, including the researcher was aware of the names of individuals who responded. The researcher was only aware of the names and email addresses of persons contacted. The aggregated information was kept in a secure password protected computer. No adverse consequences were foreseen which might affect any participants.

4.2 The survey

The questions were as follows:

1. Have you read the participant information form?
2. Have you read the participant consent form?
3. Do you consent to completing this survey?

A negative response to question 3 sent the participant to the ‘thank you’ page, using ‘skip-logic’. If agreement given, he/she moved to the next question:
4. In which country are you working?

Statements which required a graded response:

5. Legally detained patients obtain a tribunal hearing sufficiently soon after admission.
6. The onus is on the detaining authority to prove the need for compulsory detention, not on the patient to disprove such need.
7. Tribunal hearings are commonly held on the ward where the patient is detained.
8. A Treating psychiatrist, registrar or medical officer always attends all tribunal hearings in person or by video-link.
9. A social worker either personal attends or submits a report, on all involuntary patients for tribunals.
10. Tribunal hearing schedules allow sufficient time for full examination of files and discussion with all parties.
11. All patients are able to obtain free legal representation for tribunal hearings.
12. In Western Australia, mental health legislation and tribunals are administered by the Minister for Mental Health and the Mental Health Commission. In England, they come under HM Courts and Tribunal Service, and agency of the Ministry of justice. In the interests of fairness and natural justice, is mental health legislation and tribunal management best administered by Justice rather than Health?
13. Elderly patients lacking mental capacity are detained in aged care homes without approval of law, or a substitute decision-maker.
15. All psychiatrists who detain patients undergo thorough training in the Mental Health Act and related legislation.
16. Mental Health law is given a high priority by our health services.
17. The complex requirements of mental health law unreasonably divert staff and funding from direct patient care.
18. Mental Health law and procedure add very significantly to my workload.
19. Laws in this country offer good protection for elderly persons with impaired decision-making capacity.
20. Elderly persons are given medication or retrained if they object to remaining in a care/nursing home.

21. Our services support and assist people to make their own decisions where possible, rather than use substitute decision makers such as guardianship or other court procedures.

22. I have ready access to sound legal advice if I am unsure on any matters of mental health law.

23. Elderly persons are given every opportunity to gin their best level of mental capacity, before a decision is made regarding residential care placements.

24. Recognition of patient autonomy is encouraged in our services, to help reduce the need for coercion in psychiatry.

Case Vignettes (see vignette at pages 207, 208):

25. What would be the most likely outcome?
26. What would be the next most likely outcome? (Result deleted as irrelevant.)
27. What would be the least likely outcome?
28. If you think a legal guardian or another substitute decision-maker should be urgently appointed, would this most likely -----?
   Be too difficult to arrange?
   Take a long time to arrange with much difficulty?
   Require an excessive amount of time but be successful?
   Take a moderate amount of time and be successful?
   Be arranged promptly with minimal difficulty?

4.3 The responses

On October 23, 2013, 24 responses had been received out of 44 emailed requests. Although a small response number, these opinions are those of senior psychiatrists currently working in older adult psychiatry, which is a limited category of professionals. Two reminder emails were sent out and the closure date of November 8, 2013 was included. Only one recipient declined, based on insufficient recent contact with the field of study.
The response rate of 54.5% is regarded as ‘good’ according to one report.\textsuperscript{486} Response rates depend on a number of variables, one of which is familiarity of the recipients with the surveyor. This has been reflected in this survey as 17 Western Australians responded compared with 7 from England where I have far fewer current personal contacts.

The responses indicate suggestive trends in opinions only, and are not necessarily representative of majority views.

4.4 Survey results

Q5: WA

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{q5_wa.png}
\caption{Q5 Legally detained patients obtain a tribunal hearing sufficiently soon after admission.}
\end{figure}

Q5: England

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{q5_eng.png}
\caption{Q5 Legally detained patients obtain a tribunal hearing sufficiently soon after admission.}
\end{figure}

\textsuperscript{486} Division of Instructional Innovation and Assessment, The University of Texas at Austin. \textit{Response Rates}. Instructional Assessment Resources. 2007. Email: 40\% average, 50\% good, 60\% very good
WA subjects’ free comments:

In WA, hearings are often many weeks after admission.

Our inpatient unit is not authorised, but my experience has been that elderly inpatients rarely appeal to the MHRB.

Author’s comments:

Whether Tribunal hearings are held sufficiently soon after admission is a value judgement, where the outcome depends on whose concerns are being addressed. If the survey had asked patients this question, the results could have been very different.

Clinical priorities may influence opinions, including whether there has been sufficient passage of time to ensure an adequate degree of recovery before discharge is considered. There may also be a need to allow an early hearing, where patient distress at being detained is affecting treatment. Perceptions of family members, carers and authorities such as the Police and local councils, may have to be finely balanced against patient wishes and preferences. For example, where long standing squalor is the presenting problem, this may require patience and negotiations, rather than precipitous admission to hospital.\footnote{A toolkit for Local Government has been developed by the WA Public Health Department. <http://www.public.health.wa.gov.au/cproot/5845/2/Guideline%2020250814.pdf>.

While both countries favoured a positive response, it appears more positive in the UK than WA. This suggests that hearings are held sooner in the UK than in WA. This is consistent with an impression that there may be greater heed in the UK to minimising detention at an earlier stage.
WA practice was to list hearings for adults, six weeks from date of order for detention, unless directed otherwise, or in the case of minors. It is now practice in 2015 to list hearings more promptly.

In the UK delays in time to a hearing have been the subject of litigation, and resulted in directions to the Mental Health Review Tribunals, by the Care Quality Commission. 488

The role of the ECtHR has been significant in addressing this problem. There is a specific requirement under the ECHR article 5 (4) that cases be heard ‘speedily’.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful. 489

Fennell points out that the ECtHR does not specify what is implied by ‘speedily’:

Instead it asks whether on the facts of the case, there was a failure to proceed with reasonable dispatch having regard to all the material circumstances’. (Reid v United Kingdom (2003) 37 EHRR 9). 490

A subsequent case heard by the English Court of Appeal ruled that the Tribunal Secretariat practice of automatically listing all hearings for exactly eight weeks’ time was legally incorrect. 491 In England hearings for Section 2 patients must be held within seven days of receipt of an application. Note this is not within seven days of admission.

488 CQC (UK), <http://www.cqc.org.uk/content/detained-patients-give-their-views-mental-health-tribunal-process>, 5.
491 R (C) v. Mental Health Review Tribunal [2002] 1 WLR 176 (CA).
Q6 England

Q6 The onus is on the detaining authority to prove the need for compulsory detention, not on the patient to disprove such need.

Answered: 7  Skipped: 0

Author’s comments:

While 100% of the English psychiatrists held that this was almost always true’, a majority in WA were of this opinion. Two said it was ‘almost never true’ or ‘usually not true’, illustrating a range of views.
Tribunal hearings in both countries are ‘inquisitorial’, not ‘adversarial’. The Oxford dictionary defines adversarial as:

Law (of a trial or legal proceedings) in which the parties in a dispute have the responsibility for finding and presenting evidence’. In such cases the emphasis is on ‘dispute’ and the parties are in a confrontational setting.

[An inquisitorial situation is one defined in the Oxford Dictionary as:]

Law (of a trial or legal procedure) characterized by the judge performing an examining role: administration is accompanied by a form of inquisitorial justice.

Mental Health tribunals in both countries are held to be inquisitorial, but this may not be the way they are perceived by patients. In WA, the several disadvantages which patients may experience, could contribute to a perception that they are obliged to confront the authorities and the clinical staff to obtain their liberty. Carney states:

…from the viewpoint of the consumer, and the consumer’s advocate, if the consumer believes that he or she is able to exercise autonomy, the treating team may be seen as an adversary, wrongfully depriving the consumer of liberty.492

Some WA clinicians with UK experience have felt the tribunals there to be highly adversarial, and contributing to a barrier between the clinician and patient. Coates has stated:

What is anomalous, and indeed perverse, is that in England and Wales the detaining authority has no such legal representation and almost entirely relies on the Responsible Medical Officer to argue the case for continuing detention. It is theoretically possible for the Responsible Medical Officer to legally represent the detaining authority (R. on the application of Mersey Care Trust v. MHRT [2003]) but this could clearly never be to the same skill level as a trained solicitor or, indeed in certain circumstances, a barrister and rarely happens in practice.493

The response from the English psychiatrists may reflect clearer awareness of legal procedures and concepts.


Q7 WA

The hearings at our hospital are not on the ward but in a room, close to the ward.

WA subjects’ free comments: The hearings at our hospital are not on the ward but in a room, close to the ward.

Q7 England

The hearings are commonly held on the ward where the patient is detained.
English subjects’ free comments:

*Held off the ward but in the same building.*

*Usually in an adjacent building on the same site.*

*If they are not in the actual ward, they are nearly always in a room/building within 100 m.*

Author’s comments:

Of the English psychiatrists four indicated this was ‘almost never true’, and two that it was ‘usually true’. The disparity may be explained by the respondent comments that hearings were held nearby onsite. Hearings in the UK in my experience were generally not conducted on the ward, but in a spacious hospital board room or similar place, identifiably separate from the ward. This occurred even in the Special Hospital at Rampton, where security was at a very high level.

Hearings in WA were frequently held in noisy, cramped and unsuitable surroundings, sometimes apparently for staff convenience. The designated MHRB hearings room at Graylands Hospital was extremely small and basically furnished. No privacy was available for waiting participants or advocates.
Q8 WA

A treating psychiatrist, registrar or medical officer always attends all tribunal hearings in person or by video-link.

Answered: 17  Skipped: 0

Q8 England

A treating psychiatrist, registrar or medical officer always attends all tribunal hearings in person or by video-link.

Answered: 7  Skipped: 0
Author’s comments:

The survey suggests a contrast in attendance between WA and England. While some of this discrepancy relates to geographic and work-force issues, non-attendance of the psychiatrist at times in metropolitan hospitals and clinics is a matter of concern. Part of this may relate to the discontinuation of appointment of psychiatrist superintendents at WA hospitals and clinics, especially where a high proportion of psychiatrists are part-time sessional staff. Thus, there is sometimes no senior psychiatrist with administrative responsibility and continuing knowledge of the patient, available to present the view of the detaining hospital or clinic. There is considerable variation in this regard and most psychiatrists view the position responsibly. However, exceptions occur which are clearly unacceptable.\textsuperscript{494}

\textsuperscript{494} CoOV (WA) \textit{Annual Report}, 2011-2012,’The issues include psychiatrists failing to attend hearings or provide signed medical reports in time, or at all, and hearings being cancelled or postponed as a result’,26.
Author’s comments: The provision of a social work report is viewed as an important element of the hearings in England, but not in WA. In view of the position of the MHC (WA), that there needs to be greater involvement by families and carers in decisions, it would appear logical to strengthen the position of the social work report by making it a requirement, and addressing the recruitment of experienced social workers.
Q10 WA

**Q10 Tribunal hearing schedules allow sufficient time for full examination of files and discussion with all parties.**

Answered: 16  Skipped: 1

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Q10 England

**Q10 Tribunal hearing schedules allow sufficient time for full examination of files and discussion with all parties.**

Answered: 7  Skipped: 0

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184
Author’s comments: Few reviews of the length of time allocated to hearings have been located. One 2003 report by Perkins on 61 English tribunals gave an average of 75 minutes per hearing, with a range from 56 to 100 minutes.\footnote{Perkins E, \textit{Decision–Making in Mental Health Review Tribunals}, Policy Studies Institute, 2003, 53.}

Perkins also commented:

\begin{quote}
We observed occasions when as many as three tribunals were to be carried out by the same team on the same day, often not in the same location.\footnote{Above. 53.}
\end{quote}

In my experience having as few as three on the same day in WA would be exceptional, with often considerable distances between locations.
Author’s comments: These results may support the limited availability of access for patients in WA, despite a belief among some psychiatrists that legal representation is readily available. The question may be ambiguous in that while theoretically legal representation is available, in practice this is not always the case.\footnote{Mental Health Law Centre Annual Report 2014-2015, 13: reports that while representation at MHRT hearings increased from 13.2% to 16%, many clients are still not represented.}
Thesis: Doctor of Philosophy – Mental Health Law

Q12 WA

Q12 In Western Australia mental health legislation and tribunals are administered by the Minister for Mental Health and the Mental Health Commission. In England they come under HM Courts and Tribunal Service, an agency of the Ministry of Justice. In the interests of fairness and natural justice, is mental health legislation and tribunal management best administered by Justice rather than Health?

Answered: 14  Skipped: 3

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Q12 England

Q12 In Western Australia mental health legislation and tribunals are administered by the Minister for Mental Health and the Mental Health Commission. In England they come under HM Courts and Tribunal Service, an agency of the Ministry of Justice. In the interests of fairness and natural justice, is mental health legislation and tribunal management best administered by Justice rather than Health?

Answered: 6  Skipped: 1

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Author’s comments:

The opinions expressed here may reflect familiarity with what exists, rather than a view formed from experience, and understanding of the ethical and legal issues.\textsuperscript{498}

\textsuperscript{498} Chapter 3, Tribunal administration, 3.8, 129.
Carney et al have commented:

In light of the ruling in the British case concerning the independence of the Parole Board, another aspect to keep a watchful eye on is the degree of independence in the processes of appointment of MHT members, or their funding and management relationship with the relevant State department (R (Brooke) v Parole Board [2008] EWCA Civ. 29). Victoria appears to recognise this to some extent in its proposed reforms, through inclusion of a provision regarding tribunal independence ‘from any person or body, including the Minister’ (exposure draft Mental Health Bill 2010, cl 27).499

While the role of psychiatric facilities in detaining and treating patients against their will is well known and established by lawful procedures, the question of unregulated detention in aged care is less well recognised.
Chesterman et al have stated:

State-based guardianship and disability legislation – along with legislation at the Commonwealth level regulating the vast and expanding aged care system – conspire to make the legal framework in this area exceedingly complex.  

Psychiatrists appear to have suggested ‘informal’ family arrangements in aged care and detention may be widespread. While in most cases this may be justifiable and proper, the absence of effective safeguards in both jurisdictions is of concern. This is despite serious and costly attempts in England to remedy the position.

Psychiatric facilities dealing with elderly patients are required to observe the legislative provisions and ensure access to reviews necessary to protect rights. The position with respect to Commonwealth funded aged care is less patent.

The procedures by which patients can be admitted to an aged care facility are governed by the Aged Care Act 1997 (Cth). There is no WA law, other than the Criminal Code, which applies to these procedures, but WA professional staff are involved in facilitating and approving aged care services, through their participation in Commonwealth funded ACATs.

The Commonwealth Government Guidelines state:

- The role of ACATs is to determine the overall care needs of frail older people and to assist them to gain access to the most appropriate types of services.

The Guidelines also state,

...ACATs comprehensively assess older people taking account of the restorative, physical, medical, psychological, cultural, and social dimensions of their care needs. ACATs involve clients, their carers, and service providers in the assessment and care planning process.

501 Ibid, 657.
The extent to which ACAT approvals conform to the guidelines in practice, is unclear, as there appears to be no independent documentation and monitoring of legal matters such as capacity and consent prior to admission.
Author’s comments: As there is no Human Rights Act or Charter in WA some variation in opinions is to be expected. The views expressed by the English psychiatrists appear more positive. The divided views in WA may suggest that WA law and procedures are not in keeping with best practice elsewhere. A number of WA psychiatrists have trained in other States and overseas, which may influence their assessment of WA legal procedures.
Q15 England

All psychiatrists who detain patients undergo thorough training in the Mental Health Act and related legislation.

Answered: 7  Skipped: 0

Author’s comments:

Holding evidence of approved training in mental health law is a mandatory requirement for psychiatrists in the UK and must be renewed every five years. Instruction in the Mental Health Act 2014 (WA), was not mandated by the Chief Psychiatrist until 2015.
Author’s comments: These results are equivocal, but the diversity of responses is of interest. This may suggest some psychiatrists are dis-satisfied with the legal measures and the priority given by administrations in both jurisdictions.
Author’s comments: Some ambiguity arises from the word ‘unreasonably’, as it could be held that diversion of resources was reasonable. The question was posed to consider whether resources that could be better spent on patient care, were being diverted to unhelpful ends. An opinion on this was sought in the light of a report which demonstrated that the cost of the MHRT in England was substantially greater than in Australia. It may be that in Australia expenditure is too little, placing human rights at risk. As Carney et al have noted:\(^{503}\)
Author’s comments: It is difficult to draw conclusions from this finding, but the range of differing views is noted. Future studies of this area may clarify the position in the light of greatly increased clerical work required by the *Mental Health Act 2014* (WA).
Author’s comments:

The English psychiatrists appear to view their laws as offering better protection than do psychiatrists in WA. The challenge is to address legal problems without undue and costly interference with service delivery, while ensuring fair and beneficial care.
Q20 WA

Author’s comments: Concerns with medication use has been recognised equally in both countries, and these results suggest the existence of a serious problem. The remedy is complex, and depends on adequate community supports, pre-admission assessment, staffing, and resourcing policies in aged care.\textsuperscript{504}

\begin{footnotesize}
\textsuperscript{504} Chapter 6.3.3, 258.
\end{footnotesize}
Q21 WA

Our services support and assist people to make their own decisions where possible, rather than use substitute decision makers such as guardianship or other court procedures.

Answered: 15  Skipped: 2

Author’s comments: The results appear to favour a slightly more positive view in England.

Q21 England

Our services support and assist people to make their own decisions where possible, rather than use substitute decision makers such as guardianship or other court procedures.

Answered: 7  Skipped: 9

Author’s comments: The results appear to favour a slightly more positive view in England.
Q22 WA

Q22 I have ready access to sound legal advice if I am unsure on any matters of health law.

Answered: 15  Skipped: 2

Author’s comments: The scattered response from WA psychiatrists may be in keeping with the relative paucity of interactions with legal practitioners, with the occasional exception of the MHRB hearings.

Q22 England

Q22 I have ready access to sound legal advice if I am unsure on any matters of health law.

Answered: 7  Skipped: 0
Author’s comments: One of the provisions of the Mental Capacity Act 2005 (UK) is that steps are required to be taken to promote and enable a person to regain capacity where possible. The decision to admit a person to an aged care facility for example, should rarely need to be undertaken in haste. Occupying an acute hospital bed is not in itself a just reason to expedite admission into an aged care facility. Requests for urgent guardianship hearings are not uncommonly based on the need to discharge a patient from hospital, or to a ‘care awaiting placement’ (CAP) bed.\footnote{Personal communication, SAT member. Further research into outcomes of CAP is required.}
Q24 WA

**Q24 Recognition of patient autonomy is encouraged in our services, to help reduce the need for coercion in psychiatry.**

Answered: 15  Skipped: 2

![Chart showing responses to Q24 WA](chart1)

Q24 England

**Q24 Recognition of patient autonomy is encouraged in our services, to help reduce the need for coercion in psychiatry.**

Answered: 7  Skipped: 0

![Chart showing responses to Q24 England](chart2)

Author’s comments: This chart suggests scope for more active promotion of autonomy would be desirable. A reduction in the use of coercive mental health laws could improve patient perceptions and benefit outcomes.
4.5 Case vignette

The following case history is based on experience of typical cases in England and WA. Using a vignette is an accepted method of harnessing opinions on potential courses of action in a hypothetical clinical situation.

You receive a request asking you to see a 78-year-old woman in a medical ward at the general hospital. She had been diagnosed two years ago as having moderate Alzheimer’s disease and cared for at home by her husband. He has suddenly died and she was referred to hospital, following concerns from a neighbour. After investigation, no relevant physical illness has been found, but she appears depressed and tearful, as well as being confused. There are no known relatives and no advance direction. She has not been receiving any social care services at home as her husband did not consider them necessary. The staff report she is tearful and frequently attempts to leave the ward which has no locked doors. You are expected to assume responsibility for her care in your psychiatric ward as she has no current need for medical treatment. You consider she lacks decision-making capacity.

Answer choices

- Patient is visited and suggestions offered but not admitted to your hospital?
- Patient is referred to home support and day hospital for further assessment?
- Patient is sent to a secure nursing /care home?
- Patient is admitted to your hospital as an informal (voluntary) patient?
- Patient is admitted to your hospital ward under the Mental Health Act for assessment?

Pass
Q25 WA

Author’s comment: I make no judgement on the correct course, but note a trend towards hospital outcomes in WA, possibly related to a dearth of community alternatives.\textsuperscript{506}

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\textsuperscript{506} Of the five day hospitals at each PECU in 1985, none now operate as intended.
Question 28

If you think a legal guardian, or substitute decision-maker should be urgently appointed, would this most likely ------

Be too difficult to arrange?

Take a long time to arrange with much difficulty?

Require an excessive amount of time, but still result in an appointment?

Take a moderate time and be successful?

Be arranged promptly with minimum difficulty?

Q 28 WA

Q28 If you think a legal guardian or other substitute decision maker should be urgently appointed, would this most likely -----

Answered: 15  Skipped: 2

Be too difficult to arrange? 4
Take a long time to arrange with much difficulty? 6
Require an excessive amount of time, but still result in an appointment? 3
Take a moderate time and be successful? 1
Be arranged promptly with minimum difficulty? Pass

Q28 England

Q28 If you think a legal guardian or other substitute decision maker should be urgently appointed, would this most likely -----

Answered: 7  Skipped: 0

Be too difficult to arrange? 2
Take a long time to arrange with much difficulty? 4
Require an excessive amount of time, but still result in an appointment? 1
Take a moderate time and be successful? Pass
Difficulty in effecting the appointment of a substitute decision-maker promptly should be addressed in both countries. Despite the *Mental Capacity Act 2005* (UK), the DoLS and the *Guardianship and Administration Act 1990* (WA), it appears that there is a risk of some decisions bypassing these protective measures.

Experience and information from clinicians in WA suggests that, despite there being an arrangement for urgent guardianship hearings, this is infrequently used. The reasons for this are uncertain but verbal comments suggest a perception that, if the patient is currently occupying a hospital bed, the case for urgent resolution may appear to be reduced. A need to clear a bed in an acute hospital ward or emergency department, may occasion administrative pressures to make a ‘care awaiting placement’ or aged care facility admission. In this situation, a *conflict of interest* for a hospital based ACAT may arise.
Summary and conclusions

This survey was conducted to widen the range of views available, rather than base comments solely on my personal views. Because of the small number of responses, the results must be treated with caution. Nevertheless, they represent the views of 24 specialists in psychiatry of older adults, and are of value in demonstrating points of divergence, or common ground. In view of the tendency in WA to look overseas for guidance, the results suggest a need for comprehensive evaluation when adopting new legislation and programs.

The unique role of psychiatrists who can invoke legislative provisions to over-rule patient consent to hospitalisation and treatment, is balanced with legal measures intended to provide protection against unreasonable clinical decisions. Older patients in general aged care facilities may not be perceived to require comparable protective measures. In both circumstances the capacity to make a decision and consent is critically important. This has been considered in the following chapter.
5 Capacity and consent

5.1 Introduction

This chapter examines mental capacity and decision-making, including legislation in WA, and within the *Mental Capacity Act 2005*, and the *Mental Health Act 2007 (UK)*. In general, no-one has authority to make decisions for another person who is capable of making those decisions for themselves. If capacity to decide is absent or seriously impaired, then a range of provisions exist to ensure that the person is protected, and that necessary decisions can be made in their best interest. The range of protective provisions is discussed in this chapter, following a review of the nature of capacity to decide. Legislation provides the major, but not the only, elements of protection in law and procedures for persons lacking capacity.

5.2 Who decides?

Possession of decision-making capacity is a necessary pre-condition for making an informed decision on any matter. Particular importance attaches to not only decisions of a life or death nature, but also to matters of choice of lifestyle, accommodation, partnerships etc. The ALRC Report defined the task it undertook in reviewing law on capacity in these words:

> This inquiry is about ensuring people with disability have an equal right to make decisions for themselves. It is about respecting people’s dignity, autonomy and independence, while supporting them to make their own decisions, where such support is needed.\(^{507}\)

A unique feature of psychiatry is that, except for a very few special circumstances in medicine, psychiatrists have a statutory role which enables them to over-ride a person’s consent to treatment and detention in hospital.\(^{508}\) Psychiatrists should therefore be at the forefront of debate on the ethics and philosophical support for their position.

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507 ALRC Report, 124, August 2014, 23.
508 *Mental Health Act 1996 (WA)*, Div. 6, 109, Consent not required for psychiatric treatment, An involuntary patient, or a mentally impaired defendant who is in an authorised hospital, may be given psychiatric treatment without his or her consent.
According to Burns:

…our history demonstrates how context, attitudes, even political ideologies can obscure our judgement. This is not restricted to psychiatry: other branches of medicine have committed serious errors and found themselves down ethical cul-de-sacs.\(^{509}\)

Other individuals and professions may also be involved in effecting an elderly person’s admission to aged care facilities.\(^{510}\) The extent to which there is sufficient ethical consideration of the older person’s rights to make their own decisions, prior to admission or treatment warrants examination.

As the *Mental Health Act 1996* (WA) was still in use in November 2015 the issues in general still apply to this thesis. Important changes in the *Mental Health Act 2014* (WA) affecting capacity are discussed in Chapter 8.

### 5.3 Consent

The legal issues surrounding ability to offer consent are based in the law of trespass. This trespass may be over matters of land, goods, or personal matters such as health and welfare.

Mason described consent as a platform resting on a tripod:

- The three legs can be stylised as:
  - 1 Is consent legal? and, if so,
  - 2 Can it be given? and, finally,
  - 3 Has it been given?\(^{511}\)

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\(^{509}\) Burns T, *Our Necessary Shadow*, (Allen Lane 2013), 185.201.

\(^{510}\) An ACAT assessment usually requires a general medical practitioner, geriatrician, nurse, and another health professional such as a social worker, occupational therapist etc.

On the first leg, Mason commented:

… the law in this area is, to an extent, founded upon anomalies and uncertainties. These derive from its attempt to steer a course between the two poles of absolute autonomy on the part of the individual and the absolute duty of the State to protect its citizens against themselves in the interests either of the individual himself or of society.512

He went on to illustrate how changing social and political developments can alter what was at one stage illegal, to grant acceptance as legal, mentioning female circumcision and sex change procedures as examples. In respect of the topic of this thesis, changes in aged and community care, can bring about new challenges to consideration of whether actions traditionally undertaken in care are legally supportable and ethical. The Bournewood decision in England created a groundswell of activity, regarding the legality of detention of persons who were compliant with health care, but in fact could not give valid consent.513 This had been known for a long time but it required a legal challenge in an international court before serious effort to change resulted. The excessively controlling approach adopted in the UK has not proved encouraging.514

The second leg mentioned by Mason concerns the ability of the patient to give consent. Perhaps reflecting the date (1986) of this report, he considered only minors, the mentally handicapped and prisoners. The place of the elderly with dementia was not examined with the same attention given to minors and the Gillick case.515

The Guardianship and Administration Act 1990 (WA), stating the authority of a plenary guardian makes reference to the Family Court Act 1997 (WA), and regards the represented person as if, ‘a child lacking in mature understanding’ (emphasis added).516

512 Ibid 127.
515 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112,
516 *Guardianship and Administration Act 1990* (WA), Division 2, 45(1).
This anachronistic view may colour attitudes to assessing capacity in the elderly, precluding allowance for partial and fluctuating capacity, and the case for supported decision-making.

The third leg, has consent been given, deals with whether consent has been ‘informed’, and on this subject Mason is critical of this ‘ready and almost unthinking acceptance’ of the expression into the vocabulary. The Mental Health Act 1996 (WA) states the requirements for informed consent as follows:

95  (1) For the purposes of this Division a patient gives informed consent to treatment only if –

(a) the requirements of this Division have been complied with; and

(b) the consent was freely and voluntarily given.

(2) a failure to offer resistance to treatment does not of itself constitute consent to treatment.

The ability to offer consent freely may be influenced by subtle factors which are not amenable to brief and simplistic legislative construction. For example, a severely depressed patient may give consent to ECT in the belief that a treatment will result in his death, or be unable to envisage a benefit due to extreme hopelessness. An elderly patient may be under financial and family pressure to accept hospitalisation and aged care, and give consent because alternatives have not been offered or made available.

5.4 What is meant by capacity?

Capacity is the ability to do something. In a legal context, it refers to a person’s ability to do something, including making a decision, which may have legal consequences for that person, or for other people.

In earlier times when execution following conviction for a capital crime was a customary legal consequence, mental capacity was significant as a possible basis for being spared.

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517 Above Mason, 131.
518 Mental Health Act 1996 (WA) Part 5, Division 2, s 95.
519 The British Medical Association and the Law Society, Assessment of Mental Capacity (Legal Handbooks 2010)
Evidently behaviour had to be exceptional to permit crime to be excused. Whitlock mentions that:

> In the reign of King Alfred, high treason by killing, or offering to kill the king was not excused by the insanity of the offender. On the other hand, infants under the age of twelve years could not be executed for theft. 520

Whitlock quotes Sir Edward Coke who commented that the execution of a severely mentally ill person was considered unacceptable, partly because it did not provide the requisite example to others.521 Coke also stated that the law requiring execution of a man convicted of high treason who becomes mad, was repealed as it was, ‘…a miserable spectacle, both against law, and of extreme inhumanity and cruelty, and can be no example to others’.522

5.4.1 Lunacy Act 1871 (WA)

This WA legislation was modelled on that which existed in Britain, and reflected social and political perspectives on the management of mental illness at that time. The criminal law continued to be intimately bound up with questions of insanity and guilt, dealings on property and harm to others, up to the present day. The short title of the first Western Australian Lunacy Act proclaimed in 1871 dealing with ‘persons dangerously insane’, referred to matters of safe custody, prevention of crimes and care of the property and estates of affected persons.523 The Act defined a lunatic as, ‘every person of unsound mind and every person being an idiot’. What constituted an ‘unsound mind’ was not specified in the Act and remains uncertain, as recently observed by Christie.524 An ‘idiot’ refers to a person lacking reason from birth.

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521 Coke Institutes (1797) Part III, Cap 1, High Treason, 4; (online, Cornell Law School).
522 Ibid 6.
A person being ‘not under proper care and control’ or ‘cruelly treated or neglected by any relative or other person having the care and charge of him’, could result in him/her being brought in by the police and presented before two justices. If the person was a pauper, a report from a medical practitioner was required before the person was admitted to an asylum. If not a pauper, the Act specified that two medical practitioners, not in any partnership were required to provide reports setting out,

…the facts upon which he has formed his opinion that the person to whom such certificate relates is a lunatic, an idiot or a person of unsound mind; distinguishing in such certificate facts observed by himself from facts communicated to him by others; and no person shall be received into any asylum under any certificate which purports to be founded on facts communicated by others.525

Part IV of the *Lunacy Act 1871* (WA) set out detailed arrangements for managing the property and estates of a person found to be ‘lunatic or of unsound mind so as to be incapable of managing his affairs’. A special concern was to ensure payment for his care and maintenance if funds were available, and to make arrangements for debts to be paid, and support for any family.

### 5.5 Public Trustee in WA

Under provisions of the *Mental Health Act 1962* PART VI, (WA) provision was made for the ‘Care and Management of Estates of Incapable Persons’, wherein the Public Trustee was made responsible under the *Public Trustee Act* (1941).526 Under the *Mental Health Act* (1962) an incapable person was defined in a circular way as, ‘…a person declared under the provisions of Part VI, to be incapable of managing his affairs’.527

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525 Above, 34 Victoriae. No. 9. The Statutes of Western Australia 437.
526 Mental Health Act No. 46 of 1962, Part VI, 62 (2).
527 Ibid, Part VII 5. (Definitions).
Under the *Mental Health Act* (1962), 4, (1) the Supreme Court was enabled to give authority to the Public Trustee, a corporate trustee or a natural person to manage an incapable person’s estate provided it was ‘…satisfied that a person …is incapable, by reason of any mental illness, defect or infirmity, however occasioned, of managing his affairs…’.

The *Mental Health Act 1962* (WA) states: ‘An application under this section shall be made by way of originating application, supported by such evidence as may be prescribed by the rules’. 528

There was a requirement for a medical report from the superintendent or another psychiatrist mentioned in the *Mental Health Act 1962* (WA), but this would have been customarily brief stating the opinion that the patient was ‘incapable of managing his affairs’. Often the fact that the person was deemed ‘not under proper care and control’, was enough to ensure placement at Claremont Mental Hospital, particularly for intellectually handicapped young people and alcoholics with brain damage, who had no other place available to them.

Until 1970-1980 there were few nursing homes capable of managing elderly persons with dementia and significant behaviour problems. Persons with dementia from any cause readily fitted the description of being, ‘not under proper care and control’. Care for seriously disturbed or absconding risk patients could sometimes only be provided in a secure psychiatric hospital environment such as Swanbourne Hospital. 529 All patients at that time were admitted under the prevailing mental health legislation, the *Mental Health Act 1962* (WA).

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528 Ibid, Part VI 64. (2).
529 In 1972 the Hospital for the Insane, Claremont, was divided into two distinct hospitals by function. The re-named hospitals, Graylands and Swanbourne were both on the same site until 1985 when Swanbourne closed. Graylands Hospital has continued in its role as the principal psychiatric and forensic hospital for WA.
5.6 Dementia and geriatric medicine in WA

Until 1999 some patients with dementia were admitted informally to State Government, non-government, and private nursing homes, known as “C” class hospitals.\textsuperscript{530} No statutory legal documentation was engaged, and the degree to which these persons could validly consent to their admission remains unclear. Unless actively resisting, patients were assumed to allow others to make decisions on their behalf, often without authority.

Dr Richard Lefroy, the WA principal geriatrician, reported that the development of medical care for the elderly in WA was at first quite basic and patient documentation minimal.\textsuperscript{531} He illustrated this with a copy of a form to be filled out by the patient’s medical advisor requesting admission to Sunset Old Men’s Home. There was room for brief information, and only one question enquiring as to the applicant’s mental state asking: ‘To what extent is he/she mentally incapacitated?’ to which the hand-written answer was ‘nil’.\textsuperscript{532} From the miss-spelling of a common medication and paucity of details, one can speculate whether the form was completed somewhat carelessly by a medical practitioner or some other person, as recently as 1965. It was not until the development of the Extended Care Department by Lefroy, and the introduction later of the Aged care assessment Teams by the Commonwealth Government, that some order emerged in the long term medical care of the elderly, including those with cognitive impairment.\textsuperscript{533}

Lefroy mentions the fact that a number of elderly men at Sunset who were termed the ‘senile inmates’ were ‘housed in a locked ward with a high barbed wire fence.’\textsuperscript{534}

\begin{itemize}
\item \textsuperscript{530} After 1999 the major State Nursing Homes at Mt. Henry and Sunset (Dalkeith) were closed. However, ‘nursing home type’ patients continued to be admitted to regional and country hospitals.
\item \textsuperscript{531} Lefroy ab45.
\item \textsuperscript{532} Ibid, 45.
\item \textsuperscript{533} The term extended care as adopted in WA by Lefroy, referred to the extension of hospital care into the community, not the length of an admission.
\item \textsuperscript{534} Lefroy above, n68, 53.
\end{itemize}
A 1949 Department of Health report quoted by Lefroy, was addressed to the Minister for Health and stated:

They are not insane but are childish and sometimes their habits are unclean; consequently, it is necessary to confine them to the geriatric ward. It was also asserted that there were a number of men at Claremont Mental Hospital who could similarly be accommodated at Sunset.  

While a case was put up for the advantages of placing the men from Claremont at Sunset Hospital, there was clear concern regarding the legality of confinement. A letter from the Under Secretary for Health quoted by Lefroy stated:

While we have over many years placed restraint upon the movements of these old men at Sunset, we have no legal authority to do so … If challenged our defence could only be that the men were enclosed for their own protection. (WA Department of Health 1949).

Lefroy included a table of ‘Assessed care needs of persons referred (by percentage)’ at Mount Henry State Government “C” class Hospital, in which it is shown that 11.6% of the women patients required “psychiatric care”. How many of these were unable to consent to their admission was not stated. Other private and State nursing homes provided locked wards, mostly to prevent dementia patients from wandering out to busy highways or becoming lost. The only administrative basis for this was understood to be the common law of necessity or ‘duty of care’. Necessity is however more appropriately a defence against negligence claims which may arise in urgent situations. As noted by Luntz:

Leaving aside emergencies to which the defence of necessity applies and, possibly cases of intellectual disability where the patient is unable to consent, medical treatment involving a direct touching of the patient’s body which is performed without the patient’s consent is a battery.
This statement could be read as approving medical interventions without consent, in the case of persons with dementia and other disorders who are unable to give consent. Such a position would discriminate on the grounds of disability, and would not be in keeping with the UNCRPD, to which Australia is a signatory.\textsuperscript{540}

5.7 Aged care special dementia facilities in WA

One of the first \textit{purpose built} aged care facilities managing patients with dementia was ‘Rowethorpe’ at Bentley.\textsuperscript{541} However, it did not represent a significant departure from the traditional nursing care model already in place. The few special design features were of doubtful value, and did not represent a new direction in thinking about people with dementia. The legal aspect of detaining elderly persons was given little attention at the time. Of more concern was the prevention of harm befalling a person through wandering away; being a ‘wanderer’ became the focus of attention, rather than the detention.

An entirely new type of specially designed and staffed ‘secure hostel’, providing long term home-style accommodation for the elderly with dementia, materialised with the opening of the special dementia unit of Anglican Homes at Bull Creek in 1985 (Lefroy Hostel). While a number of nursing homes had locked areas for “wanderers”, this was the first attempt in the aged care sector in WA to provide specially trained dementia care staff, not necessarily nursing staff, and a homely, but safe environment.\textsuperscript{542}

\begin{itemize}
\item \textsuperscript{540} UNCRPD, opened for signature 30 March 2007, (entered into force 3 May 2008).
\item \textsuperscript{541} Rowethorpe was promoted in the 1980s as a model for dementia care, operated as part of a Perth retirement complex, Swan Cottage Homes.
\item \textsuperscript{542} A parallel should be noted with the introduction of social trainers in the intellectual disability field in WA. Also, Isaacs B, Birmingham England, who developed a ‘standard hostel with additional staff’ – rather than a nursing home’. See Lefroy, n 530, 96.
\end{itemize}
The distinction between nursing homes and hostel facilities was later removed by the Federal Government under the ‘Ageing in Place’ policy.\textsuperscript{543}

Currently all aged care residential facilities include persons with dementia, and provision of a safe environment is a requirement.\textsuperscript{544} As a consequence, some patients with full decision-making capacity are also held in facilities which they cannot leave without assistance.\textsuperscript{545}

5.8 WA Mental Health Services for elderly persons

Elderly patients were admitted to psychiatric hospitals at Claremont (Swanbourne and Graylands), Heathcote and Lemnos, but unlike the State geriatric hospitals, there was at least some form of legal documentation to provide for their detention.\textsuperscript{546} There was little consideration of consent or mental capacity, nor was the topic taught or examined in any depth. Legal issues only relatively rarely intruded on the daily work of the mental health hospitals in WA. No formal training in psychiatry was available in WA, and those interested in obtaining psychiatric qualifications were obliged to study in other States or overseas.\textsuperscript{547}

Only one part time clinical psychologist in the State Mental Health Service visited Claremont Hospital, a very few welfare officers, and no social workers until 1959.\textsuperscript{548} Nursing education in mental health was at a very basic level until the introduction of properly qualified nurse educators in 1953.\textsuperscript{549}

\begin{itemize}
  \item \textsuperscript{543} This followed the introduction of the \textit{Aged Care Act 1997} (Cwth). http://www.aihw.gov.au/ageing-in-place.
  \item \textsuperscript{544} Australian Government Aged Care Quality Agency, Results and processes guide, 87: Principle: Care recipients live in a safe and comfortable environment that ensures the quality of life and welfare of care recipients, staff and visitors.
  \item \textsuperscript{545} Personal observations at aged care facilities.
  \item \textsuperscript{546} \textit{Mental Health Act 1962} (WA).
  \item \textsuperscript{547} It was possible to sit for a Diploma in Psychological Medicine, but no educational resources or teaching were available in WA. The first UWA Professor of Psychiatry, Ian Oswald, arrived in 1965.
  \item \textsuperscript{548} Foley M, The Origins of Mental Health Social Work in Western Australia: A Psychiatric ‘Re-conception’ [online]. \textit{Studies in Western Australian History}, No. 25, 2007: 132-147
  \item \textsuperscript{549} Ron Dee from the UK appointed as first qualified nurse educator in mental health 1953.
\end{itemize}
In the early 1960’s patients’ medical records were not kept on the wards, and documentation was only written up after the psychiatrist or medical officer had completed his rounds.\textsuperscript{550} Only the medication charts remained accessible on the wards, and a register of daily events was kept by the nursing staff in one large ledger in each ward. Gross overcrowding and Dickensian environmental conditions were evident from personal observation, in 1964.\textsuperscript{551}

In England, the Royal Commission on the Law regarding Mental Illness and Mental Deficiency, took place between 1954 and 1957.\textsuperscript{552} The findings recommended a shift from a mainly legal focus to a medical one. To counter this shift, many new measures such as the MHRT, intended to ensure protection of patient rights, were introduced.

The Law Society (UK) published a discussion document in January 1989 on capacity, coinciding with the \textit{Re F} (Mental Patient: Sterilisation) case.\textsuperscript{553}

The Commission stated:

This case drew public attention to the fact that English law now possesses no procedure whereby any other person or a court can take a medical decision on behalf of an adult patient without capacity to take that decision.\textsuperscript{554}

\textsuperscript{550} Personal communication, Dr Fred Bell, Director MHS obtained this change when he was a psychiatrist at Claremont hospital and directed the records to be held on the wards.

\textsuperscript{551} Stoller A, Arscott K, \textit{Mental Health Facilities and Needs of Australia}, (Government printing Office, Canberra, 1955. ‘Claremont Hospital had 1498 patients in residence with only 3 on trial leave. Overcrowding was estimated to be 20% on the male side and 25% on the female side.’\textsuperscript{132}.

\textsuperscript{552} The appointment of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, comprising representatives of the medical and law professions and under the chairmanship of Baron Percy of Newcastle, was announced in October 1953 and made by Royal Warrant of 23 February 1954. \textless http://discovery.nationalarchives.gov.uk/details/r/C10964\textgreater .

\textsuperscript{553} \textit{Re F v West Berkshire Health Authority} [1990] 2 AC 1.

5.9 Development of Guardianship in WA

In 1979 the Director of MHS, Dr Fred Bell recommended the closure of Swanbourne Hospital. Discharging patients from Claremont Hospital to community based facilities had been in operation since 1960, and admission of patients *intellectually disabled from birth* was declining. The buildings were deemed unsuitable, and maintenance was simply ‘sending good money after bad’.

In 1980-1, a review of the *Mental Health Act 1962* (WA) was established by government. The task was divided into consideration of general psychiatry patients, forensic matters and the intellectually handicapped and elderly. The principal focus of the last-named committee was to provide a form of legal status for parents and family members in decision-making through guardianship.

A significant factor in this review was the planned closure of Swanbourne Hospital, which housed approximately 400 intellectually handicapped and elderly patients, mostly suffering from dementia or chronic psychoses. During the committee meetings leading up to the preparation of what later became the *Guardianship and Administration Act 1990* (WA), the special interests of two groups were raised. One comprised carers of the intellectually disabled patients, and the other was the carers of elderly with loss of mental capacity. Many carers had incorrectly assumed that, as parents or next of kin they were legally entitled to make decisions on behalf of persons lacking capacity.

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556 The name ‘Division of Intellectual Handicap’ (DIH), of MHS was later changed to ‘Disability Services’.
557 I was appointed to this committee, being the Psychiatrist-Superintendent of Swanbourne Hospital.
Several events influenced community attitudes towards the care of intellectually handicapped younger people around this period. One of the first was the conviction of Dr Maurice Benn for killing his intellectually handicapped son.558

The next major influence was the outcry which resulted from the placement of a small group of bed-ridden, severely handicapped young people, at a small hospital (Tresillian) in the community at Nedlands. A small number of local residents objected and complained to their Council. The local Member of Parliament (Sir) Charles Court was also the Premier at the time, and a transfer to another facility was arranged, but this also led to a major public objection. A parent based support group for the patients, ‘Watchdog’, was heavily involved, as was the Slow Learning Children’s Group. Many parents were concerned that they had very little influence over placement and health decisions affecting their family members, who were now adults chronologically. Adult guardianship was envisaged as a means of addressing this concern, the historical origin and development of which has been documented by Carney.559

The families of patients with dementia were placed in a similar position, having no legal authority to make decisions regarding elderly parents, although it was commonly believed to be otherwise. It was thought objectionable that in some cases the principal means of providing care for persons with dementia and behaviour problems, was admission to an asylum under the Mental Health Act 1962 (WA).

558 Earl D, Conference Paper: Reviewing Dr. Benn July 13, 2010; Online at http://davegearl.com/ Dr M Benn a UWA mathematics academic became seriously depressed at the birth of his intellectually disabled son, and fearing institutional care, murdered the boy. Sentenced to death in 1964, this was commuted to 10 years’ imprisonment.

Following a public meeting in Perth attended by over 500 people, the first Alzheimer’s and Related Disorders Society (ADARDS) in Australia was convened.\footnote{The Swanbourne Hospital Social Work Department and the WA Mental Health Association were closely involved in the moves to establish ADARDS, until they moved to new premises. Opportunity for cooperation and contacts appears to have been lost since.}

In planning the replacement of Swanbourne Hospital, the goal was not only to provide new buildings, but also new methods of delivering treatment in the community. Alternatives to certification under the \textit{Mental Health Act 1962} (WA), for persons with dementia and behaviour problems was sought. It was expected that the new inpatient facilities, named Lodges, would not come under the \textit{Mental Health Act 1980} (WA), but would be no different to general hospital wards and State nursing homes. Patients were to be treated under a ‘duty of care’, unless specifically objecting, in which case the mental health legislation was to be used. If the patient was objecting or required compulsory psychiatric treatment, they could be admitted, in the first instance, to an approved hospital under the \textit{Mental Health Act 1962} (WA). This may partly explain the point raised by Moran who noted that:

> Interestingly the GAA originally prevented guardians from consenting to the voluntary or involuntary treatment of a represented person in an approved hospital under the Mental Health Act 1962 (WA). This exclusion was repealed by consequential amendment when the MHA was enacted in 1996, leaving the Act silent as to its intended relationship with the GAA.\footnote{Moran C, \textit{The Voice of Reason}? Honours dissertation, UWA 2009.}

The policy reason for the clause preventing guardians from consenting, was very likely the view of MHS administration, that no new intellectual handicap patients would be admitted into psychiatric hospitals, solely based on their disability.
5.10 The Public Advocate

An important development associated with the *Guardianship and Administration Act 1990* (WA) was the appointment of a Public Advocate, with responsibility for persons who did not have any, or any suitable person, to act as guardian.

Another key concept was that a guardian, including the Public Advocate, would only be appointed as a ‘guardian of last resort’.  

Carney and Tait have identified Guardianship as an innovative development, in the title of their book ‘The Adult Guardianship Experiment – Tribunals and Popular Justice.’ In his argument, he suggested that Australia had embarked upon: ‘one largely unreported experiment in popular justice...’

The transition to guardianship with responsibility for personal as well as property decisions marked a significant change in legal procedures in WA. Whereas the Public Trustee was only concerned with financial decisions, the new Guardians including the Public Guardian, were required to take on a much broader responsibility in personal care.

The web site of the WA Guardianship and Administration Board informs readers of this enhanced role:

> The Guardianship and Administration Act 1990 (the Act) recognises that people who are not capable of making reasoned decisions for themselves may need additional support and assistance not only to ensure their quality of life is maintained, but also to protect them from the risk of neglect, exploitation and abuse. The Act provides that the State Administrative Tribunal or SAT may appoint a guardian for a person with a decision-making disability. This allows a guardian to be appointed as a substitute decision-maker.

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562 *Guardianship and Administration Act 1990* (WA), 4. (2) (c) (d) (e).
564 Guardianship and Administration Board Information Sheet 4, web page, accessed 12, September, 2012.
These appointments may be plenary or limited, following principles detailed in Part 2 of the Guardianship and Administration Act 1990 (WA). The principles are worth noting in that they affirm that the autonomy of the individual is to be presumed, and that ‘best interests’ and the least restrictive means is the primary concern in proceedings. Unlike the Mental Health Act 2014 (WA), the Principles are stated near the front of the Act.

5.11 Substitute decision-making

With the rise of the civil libertarian and consumer movement, attention turned to the rights of individuals to make their own decisions, unless unable to do so through lack of mental capacity. No medical or social intervention is permitted when a person with mental capacity objects. The law was stated in a Canadian case concerning a Jehovah’s Witness who was refusing a blood transfusion.

The right to determine what shall be done with one’s own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based.

In this case the attending doctor was sued and the Court found that he had committed battery and was obliged to pay damages.

In an earlier case Cardozo J found as follows:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.

568 Schloendorff v The Society of New York Hospital (1914) 211 NY 125.
Decision-making capacity can be impaired in many ways, and has been the subject of legal concerns from earliest times. An individual may never have gained enough mental capacity to make decisions, or later become incapacitated through illness or injury. The position of those who have had full capacity, but lost it through disorders associated with old age such as dementia, is an area of growing concern.\textsuperscript{569} A large proportion of the case law in the UK, relates to persons with intellectual disability from birth. Other forms of cognitive incapacity may arise from traumatic injuries, and neurodegenerative disorders. These also form a major component of new case law, especially when end-of-life issues arise.

5.12 Capacity and competence

These terms are sometimes distinguished from one another and at other times used interchangeably.\textsuperscript{570} The term capacity is described as: ‘… ultimately a legal concept’, in a guide for Doctors and Lawyers published by the British Medical Association.\textsuperscript{571}

The Victorian Law Reform Commission (VLRC) stated:

7.9 The term ‘competence’ is sometimes used instead of capacity, especially in North America, to describe this fundamental concept. Although some people suggest that competence is a legal concept and capacity a medical one, we prefer the view that the terms have the same meaning and can be used interchangeably.\textsuperscript{572}

It appears that the terms are usually treated as synonyms in Australian law, with capacity being the more common expression.

\textsuperscript{569} OPA (WA) Annual Report 2014-2015; ‘Demand for the Office’s statutory services continues to rise each year. Western Australia’s’ growing and ageing population, combined with the prevalence of dementia, are key factors driving demand. People may also lose decision-making capacity as a result of mental illness, a brain injury from an accident, illness or substance abuse, or lack capacity because of an intellectual disability from birth’.

\textsuperscript{570} Meynen G, Med Health care and Philos (2009), Pub online 11 June 2009, Springer.


5.13 How is capacity measured or assessed?

Assessment of capacity is a continuous process not confined to medical professionals, but can include family members, lawyers, paid carers, accountants, bank staff etc., depending on the decision required to be made. Assessment is routinely undertaken by all grades and branches of medical professionals, and is a specific subject for psychiatrists in their everyday clinical care decisions, as well as in some complex cases referred for a second opinion.

5.14 Medical assessments of capacity

Capacity must be judged in tandem with the nature of the actual decision required at the time. Thus, the protections available need to be tailored to the seriousness of the consequences of the decision for an individual. In this regard the quality of medical or other professional opinions given in respect of assessment of capacity is critical. The concept of a ‘sliding scale’ of capacity has been criticised as giving an evaluator too much scope to apply a cut-off.\(^5\) Where sensibly applied, with appropriate patient and family/carer input, concerns should be reduced.

5.15 WA psychiatrist training

In the psychiatric registrar training program, due attention to medico-legal matters is paid, before moving on to sub-specialty sectors such as older adult psychiatry. The first formal curriculum statement for Fellowship of the Royal Australian and New Zealand College was approved in 1995.

The 2002 curriculum included attention to attitudes, knowledge and skill objectives expected to be gained during the first three years of training in psychiatry. Trainees are required to demonstrate knowledge of, ‘The principles of legislation which relate to the practice of

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psychiatry, with particular emphasis on mental health legislation, including its local application.\textsuperscript{574}

While knowledge of law can be taught formally, the application to clinical work may have unexpected problems.\textsuperscript{575} As an example, many registrars and consultant psychiatrists have obtained their training overseas, and are of a different cultural background to their patients. In some cultures, the doctor is expected to provide definitive advice to patients, and it would be contrary to common practice to ask the patient for their opinion. In such cases, it is expected that the doctor knows best, a concept recently less acceptable to Western medicine and patients.

While most consultants are well trained in mental health law, particularly those with United Kingdom experience, this is not always the case with Australian consultants. For many older psychiatrists, knowledge of law was obtained almost entirely ‘on the job’ and from reading. It was assumed that one knew the legislation, and the jurisprudential, ethical, or social issues involved were infrequently mentioned. There were no mandatory requirements for training in mental health legislation in WA until 2015, in stark contrast to the position in the UK.\textsuperscript{576} Apart from matters of knowledge of law, the philosophy and ethics of treatment and detention warrant more attention.

\textbf{5.16 Training in mental health law in England}

What was earlier termed Section 12 approval in the UK, now Approved Clinician, is a requirement under the \textit{Mental Health Act 1983} (UK). Approval can only be granted on presenting evidence of having attended accredited training courses. Training, must meet the competencies set by the National Advisory Group for Approved Clinician Training.

\textsuperscript{574} RANZCP, Curriculum Basic Training Psychiatry, Approved GC (26/10/02) Version 1.

\textsuperscript{575} Personal interview with Associate Prof. Helen Slattery, Coordinator of Postgraduate Training, RANZCP WA, 22 August 2012.

\textsuperscript{576} The Chief Psychiatrist has mandated training for clinicians in the Mental Health Act 2014 (WA).
Guidance. Approved training courses occupy two full days for the initial course, covering the relevant mental health law and recent changes, at a cost of £375 (A$540). Approved Clinician recognition is required for appointment to a consultant position, and must be renewed by a one-day refresher course every 5 years for consultants under 65, and every twelve months for those over 65.

Training and approval is taken very seriously in the UK and has been the subject of judicial appeal findings. In the case of SC v BS Court of Protection (2011) it was held that a professor of psychiatry with experience of autism disorders and criminal law proceedings, was not an acceptable expert witness in a case concerning mental capacity, because he had not been trained in the Mental Capacity Act 2005 (UK). Although he had examined the patient over a two hours long interview, it was felt by Baker J that his finding that the patient did have mental capacity could be challenged.

The decision concerning capacity is crucial and complex and the court needs the best evidence it can get on the matter. Professor T is widely respected as an expert in autism but has not satisfied me that he has sufficient experience in applying the capacity test in proceedings under the Mental Capacity Act. I expect in due course he will apply that expertise but not in time for this case, which is one in which the issue of capacity is unusually complex and of fundamental importance.\textsuperscript{577}

The RANZCP Faculty of Psychiatry of Old Age training curriculum includes the following knowledge requirement:

\textbf{K 3.6} The principles of medico-legal aspects to the practice of psychiatry in old age, with particular emphasis on mental health and guardianship legislation, including its local application, testamentary capacity, enduring power of attorney and informed consent.\textsuperscript{578}

\textsuperscript{577} SC v BS Court of Protection, claim 11987961, 2011.
\textsuperscript{578} RANZCP Faculty of Old Age Psychiatry Curriculum, Fellowships Board 1995.
5.17 Level of legal knowledge of psychiatrists and health practitioners

Concerns have been expressed at the level of knowledge of mental health law, by clinicians whose role includes assessment of a person’s capacity to consent to treatment or procedures. Research by Herrmann in 1994 looked at the knowledge amongst trainee psychiatrists in a Canadian geriatric psychiatry educational program.579 The table of results indicated a significant lack of adequate knowledge/skills in the areas of medico-legal issues and ethics.

A 2002 survey by Jackson and Warner in England comprised a cross-sectional analysis of knowledge of consent and capacity, conducted with psychiatrists, geriatricians, general practitioners and medical students in final year of training.580 Incorrect answers were given by 42 per cent of psychiatrists, 66 per cent of geriatricians, 80 per cent of general practitioners and 85 per cent of students. They concluded that more attention to this subject was required at both undergraduate and postgraduate stages of training.

Since the Bournewood case in 1995 there has been much greater awareness of the issues and additional training has been made available in Britain, not only to psychiatrists, but including all medical practitioners, health care professionals, care home operators and social services staff. A 2011 report indicated that trainees in psychiatry in the UK still lacked adequate knowledge of mental health legislation.581

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A South Australian report examined recording of grounds for detention written down by medical practitioners. Research of 2,491 consecutive forms demonstrated that in 2008-2009, only 40% of these met the legal criteria for involuntary detention.\textsuperscript{582} Brayley, (Psychiatrist and Public Advocate for South Australia) stated that:

The task of succinctly documenting the legal grounds for involuntary admission should protect the rights of patients when these grounds are not met. The legal requirement to document the grounds for detention reflects the gravity of the loss of liberty for the patient.\textsuperscript{583}

No similar studies have been undertaken in WA at this time. The British Medical Association and the Law Society have published a 270-page book as a guide to assessment of capacity, for legal and medical practitioners.\textsuperscript{584}

\textbf{5.18 Capacity and personal autonomy}

Autonomy refers to the ability to manage one’s own social, lifestyle, financial and health matters independently, making decisions for oneself as they choose. It has become generally accepted in modern legislation that individuals must be presumed to have legal capacity, unless otherwise established.

The \textit{Guardianship and Administration Act 1990 (WA)} states:

\begin{itemize}
\item (2) (b) Every person shall be presumed to be capable of –
\begin{itemize}
\item Looking after his own health and safety;
\item Making reasonable judgements in respect of matters relating to his person;
\item Managing his own affairs; and
\item Making reasonable judgements in respect of matters relating to his estate.\textsuperscript{585}
\end{itemize}
\end{itemize}

\begin{itemize}
\item \textsuperscript{582} Brayley J, Alston M, Rogers K, Legal criteria for involuntary mental health admission: clinician performance in recording grounds for decision, MJA 203 (8) 19 2015, 334.
\item \textsuperscript{583} Ibid 334.
\item \textsuperscript{584} Letts P, (Ed) \textit{Assessment of Mental Capacity}, The British Medical Association and the Law Society, Third Edition 2010.
\item \textsuperscript{585} \textit{Guardianship and Administration Act 1990 (WA)} Part 2, s.4, (2) (b).
\end{itemize}
Claiming a person does not have capacity is a rebuttable position. It places the onus on a person disputing the person’s capacity, to establish the case rather than on the patient. Desirable as this may be as a statement of policy, it may lend itself to an assumption that support with decision-making is not required. This could reduce the apparent necessity for involvement by safeguarding bodies, and lead to neglect of due responsibility to ensure protection where needed. The House of Lords reported that misuse of presumption of capacity may result in no support, rather than graded support matching the person’s needs.\textsuperscript{586}

The opportunity for a person to exercise their own wishes, may be compromised through social and attitudinal perspectives, held by persons who irresponsibly assume control of an individual. A stereotypical focus on the possibility that a person may lack capacity, excluding positive aspects of mental capacity, is a risk. Because a person has been diagnosed professionally as having dementia, it does not imply that decision-making capacity has been entirely lost. On the other hand, it may be assumed that a person has full capacity, whereas the ability to follow a complex financial or lifestyle decision may have been lost, which could lead to financial abuse in certain circumstances. An example is where family members take over an apparently consenting person’s accommodation, without the person retaining full appreciation of consequences such as payments for upkeep, legal ownership etc.\textsuperscript{587}

The risk of stereotyping can apply to medical professionals, especially psychiatrists who may be only consulted in the matter when support for a finding of incapacity is suspected. Their experience may be coloured by frequent association with persons clearly lacking capacity. On the other hand, it may occur that a doctor, who has known a patient for many years, fails to detect gradual and subtle alterations in mental function.

\textsuperscript{586} House of Lords, \textit{Mental Capacity Act 2005}: Post legislative scrutiny, Select Committee Conclusions and Recommendations, 3.

\textsuperscript{587} Detinue; Wrongful (tortious) detention of goods after a person with a right to immediate possession has lawfully requested their return. Australian Law Dictionary (Oxford 2010) 183.
Recognising mental capacity and autonomy as a positive attribute in the doctor-patient relationship, has emerged in recent decades following a long tradition of medical paternalism. An editorial by Drake and Keegan in an American Psychiatric Association Journal states:

‘Like fish unable to discover water, many psychiatrists struggle to recognise their own paternalism’.  

[The editorial continued:]

…it is time to take the high road and heed the ethical imperative upon which the practice of shared decision making rests: Autonomous adults have the right to determine what happens to their bodies and minds, “My body, my mind, my choice”, as the consumer-survivor calls it”.

Autonomy has assumed increased importance with heightened consumer awareness and interest in patient-centred decision-making. The growth of attention to advance directives in respect to treatment generally, and increasing sophistication in expression of consumer views are clearly important considerations.

While autonomy has been a topic in international journals of law and medicine for many years, issues of philosophy, history and ethics in psychiatry under which autonomy can be included, have become better recognised within the Royal Australian and New Zealand College of Psychiatrists (RANZCP). A communication from the History and Philosophy Special Interest Group stated:

Dr White informed the attendees that the Special Interest Group [SIG] in History and Philosophy of Psychiatry is a small group that aims to increase the knowledge and expertise of the College in areas such as ethics, the philosophy of mind, the philosophy of science and the historical roots of psychiatry in Australia and in New Zealand. For more than a decade the Group has held (local) meetings in Sydney. However, attendances at local meetings has been problematic and, in recent years, decidedly poor. In sharp contrast to the failure of local meetings, our initiatives at Congress during the last four years have met with considerable success.

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589 Above.
590 Email to members of RANZCP Special Interest Group, 13 July 2012.
Issues such as autonomy, ethics and philosophy have only occasionally been raised in educational programs within psychiatric services in Western Australia. The Medical Defence Association has raised the topic in general terms, and provided educational seminars, mostly relating to surgical and medically intrusive procedures.

Medico-legal concerns in Australia have increased since the case of Rogers v Whittaker.\textsuperscript{591} Fear of the tort of negligence has generated greater awareness and improvements in form completion and check-list procedures. More demanding areas such as ensuring patients are fully informed, and assessed for capacity to consent, may be less thoroughly addressed. The HDWA consent to treatment form has no provision for assessing the patient’s capacity to consent, concentrating on noting they have been informed of proposed interventions.\textsuperscript{592}

The Chief Justice of WA selected the following excerpt from Hansard to underline the importance of autonomy, in his summary of the Brightwater case.

> In the Second Reading Speech given in support of the Bill, the Hon Mr Jim McGinty MLA said:
> The principle of personal autonomy is central to the bill. The bill establishes a simple, flexible scheme whereby persons can ensure that, in the event that they become mentally incompetent and require medical treatment for any condition, including a terminal illness, their consent, or otherwise, to specified treatment can be made clear in an advance health directive and or alternatively treatment decisions can be made by an enduring guardian chosen by them. ...

Autonomy is described in the VLRC report quoting from Mackenzie as; ‘… the authority to make decisions of practical importance to one’s life, for one’s own reasons, whatever those reasons might be.’\textsuperscript{594}

\textsuperscript{591} Rogers v Whittaker, (1992) 175 CLR 218.
\textsuperscript{592} HDWA Consent Form A. Patient Consent to Treatment or Investigation.
\textsuperscript{593} Brightwater (2009) WASC 229, at 47.
Autonomy in decision-making embraces many issues besides medical treatment. How one spends money, agrees to marry, or accept a residential care placement, are all occasions when personal autonomy may be challenged. Of special relevance is decision-making in respect to psychiatric treatment, and aged care facility placement.

5.19 Tests of mental capacity

There have been many tests of mental capacity developed; the most widely known would be the MacArthur Competence Assessment Tool-Treatment (MacCAT-T). A study of published papers by Okai identified 29 different capacity assessment tools. Screening tests for dementia such as the MMSE (Folstein) are insufficient as measures of capacity. Assessment must address several dimensions according to the nature of the decisions to be made, their complexity and seriousness. The emotional state of the person, their knowledge and comprehension of the issues, and ability to weigh up choices available all should be considered. Comprehensive assessment is no small task for the clinician as well as the subject.

Concerns have been expressed that the tests do not compensate for various circumstances applying to an individual such as ethnic and cultural background, education, communication difficulties etc. Some tests are time-consuming and others give a tick-box approach, which may bypass real understanding of the process. Demand for authoritative reports has driven commercial and academic endeavours in this field.

595 MacArthur Competence Assessment Tool for Treatment (MacCAT-T).
5.19.1 Tests under Mental Capacity Act 2005 (UK)

The Act requires a two-stage assessment; first that there is evidence of an impairment or disturbance of mind or brain function, and second that because of the impairment the person is unable to make a particular decision at the relevant time.\textsuperscript{598}

5.20 Indigenous persons and capacity

A recent journal article has drawn attention to concerns regarding indigenous persons lacking mental capacity in Australia.\textsuperscript{599} The authors draw attention to the place of Guardianship and substitute decision-making in Australia, suggesting that this Western European concept may overlook important cross-cultural factors. This can occur through difficulties with assessment as well as procedures that may not be culturally correct. The use of a common screening tool, the Mini-Mental State Examination (MMSE, Folstein), is inappropriate for several reasons, but particularly its reliance on education and understanding of the test. The MMSE was intended to be a simple and brief screening test for dementia. However, it has been used and misused in many environments where it is not appropriate. Clements refers to the development of more culturally acceptable tests, including in WA the Kimberley Indigenous Cognitive Assessment (KICA).\textsuperscript{600}

In addition, reference is made to the requirements only applying in WA and Queensland, to have consideration of cultural values when determining best interests, in proceedings of the Guardianship and Administration Tribunal.\textsuperscript{601}

\textsuperscript{598} Letts above n580, 16.2, 161.
\textsuperscript{601} Guardianship and Administration Act 1990 (WA), Part 5, Division 2, s 51, (h).
5.20.1 WA

Without limiting the generality of subsection (1), a guardian acts in the best interests of a represented person if he acts as far as possible –

(a) As an advocate for the represented person;

(h) In such a way as to maintain the represented person’s familiar cultural, linguistic and religious environment.

5.20.2 Queensland

Maintenance of environment and values

(1) The importance of maintaining an adult’s cultural and linguistic environment, and set of values (including any religious beliefs), must be taken into account. (2) For an adult who is a member of an Aboriginal community or a Torres Strait Islander, this means the importance of maintaining the adult’s Aboriginal or Torres Strait Islander cultural and linguistic environment, and set of values (including Aboriginal tradition or Island custom), must be taken into account.

The matter of cultural factors was also taken up in a WA Law Commission Report, which drew attention to several problems with access by indigenous persons to Guardianship and Administration. These included the well-recognised fact that aboriginal persons may be reluctant to interact with government authorities, in view of past experience and cultural factors in communication etc.

Health and social welfare staff may be unaware of who they should consult in the family or kinship structure. Recommendation 73 was included in the final report as follows:

That, as part of its assessment of its procedures and protocols for dealing with hearings involving Aboriginal people, the State Administrative Tribunal take steps to ensure that members are aware of Aboriginal perspectives in the process of assessing the decision-making capacity of an Aboriginal person who may be the subject of an order for guardianship or administration.

Western Australia has a very large indigenous population compared to the other States, except for the Northern Territory. Statistics show that in 2006 WA had an estimated

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602 Guardianship and Administration Act 2000 (Qld) Schedule 1, 9.
77,900 indigenous persons, representing 3.8% of the State population. However, 15% were in remote and 26% in very remote areas, thereby greatly aggravating difficulties in ensuring autonomy in decision-making in these communities.

Concern has also been expressed regarding other citizens who are culturally and linguistically diverse, as assessment tools and procedures may be biased towards a Western European model with attendant communication problems.606

5.21 Incorrect use of assessment tools – the MMSE (Folstein)607

Screening systems form a major component of medical practices. However, the validity and reliability of the instruments used is critical to their safe and effective use. An appreciation of the real value and limitations of screening tools is essential. The MMSE was designed in 1975 as a screening tool for general use by a range of clinical staff. Since then it has gained widespread use internationally and has been translated into many languages. However, it is instructive to consider the observations Folstein made in 1989. He described how the test was carried out on patients in three wards of a long-stay geriatric hospital in New York. At the time, neurologists tended to conduct bedside assessment of sensory and motor function, but formal psychological testing was required for what Folstein termed, ‘quantification of the cognitive state’. He indicated the tests were developed overnight by himself and his wife, based on items he felt were clinically useful, and could be scored easily with little interpretation.

We had no grant, no training in psychometrics or statistics, no power analysis, and no factor analysis – just the confidence of youth. On many occasions I have been reminded that the MMS is uninterpretable because it has heterogeneous factors, has ceiling and floor effects, and is too insensitive. All of these criticisms are correct, but the test works.608

607 Mini-mental-state-examination.
The popularity and widespread use establishes the place of the MMSE as a useful screening tool. However, there is a danger in its potential for misuse, as with any screening instrument. The application of the test in the UK for decisions on which patients should, or should not, have dementia treatment medication, is a case in point. There are many additional factors to be considered in a clinical examination for assessment of capacity, and a simple score from the MMSE may overlook these. If the person is depressed, preoccupied and anxious, irritable, and hostile or temporarily confused due to illness, these issues may not be detected. The use of the test by untrained persons may have a value in certain situations, but should only be regarded as a screen, not a diagnostic instrument. According to Monroe and Carter, the test has a number of significant limitations which must be taken into account:

The MMSE was designed for use as a screening device for cognitive impairment (Folstein et al. 1975; Tombaugh and McIntyre 1992). Positive screening means that cognitive impairment likely exists. The MMSE was not developed to diagnose dementia and should not be reported as doing such. The MMSE does not differentiate among the various causes of dementia such as Alzheimer’s disease or vascular dementia (Foreman et al. 1996). Accurate differential diagnosis of dementia requires additional neuropsychiatric testing (Reisberg 2007).

It is important to note that capacity is a complex matter, open to impairment temporarily, and not only by dementia. Charland notes the matter of decision-making arises in a variety of contexts including, heroin prescription for addicts, treatment refusals in anorexia, and research participation in depression. He states:

Decision-making capacity is one of the pillars of the doctrine of informed consent. I have argued that contemporary theoretical models and psychometric instruments used to assess decision-making capacity suffer from a pernicious cognitive bias that renders the underlying construct of capacity theoretically invalid.

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5.22 Limits to autonomy

A right to individual autonomy is not the only consideration in decision-making. Critical as personal autonomy is to freedom of choice and liberty; it is not without its limits. Living in a society creates obligations to others, and results in a degree of restriction of freedom to do as we may please. Such restrictions are social in nature and hence will be influenced by a range of religious, cultural, and political factors. Consequently, medical interventions are bound to consider more than the individual’s wishes, but also the wishes and directions of others.

5.23 Suicide

While one could hold that it is an absolute right for the individual to decide whether to continue living, this decision impacts upon family, friends, and the wider community. The complexity of this subject has been exemplified in the case of Kerry Woolerton.\textsuperscript{611} Ms Woolerton took a lethal overdose of anti-freeze, and presented herself to the emergency department at the Norfolk and Norwich hospital emergency department. She showed the medical staff a document, which was held on urgent legal advice, to be a valid advance directive refusing any treatment other than that necessary to avoid suffering while she died. Her wishes were followed and she died without treatment. She had a substantial prior psychiatric history and had attempted suicide many times. Although the County Coroner upheld the decision of the medical staff, her family were reported to be considering legal proceedings against the hospital and staff. The NHS Health secretary has been reported as saying the legislation needs to be revisited.

The Mental Capacity Act 2005 (UK) which made a provision for ‘living wills’, was not intended by parliament to be a means of facilitating suicide.\textsuperscript{612} Guardianship legislation in WA ensures an event such as the Woolterton suicide should not occur. In the event of urgent treatment for suicide, the Guardianship and Administration Act 1990 (WA) states:

(2) The health professional may provide the treatment to the patient despite —

(a) the patient having made an advance health directive containing a treatment decision that is inconsistent with providing the treatment; or

(b) the patient’s guardian or enduring guardian or the person responsible for the patient under section 110ZD having made such a treatment decision in relation to the patient.\textsuperscript{613}

5.24 Beyond autonomy

An alternative view of the primacy of autonomy has emerged addressing the issue of a too limited view of medical law and consent.\textsuperscript{614} McCall Smith, a professor of medical law at Edinburgh University challenged the single perception of autonomy as necessarily positive for the individual and for society.\textsuperscript{615} He argued that autonomy has a pre-eminent position in medical law that is at times leading to unwarranted restriction and rigidity which ‘places physicians in a straitjacket’. He suggested this particularly applies in psychiatry where the use of non-consensual treatments may be necessary at times, but where it is increasingly difficult for some treatments to be used, such as electro-convulsive therapy. McCall does not minimise the importance of protection for persons lacking capacity, but that there must be some balance in the arguments:


\textsuperscript{613} Guardianship and Administration Act 1990 (WA) Section 110ZIA inserted by No. 25 of 2008 s. 11.


Concern over the rights of the mentally ill is rarely misplaced, but to focus on their autonomy rather than their plight may simply have the effect of depriving them of justifiable paternalistic intervention.\textsuperscript{616}

This is an echo of American legislation regarding homeless and alcoholic patients, which led to the observation by the psychiatrist Treffert that, following a number of deaths in the community, they had, ‘Died with their rights on’.\textsuperscript{617}

\textbf{5.25 Mental capacity and legal safeguards for elderly persons}

There are many reasons why accurate assessment of mental capacity is pertinent to protection of elderly persons. The differing activities and circumstances, in which decisions are made, can have a range of effects for the individual. Some of these are very serious such as consenting to surgery, decisions on end of life care, or agreeing to admission to a nursing home. The Victorian Law Reform Report lists the following activities for which differing standards of capacity may apply:

- Entering into a valid contract
- Making a will
- Voting in elections
- Consenting to sexual relations
- Getting married
- Responsibility for criminal conduct \textsuperscript{618}

Entering an aged care facility entails signing a contract with the care provider. Legal aspects of entering formal contracts of this nature and complexity deserve close attention. An ALRC Report refers to a case notified to them where an 83-year-old woman of European origin had difficulties in achieving protection of her rights in a nursing home.

\textsuperscript{616} Ibid, 26.
\textsuperscript{617} Treffert D, \emph{The Wisconsin Psychiatrist}, Summer Fall 2006, Vol 4 No 1, 15.
The woman did not have dementia, but this was assumed by the nursing home, and, due to further misunderstandings and lack of cultural awareness, the Adult guardian and Public Trustee were mistakenly appointed.\textsuperscript{619}

The focus of the Aged Care Act 1997 (Cth) appears to be concerned mainly with the care provider’s situation, ensuring compliance and subsidies from the Commonwealth. Persons lacking capacity to consent to admission are mentioned only briefly.

96-5 Care recipients etc. lacking capacity to enter agreements

If:

(a) this Act provides for an approved provider and a care recipient, or a person proposing to enter an *aged care service, to enter into an agreement; and

(b) the care recipient or person is, because of any physical incapacity or mental impairment, unable to enter into the agreement;

another person (other than an approved provider) representing the care recipient or person may enter into the agreement on behalf of the care recipient or person.

Note: The agreements provided for in this Act are *accommodation bond agreements, *accommodation charge agreements, home care agreements, *extra service agreements and *resident agreements.

96-6 Applications etc. on behalf of care recipients

If this Act provides for a care recipient to make an application or give information, the application may be made or the information given by a person authorised to act on the care recipient’s behalf.\textsuperscript{620}

5.26 Protections available in law

The ability to make informed decisions about one’s property, health and lifestyle is protected in common law.

\textsuperscript{620} Aged Care Act 1997 (Cth), 2013 Compilation, 390.
As early as 1767, a case was brought in England against three practitioners: a physician, a surgeon and an apothecary. They had operated on a patient using an experimental technique, in an attempt to rectify a broken leg with a metal device, which failed. The patient was not informed this was an experimental procedure and it was performed without his knowledge and consent to the experiment.\textsuperscript{621}

What is important in this case is that the issue was not alleged lack of skill or negligence, but absence of fully informed consent.

The Court stated:

This was the first experiment with this new instrument; and although the defendants in general may be as skilful in their respective professions as any two gentlemen in England, yet the Court cannot help saying that in this particular case they have acted ignorantly and un-skilfully, contrary to the known rule and usage of surgeons.\textsuperscript{622}

Writing on the doctrine of informed consent, Young has explained the difference between litigation over matters of consent and cases arising from negligence.\textsuperscript{623} The legal term ‘trespass’ refers to a wrongful act which causes harm to another. Young states that ‘until the case of \textit{Sidaway v Bethlehem Royal Hospital} (1985), cases were considered to be ‘trespass for assault’, when informed consent was lacking’.\textsuperscript{624} The Sidaway case affirmed that more was required of a medical practitioner than merely the Bolam position. The Bolam decision provided only that the medical practitioner had provided a level of skill, equivalent to the standards which should be expected of a correspondingly well informed and competent colleague.\textsuperscript{625} Sidaway required that the practitioner obtain fully informed consent in addition. Scarman, the judge in this House of Lords case re Sidaway, commented:

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{621} \textit{Slater v Baker}, (1767) 95 E.R. 860.
\item \textsuperscript{623} Young PW, \textit{The Law of Consent}, (Law Book Company 1986), 101.
\item \textsuperscript{624} \textit{Sidaway v Bethlehem Royal Hospital} (1985) A.C. 871 480.
\item \textsuperscript{625} \textit{Anderson v North West Strategic Health Authority} [2015] EWHC 3563 (QB) (08 December 2015), 45: There is no dispute in this case that, in order to succeed in establishing a breach of duty, the claimant must prove on a balance of probabilities that the clinicians did some act or failed to act in a way in which no reasonably competent clinician would have acted or failed to act, \textit{Bolam v Friern Hospital Management Committee} [1957] 1 WLR 582.
\end{itemize}
\end{footnotesize}
In my view the question whether or not the omission to warn constitutes a breach of the doctor’s duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court’s view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.626

A significant recent Western Australian case is that of Brightwater Care Group v Rossiter.627 The cases cited in this decision include a number decided in England. In the case of Airedale NHS Trust v Bland, the House of Lords stated:

The first point to make is that it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent.628

The Brightwater decision confirmed the right of an individual to direct his own medical treatment providing he was competent to do so. The fact that refusing medical treatment would result in death did not invalidate his decision. The case arose, because the treating hospital and medical staff were concerned at the prospect of sanctions under the WA Criminal Code, if they complied with the directions of the patient to withhold percutaneous-gastric (PEG) feeding.629

Martin CJ stated at the outset:

The only issue which arises for determination in this case concerns the legal obligations under Western Australian law of a medical service provider which has assumed responsibility for the care of a mentally competent patient when that patient clearly and unequivocally stipulates that he does not wish to continue to receive medical services which, if discontinued, will inevitably lead to his death.630

626 Sidaway v Bethlehem Royal Hospital (1985) par 3.1.
629 Criminal Code Act (1913), (WA), 222,223.
In his conclusion, Martin CJ confirmed the right of Mr Rossiter, who was held to be competent to make his own decisions, to require Brightwater to desist from providing him with nutrition and hydration. Brightwater for their part were declared not criminally responsible for the life or death of Rossiter, in the event that happened. Additionally, the provision of such palliative treatment as Rossiter requested from his treating doctor would not invoke prosecution under the Criminal Code of WA.

A key issue was the capacity of Rossiter to make decisions regarding termination of his treatment. It is important to note that he was assumed to have capacity in the absence of any evidence to the contrary. In addition evidence was given by his doctor that Rossiter did have:

… capacity to comprehend and retain information given to him in relation to his treatment, and has the capacity to weigh up that information and bring other factors and considerations into account in order to arrive at an informed decision.

No person or professional can examine or treat any individual without the consent of that person, with a few exceptions. These exceptions apply only to emergency treatment necessary to save life, and where authorised under specific public health or mental health legislation. To examine or treat without consent or lawful authority is an assault which is unlawful and comes within the relevant Criminal Code for WA. The definition of an “assault” in the Code states,

Any person, who strikes, touches or moves, or otherwise applies force of any kind to the person of another, either directly or indirectly, without his consent … is said to assault that other person, and the act is called an assault.

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632 Ibid.
633 *Criminal Code Act* (1913), (WA),222- 223.
The phrase ‘without his consent’ is central to the argument. The critical point at which an individual’s capacity to consent can be usurped, is at times more difficult to establish than is generally accepted. A recent Supreme Court UK case has reinforced the importance of gaining a patient’s consent including information regarding material risks, and any reasonable alternative. The case concerned a patient whose baby was injured during delivery by an obstetrician. The alternative of a caesarean section had not been offered.

The editor in chief of the BMJ wrote:

Here the Supreme Court has landed a clear and crucial blow to medical paternalism. Instead of a responsible body of medical opinion, the judgement now rests with "a reasonable person in the patient’s position."\textsuperscript{635}

Risks associated with admission into aged care or psychiatric facilities, need to be better recognised by clinicians, patients, and the community. While the great majority of people benefit from judicious aged care recommendations, the reality of risk of harmful outcomes must be weighed against anticipated benefits.\textsuperscript{636}

\subsection*{5.27 Capacity assessment clinics/services}

In view of the complexity and potential impact of mental capacity assessments, it should not be assumed that it is a simple or routine procedure, with limited regard to the education and qualifications of the professionals offering these services.

\textsuperscript{634} Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland), [2015] UKSC 11.
\textsuperscript{636} See Chapter 6.3, Risks of harm.
The degree of capacity necessary should be considered in proportion to the seriousness of the decision being made. This was stated in the *Masterman-Lister v Jewell* case:

> While the mental disorders identified by the various medical reports in the present proceedings are of such a nature that, if present to a sufficiently severe degree, are undoubtedly capable of rendering a sufferer incapable of managing his property and affairs, the conclusion that I have come to on all the evidence before me is that the degree and extent to which Martin suffers from such disabilities falls far short of that standard.  

637

**5.28 Mental Health Act 1996 (WA)**

The ability to consent is a core issue in the detention of involuntary patients under the *Mental Health Act 1996 (WA)*. However, the Act has very little to say about capacity, other than a reference to capacity to give informed consent:

26. Persons who should be involuntary patients

(1) (c) the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment; and… 639

Under Division 2 of the WA Mental Health Act 1996 the subject of informed consent is covered in only two pages. A presumption of capacity is not stated. While there is mention of ‘Capacity to give informed consent’, this briefly refers to three requirements for lack of capacity to be established:

96. Capacity to give informed consent

A patient is incapable of giving informed consent unless he or she is capable of understanding --

(a) the things that are required by this Division to be communicated to him or her;

(b) the matters involved in the decision; and

(c) the effect of giving consent. 640

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638 Mental Health Act 1996 Part 3, Sec. 26. (1) (c).
639 Mental Health Act 1996, (WA) Part 3, Division 1, p 17.
640 Mental Health Act 1996 (WA), Part 5, Division 2, s. 96.
Allowing sufficient time for the patient to attain capacity, and to seek advice is mentioned briefly.\textsuperscript{641}

5.28.1 Medical reports

While the legal finding of incapacity is established by judicial or quasi-judicial proceedings, this relies significantly, but not exclusively, on the provision of medical evidence. At times the medical evidence can be set aside. A comment by Bennett and Hallen states:

\begin{quote}
\textit{…while health professionals will provide their opinions regarding the decision-making capacity of the person to the tribunals, the tribunal will make the ultimate decision based on the whole of the evidence.}\textsuperscript{642}
\end{quote}

Reasons for setting aside an opinion may include that the doctor reporting was not the patient’s usual medical practitioner, did not hold qualifications supporting specialised experience in assessment of capacity, or that the report failed to address important details.

Guidance is provided in the UK for both lawyers and medical practitioners regarding the issues to be addressed in preparing reports about capacity.\textsuperscript{643} The BMJ & Law Society publication covers issues the lawyer should note when requesting a medical opinion, as well as the requirements for a comprehensive and accurate medical assessment. UK mental capacity legislation

The \textit{Mental Capacity Act 2005} (MCA UK) includes a set of six principles to be followed, the clinical circumstances and conditions under which a lack of capacity may be established, definition of criteria when a person may be unable to make a decision and a requirement to

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\textsuperscript{641} Ibid, Division 3, s 98. \\
\textsuperscript{642} Hallen H, Bennett P, Guardianship and financial management legislation: what doctors in aged care need to know, \textit{Internal Medicine Journal} 2005, 35, 486. \\
\textsuperscript{643} Letts above, n584.
\end{flushright}
act in a person’s ‘best interest’.\textsuperscript{644} The MCA UK sets out provisions under which deprivation of liberty can be authorised, and contains a detailed Code of Practice.

While a Code of Practice does not have the full authority of statutory law, if a clinician departs from the Code there must be very good grounds for doing so.\textsuperscript{645} Departure from the Code would only be permitted if it was ‘Wednesbury unreasonable’.\textsuperscript{646}

The non-adherence to a Code may be subjected to a judicial review. This is explained in the Introduction to the Code of Practice for the Mental Health Act 1983 (UK) which sets out the purpose and legal status of the Code:

While the Act does not impose a legal duty to comply with the Code, the people listed above to whom the Code is addressed must have regard to the Code. The reasons for any departure should be recorded. Departures from the Code could give rise to legal challenge, and a court, in reviewing any departure from the Code, will scrutinise the reasons for the departure to ensure that there is sufficiently convincing justification in the circumstances.\textsuperscript{647}

The \textit{Mental Health Act 1996} (WA) does not set out guidance to ensure presumption of capacity. Steps recommended to improve a patient’s informed consent are mentioned briefly. Improving capacity to consent receives little attention other than time to consider and provision of forms of communication of information.\textsuperscript{648} These steps could include delaying to allow for an improvement in mental function, and ceasing unnecessary medications.

\textsuperscript{644} \textit{Mental Capacity Act 2005}, ss. 1-6 (as amended by Mental Health Act 2007) 186.
\textsuperscript{646} \textit{Associated Provisional Picture Houses Ltd. V Wednesbury corp.} [1948] 1 KB 223. A degree of unreasonableness such that no fair person would agree.
\textsuperscript{648} \textit{Mental Health Act 1996} (WA) s98.
5.29 Rights to appeal decisions in WA psychiatric hospitals

Voluntary patients, including those without mental capacity have no statutory right of appeal. It is believed that if they are not resisting treatment or care in a locked ward, it is not necessary to engage the Mental Health Act 1996 (WA). This is precisely the situation which prevailed in England resulting in the Bournewood case.\textsuperscript{649} Voluntary patients have no access to the services of the CoOV. It is 17 years since concerns were first raised by the CoOV, and has been repeatedly mentioned in annual reports.\textsuperscript{650} The matter was raised by them with the Ombudsman in 2001, who recommended seeking advice from the Crown Solicitor’s Office. According to the CoOV, a report from the Deputy Crown Solicitor indicated his opinion that;

> The existing assessment and management regime did not breach civil law.

> The “position under the criminal code is one of some difficulty’ for which there is no easy solution, and

> The matter of extending the Council’s jurisdiction ought to be seriously considered.

> The Council’s position has always been that the detaining of voluntary patients in an authorised hospital, other than as authorised by the Mental Health Act 1996, (the Act) is in breach of the Criminal Code. This effectively places the staff and their employer, the WA Government, at risk.

> The opinion failed to address this matter.\textsuperscript{651}

The former CP advised verbally in response to an email from staff in 2007 that:

> …any agreement from the relatives and even consent from a guardian appointed by the Guardianship and Administration Board would be insufficient legal protection or best practice care for the patient and stff. He would strongly advise that the powers and protections of the Mental Health Act 1996 (MHA) would be the most appropriate legal and clinical approach to the management of this patient.\textsuperscript{652}

\textsuperscript{651} Annual Report CoOV, 200102002, 12.
\textsuperscript{652} Email from OCP, 31 October 2007.
The *Mental Health Act 2014* (WA) has not addressed the issue, nor has it been considered in parliamentary debates.

Appeals against decisions to detain a patient can be made to the MHRB in the case of detained patients. Patients who are dissatisfied with the result of an MHRB hearing may request a further review by SAT (WA), which is a new hearing on the merits of the case and not an appeal against the first tribunal result.

Appeals may also be made to the Western Australian Supreme Court on a matter of law, if leave is granted, but this occurs infrequently. No appeals on mental health cases proceed further than the WA Supreme Court. There is no legal avenue of appeal beyond the High Court of Australia since abolition of appeals to the Privy Council, and no equivalent to the ECtHR.

Appeals to the Privy Council from decisions of the High Court were effectively ended by the combined effects of the Privy Council (Limitation of Appeals) Act 1968 and the Privy Council (Appeals from the High Court) Act 1975. However, a right of appeal to the Privy Council remained from State courts, in matters governed by State law, until the passage of the Australia Acts, both State and Federal, in the 1980s.653

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5.30 Conclusion

There were 16,350 aged care residential places in WA in 2015.\textsuperscript{654} No records are kept as to how many or which of these are locked at all times, but accreditation standards require attention to safety of residents.\textsuperscript{655} Over 50\% of these residents have dementia or a related condition potentially affecting their decision-making capacity.\textsuperscript{656} The Public Guardian has sole decision-making responsibility for the care of 1383 individuals, suggesting the majority in aged care are placed under informal arrangements. These informal admissions are not monitored by any form of legal oversight before or afterwards.

ACAT assessments provide approval for the aged care provider to accept the person, and receive subsidies from the Commonwealth.\textsuperscript{657}

Mental capacity to decide for oneself or on behalf of another person, requires care to ensure ethical practices and prevent abuses. In this chapter capacity has been examined, and instances where impaired or absent capacity has potential for serious adverse effects on an individual’s autonomy, health and lifestyle discussed. The emergence of a growing elderly population has had an impact on the development of services for the care of persons with dementia in WA. Admission to these services in psychiatric hospitals and aged care facilities requires different procedural methods of legal oversight, to ensure minimisation of harm as a consequence. How accurately capacity to consent is assessed in practice, and the effectiveness of legal procedures involved in detention and admission into aged care facilities are critical points for further research.

\textsuperscript{654} AIHW Canberra, \textit{Dementia in Australia}, 2013, 113.
\textsuperscript{655} Personal correspondence, Australian Aged Care Quality Agency WA, December 11, 2015.
\textsuperscript{656} Above, n648, 60.
\textsuperscript{657} \textit{Aged Care Act 1997} (Cth), As amended, Compilation 2013.
6 Procedural and substantive justice: human rights

This chapter examines the source of obligations of governments, departments, and professional staff, to respect the liberty and informed wishes of elderly persons. It considers the legal and legislative provisions which require those involved in patient care, to pay due attention to human rights and liberty.

6.1 Obligations under International Law

The Australian Government has signed and ratified seven major human rights treaties, and a number of optional protocols. Of these the most relevant to this thesis is the UNCRPD.\(^{658}\) Performance under the Human Rights Convention is monitored under a Universal Periodic Review (UPR) under which the Australian Government and other non-government agencies report to the UN.\(^{659}\)

A treaty is an agreement with other nations, many of which relate to external matters, trade etc. A treaty is not binding on the Commonwealth or State laws unless expressly incorporated into domestic law. Courts may pay attention to treaties and conventions, particularly where parliament has indicated an expectation and willingness to comply.

The overall purpose of the Bill is to bring mental health legislation into line with community expectations, to codify good practice from an Australian and international perspective; and to further emphasise the importance of human rights, particularly given that Australia is a signatory to the United Nations Convention on the Rights of Persons with Disability of 2006.\(^{660}\)

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\(^{659}\) Ibid. Universal Periodic Review of Australia in 2011.

\(^{660}\) Hames R, Minister for Health WA, Hansard: First reading speech, Mental Health Bill 2013, 23 October 2013.
Cranwell has elaborated the Australian scene:

It has been generally accepted that treaties are not directly incorporated into Australian law by the act of ratification or accession. A treaty per se does not form part of domestic law unless implemented by legislation and, in the absence of such legislation, it cannot create rights in or impose obligations on Australian citizens and residents. However, this does not mean that treaties have no influence at all on Australian law prior to incorporation.\textsuperscript{661}

According to Zuckerberg the position in Canada is similar:

In assessing compliance, it is worth mentioning that ratified international conventions, such as the ICCPR, are of no force or effect within the Canadian legal system until incorporated into domestic law. The effect of a treaty that is not expressly implemented through domestic legislation is unclear. International law appears merely to constitute one of many sources of guidance to Canadian courts in interpreting statutes. International conventions can be taken into consideration in interpreting legislation whose meaning is not settled and clear.\textsuperscript{662}

Despite strong criticism in the WA Parliament during debates on the Mental Health Bill 2013, the government made provision in Regulations for observance of the ICD and DSM diagnostic codes.\textsuperscript{663} Zuckerberg again:

International standards refer not only to the qualifications of persons who make a determination of mental illness but to the diagnosis as well. A mental health institution may involuntarily admit a person only if she has a mental illness diagnosed under internationally accepted medical standards. Thus, domestic legislation will also need to incorporate standardized diagnostic systems.\textsuperscript{664}

Thus, if WA mental health law is to claim parity with international standards and expectations, there must be greater informed discussion and education in the community, including explanations for adopting policies in this new and enlarging field of law.


\textsuperscript{663} Government Gazette, (WA) November 13, 2015, \textit{Mental Health Act Regulations}, 4677.

\textsuperscript{664} Zuckerberg above, n656, 515.
6.2 Fiduciary relationships and duties

Definition; ‘A fiduciary duty is a legal duty to act solely in another party’s interests’\textsuperscript{665}. For a fiduciary relationship to arise there must be a relationship such as doctor/patient, or solicitor/client. That relationship may be breached where reasonable care is not taken to avoid harm. A further component is the claimed status of the person creating trust, e.g. consultant, doctor, etc.

In this chapter I have sought the legal and moral basis for the need to recognise the rights of elderly persons to be fully consulted and treated fairly when medical treatment is proposed, or where residential care placement is an outcome.

The word ‘fiduciary’ is not one in common use in medical and psychiatric discussions. However, a connection between fiduciary law and medical practice has emerged with the growth of patient activism, and recognition that medical benevolence is no longer an appropriate or sufficient basis for transactions between patients and doctors. In turn the responsibility of the state or governments is increasingly defined in terms of obligations owed to citizens. In Australian jurisdictions, this is generally subsumed under the expression, ‘duty of care’ or ‘necessity’. However, these are ill-defined terms, and may provide little real protection to the recipient of care.

Beauchamp and Childress state the essential elements in a professional model of due care are:

1. The professional must have a duty to the affected party.
2. The professional must breach that duty.
3. The affected party must experience a harm.
4. The harm must be caused by the breach of duty.\textsuperscript{666}

\textsuperscript{665} Legal Information Institute, online, <www.law.cornell.edu/wex/fiduciaryduty>.
The Canadian Medical Protective Association includes the following in its handbook for medical practitioners:

Fiduciary duty Courts have long recognized that the physician-patient relationship is built on trust; this relationship of trust is recognized in the concept of fiduciary duty. Physicians’ fiduciary duty means they must act with good faith and loyalty toward the patient and never place their own personal interests ahead of the patient’s. Claims of a breach of fiduciary duty are most often brought when it is alleged that the physician has abused the trust within the physician-patient relationship by having an inappropriate sexual relationship or committing sexual misconduct. However, fiduciary duty may be asserted regarding any duty imposed by law (My emphasis) arising from the physician-patient relationship. The hallmarks of a fiduciary duty are: an imbalance of power between the parties (often found by courts to exist between doctors and patients), ability in the stronger party to affect the weaker party’s financial or other interests, and a particular vulnerability on the part of the weaker party.667

Paul Miller stated that:

The law of fiduciaries has been developed in an unprincipled manner. Consequently, the common law lacks a clear idea of the nature of the fiduciary relationship, the justification for fiduciary duties, and the purpose of fiduciary remedies.668

Attention to fiduciary obligations has been commonly focussed upon torts such as medical negligence and clinician – patient abuses, rather than other aspects of the doctor patient relationship.669 Luntz and Hambly stated; The law of torts determines whether a loss that befalls one person should or should not be shifted to another person.670

A reference book on Tort Law and Human Rights by Wright opens with her statement:

My interest in the relationship between tort law and the implementation of international human rights standards, particularly the European Convention on Human Rights, was prompted by a series of cases decided in the last decade that challenged the English Courts to make public authorities accountable for their actions.671

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669 Davies M, Malkin I, Torts (Butterworths 2012) 2. The word ‘tort’is French for ‘wrong’, and torts are wrongs committed by people on other people. They are often described as civil wrongs’, to distinguish them from criminal wrongs.
670 Luntz H, Hambly D, Torts: cases and commentary, (Butterworths 1995) 4th Ed. [1.1.7]
Wright then indicated the cases which triggered her interest were *X v Bedfordshire County Council*\(^\text{672}\) and later *Osman v UK*.\(^\text{673}\) The first case involved five children who were claiming negligence by Bedfordshire County Council through not providing help in the form of removal from abusive and ill-treating parents. This case was important in illustrating the relationships between individuals and a local authority which was expected to protect their interests. The complainants alleged that the responsible body had failed to do so. It is useful in asserting that a duty of care can arise between the State as an authority and the individual.

In the case of *X v Bedfordshire County Council* one of the Lord Judges stated:

(C) The common-law duty of care

In this category, the claim alleges either that a statutory duty gives rise to a common-law duty of care owed to the plaintiff by the defendant to do or refrain from doing a particular act or (more often) that in the course of carrying out a statutory duty the defendant has brought about such a relationship between himself and the plaintiff as to give rise to a duty of care at common law. A further variant is a claim by the plaintiff that, whether or not the authority is itself under a duty of care to the plaintiff, its servant in the course of performing the statutory function was under a common-law duty of care for breach of which the authority is vicariously liable.\(^\text{674}\)

I suggest that where an elderly person;

1) has his or her human rights and access to procedural justice restricted or denied, in the course of hospital and medical or health care and;

2) has their consent to medical treatment or residential care placement unjustly or unreasonably over-ruled, and;

3) as a consequence of inappropriate nursing home or residential care placement suffers mental, physical harm or death, then;

\(^{672}\) *X v Bedfordshire County Council* [1995] 2 AC 633.

\(^{673}\) *Osman v the United Kingdom*, ECtHR, (87/1997/871/1083): Claimants case that Police failed to act to prevent two homicides was supported.

4) professionals and government authorities who contributed to this outcome may be culpable morally and at law.

Appealing to duty of care as justifying or permitting acts to persons unable to consent, and have the potential risk of causing harm, is unsound. It was the invocation of duty of care which precipitated the Bournewood case in the first place. That position was at first upheld by the High Court, rejected by the Court of Appeal, then upheld again by the House of Lords, and later rejected by the ECtHR.\textsuperscript{675}

The practice of informally admitting persons lacking decision-making capacity to authorised hospitals in WA, without the statutory protections of mental health or guardianship legislation, may be unlawful if the common law of necessity does not provide adequate protection. A test case may be required to settle the matter as in Bournewood.

6.3 Fiduciary relationships of the State and Commonwealth

The Federal Government of Australia and the State government of WA, are employers of professionals in various categories in the health professions. As such they may have a non-delegable obligation or vicarious liability for the actions of their employees in certain circumstances.\textsuperscript{676}

\textsuperscript{676} Australian Law Dictionary, (Oxford 2010), 601: An employee who is negligent is primarily liable and the employer is vicariously liable; at common law both are jointly and severally liable.
6.3.1 Liability and duty of care

On the subject of medical liability, Luntz and Hambly state: ‘The relationship between medical practitioner and patient is one of the oldest in which a duty of care was recognised.’

They discuss several Australian cases where medical negligence was a factor, and point out that the Australian Courts do not feel obliged to strictly observe the principles espoused in the Bolam case in England. The Bolam case, for many years a yardstick in determinations of medical negligence is no longer so highly regarded. Previously under the Bolam test a professional accused of negligence could assert that the standard of care necessary, was only that of the average reasonably well informed and skilled person. In Bolitho v City and Hackney Health Authority Lord Browne-Wilkinson stated:

My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant’s treatment or diagnosis accorded with sound medical practice.

The case of Naxakis v Western General Hospital also has important connotations.

The Bolam rule, which allows that the standard of care owed by a doctor to his or her patient is “a matter of medical judgment”[12], was rejected by this Court in Rogers v Whitaker [13]. In that case it was pointed out that, in Australia, the standard of care owed by persons possessing special skills is that of “the ordinary skilled person exercising and professing to have that special skill [in question]”[14]. In that context, it was held that “that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade”[15].

677 Luntz H, Hambly D, Torts: cases and commentary, (Butterworths 1995) 4th Ed. [7.9.1]
678 Bolam v Friern Hospital Management Committee (1957) 1 WLR 583.
681 Naxakis v Western General Hospital (1999) 197 CLR 269. 20.
The argument has moved from the issue of skill and care alone, to one of providing sufficient information for the person to make an informed decision.\footnote{Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland), [2015] UKSC 11.}

The case of Rogers v Whitaker proved a turning point in identification of \textit{duty of care} in Australian litigation.\footnote{Rogers v Whitaker [1992] HCA 58; (1992) 175 CLR 479, F.C. 92/045.} This case was stated in an appeal by special leave to the High Court in Canberra, from a decision of the NSW Court of Appeal, which had dismissed the appeal from Rogers, an ophthalmic surgeon, to the Supreme Court in NSW. The NSW Supreme Court had awarded Whitaker substantial damages arising from failed eye surgery, which had left her totally blind. The High Court dismissed the appeal on the basis that although the operation which resulted in her blindness had been performed ‘with the required skill and care’, the patient had not been properly informed as to the risk of the complication which followed. Although a relatively rare complication the patient’s right to know of relevant risks, created an obligation on the practitioner to allow the patient the right to choose surgery or not, with full knowledge. The position adopted here was not a questioning of the practitioner’s skill or knowledge, but rather the assertion of the patient’s right to be fully informed, and choose to consent or refuse. This was rather different to the previously accepted position following Bolam, in that although the skill employed by the surgeon was that of a competent practitioner, the patient’s level of understanding of the risks or benefits raised a question of a different order, and one that was more correctly the subject of a legal, rather than professional decision.

The judges in the Rogers v Whitaker case considered the issue of ‘informed consent’, but decided it was not relevant in this case, nor were terms such as ‘the patient’s right to self-determination’.\footnote{Rogers v Whitaker [1992] HCA 58; (1992) 175 CLR 479, F.C. 92/045, 15.} Informed consent was held not relevant as this would go to the validity
of the patient’s consent, which was a different issue. What was critical was the duty of care of the surgeon stated in Rogers v Whitaker as:

The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.685

The significance of Rogers v Whitaker in terms of this thesis is that it confirmed a patient’s right to comprehensive knowledge of what is to happen to them, because of medical interventions. Where capacity to consent is impaired, the patient’s rights must still be ensured in some way. The practitioner must not only ensure the patient has been provided with adequate information upon which to base a consent, but they must also ensure the patient is capable of comprehending the information, so that a valid choice can be made. If not, then alternatives must be sought for obtaining consent, and this can be provided in several legally acceptable ways including guardianship.

The common-law duty of care has been the subject of a High Court decision in Hunter and New England v McKenna.686 The Court held that a hospital which discharged a patient who subsequently killed an accompanying friend, did not owe a duty of care to the family of the deceased friend. This hinged on several factors but mainly that the Mental Health Act (NSW) limited the powers to detain where less restrictive care options were available.687

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685 Ibid, 16.
686 Hunter and New England local health district v Merryn Elizabeth McKenna, Hunter and New England local health district v Sheila Mary Simon & Anor [2014] HCA 44.
687 Ibid, 25.
6.4 Risk of mortality, physical or psychological harm

In the context of this thesis, some decisions leading to detention in psychiatric hospitals or aged care facilities, have a potential for serious adverse results.\footnote{Australian Medical Association Position Statement, Restraint in the care of people in residential Aged care Facilities, 2015: The patient’s needs and rights should always be the first consideration when considering the application of restraint. Patients have died or been seriously injured by restraints. On the other hand, patients and staff have been injured by lack of restraint.} Irreversible interventions with a potential for harm require close attention to legal concerns. When the decision to intervene is not made by an autonomous individual, but by another person with, or at times without, legal authority this should be of special concern.\footnote{Inghelbrecht E, Bilsen J, Mortir F, Deliens L, The Role of Nurses in physician-assisted deaths in Belgium, \textit{CMAJ}, June 15, 2010, Vol 182, No9 (abstract): ‘Interpretation: By administering the life-ending drugs in some of the cases of euthanasia, and in almost half of the cases without an explicit request from the patient, the nurses in our study operated beyond the legal margins of their profession’;} For most elderly people admitted to hospitals or aged care facilities, outcomes are most likely to be beneficial, although at times stressful for the person and carers.

Decision-making in this area can be fraught with serious risks including suicide, particularly in the case of elderly males. A healthy 92-year-old WA man was reported to have committed suicide in 2015, because he did not want to ‘rot in a nursing home’. He left a substantial bequest to an organisation promoting euthanasia, and the matter is now before the courts.\footnote{Amanda Banks, Legal Affairs Editor, The West Australian, August 26, 2015. A notice published in the WA Voluntary Euthanasia newsletter in September said Mr O’Brien, also known as Bill, was a passionate supporter of “our right to an end of life choice”. “Bill decided that 89 was old enough,” it said. “He had no intention of rotting in a nursing home. In late July 2014, with the aid of Nembutal, he took his own life.”}

The APA Manual for psychiatrists in America states:

Nursing home placement entails a radical change in a patient’s definition of self and in other’ perceptions of the patient. Fear of nursing home placement is a common precipitant of suicide (Loebel et al 1991). Nursing home placement can disrupt the conduct of marital and social relationships and impoverish the patient, a non-institutionalised spouse, or other family members.\footnote{American Psychiatric Association, \textit{Manual of Nursing Home Practice for Psychiatrists}, January 4, 2000, Chapter 8, Legal and Ethical Issues, 59.} 

A healthy 92-year-old WA man was reported to have committed suicide in 2015, because he did not want to ‘rot in a nursing home’. He left a substantial bequest to an organisation promoting euthanasia, and the matter is now before the courts.\footnote{Loebel, J. P., Loebel, J. S., Dager, S. R., Centerwall, B. S., & Brandon, S., et al. (1991). Anticipation of Nursing Home Placement may be a Precipitant of Suicide Among the Elderly. \textit{Journal of the American Geriatrics Society}, 39, 407-408.}
6.4.1 Relocation and risk of harm

An extensive literature review conducted by Smith in 2000 concluded:

Although the immediate literature is ambiguous and sometimes contradictory, with numerous inherent methodology problems, it is possible to draw some tentative conclusions. In the US, Canada and the UK, most of the studies which found a significant increase in mortality or a decline in health status demonstrated one or both of the following two factors: higher proportions of individuals with substantial physical and mental impairment, and no relocation preparation programme.\(^{693}\)

Elderly patients in acute general hospitals have become a focus for blocking beds in acute care and emergency departments. In 2014 the WA Minister for Health claimed that a shortage of aged care beds in WA was contributing to hospital overcrowding, ambulance ramping, and described the management of the aged care system as ‘atrocious’, and ‘we know that at any one time 70 to 80 beds are being chewed up (by people waiting for aged care beds).\(^{694}\)

The chief executive of Aged and Community Services WA added that: ‘Emergency departments are also flooded with older people who wouldn’t need to visit hospital if they lived in an aged care facility.’\(^{695}\)

Self-interest of some aged care providers should be recognised as a potential conflict of interest, that may impact adversely on patients’ wishes. A balanced promotion of residential care and home care choices should be encouraged.

In view of these political and resource-driven problems, there is a risk that elderly frail people are identified as *bed-blockers*, subjected to unduly rapid relocation to care awaiting placement beds, and placed in aged care homes without adequate preparation and decision-

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Note: Of over 200 patients transferred from Swanbourne Hospital to the new psychogeriatric lodges in 1985, no deaths resulted. One terminally ill patient died of cancer two weeks afterwards. Staff and patients had intensive relocation preparation prior to the moves.


\(^{695}\) Ibid.
The failure to provide home care and other forms of community support contributes to the increased risks of premature and unwanted institutional care. In view of the risk of serious adverse results following re-location, the legality of pressured decision-making by health professionals must be considered carefully.

6.4.2 Adverse results from relocation

Lethal consequences followed the rapid relocation of 19 elderly psychogeriatric patients at Park Prewett hospital in England, contrary to the advice of the regular consultant psychiatrist. Eight patients died, three within two weeks of the move. However, in another study of patients discharged from an Addenbrooke’s Trust Hospital due to closure of continuing care wards, a serious adverse result was not proven. In that case the patients were in an 18-bed dementia assessment and respite ward and there was no indication the transfers were pressured by circumstances as they were described as ‘routine discharges’. Nevertheless, by 12 months after discharge 50% had died.

As a common reason given for aged care home placement of elderly persons is to provide greater protection of health and safety, it is of interest to consider the risks associated with relocation.

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696 The expression bed-blockers may have originated in a 1986 article which drew attention to difficulties arising from the increasing elderly population in acute hospitals. Coid J, Crome P, Bed-blocking in Bromley, Br Med J (Clin Res Ed) 1986;292:1253

697 Carers in Australia, Assisting frail older people and people with a disability, October 2004 Australian Institute of Health and Welfare Canberra AIHW Cat. No. AGE 41: It has been observed in the Aged Care Assessment Program that Aged Care Assessment Team recommendations for low-level residential care for people who live alone are often based on psychosocial needs as much as functional dependency; living with others helps people to remain in the community until they require high-level care.


699 Stockdale, R, Dening T, Mortality in Patients with Dementia Following their Discharge from Hospital, International Journal of Geriatric Psychiatry, 15, 2000, 870-871.
An American study in 1992 concluded:

Among the 549 respondents placed in nursing homes, the risk of dying there was greater for older adults, men, those who had not lived in multigenerational households, persons who did not worry about their health, individuals with more upper body limitations, and respondents having a history of valvular heart disease or cancer. The odds of dying were 2.74 times greater among the 574 respondents placed in nursing homes than among the 4,602 respondents who remained in the community.\(^700\)

While the mortality rates for persons placed in nursing homes may be expected to be higher due to factors contributing to more serious illness, this paper illustrates that social and less obvious clinical aspects may also be significantly involved. It does indicate the importance of multidisciplinary decision-making, should admission to an aged care facility be proposed.

The special hazards of aged care facility admission for patients with dementia has been demonstrated in an American 2004 paper which stated that:

At nursing home admission, only 1.1% of residents with advanced dementia were perceived to have a life expectancy of less than six months; however, 71% died within that period.

Nursing home residents dying with advanced dementia are not perceived as having a terminal condition, and most do not receive optimal palliative care. Management and educational strategies are needed to improve end-of life care in advanced dementia.\(^701\)

### 6.4.3 Harmful restraint practices

In Australia, as in many other advanced countries, the use of physical restraints and psychotropic medications in aged care facilities has come under increased scrutiny. A report by Alzheimer’s Australia in 2014 drew attention to significant concern by carers and in media reports.\(^702\) On the matter of physical restraint the report noted research supporting the following:

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The prevalence of physical restraint in aged care facilities varies and evidence suggests prevalence ranges from 12-49%.

Physical restraints can have a range of adverse psychological and physical effects. Research has shown that overall physical restraints do not prevent falls and may in some cases cause deaths.

There are some situations in which it may be appropriate to use physical restraint for a short period of time, but clinical guidelines indicate that physical restraints should always be an intervention of last resort.\textsuperscript{703}

The article also advises prior consultation with the carer and/or legal representative. The importance attached to ensuring legally correct procedure are followed is evident in the following passage from the report:

Assault, false imprisonment and detinue are unlawful unless one of the following legal defences exists:

- Informed consent by the person with a full understanding and comprehension of the situation.
- Consent by a guardian with a restrictive practices function.
- Self-defence – where the person believed on reasonable grounds that it was necessary self-defence to restrain the other person. For example, holding the arms of a person who is about to hit you or someone else, but not if there is a clear opportunity to get away.
- Necessity – where it was believed on reasonable grounds that it was necessary to do what was done to avoid death or serious harm. For example, grabbing someone who was about to walk in front of a car.\textsuperscript{704}

6.4.4 Psychotropic medications

The RANZCP clinical recommendations on psychotropic medication use in residential aged care, promotes non-drug alternatives as the first line of approach with careful prescribing and consent as key issues, particularly where the patient is unable to give consent.

By using a simple biopsychosocial model [a methodical approach that examines behaviours in terms of antecedents (A), the exact behaviour (B) and the consequences (C)] and by educating carers, it is possible to effect change by manipulating triggers in the physical or social environment or altering responses to the behaviour which perpetuate it, rather than using a pharmacological intervention.\textsuperscript{705}

\textsuperscript{703} Ibid, 7.
\textsuperscript{704} Ibid 6.
\textsuperscript{705} Clinical Recommendations developed by the RANZCP Faculty of Psychiatry of Old Age (New Zealand) 3, <http://www.bpac.org.nz/a4d/resources/docs/RANZCP_Clinical_recommendations.pdf>.
The risk of very serious adverse effects is noted in the guidelines.

The potential for stroke and death should be discussed when these medicines are used in the context of dementia.\textsuperscript{706}

\textbf{6.4.5 Risk of financial abuse}

Detinue is the unlawful possession of another person’s property, and may apply where an elderly person’s home and goods are commandeered by a family member or carer for their own use without legal or other authority.\textsuperscript{707} Cases of financial abuse of this type in the English Court of Protection, are recorded in extremely precise details. They illustrate the bitterness and manipulation of an elderly person which may occur for ulterior motives. The case of London Borough of Redbridge v G received considerable press publicity including an application by the media to be represented in court.\textsuperscript{708} In this case the carer had insinuated herself into the elderly person’s home to gain an advantage for herself with the immigration authorities, and was refusing to permit the local authority to monitor the position.

In WA, an Advocare hot-line received 500 calls in its first year of operation, most dealing with financial abuse by relatives.\textsuperscript{709} While phone hot-lines increase the number of calls, their effectiveness appears unclear.\textsuperscript{710}

\textbf{6.5 Decisions where legal requirements must be met}

In the \textit{Guardianship and Administration Act} (1990) specific attention is paid to sterilisation and end of life decision-making. Specific decisions are considered so important that only a review by a legal procedure will permit the intervention to proceed.\textsuperscript{711} Some decisions have

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{706} Ibid, 6.
\item \textsuperscript{707} In the UK detinue has been absorbed into other legislation, but continues in Australia as a trespass action.
\item \textsuperscript{708} \textit{London Borough of Redbridge v G & Ors} [2014] EWCOP 17 (21 July 2014). URL: \texttt{http://www.bailii.org/ew/cases/EWCOP/2014/17.html}
\item \textsuperscript{709} Cathy O’Leary, The West Australian, January 16, 2016.
\item \textsuperscript{711} \textit{Guardianship and Administration Act 1990}, Part 5, Div. 3, 57- 59. (Re sterilisation of non-consenting adult).
\end{enumerate}
\end{footnotesize}
interest to society at large, and are not confined to an individual’s circumstances. For example, concerns would be expressed if sterilisation of mentally ill or intellectually disabled persons without consent became a routine, under malevolent political and medical regimes as occurred in Nazi Germany. End of life decisions are also very likely to involve both personal autonomy and wider interests. In the *Brightwater v Rossiter* case, the Right to Life Campaigners were granted special recognition by the court, in view of their concerns regarding euthanasia.\(^7\)

### 6.5.1 Human rights

The legal and moral basis for asserting the existence of human rights is complex and forms a basis for much arcane legal philosophy, as well as misunderstanding within the community. Simmonds refers to this difficulty when quoting from his analysis of the writing of Hohfeld that:

…what has been taken for the internal complexity of rights is in fact the ambiguity of the word ‘right’. In other words, we do not have a single concept with distinct juridical consequences, but several different concepts which happen to be referred to by the same word. Thus, rights do not entail both the impermissibility and the inviolability of the right-holder’s action: it is rather the case that in one sense (‘privilege’ or ‘liberty’) rights entail the permissibility of an action, while in another quite distinct sense (‘claim right’) they entail a duty incumbent upon some other person, and owed to the right-holder.\(^7\)

The relevance of giving some thought to these complex and longstanding positions amongst legal theorists, is to assert the importance of understanding precisely what is meant by, and the likely impact of, legislation described as ‘rights-based’.

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\(^7\) *Brightwater Care Group (Inc.) v Rossiter* [2009] WASC 229, 23, *Amicus Curiae*: Mr P O’Meara (Right to Life Association)

McSherry and Weller state;

‘Rights-based legalism’ is thus a term that can be used to describe a cycle that gives precedence to mental health laws that refer to the rights of individuals with mental illnesses somewhere in their provisions.\(^7^{14}\)

The question is, does such an approach by parliament refer to the right of a person to expect a benefit or service, or has a right to expect a benefit been associated with a duty to provide a benefit or service? Declaring mental health legislation as strengthening rights may be politically popular, but how the anticipated benefits through rights will be resourced, provided and by whom, must be addressed.\(^7^{15}\)


\(^{715}\) WA Parliament Council Hansard, Tuesday 14 October 2014: Hon Helen Morton, ‘The passage and implementation of the new mental health legislation will strengthen the rights of people experiencing mental illness’.
6.6 Conclusion

This chapter has demonstrated the sources of fiduciary responsibility of government agencies and health professionals. Institutional measures in the form of mental health legislation and consent to treatment policies, should provide protection of the rights of older persons, especially where capacity to consent may be lacking.

Concern regarding professional and State liability in aged care, must be centred in the legal rights of the patient to full information regarding the risks and benefits of any intervention. Where any health intervention occurs in the absence of capacity to give informed consent, there must be a heightened concern to ensure correct application of the law and procedures.

The next question is, what is the risk to an elderly person of placement in a psychiatric or an aged care facility? The answer not only lies with the extensive literature on ‘relocation trauma’, but with the evidence that the results of placement into care facilities are not without risk of actual physical and mental harm. Risks may be two-fold, to the patient on one hand, or to the health care worker and his or her employer. Although measures are undertaken within residential facilities to minimise risks, there must be attention given to the decision-making procedures that may ultimately result in admission and increased risk of harm.

The next chapter considers the position in WA by reviewing the historical basis of current mental health services in psychiatry, and in aged care. The origins of Guardianship in WA, and what is occurring currently hospitals and aged care facilities, Elder Abuse and brief mention of actions taken elsewhere to improve the situation.
7 Detention and problems in WA

This chapter reviews several problems which arise in WA, despite legislation and procedures intended to protect elderly persons. The move from psychiatric hospitals to community care, and role of Commonwealth funded aged care facilities are important factors in the genesis of concerns.

7.1 Deprivation of liberty: History and organisation of hospital care systems in WA

The reorganisation of care for older people in WA psychiatric hospitals in the early 1980’s, led to major legal, social and clinical changes. These changes were largely influenced by similar changes occurring in other countries, which began in the 1950-70 decades. WA was well advanced in this process, closing Swanbourne Hospital in 1985, 10 years ahead of the peak of closures in England.

I prefer to use the term de-hospitalisation rather than de-institutionalisation, as the latter term has been used in a pejorative and loose manner, to refer to the indiscriminate emptying of mental hospitals. The American psychiatrist Torrey has commented on these developments.

The adverse effects of institutionalisation were described by Russell Barton in 1976. As psychiatrist-superintendent of Severalls Hospital, Essex, he described what he termed ‘institutional neuroses’. Barton’s thesis was that patients incarcerated in mental hospitals without employment or stimulation developed a neurotic condition over and above the

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716 Campbell C, Miller W, Health Services and Facilities for the Mentally Ill in Western Australia, 1981.

It is now extremely difficult to find a bed for a seriously mentally ill person who needs to be hospitalized. In 1955 there was one psychiatric bed for every 300 Americans. In 2005 there was one psychiatric bed for every 3,000 Americans. Even worse, the majority of the existing beds were filled with court-ordered (forensic) cases and thus not really available. In historical perspective, we have returned to the early nineteenth century, when mentally ill persons filled our jails and prisons.
psychiatric condition which occasioned their admission. In everyday parlance, he sought to
demonstrate the age-old maxim, namely, ‘No work is a dangerous occupation’; a maxim as
true for the insane as it is for the sane. These comments were supported recently by Sachs
in commenting on the wholesale closure of mental hospitals in America:

For many patients, who had previously enjoyed work and activity, there was now little left but sitting
zombielike, in front of the now never turned off TV.

De-institutionalisation, in the context of its time, was the removal of the negative
environmental and social effects of regimented communal living arrangements. It could
apply to large and small institutions, and to staff as well as patients.

7.2 Closure and relocation of Swanbourne Hospital

In 1979-1980, after a scathing report on conditions by Dr F Bell, the Director of MHS, the
government of WA agreed to close Swanbourne Hospital, a mental hospital housing 300 -
400 persons, formerly the major part of Claremont Hospital. By 1980 Swanbourne Hospital
housed elderly psychiatric patients, mostly with organic brain disorders and intellectual
disability. A comprehensive State-wide plan was drawn up in 1981, including redesign of
the model of services for the elderly. Miller consulted widely, and the following indicates
the adopted philosophical basis for service delivery.

A fundamental objective in the care of the elderly disabled, is to enable them to live independently
in their own homes. When this is no longer possible, we should ensure that they are cared for in
environments which match their needs and wishes, and respect their rights to privacy and
dignity.

Intellectual disability patients were transferred out of psychiatric wards to the care of social
trainers, a new category of workers. In a process that had its origins in the early 1960’s, they

718 Obiituary, Russell Barton; *The Psychiatrist* (2003) 27: 35
719 Sacks O, Asylum: *Inside the Closed World of State Mental Hospitals*, Essay foreword, Photographic
Collection, Payne C., (MIT Press 2009), 5.
were discharged to non-psychiatric community hostels and special nursing care facilities, where they were not subject to the *Mental Health Act 1962* (WA). This resulted from a drive by parents and medical staff towards “normalisation” of the care of intellectually disabled persons, recognizing their needs as social and educational, rather than medical and psychiatric.

The remaining elderly patients, mostly suffering from dementia, and others who had psychiatric illnesses, but were aged and physically frail, were transferred to a range of smaller facilities, with residential, day care, and community outreach services. These were, located on, or closely linked with general hospital sites, and dispersed around the Perth metropolitan area. Five were purpose built Psychogeriatric Extended Care Units (PECUs) comprising inpatient beds, an integrated day hospital and therapy wing, and a community outreach team.\(^\text{722}\) It is important to record that the term *extended care*, did not apply to the length of hospital stay. Following the example of Lefroy, the term applied to the *extension of the hospital services into the community*.

Other units intended for elderly services comprised a joint psychiatric/medical assessment unit, a community ‘cluster housing’ unit, a converted private home and Lemnos Hospital, an 88 bed ex-servicemen’s hospital. The total included 322 residential places, with respite and day hospital resources. Day hospitals were regarded as a means of reducing the need for residential mental health beds, and providing community based services close to local general hospitals. They are no longer operating; the cluster homes were disbanded and extension into country areas did not eventuate.\(^\text{723}\)

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\(^{722}\) Kesteven PL, Psychogeriatric Extended Care Units in Action, paper delivered at SYSTED 87, Perth, 1987.  
\(^{723}\) Above, n711, 35.
Planning for the replacement facilities had been undertaken by MHS at a time when it was an independent government department, reporting directly to the Minister for Health.\textsuperscript{724} After the election of a new government in 1984, the Departments of Public Health, Hospital and Allied Health Services, and MHS were merged into the HDWA. Responsibility for State mental health services came under the Commissioner for Health, not a psychiatrist, and regional managers.

### 7.2.1 Detention and “duty of care”

At the commencement of planning for the replacement of Swanbourne Hospital and the provision of new mental health facilities for older persons, a review of the type of units to be developed was undertaken. This resulted in the identification of three categories of facility.

1. Acute admission and assessment units based in district general hospitals. In view of known difficulties in the major general hospitals due to ‘wandering’ patients, a capacity to contain them safely was required. Miller recommended joint geriatric/psychiatric assessment units in each of the major Teaching Hospitals, which did not materialise.

2. Medium stay units with day hospital wings, community treatment teams and secure inpatient areas. These were also required to be secure, but as some patients may not have had dementia and were not so much at risk of ‘wandering’, a system of combination door locks was installed on the inside of entry doors. This allowed free passage from outside for staff and visitors, but persons wishing to leave would need

\textsuperscript{724} Ibid 37.
to be able to remember the allocated combination numbers. In addition, the ward gardens were surrounded by modest height walls of domestic scale.

3. Nursing staff establishment consisting of two to each eight patients for most of the day, was also an important form of ‘passive security’, as was the intention to engage patients in social and therapeutic activities.

4. Open community located ‘cluster housing’, where security to detain patients was not required.

When planning the closure of Swanbourne Hospital, it was intended that the PECUs would be no different to general geriatric and head injury hospital wards in Perth, some of which were fitted with special keypad locks to prevent patients leaving without staff knowledge. The only authority for this form of detention was the common-law duty of care, and responsibility of staff to avoid harm be-falling patients. Although not legally tested this was considered a necessity in provision of safe care.

The policies and procedures for new admissions were documented in loose leaf binders, allocated to each new PECU. No patients were to be admitted without prior community team assessment, and then only with a signed form of approval from family or carers, usually arranged by the social worker on the assessment team. That family or carers did not have legal authority to approve admission was understood by staff. The form also made it clear that admission was not for permanent care, but for only as long as a clinical need continued, to ensure subsequent placement was anticipated and not obstructed. The PECU’s were never intended to be permanent care facilities, although some patients with persistent mental illness or behaviour requirements beyond the capacity of nursing homes or hostels were retained until placement could be safely effected.
Where admission was resisted but necessary under the *Mental Health Act 1962* (WA), customary practice was to admit the patient *on the papers*, to an authorised hospital and transfer them immediately to the psychogeriatric unit on ‘aftercare’, under the provisions of the *Mental Health Act 1962* (WA). This ensured that at least a BoV review, and some protective provisions of the mental health legislation were available, admittedly limited in scope. This was considered an unsatisfactory arrangement, but no other procedure was available or suggested at the time.

### 7.2.2 HDWA consent policy

A detailed and mandatory consent policy was published by the HDWA in 2011:

- For the purposes of this policy treatment means any medical, surgical or dental treatment or other health care, including life-sustaining measure or palliative care.
- The consent process should be considered as a series of steps.
  1. Inform the patient about the proposed treatment
    - Provide the patient with all the information that will assist him or her to reach an informed decision; that is, whether or not to consent to the proposed treatment.
    - The information must include a description of the proposed treatment and any material risks.

All Health Department staff involved in placement of patients in aged care facilities must observe the policy. However, once the person has been placed, there are no formal procedures to monitor whether the required steps were in fact taken as required.

### 7.3 Transfer of long-term PECU patients

WA government policy, while not expressly stated, appears to favour diversion of elderly persons with dementia to Commonwealth funded aged care services. This was demonstrated in the transfer of a small number of patients from the PECU’s to two non-government aged care units. Additional State funding was provided to “top up” the Commonwealth Southern Cross High Dependency Units (HDU). Information on costs etc. was not available due to “commercial in confidence” requirements.
subsidy. These patients were not capable of consenting to transfer to the NGO units, but it was agreed that their care would be “consistent with the spirit” of mental health legislation, although this expression was not explained. Patients so placed have proved difficult to move on, limiting the value of this system. Nevertheless, it forms a key element of MHC future planning.\textsuperscript{726}

7.4 Authorised hospitals

Under the WA mental health legislation, it is the physical hospital site or location that is designated an “authorised hospital”, for admissions under the Mental Health Act 1996 Sec 21, (a) (WA):

\begin{enumerate}
\item Authorisation of hospitals
\begin{enumerate}
\item The Governor may by order published in the Gazette –
\item authorise a public hospital, or part of a public hospital,
\item for - (i) the reception of persons; and
\item revoke or amend and order so made.\textsuperscript{727}
\end{enumerate}
\end{enumerate}

This contrasts with the position in the United Kingdom where the authority to detain persons is vested in the Hospital Managers. The NHS Hospital Trust management are responsible for detention, rather than the location and physical set of buildings.

In WA, private psychiatric hospitals can also be “authorised”, but none have chosen to apply. Four of the authorised public hospitals are managed by private or non-government agencies and are co-located with private or NGO hospitals. This trend is expected to continue. None of the new facilities for the intellectually handicapped were \textit{authorised} under the \textit{Mental Health Act 1996} (WA). Aged care facilities are not authorised to detain patients under mental health legislation.

\textsuperscript{726} WA Mental Health, Alcohol and Other Drug Services Plan 2015–2025, Non-acute community long-stay (Nursing Home – Older Adult): 57.

\textsuperscript{727} Mental Health Act 1996, s21.
7.5 Changes in role of the PECUs

The new facilities (termed Lodges), to which the Swanbourne Hospital patients were transferred in 1985 were never designed nor envisaged as authorised hospitals. It was expected the Bentley Joint Assessment Unit (JAU) and Lemnos Hospital would serve as authorised hospitals, for elderly patients requiring admission under mental health legislation. However, the JAU was later transferred to the general hospital at Bentley for other uses, and the only approved hospital for the elderly at Lemnos was closed in 1999.

Admissions to PECU’s normally occur only after domiciliary or community assessments, consistent with minimising potentially harmful or needless admission. Day hospitals were to be a key element in this endeavour.

In 1985 there were four authorised hospitals which were expected to continue to accept urgent admissions of elderly patients under the Mental Health Act 1962 (WA). With the closure of three of these in subsequent years, four of the PECU’s were gazetted by the Health Department as authorised hospitals, and made subject to the provisions of the Mental Health Act 1996 (WA). No administrative, staffing or design criteria were addressed in the change of role from medium stay psychogeriatric unit, to acute services and authorised hospitals.

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728 The Bentley JAU was purpose built and designed along the lines of the Arie model in vogue at Nottingham England where a general medical ward and a psychogeriatric ward were adjacent and operated administratively as one unit. Due to staffing problems, this JAU ward was closed and incorporated into the general hospital. It had been intended that this would be an Authorised Hospital for the areas South of Perth, but this was not put into operation.

729 Hospitals closed were Heathcote, Lemnos and Bentley JAU.
7.6 Origins of Guardianship in WA

7.6.1 1980 review of legislation

The WA Government directed a review of the Mental Health Act 1962 (WA) to be undertaken by three separate committees in 1981.\(^\text{730}\) The first committee addressed psychiatric legislation; the second attended to forensic psychiatry issues. The third committee, of which I was a member, planned a Guardianship Act, to address the legal issue of incapable patients in hospitals and the community. This committee considered intellectually handicapped patients and their parents, many of whom had assumed, incorrectly, that they already held full authority over the medical care and welfare of their family members. The need to clarify the legal position of the elderly was included in view of planning for replacement facilities.

Another concern at the time was the inflexible requirement of the Mental Health Act 1962 (WA), under which any compulsorily admitted patient who was found incapable of managing his affairs, had to be notified to the Public Trustee by the psychiatrist superintendent, within one month of admission.\(^\text{731}\) The Supreme Court could appoint the Public Trustee or any other person to manage the person’s estate. This was an expensive process and in many cases caused unnecessary distress and stigmatisation to families and carers. The Public Trustee had no role in medical or welfare decisions. Guardianship legislation was intended to provide a less formal and cost effective remedy. It was also proposed that a guardian should only be appointed when required or indicated as being necessary. This proposal was strongly supported by the parents of intellectual disability patients, wary of undue interference by a State authority.


\(^{731}\) Mental Health Act 1962, s63(1).
The *Mental Health Act 1981* (WA) was passed by Parliament but not proclaimed. It included extensive provisions for the control of estates of incapable patients. An important statement was placed at the opening lines of section 76, (1), ‘A person shall not, by reason only of his being a patient, be deemed to be incapable of managing his affairs’. However, as the Act was not proclaimed, the legal requirement requiring the hospital superintendent to report an incapable patient to the Public Trustee, remained in operation. This could lead to a Supreme Court intervention and appointment of a ‘manager’ of the incapable person’s estate. The powers of any manager were limited to the estate of the affected person, and there was no legal responsibility for personal care or medical procedures. Disputes requiring judicial determination remained under the inherent jurisdiction of the Supreme Court of WA.\(^{732}\)

It was not until enactment of the *Guardianship and Administration Act 1990* (WA), that substitute decision-making procedures began to operate as envisaged in 1981. The passage of the *Mental Health Act 1996* (WA) introduced additional protective requirements for psychiatric patients, particularly the MHRB and the CoOV.

### 7.7 The problem of ‘voluntary’ admissions to psychiatric hospitals

This topic has been raised by Bingham and named ‘The Breggin Gap’.\(^{733}\) Her case referred to a young schizophrenic male patient who agreed to remain in a mental health unit, because of fears he would be detained under the Mental Health Act 1983 if he did not cooperate with the staff.

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\(^{732}\) Martin W, CJ, *Declaratory Relief since the 1970’s*, speech at UWA Club, 30 November 2007. (Reviews the value of the declaratory function of the Supreme Court in WA.)

This situation was first described by the American critical psychiatrist Peter Breggin in 1964,\(^\text{734}\) and has similarities with the ‘Bournewood gap’ referred to by Lord Steyn in 1998.\(^\text{735}\) The issue is that consent may be given under subtle or overt threat of detention, as well as lack of awareness that one is in fact detained.\(^\text{736}\)

### 7.8 Voluntary patients without mental capacity in WA

The matter of ‘voluntary’ patients in the older adult psychiatry unit was brought to the attention of several authorities in 1999. Patients were clinically reviewed routinely and frequently as to suitability for discharge.\(^\text{737}\) No assurances that our procedures were acceptable could be obtained, only that the matter was considered a serious one. Psychiatrists requested a meeting from which a HDWA ‘forum’ was held, which did not arrive at any firm conclusions around issues regarding elderly ‘voluntary’ patients. Subsequently staff have been concerned they are placed in an invidious position, where some resisting and incapable patients are managed informally, outside the *Mental Health Act 1996* (WA) in authorised hospitals. The Chief Psychiatrist’s office issued a statement of policy but questions for clinicians have remained.\(^\text{738}\) Essentially this reply returned to the issue of the actively resisting patient, but did not address the patient who was unable to recognise his detention and not resisting.\(^\text{739}\)

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\(^{735}\) Regina v. Bournewood Community and Mental Health N.H.S. Trust, Ex parte L. [1998] 3 W.L.R. 107, Lord Steyn; ‘an indefensible gap in our mental health law’.

\(^{736}\) Meering v Graham White Aviation Co. Ltd. [1919] 122 Law Times 44.

\(^{737}\) At Selby Lodge all patients, whether voluntary or detained under the Mental Health Act, were reviewed daily by the medical officer, and weekly by the psychiatrist, registrar, medical officer, clinical pharmacist, and nursing staff. Weekly meetings were held, including the entire treatment team, reviewing all aspects including discharge plans. Additionally, family conferences were held as required, either soon after admission or when planning discharge. (Applicable 1999).


\(^{739}\) Meering v Grahame-White Aviation Co. Ltd. (1919) 122 L.T. 44.
The correct legal position, remains uncertain and has not been tested by a Court, although concerns have been expressed in reports to Parliament from the CoOV, who have no authority to represent voluntary patients.\textsuperscript{740}

In March 2012, the RANZCP Faculty of Psychiatry of Old Age (FPOA) submitted a report to the MHC regarding the \textit{Mental Health Bill 2011} (WA). This included the following observation:

Many elderly patients are currently treated as voluntary patients and detained in an inpatient facility although they are not consenting to treatment on the grounds that:

- they have a mental illness which is potentially treatable \textit{AND}
- they temporarily (in the case of delirium) or permanently lack capacity to consent to treatment

However, they are not refusing or resisting treatment and their NOK and family/friends are consenting to the treatment plan and there is no valid advanced care directive opposing treatment. FPOA recommends that these patients should not be subject to the scrutiny of the MHT unless the family, patient, psychiatrist or advocate requests this.\textsuperscript{741}

The fact that elderly persons lacking capacity are still being admitted as ‘voluntary’ patients to old age psychiatry units, which are now \textit{authorised} hospitals, indicates that concerns raised over 30 years ago, remain unresolved. The Mental Health Advocacy Service is unable to represent these patients under the \textit{Mental Health Act 2014} (WA) as they are not \textit{identified persons}.\textsuperscript{742}

\textsuperscript{740} CoOV Annual Report, 2010-2011, Part three, (mentions that this issue was first raised by them in 1998-1999.

\textsuperscript{741} RANZCP Faculty of Psychiatry of Old Age, Submission to Mental Health Commission re Mental Health Bill 2011.

\textsuperscript{742} \textit{Mental Health Act 2014} (WA), part 20, Div. 1, 348.
7.9 Legislative response

In 2013 the Minister for Health stated in Parliament:

The role of the tribunal in conducting mandatory reviews of long-term voluntary patients is one of the important extensions of the rights of vulnerable groups that this legislation will bring about. To date, long-term voluntary patients have not had the right of a review. While they are voluntary, the nature of their mental illness may preclude them from effectively exercising their rights as voluntary patients, such as to discharge themselves. A review by the tribunal will oblige a mental health service to review the patient’s treatment, support and discharge plan.743

The Tribunal only reviews adult patients who have been resident in an authorised hospital over six months.744 This fails to address the issues regarding admission of voluntary patients unable to consent. It may also reflect a perception in government that hospitals have been unwilling to discharge some long-term patients, conveniently overlooking an absence of suitable community based alternatives.745 The statement unfairly implies a lack of diligence on the part of services, which is unproven. An FOI application to the HDWA reported there were only 33 separations of persons of any age, from authorised hospitals in 2014, who had remained over six months.746 Of these 11 were over 65 years of age. To remedy this, the Advocacy Service should review all voluntary patients notified as lacking capacity, and refer to the MHRT if indicated. This could be consistent with measures the CoOV has been asking for since 1998.747

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744 Mental Health Act 2014, (WA) s404 (b) (i).
745 The MHRB Annual report 2012 noted: From the Board’s perspective the issue of the lack of supported accommodation in the community is most frequently seen when reviewing the involuntary status of persons who have been detained in authorised hospitals for considerable periods of time.
746 FOI Reference 15 335, Hospital Morbidity Data Collection, HDWA, 23 November 2015.
747 CoOV Annual Report, 1998-1999, 6.1, Council considers that amendments should be made to the Act such that all persons detained in authorised hospitals, whatever their status, should fall within the jurisdiction of the Council. This matter has formed part of the Council’s submission in relation to amendments to the Act.
7.10 Safeguards in England

The main safeguards for psychiatric patients and people lacking mental capacity are to be found in the *Mental Health Act 2007* and the *Mental Capacity Act 2005*. There are also several other legal provisions which can be invoked. For example, there are Adult Safeguarding Teams, and Local Authorities have policies in place to address abuse of vulnerable persons, including the elderly.

7.11 The *Mental Health Act 2007* (UK) and Deprivation of Liberty Safeguards (DoLS)

Measures intended to address the ‘Bournewood case’ are the DoLS which were ‘piggy-backed’ on to the *Mental Health Act 2007* (UK), and implemented in 2009. While the Mental Capacity Act (MCA) has received a good measure of support, the DoLS have met a mixed but generally negative reception.

Brenda Hale J, commented in 2009 as follows:

> So now the mental health law community has to grapple with two pieces of legislation, three Codes of Practice, and a multitude of case law both in the UK and Strasbourg. … But I continue to ask myself what is all this law for?  

In the case of the Mental Capacity Act and the DoLS there is evidence that costs have been higher than anticipated. Shah et al demonstrated the cost of each DoLS assessment was £1277. This was twice the budget figure estimated. It was only the fact that fewer assessments than predicted were conducted that enabled the budget to be met in the first year of operation. Inexplicably there have been significant variations in the regional uptake of

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DoLS applications. \textsuperscript{751} The extent of these variations in the one country suggests unsatisfactory compliance by local authorities.

The Mental Health Alliance, a body of UK consumers and service providers prepared a pre-publication report indicating serious flaws in the operation of this expensive legal remedy. Of particular concern is that despite these high costs, the outcome for persons deprived of their liberty would appear to have changed very little. The Mental Health Alliance report found:

Nevertheless, where agencies have managed, with a great deal of effort, to make it work reasonably well, DoLS does perform a valuable protective function and has achieved at least some of the objectives set out for it, demonstrating that there is a need for a measure of this kind.

In view of these basic flaws, the Alliance believes that the scheme should now be either drastically revised, or be replaced by an alternative, more cost-effective way of meeting the requirements of Article 5 of the ECHR in relation to the detention of people who lack mental capacity.\textsuperscript{752}

At the Cardiff Law School \textit{Taking Stock} Conference in 2010, informal comment was heard that the better course would have been to revise the existing Guardianship provisions to make them more fit for purpose, rather than the DoLS.

More recent information has confirmed the scale of problems.

Local authority adult social care departments surveyed* by ADASS say they expect the number of deprivation of liberty (DoLS) referrals from hospital and residential settings to rise from 10,050 in 2013/14 to 93,900 in 2014/15. These figures have been given to the hearing being held by Sir James Munby, President of the Court of Protection in the in the Royal Courts of Justice.

At the same time the number of DoLS requests from domestic settings where the State has a responsibility, and which end up in court, are likely to rise from 134 in 2013/14 to 18,633 in 2014/15.

\textsuperscript{751} Care Quality Commission, (UK) \textit{The operation of the Deprivation of Liberty Safeguards in England 2009/10}, 6.

\textsuperscript{752} Mental Health Alliance, \textit{Pre-publication draft}, 25 November 2011, online.
According to ADASS: “Put together, these activities reflect an overall 10-fold increase from 10,184 in 2013/14 to 112,533 in 2014/15, while the councils polled anticipate additional costs of £45.195m for 2014/15.”

Gordon et al have commented:

This comes while local authorities are cutting social care for adults with dementia as a consequence of government austerity (emphasis added).

7.12 Adult safeguarding (UK)

Adult safeguarding is a relatively recent development in England and Wales. It represents the drawing together of roles and responsibilities of various government agencies in ensuring appropriate action where adult protection is a concern.

The most significant step forward in UK actions in this area was the publication jointly by the Home Office and The Department of Health, of the ‘No Secrets’ report in 2000. In the foreword signed by ministers of the Home office and the Department of Health, it states, ‘The development of these codes of practice should be co-ordinated locally by each local authority social services department’. This is significant in that the codes of practice, while not having the status of statute law, can gain significant legal standing. If there is a significant departure from a code of practice, there could be a legal case for a judicial review. Thus, the agency would be required to observe a code unless it was prepared to substantiate reasons for not adhering as required. The guidance was issued under Section 7 of the Local

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755 <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/349100/OPGsafeguardingpolicy.pdf>. Safeguarding is the term that describes the function of protecting adults and children from abuse or neglect. It is an important shared priority of many public services, and a key responsibility of local authorities.


Authority Social Services Act 1970 which requires local Authorities to exercise social services functions under guidance of the Secretary of State.\cite{58}

7.12.1 Law Commission recommendations (UK)

The Law Commission described the existing legal position since 1948 as, ‘a complex and confusing patchwork of legislation’.\cite{59} Their advice proposed a statutory duty on local authorities to investigate cases of abuse and neglect, and emphasise the importance of inter-agency multi-disciplinary working. To achieve this, they recommended ‘Adult safeguarding boards’. These would be statutory bodies which would, ‘keep under review the procedures and practices of public bodies which relate to safeguarding adults’. The standing of adult protection in the UK is significantly enhanced by the location of Adult Protection Teams within local authorities, but the actual extent of new resourcing is not clear. For example, one Local Authority merged the DoLS Team with their Adult Protection Team.\cite{60} This could be appropriate use of resources, or possibly requiring additional services from the same staff.

7.13 Western Australian provisions re elder abuse

There are no statutory provisions in WA which address elder abuse specifically, although government agencies have multi-disciplinary liaison arrangements in place.\cite{61} Arrangements for protective action and education have priority. Several protocols have been published, but these do not have the authority of Codes of Practice as are issued in the UK.\cite{62}

\begin{itemize}
  \item \textsuperscript{58} Local Authorities Social Services Act (1970), \textit{<http://www.legislation.gov.uk/ukpga/1970/42/contents/enacted>}.  
  \item \textsuperscript{59} Spencer-Lane T, Reforming the legal framework for adult safeguarding: The Law Commission’s final recommendations on adult social care, \textit{The Journal of Adult Protection}, Vol 13 No. 5 2011 275-284.  
  \item \textsuperscript{61} Alliance for the Prevention of Elder Abuse, APEA (WA).  
  \item \textsuperscript{62} The legal status of the Code was explained in \textit{R (Munjaz) v Ashworth Hospital Authority} (2005) UKHL 58. From 3/11/08 the Mental Health Act 1983 was amended with the intention of setting the situation out in statute.
\end{itemize}
Protocols published in WA commenced with the Council on the Ageing (COTA) report, *Elder Protection: A Protocol for Government Agencies 1997*. This was published by the Office of Seniors Interests, a small government agency which states; ‘Agencies are encouraged to consider and include the following matters when developing policies and procedures on elder abuse’, followed by a list of relevant topics.

The protocol details the roles of the Office of the Public Advocate (OPA) and the *Guardianship and Administration Act 1990* (WA) in situations where the person may not have decision-making capacity. The PA’s role is a statutory one to protect the interests of persons lacking decision-making capacity, in situations where there is no other, or any, suitable person to assume the role. The OPA has a role in assisting the SAT in decisions about the appointment of a guardian or administrator.

### 7.14 WA Criminal Code

Legislation with sanctions against elder abuse is limited to the *Criminal Code Act 1913* (WA). The code refers to stealing, concealing of wills and deeds, funds held under direction, fraud, physical abuse and assaults, social abuse, sexual abuse, psychological abuse and neglect. This 100-year-old law provides the only criminal law sanction against unlawful detention in psychiatric units or aged care facilities, with a liability to 10 years’ imprisonment.\(^{763}\)

The Federal Government has specific responsibility for dealing with elder abuse issues in federally funded aged care services including residential care. The Commonwealth Government has legislation which addresses elder abuse and requires police checks of staff and mandatory reporting of incidents.\(^{764}\) However, while acts of physical abuse and property

\(^{763}\) *Criminal Code Act 1913* (WA) s333.

\(^{764}\) *Aged Care Act 1997* (Cth).
crimes are important, there is little attention to monitoring admission into hospital or residential care in the first place.

7.15 The Mental Health Act 1996 (WA)

The legal requirements for compulsory treatment of psychiatric illnesses in WA, is provided by the Mental Health Act 1996 (WA). It is consistent with Winterwerp v. the Netherlands, requiring medical evidence of a mental illness, and an opportunity to challenge detention.\textsuperscript{765} The case of Mr Frits Winterwerp is frequently noted in judgements, and is significant as a case regarding a psychiatric patient presented to the ECtHR in 1972. The hearings in Strasbourg were adjourned for two weeks to allow written submissions from the governments of the United Kingdom and Northern Ireland. Mr Winterwerp had been committed to a psychiatric hospital by the instructions of the local Burgomaster and detained until six weeks later when the District Court extended his detention. At that time the Burgomaster was not required to obtain any prior medical reports. His detention was then renewed each year on applications by his wife initially, and later by the public prosecutor, the District Court having received medical reports from his treating doctor.

Winterwerp complained that he was not heard in person by the Courts, not notified of the orders, did not receive any legal assistance and had no opportunity to challenge the medical reports.

It is of interest to observe that a similar position was exposed in WA in 2012 Regarding Marlon Noble, an indigenous man detained under the Criminal law (Mentally Impaired Defendants) Act 1996 (WA), who was detained in prison for ten years.\textsuperscript{766} The legal and medical body which reviewed his case annually did not see him in person, nor was he legally

\textsuperscript{765} Winterwerp v. the Netherlands - 6301/73 [1979] ECHR 4 (24 October 1979).
represented. Due to a degree of intellectual handicap which impaired his capacity, he was further disadvantaged and unable to defend himself. While the forensic legislation is not a subject of this thesis, the case is mentioned to draw attention to the human rights limitation of related legal procedures in WA operating as recently as 2012. Lessons on the detention of psychiatric elderly patients and other persons in aged care facilities may be drawn from this observation.

In another leg to his appeal Winterwerp complained of the loss of his civil capacity. As reported in the case the Netherlands mental health legislation at the time stated:

21 Any person of full age who is actually confined in a psychiatric hospital automatically loses the capacity to administer his property (Section 32). As a consequence, all contracts entered into by the person after his confinement are void and he cannot legally transfer property or operate his bank account.

A guardian was appointed for Mr Winterwerp in 1971 to manage his affairs, but the guardian did not request his release. European experience with guardianship suggests it has been misused in many cases, especially in some Eastern European countries.

The ECtHR found as follows:

67. To sum up, the various decisions ordering or authorising Mr. Winterwerp’s detention issued from bodies which either did not possess the characteristics of a “court” or, alternatively, failed to furnish the guarantees of judicial procedure required by Article 5 para. 4(art. 5-4); neither did the applicant have access to a “court” or the benefit of such guarantees when his requests for discharge were examined, save in regard to his first request which was rejected by the Regional Court in February 1969. Mr. Winterwerp was accordingly the victim of a breach of Article 5 para. 4 (art. 5-4).

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769 Winterwerp above, n756, 21.
770 Stanev v Bulgaria Application No. 16760/06 ECHR. Accessed online HUDOC. See also Mental Disability Advocacy Centre at http://www.mdac.info/en.
771 Winterwerp above, n756, 67.
This finding emphasises the importance of a ‘court’, and strengthens the argument that the equivalent body in WA, The MHRB, should have at least the essential characteristics of a court, which must include observance of independence and the rule of law.\textsuperscript{772} Despite Winterwerp \textit{v. the Netherlands} being an old case, it is still relevant as it provides some key elements of much of the mental health legislation enacted in various countries including Australia. It is important to note that Mr. Winterwerp clearly had a significant mental disorder and needed care and supervision. The arrangements for providing this care needed to be legally sound and regularly reviewed, to provide a legitimate basis for his continued detention and treatment.\textsuperscript{773}

WA legislation appears aligned to the ECHR in requiring a judicial process to review compulsory mental health detention, although the Convention has no statutory influence in Australia. However, the MHRB procedures do not compare well with similar hearings of the MHRT in the UK, as outlined in chapter 3. There are no provisions for health or social care approved deprivation of liberty, other than by guardianship or mental health legislation. However, a guardian with plenary authority, may approve an incapacitated patient being held in a nursing home with locked or otherwise permanently secured doors, to prevent them leaving unescorted. Under the \textit{Guardianship and Administration Act 1990} (WA) the authority and functions of Guardians provides:

45. Authority of plenary guardian

(1) Subject to section 43(3), where a person is appointed as a plenary guardian, or 2 or more persons are appointed as joint plenary guardians, he or they have all of the functions in respect of the person of the represented person that are, under the Family Court Act 1997, vested in a person in whose favour has been made —

\textsuperscript{772} <http://thelawdictionary.org/court/>: Court: An organ of the government, belonging to the judicial department, whose function is the application of the laws to controversies brought before it and the public administration of justice.

\textsuperscript{773} Winterwerp above, n756, 23- 32.
(a) a parenting order which allocates parental responsibility for a child; and

(b) a parenting order which provides that a person is to share parental responsibility for a child, as if the represented person were a child lacking in mature understanding, but a plenary guardian does not, and joint plenary guardians do not, have the right to chastise or punish a represented person.

(2) Without limiting subsection (1), a plenary guardian may do any of the following —

(a) decide where the represented person is to live, whether permanently or temporarily;

(b) decide with whom the represented person is to live;

(c) decide whether the represented person should work and, if so, the nature or type of work, for whom he is to work and matters related thereto;

(d) subject to subsection (4A), make treatment decisions for the represented person;

(e) decide what education and training the represented person is to receive;

(f) decide with whom the represented person is to associate;

(g) as the next friend of the represented person, commence, conduct or settle any legal proceedings on behalf of the represented person, except proceedings relating to the estate of the represented person;

(h) as the guardian ad litem of the represented person, defend or settle any legal proceedings taken against the represented person, except proceedings relating to the estate of the represented person.\textsuperscript{774}

The origins of the guardianship provisions intended for intellectually disabled children, are clearly reflected in this description of the functions of a guardian. There is reference in the \textit{Guardianship and Administration Act 1990} (WA) to dementia in the list of mental disabilities, which includes an intellectual disability, a psychiatric condition, an acquired brain injury and dementia.\textsuperscript{775} Capacity is mentioned in the \textit{Guardianship and Administration Act 1990} (WA) on two occasions, both in connection with enduring power of attorney.\textsuperscript{776}

The Act does not include a charter or statement, nor any reference in the long title, setting out any principles or policy regarding assessment of capacity.

\textsuperscript{774} \textit{Guardianship and Administration Act 1990} (WA), [s.45 amended by No. 7 of 1996 s. 20; No. 69 of 1996 s. 34; No. 41 of 1997 s. 32; No. 70 of 2000 s. 8; No. 35 of 2006 s. 205; No. 27 of 2007 s. 25; No. 25 of 2008 s. 6; No. 47 of 2008 s. 64; No. 17 of 2014 s. 22(2) and (3).]

\textsuperscript{775} Ibid, Part 1 – Preliminary, 3 (1) p4.

\textsuperscript{776} Ibid, Sec. 104, Execution of Enduring Power of Attorney, (1a) (1) b (ii).
In contrast the MCA 2005 (UK) commences with a statement of principles to be adopted in carrying out the functions of the Act:

1 The principles

(1) The following principles apply for the purposes of this Act.

(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.\footnote{Mental Capacity Act 2005 (UK) Principles. <http://www.legislation.gov.uk/ukpga/2005/9/pdfs>., 293}

The MCA 2005 (UK) also includes an extensive Code of Practice.

7.16 Meaning of ‘mental illness’

Mental illness is defined under the Mental Health Act 1996 (WA) Act as:

(1) For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgement or behaviour to a significant extent.

The presence of mental capacity to consent or refuse treatment is only briefly mentioned in the Mental Health Act 1996 (WA) as follows:

96 Capacity to give informed consent

A patient is incapable of giving informed consent unless he or she is capable of understanding –

(a) the things that are required by this Division to be communicated to him or her;

(b) the matters involved in the decision; and

(c) the effect of giving consent.
There is no mental capacity legislation in WA, and persons lacking capacity are informally treated under the common-law duty of care, or under the provisions of the *Guardianship and Administration Act 1996* (WA).

Persons with mental illness or brain diseases such as dementia can be admitted to psychiatric hospitals under the *Mental Health Act 1996* (WA), or informally under common law. An “authorised hospital” is one which has been designated as such under the *Mental Health Act 1996* (WA) for the reception and treatment of patients with mental illness. Aged care facilities are not authorised for detention of patients under the *Mental Health Act 1996* (WA).

### 7.17 Other medical or brain conditions in WA

Intellectual disability is not considered a mental illness within the *Mental Health Act 1996* (WA). Persons who are intellectually disabled may be admitted to a psychiatric hospital only if they suffer from a mental illness as defined in the Act. Following the Beacham Report of 1982, separation of the intellectually handicapped from psychiatry, which had commenced in the early 1960 period in WA, was completed. An Authority was established as recommended by Beacham, which is now subsumed into the Disability Services Commission (DSC). This Commission reports to the Premier through the Minister for Mental Health.\(^778\)

Other brain disorders such as Alzheimers dementia and related conditions, head injury, cerebrovascular disease or strokes may also result in impaired capacity. Since the introduction of the *Guardianship and Administration Act 1990* (WA), these individuals have escaped the stigma of mental health legislation, unless there are additional factors requiring psychiatric intervention.\(^779\)

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\(^779\) In addition, new residential facilities for younger dementia patients and head injured have been developed, e.g. Brightwater Care Homes.
7.18 Other medical or brain disorders in England

The definition of mental illness under UK legislation has been altered significantly by the Mental Health Act 2007 (UK). Whereas previously there were four categories, viz. mental illness, mental impairment, psychopathic disorder and severe mental impairment these terms have now been discontinued.

In its submission to The House of Commons Joint Committee on the Draft Mental Health Bill 2004, Mencap, the principal advocacy body for learning disability patients and carers, made the following points:

> A learning disability is not a mental illness. Mencap believes that it is fundamentally wrong for someone with a learning disability to come under mental health legislation unless they also have a mental illness.\(^7^8^0\)

The case for separation from psychiatry was argued unsuccessfully by Mencap in the UK in 2004, and intellectual handicap services and legislation remain firmly in the hands of members of the Royal College of Psychiatrists. The Intellectual Handicap Division of the Royal College of Psychiatrists has 1200 members. There are a very high number of legal cases in the UK involving mental health legislation, where intellectual handicap is the sole or principal medical diagnosis.

7.19 Detention in WA public psychiatric hospitals

In 1981 Swanbourne Hospital housed 350-400 patients. Most were elderly including many persons with intellectual disability from birth, awaiting transfer to specialist staffed hostels. When the replacement residential units for Swanbourne Hospital were being designed, questions of patient safety, with free access for relatives and visitors arose.

\(^{7^8^0}\) Valuing People, above, n 469, 59.
Key pad locks were introduced, providing free entry but restricted exit. It was assumed, without legal opinion or debate, that persons lacking capacity to memorise the key pad code, also lacked capacity to express a view regarding their detention.

Key pad locks were adopted in all new psychiatric facilities for the elderly, and are widely adopted in nursing homes and dementia specific nursing homes throughout WA. The rationale employed was that the common-law duty of care justified these precautions, in the case of persons unable to guard against common dangers. It was also felt beneficial that entry during normal working hours, was unrestricted for carers and visitors who were provided with the unlock code by staff.

In retrospect, more careful and informed consideration of the ethical and legal issues of deprivation of liberty should have taken place. Additional architectural measures to provide a similar level of security were adopted in some other states in Australia. These included interior design of the ward exit so that it appeared less conspicuous or concealed within a wall. The intention was to provide security through a less threatening or stressful environmental approach, but legal reliance remained essentially on the common law of ‘necessity’ or ‘duty of care’.781

7.19.1 Local data on detention/admissions older adult mental health patients in WA

Ascertaining the numbers of persons over 65 detained in WA psychiatric hospitals proved surprisingly difficult to verify with accuracy. The extent of use of compulsory powers under the Mental Health legislation, is not one of the Health Department or Mental Health Commission’s Key Performance Indicators (KPI), and consequently is not included in the table of KPI’s included in the HDWA Annual Report to Parliament.782 Unfortunately, there

781 CADE units (NSW) (Fleming and Bowles), and the Alzheimer’s Nursing Home in Hobart (Tooth), were also examples of innovative design features intended to minimise distress while providing secure and safe care.

is limited data publicly available, which reveals an unsatisfactory state of affairs. While privacy must be protected, publication of the number and location of persons detained under involuntary mental health legislation, should be required in the interests of protection of civil rights. As many jurisdictions have reduction of coercion as a goal in mental health care, absence of information on under or over-use of coercive practices is not acceptable.\textsuperscript{783}

Under a Freedom of Information (FOI) request, the following data was obtained.\textsuperscript{784} Note that this data refers to individual persons, some of whom may have had more than one admission/separation.

There were 633 persons over the age of 65 years who separated in 2014 from Western Australian (WA) older adult authorised and non-authorised public and private hospitals.

During 2014, there were 152 persons over the age of 65 years who were treated as an involuntary patient at some point during their episode of admitted care in all of WA’s authorised hospitals.\textsuperscript{785}

Based on the FOI data, one can deduce that 633 – 152 persons = 481 persons were voluntary admissions. How many of these persons were lacking capacity to consent to their admission is not known. Prospective research is required to quantify this issue.

\textbf{7.19.2 Health Department of WA.}

Alternative data from the HDWA indicates a total of over 1,000 persons over 65, were admitted to WA mental health hospitals in 2015-2016. This would suggest that the data of 633 separations obtained under FOI was too low. The higher figure would also be more

\textsuperscript{783} The only information publicly available on a national basis is the rate of use of seclusion.
\textsuperscript{784} Hospital Morbidity Data Collection, Purchasing and system performance, WA Department of Health, 23, November 2015.
\textsuperscript{785} The 24 bed older adult mental health unit at Osborne Park Hospital is not an authorised hospital.
consistent with the growth and ageing of the population in WA, with increased activity at all older adult mental health inpatient units. In 1985-1986, following the closure of Swanbourne Hospital, there were 336 admissions to all seven psychogeriatric units. By 1986 -1987 this had risen to 551 admissions.\footnote{Admissions, not necessarily number of persons, due to respite and repeated admissions of the same person.} These were recorded at each PECU by a graduate assistant researcher on a dedicated personal computer operated at Swan Lodge.

With the introduction of regionalised management, this information gathering, intended to locally track the performance of each unit, was discontinued.

### 7.19.3 Mental Health Review Board (now Tribunal)

The WA Health Department was unable to provide an answer under FOI to the number of tribunal hearings held for persons over 65 years of age, who were detained under the \textit{Mental Health Act 1996} (WA). This information was also requested from the MHRB on two occasions but no response was received. The last Annual Report for the MHRB available online was for 2011-2012 and contained no demographic data based on age. The 2012 report stated that the total number of compulsory orders in 2011-2012 was 2955 persons of all ages. This comprised 2626 persons admitted as inpatients and 329 on CTO’s. This number would be expected to have increased significantly since 2012.

A Curtin University report states:

> Today around 13 per cent of the Western Australian population is aged 65 years and older – this is projected to increase to over 18 per cent by 2050.\footnote{Prof. Duncan A, Bankwest Curtin Economics Centre (BCEC), Media Release, November 18, 2015.}

As an estimate, 13 percent of 2626 suggests that possibly 341 persons over 65 may have been admitted as involuntary patients in 2011-2012. The balance would necessarily have been \textit{voluntary} patients, but their capacity to make informed consent is speculative. Lack of reliable public information in this matter must be of concern.
7.19.4 AIHW statistics

Using national statistics from the Australian Institute of Health and Welfare the following estimates were deduced.\textsuperscript{788} Note that this data refers to admitted patient separations being distinct episodes of admission, care and separation, not individual persons.

Number of admitted patient separations for whole of Australia with specialised psychiatric care (SPC) 2013-2104: 152,458.\textsuperscript{789}

No. of SPC separations for persons 65 years of age and over. 18,059

Percentage of SPC separations of persons over 65; whole of Australia 11.8%

Rate of all admitted over 65 patient SPC separations Australia 5.3 per 1000 of popn.

Population of WA 2014 2,589,000

Population of WA over 65 estimated 13\% of 2,589,000 336,570

Estimated over 65 SPC separations in WA (336.570 X 5.3) 1784\textsuperscript{790}

\% SPC involuntary separations whole of Australia 29\%

Estimated involuntary separations over 65 in WA, (29\% of 1784) 517

Estimated voluntary separations over 65 in WA (1784 – 517) 1267

\textsuperscript{788} AIHW, Mental health services in Australia, Table AD 6.
\textsuperscript{790} This is not the actual number of persons as some may have several admissions/separations.
The figure of 1784 total separations is significantly higher than the figure of over 1000 referred to at 7.19.2 above, and based on HDWA information. It is also much higher than those provided under FOI. Consequently, it is unclear whether the FOI, HDWA or the AIHW deduced statistics are more likely to be correct.

This underlines the necessity for accuracy and transparency in information regarding the use of detention in mental health facilities. In view of the goal of reducing coercion in many countries, accurate data is essential to recording progress or lack of it in this regard.

7.20 Detention in Commonwealth-funded aged care facilities

WA had a total of 15,133 persons in aged care facilities at 30 June 2011.\(^{791}\) Of these 52% were diagnosed as suffering from dementia according to the Aged Care Funding Instrument (ACFI).\(^{792}\) Others could be anticipated to lack mental capacity for a range of health conditions and circumstances. Some aged care facilities are designed specifically for persons with dementia and secured to prevent accidental wandering away.

The WA office of the Commonwealth Aged Care Quality Agency advised there were 238 accredited residential aged care homes in WA in 2015. No records are kept of which homes are locked always, or have secured wings/areas, and there was no repository of this information known to the Agency. The Agency reply stated there were no Accreditation Standards directly related to approval of locked facilities, other than the safe and appropriate use of restraints.\(^{793}\)

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\(^{791}\) AIHW Services and Places, data cubes, 1, 30 June 2011.

\(^{792}\) AIHW, 2012. Dementia in Australia. Cat. no. AGE 70. Canberra.

\(^{793}\) Paul Richards, State Director, emailed reply, 11 December 2015.
Given the reliance in WA on the common law in secure nursing homes, dementia specific hostels and psychiatric units, the relevance of the Bournewood case regarding admission, detention and treatment of incapacitated persons is compelling.\(^\text{794}\)

### 7.21 False imprisonment

The detention of people in aged care facilities without legal provisions in place, could amount to false imprisonment. In the case of *Trevorrow v SA*, the judgement of Gray SCJ, states:

> [His Honour continued: 196]

> It cannot be too strongly stressed that these basic matters are not the stuff of empty rhetoric. They are the very fabric of the freedom under the law which is the prima facie right of every citizen and alien in this land. They represent a bulwark against tyranny.\(^\text{795}\)

### 7.22 Victorian Law Reform Commission (VLRC): Guardianship

A 700-page report by this body has covered in depth many of the concerns raised in this thesis.\(^\text{796}\) In Chapter 15 the report deals with ‘Restrictions upon Liberty in Residential Care’, and includes detailed consideration of the Bournewood case. It provides an outline of problems from differing perspectives, and discussion of number of options for addressing the legal and practical issues. The following are some key issues from this extensive report:


\(^{795}\) *Trevorrow v State of South Australia* (No 5) [2007] SASC 285 (1 August 2007), 982.

There is no common law or statutory power permitting the family member or friend to provide substituted consent to these practices, (informal consent to restrictive practices).

The family members or unpaid carers who are often asked to approve these arrangements act as ‘de facto’ guardians. However, unlike enduring guardians or guardians appointed by the Victorian Civil and Administrative Tribunal (VCAT), there is no formal recognition of their role or scrutiny of informal arrangements involving restraint of liberty.

The number of people in supported residential care is likely to grow quite substantially over the next two decades as the community ages and life expectancy increases. It will be an ongoing challenge to devise fair, efficient and practical safeguards for the many people who are likely to need someone to decide where they will live and, in some instances, whether they should be detained or restrained for their own welfare. Appointing guardians for all the people who lack capacity to consent to these practices would probably place an unsustainable demand on VCAT and the Public Advocate.

Liberty is one of the most important values protected by the common law. Any interference with a person’s liberty is unlawful unless it is authorised by law. The common law has developed causes of action—an application for a writ of habeas corpus and the action for false imprisonment—that allow people to test the lawfulness of any deprivation of liberty and that provide remedies when a person is found to have been unlawfully deprived of their liberty.

False imprisonment is a tort, or civil wrong, that is committed whenever a person directly, and either intentionally, negligently or recklessly, causes the total restraint of the liberty of another person without lawful justification. While false imprisonment is a form of trespass, it is not necessary for there to be actual force or direct physical contact. The tort is committed when a person’s liberty is restrained by means which causes them to submit to their deprivation of liberty.

An ACAS assessment occurs as part of the admission process to many aged care facilities in Victoria. However, an ACAS assessment does not specifically address formal substitute decision-making arrangements when a person with impaired decision-making ability is admitted to an aged care residential facility.

The report considered a variety of submissions from individuals and groups, some of which held conflicting views. One Legal Aid organisation was reported as often receiving calls from persons who felt they were ‘trapped’ in an aged care facility and unable to return home due to the wishes of family members.
Of special concern was the comment from the Aged Care Assessment Service that:

Aged Care Assessment Service in Victoria submitted that: This process informally occurs now where the next of kin/family are asked to accept responsibility for a decision, or carer/family declare they are unwilling to retain a role in caring for the person at home, thus decision is made for residential care. Currently there is no scrutiny of this process. (emphasis added). 799

After listing these the report anticlimactically concluded:

15.118 The Commission is not proposing any changes to these practices even though the existing informal arrangements clearly lack any legal foundation.

15.120 The Commission does not believe that there is widespread support for new formal processes to govern place of residence decisions for every person who lacks the capacity to consent to living in supported residential care. The existing combination of informal arrangements and formal decisions by VCAT-appointed guardians in some difficult cases appears to operate reasonably well for the moment.

7.23 Bournewood in Australia

The restriction of liberty in aged care and mental health facilities in Victoria has been compared with that in the Bournewood case in a 2014 paper by Williams. 800 The authors examined the Bournewood case as illustrating the issues of decision-making in persons with disability, and made specific references to the topics of false imprisonment, habeas corpus, guardianship and the UNCRPD, all of which have been raised in this thesis. They observed that the DoLS as developed in England were unsuitable for use in Australia, being plagued with high implementation costs and unlikely to be effective, particularly in view of the fragmentation of responsible authorities, State and Commonwealth. Their recommendations considered the VLRC Report and changes to Guardianship, but did not favour those proposals. Instead they have opted for another concept:

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799 Ibid, 15.92.
Any proposal to address the problems identified in the article must begin from the principle, central to the decision in HL and s 21 of the Victorian Charter that any interference with a person’s liberty is unlawful unless authorised by law.  

This appears a tautological comment, which does not in fact advance their case as far as they might hope, as they had already disposed of most alternative forms of ensuring compliance with law as being too difficult, costly, or ineffective. They have supported Victorian legislative arrangements embodied in the Victorian Disability Act 2006. A statement at 16 indicates the difficulties they have identified:

A comprehensive proposal to address the problems identified must consider the dual regulatory regimes of the Commonwealth in aged care and that of Victoria in relation to disability, mental health and private residential providers. A solution should be sufficiently robust to protect vulnerable people but workable enough that service providers actually implement it.  

Their paper recommends an enhancement of the Senior Practitioner role in the Disability Act 2006 (VIC), although they indicate this too is not ideal. The most positive element of their report is an emphasis on measures to reduce the need for coercion and detention rather than searching for purely legal remedies. 

As an example, in regard to admission to residential care they state:

Admission is not always based on clinical risk (it may be based on a lack of alternative care options) and a health professional should arguably not be involved in these decisions at all. The involvement of the head of a residential facility is especially inappropriate in relation to admission, given his or her professional and pecuniary interest in ensuring that a person is admitted.
Human rights and psychiatry in WA

Human rights, as an obligation of State and Commonwealth governments in Australia, has received a mixed response. There is no Human Rights Act in WA, and little evidence of any intention to address the position. There is also no equivalent to the Charter of Human Rights and Responsibilities Act 2006 (Vic). Considerable public and staff interest was generated in 1993, by the publication of a report by the Commonwealth Human Rights Commissioner, Brian Burdekin which examined mental health services in all States. In his summary Burdekin noted the reason for undertaking the inquiry:

My initial reason for conducting this inquiry came from evidence presented to the homeless children’s inquiry which suggested that in many areas the human rights of individuals affected by mental illness were being ignored or seriously violated.

Further research also indicated:

- widespread ignorance about the nature and prevalence of mental illness in the community;
- widespread discrimination;
- widespread misconceptions about the number of people with a mental illness who are dangerous;
- and a widespread belief that few people affected by mental illness ever recover.

Since the Burdekin Inquiry there has been a considerable increase in public awareness and discussion on mental health topics, with attention to early intervention and community support. Drug abuse, crises in Emergency Departments and suicides have trended in prominence rather than human rights or older persons.

Informal or ‘voluntary’ patients in WA in 2015

The legal position of persons lacking capacity to consent remains like that which applied in the UK after passage of the Mental Health Act 1959 (UK). Lord Steyn observed what had been the rationale in the 1959 Act, in his decision on the Bournewood case in 1998:

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806 Ibid, Introduction.
The desired objective was to avoid stigmatising patients and to avoid where possible the adverse effects of “sectioning” patients. Where admission to hospital was required compulsion was to be regarded as a measure of last resort. The Mental Health Act of 1959 introduced the recommended changes. Section 5(1) was the critical provision. The marginal note reads “Informal admission of patients”. Section 5(1) provides:

“Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained.”

[He continued]

The general effect of the decision of the House is to leave compliant incapacitated patients without the safeguards enshrined in the Act of 1983. This is an unfortunate result. The Mental Health Act Commission has expressed concern about such informal patients in successive reports. And in a helpful written submission the Commission has again voiced those concerns and explained in detail the beneficial effects of the ruling of the Court of Appeal. The common-law principle of necessity is a useful concept, but it contains none of the safeguards of the Act of 1983. It places effective and unqualified control in the hands of the hospital psychiatrist and other health care professionals. It is, of course, true that such professionals owe a duty of care to patients and that they will almost invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are sufficient safeguards against misjudgments and professional lapses in the case of compliant incapacitated patients. Given that such patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of the Act of 1983 from a large class of vulnerable mentally incapacitated individuals. Their moral right to be treated with dignity requires nothing less.

From reading of Lord Steyn’s opinion, it can be concluded that although he felt that detention of HL in this case was legally correct, it was, nevertheless, unacceptable. He stated:

If the decision of the Court of Appeal is reversed almost all the basic protections under the Act of 1983 will be inapplicable to compliant incapacitated patients: see section 57(2) for an exception. The result would be an indefensible gap in our mental health law.


808 Steyn, above, n 787.
This statement became the source of the expression which passed into common use as ‘The Bournewood Gap’.\(^{809}\) The position in WA is like the pre-Bournewood period, in that despite representations from the CoOV annual reports since 1998, the legal status of voluntary patients in psychiatric hospitals and aged care facilities remains in limbo.\(^{810}\)

### 7.26 Elder abuse

WA has no statutory provisions covering elder abuse other than the criminal law.\(^ {811}\) A study of elder abuse in WA was published in 2011 by the crime Research Centre of the University of WA.\(^ {812}\) This report was described as a ‘Qualitative and Quantitative Investigation of existing Agency Policy, Service Responses and Recorded Data’ and produced in a joint initiative with Advocare Inc., supported by Lottery West which funded the research. Advocare is an independent patients and carers rights organisation in WA. However, it has a link with the Federal Government Home and Community Care program, which may possibly compromise the issue of independence.

Key issues covered in the Executive Summary were:

- Problems with the definition of elder abuse including the extent of the social context.
- Financial abuse was the most commonly reported type of abuse, frequently related to misuse of Enduring Powers of Attorney.
- A trend towards increasing numbers of cases was noted, but problems of data collection impeded gaining a clear picture of what is happening.
- Lack of ‘a cohesive approach to elder abuse across government and non-government organisations’ was observed.
- It was found that elder abuse was not well recognised by the public as a significant issue. Child abuse and domestic abuse held a higher public profile.

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809 See Chapter 7: The Breggin Gap 272.
812 Clare M, Blundell B, Clare J, Examination of the extent of elder abuse in Western Australia, April 2011.
An important comment in the Executive Summary follows:

It has been noted that elder abuse research, policy and practice is about thirty years behind research, policy and practice in child abuse and domestic violence. Due to this fact, it tends to lack conceptual clarity and be poorly defined and measured. While a problematic concept, elder abuse is an issue of deepening concern in our ageing society and the challenge for government and welfare agencies is to ensure that there are adequate resources available to respond to it effectively.\textsuperscript{813}

Organisations which participated in this research comprised APEA: WA, the Alliance for the Prevention of Elder Abuse WA, the Older Persons Rights Service and SAT (WA). APEA WA includes the Health Department and the Mental Health Commission. It is surprising then, that in the chapter on Research Methodology it is noted that:

The Health Department WA was not able to be included as, despite contacting numerous people within the Department, we were not able to identify anyone to interview, and were instead referred on from person to person to no avail. However, we were able to interview two practitioners from the Older Adult Mental Health Services, who fall under the aegis of the Health Department, and two professionals working in hospitals participated in the focus groups, so there was some Health department input, however minor.

Legal Aid were also not interviewed, as they commented that elder abuse cases were extremely rare and they did not keep any statistics by age, so they did not believe that they had anything useful to contribute.\textsuperscript{814}

The lack of interest from HDWA is of concern. It may reflect a lacuna in appreciation of the importance of human rights and liberty in the community and WA government, as well as in health and related services. It is also consistent with the basic concerns of this thesis, viz. that elderly persons in WA may have their human rights inadequately protected by legislation and procedures. If WA government agencies are not being obliged to address alleged criminal and flagrant abuse, then subtle forms may be undetected and tolerated.

\textsuperscript{813} Ibid, Executive summary, 2.
\textsuperscript{814} Clare Ibid 13.
This may include relocation into aged care or psychiatric facilities, without due attention to effective safeguards.

The relocation of an older person with a disability to an aged care facility, and the management of the finances and property of older people living in the community/residential settings, raise complex financial, health care, and legal issues for the individual, family members, and service providers.815

Exploitation can occur where undue pressure is applied, or a person’s wishes ignored when effecting relocation, sometimes to the advantage of other family members, or to expedite discharge from a hospital bed.816

An agency responsible for protecting the rights of the elderly in WA is Advocare Inc., an independent advocacy agency. In an online report Advocare noted that a new helpline dealing with elder abuse opened in 2014, received 400 calls in their first twelve months.

The victims are often frail or unwell and reliant on family who are robbing them of their life savings and more often than not, subjecting them to more than one kind of abuse. The statistics also revealed that it is mainly females who are carrying out the abuse and, the majority of the time, the abuser is the actual daughter or son of the victim.817

7.27 Responses in other Australian states

Other States in Australia have advanced programs and policies dealing with elder abuse. South Australia published a report entitled, ‘Closing the gaps’ commissioned by the Office of Ageing and Disability Services in 2010.818 Their report draws attention to the United Nations Principle 17 which states, ‘Older persons should be able to live in dignity and security and be free of exploitation and physical and mental abuse.’819

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816 This has been termed: Family-Mediated Abuse and Neglect of Elderly Persons.
819 Ibid, 6.
Significantly they state:

…anecdotal evidence suggests there are barriers to individual agencies’ level of response which result in gaps in the system, leaving some vulnerable older person without an adequate response or protection. Some responses erode the rights of the older person by removing their decision making ability simply to protect them from being harmed or abused by another person.820

[The report also states that:]

Compared to overseas models, our systems often focus on the mental capacity of victims of abuse, providing support and intervention to those people who have a ‘mental incapacity’, but failing to provide a quick, practical assistance to keep vulnerable people in our society safe.821

There is no hard and fast line to be drawn between partially and fully vulnerable. That vulnerable and incapacitated people are well served by existing protocols cannot be assumed. The position that many individuals in WA need improved protection from abuse is valid. The suggestion that those under existing statutory arrangements are not also at similar risk, is a matter for disagreement. Without research to establish the position, it should not be assumed that current legislation and policies provide adequate protection.

7.28 Australian Complaints Commission

On January 1 2016, a new Australian Aged Care Commissioner commenced operations. The attention to independence should be noted with approval.

The Aged Care Complaints Commissioner is independent. We resolve complaints about Australian Government funded aged care for the community. We are separate from the Department of Health who fund and regulate aged care.822

However, duplication of resources and responsibilities with state health professionals may be problematic.

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820 Ibid, 6.
821 Ibid, Executive summary, 10.
7.29 Conclusion

Detention of elderly persons in psychiatric hospitals and aged care facilities in WA has emerged as an issue due to two principal factors. One is the trend which followed international developments resulting in dis-institutionalisation in mental health care. The second has been the demographic shift, resulting in a substantial part of the aged population developing dementia and other disorders, leading to residence in aged care facilities. The resulting legal and ethical issues have been largely sidelined by authorities, such as the HDWA and the MHC. This is in contrast with the substantial interest in other States and internationally.

The divided responsibility between the Commonwealth government and the Australian States is an additional unhelpful complication, and a barrier to effective resolution. How to avoid claims of false imprisonment and abuse of human rights in aged care has been elusive world-wide, particularly in the UK. There appears no single outstandingly successful model which balances protection with practicality and economy. The next chapter examined the Mental Health Act 2014 (WA), which came into effect on November 30, 2015. It considers whether the legislation can be regarded as an adequate response to the issues outlined in this and preceding chapters.

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823 Chapter 7.1, 271.
8 Deprivation of liberty in WA mental health hospitals

8.1 Detention and The Mental Health Act 2014 (WA)

This chapter examines the potential impact of the *Mental Health Act 2014* (WA) on elderly persons, and reviews whether it offers improved protection for elderly people in WA. The *Mental Health Act 2014* (WA) was approved by the WA Parliament on 16 October 2014. It was preceded by the release of an Exposure Draft Bill in 2011, and the *Mental Health Bill 2013* (WA), introduced into the WA Parliament on 23 October 2013 by the Minister for Mental Health, the Hon. Helen Morton, MLC. The Act received Royal assent on November 3, 2014 and was made operational on November 30, 2015.\(^{824}\)

8.2 The Mental Health Act 2014 (WA)

The principles expected to govern mental health law in WA have been stated in the *Mental Health Act 2014* (WA):

Principle 1: A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against them.

Principle 2: A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.\(^{825}\)

8.3 Comments on selected changes

The *Mental Health Act 2014* (WA) comprises 402 pages of legislation. In addition, the CP’s Guidelines amount to 265 pages explaining and consolidating the practical issues for clinicians. This chapter considers only a selection of changes in the new Act, in the light of experience. It will not attempt a comprehensive review of all sections of the new Act, but

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\(^{825}\) *Mental Health Act 2014* (WA), Schedule 1, 392.
will give an indication whether it suitably addresses concerns raised in the preceding chapters.

The Minister noted that the current *Mental Health Act 1996 (WA)* had a provision requiring review five years after commencement. This review had been conducted by Holman in 2003 but no tangible action was taken until 2013 to address his recommendations.\(^{826}\) The results of the review are therefore to be felt at least 18 years from the implementation of the 1996 legislation.

Concerns expressed by the Minister were that the current Act (*Mental Health Act 1996 (WA)*):

\[
\ldots\text{does not reflect community expectations and needs to be modernised to reflect good practice and ensure adequate safeguards for people experiencing mental illness. Importantly, the 1996 Act fails to include any special protections which reflect the additional vulnerability of children, and Aboriginal and Torres Strait Islander people. Families and carers are also not recognised under the current Act.}
\]

One of the real innovations of the Bill is the inclusion of the Charter of Mental Health Care Principles. This was developed in a 2011 forum coordinated by the Mental Health Commission. The forum comprised a diverse group of over 30 mental health consumers.\(^{827}\)

However, the proposal to include a charter of principles was already ten years overdue, and did not reflect or build upon existing hospital and HDWA guidelines. Holman had recommended a set of principles in 2003.

1.4 The Objects of the WA Act in section 5 should be replaced with two new sections: one being a new set of objects modelled to an appropriate degree on section 3 of the NT Act; and the other being a ‘set of fundamental principles modelled on section 3 of the NT Act, including notably, the sections containing principles relating to aborigines and Torres Strait Islanders (sec 11 of the NT Act) and the rights of carers (sec 12 of the NT Act).\(^{828}\)


\(^{828}\) Holman above, n 804, 4.
The Mental Health Act 2014 (WA) provides a Charter of Mental Health Care Principles, but unlike the Northern Territory (NT) legislation, it has been relegated to Schedule 1 on pages 392 to 394. The English MCA 2005 made a special point of placing the guiding principles at the forefront.\footnote{Jones R, Mental Capacity Act Manual, (2005 Sweet and Maxwell), General note 9/11.} Jones recorded that the Joint Committee of the House of Commons and the House of Lords which scrutinised the draft Mental Incapacity Bill 2003, recommended the name be changed to Mental Capacity Bill, and that a statement of principles should appear on the face of the Act.\footnote{Ibid, 9/8, 9/11.}

Jones stated:

> The Committee believed “that such a statement inserted as an initial point of reference could give valuable guidance to the courts, as well as helping non-lawyers to weigh up difficult decisions.”\footnote{Ibid, \textsuperscript{831}}

### 8.4 The Chief Psychiatrist (CP): Annual Report

Regarding the CP, Holman recommended:

> The responsibilities and functions of the Chief Psychiatrist should be strengthened in setting standards and quality assurance.

> …replace subsection 10(d) such that the CP is no longer required to report on matters to the Mental Health Review Board (MHRB), but rather is required to make an annual report to the Minister for Health and the Director-General on matters that are the CP’s responsibilities; and that the Minister shall table the report before each House of Parliament.\footnote{Holman above, n 804, 5.}

At that time the Minister referred to by Holman was the Minister for Health, as there was no Minister for Mental Health. Under the Mental Health Act 1962 (WA), the Director administered the MHS, subject to the control of the Minister for Health.\footnote{Mental Health Act 1962 (WA), s 6,7.} The Director was required to provide a, ‘report in writing of the administration of the Department, of the medical care and welfare of persons treated under this Act, in general…’\footnote{Ibid, s6.} Copies of these
reports are still available and provide detailed information on statistics, as well as informative reports from senior staff recording both progress made and impediments experienced.

Through the events of 1984 which entailed the formation of the HDWA, the CP replaced the Director of Mental Health Services, and the MHS department was abolished, subsuming it into general health services. The CP was made, ‘…subject to the general direction and control of the Commissioner.’\textsuperscript{835} The CP was not required to provide an Annual Report to Parliament, which Holman recognised as a deficiency. He recommended that the CP is required:

\[\ldots\text{to make an annual report to the Minister for Health and the Director General on matters that are the CP’s responsibilities; and that the Minister shall table the (my emphasis) report before each House of Parliament.}^{836}\]

The role of the CP in the \textit{Mental Health Act 2014} (WA) has been relegated to page 343 under Part 23, Division 2 – Chief Psychiatrist. The CP is appointed on the recommendation of the Minister for Mental Health and \textbf{may be directed by the Minister:}

\begin{quote}
The Minister may, after consultation with the Chief Psychiatrist, issue written directions about the general policy to be followed by the Chief Psychiatrist in performing functions under this Act.\textsuperscript{837}\end{quote}

The CP is required to submit his annual report to the Minister for Mental Health, who in turn must ‘cause \textbf{g} copy of \textbf{g} (my emphasis) report referred to in section 533(1) to be laid before each House of Parliament…’\textsuperscript{838}

\begin{flushright}
\begin{footnotesize}
\textsuperscript{835} \textit{Mental Health Act 1996} (WA), Div.2, 11.
\textsuperscript{836} Holman above, n 804, 2.1.
\textsuperscript{837} \textit{Mental Health Act 2014} (WA), Part 23, Div. 2, s 516 (1).
\textsuperscript{838} The Public Advocate is required to provide an Annual Report in similar terms, but stated as: The Minister shall cause the report etc: \textit{Guardianship and Administration Act 1990}, Part 8, s101(2).
\end{footnotesize}
\end{flushright}
My concern is that the CP’s report will not be independent of the Minister, who can edit and direct the contents to suit. Annual reports to parliament are important avenues by which professional mental health staff, were in the past able to submit a permanent public record of their activities. They were useful historical and research documents, less subject to government or ministerial control, providing a degree of transparency and available to a wide audience.

The Australian Government has issued guidelines which include the position where the office-holder has a statutory obligation to report good practice, as is the case with the CP.\textsuperscript{839}

The WA Public Sector Commissioner has stated the importance of transparency and accountability in official reports to Parliament.

\begin{quote}
Annual reports are an important tool in ensuring public sector transparency and accountability by providing the Western Australian Parliament with information about the performance of the public sector. They are also increasingly important in assisting the public’s understanding of the diverse operations of government agencies.\textsuperscript{840}
\end{quote}

The importance of transparency is diminished if Annual Reports can become a glossy media exercise, rather than a reference source on matters affecting human rights and liberty.\textsuperscript{841}

The position of the CP transferred from the HDWA to the MHC in 2015. There is no annual report from the CP within the Annual Report of the MHC for 2013-2014.\textsuperscript{842}

\textsuperscript{839} Australian Government Department of the Prime Minister and Cabinet, Government Guidelines for Official Witnesses before Parliamentary Committees and Related Matters - February 2015 online.


\textsuperscript{841} MHC Annual Report 2013-14: Images portrayed a negative view of older persons as stooped and on walking aids. My letter of criticism was dismissed by a media representative.

\textsuperscript{842} MHC Annual Report, 2013-2014, prepared under Sec.61 of the Financial Management Act 2006.
The opportunity for a statutory office holder charged with monitoring standards, to represent his or her report directly to parliament, on clinical and professional matters of public interest, has been lost.

During the Parliamentary debates, attempts by members of parliament to comprehend changes occurring in the provision of facilities, were demonstrated to be inadequate. The Minister was, for example, unable to tell a member how many patients were being held under guards at WA emergency departments because of reductions in beds at Graylands Hospital. \textsuperscript{843} The Minister stated that such information was not captured in the current record systems of the Health Department. Some of these patients were referred for admission under the \textit{Mental Health Act 1996} (WA), but could not be accommodated immediately. The CP should normally be able to provide this type of information in Annual Reports. \textsuperscript{844} Annual reports should not shy away from stating where problems were occurring, ensuring compliance by government and hospitals meeting their legal and human rights obligations towards detained patients.

### 8.5 Role of the Mental Health Tribunal (MHT)

The introduction of the MHRB in the \textit{Mental Health Act 1996} (WA) presented a new concept and set of procedures to WA clinicians, patients, and lawyers. As was outlined in chapter 2, the historical development of mental health care emerged gradually from a punitive confinement system, through stages ensuring at least some basic legal oversight of the process, to a more humane and therapeutically intended one. This last stage has combined to varying degrees at different times, medical as well as legal contributions with review and admission procedures.

\textsuperscript{843} Hon Stephen Dawson, Hansard WA Parliament, Council Tuesday 16 September 2014, 1339.

\textsuperscript{844} The final MHS Annual Report, was presented under section 8 (6) of the Mental Health Act 1962 to both Houses of Parliament, in October 1984 by The Director, Dr R Kosky. Senior staff drew attention to the statistical information available, and freely expressed their opinions of both the positive and negative aspects of the reports.
The transition from a mainly judicial/legal system requiring a magistrate, and supplementary medical reports, towards an increased medical role, placed medical practitioners in a position simultaneously authorising detention and providing treatment and care. The pendulum between the two systems has swung over the decades, with the legal requirements to authorise detention by a magistrate after receipt of medical reports, changing to a more medically initiated process with legal checks and balances.  

The MHT is addressed in the background to Chapter 9 of the CP’s Clinician’s Practice Guide:

9.1.1 All jurisdictions in Australia have moved from a strict ‘medical model’ in relation to involuntary care and detention to a ‘legal model’. This imposes specific criteria for involuntary status and seeks to ensure the procedural fairness of decisions made through a process of independent review.  

It should be noted that the detention of persons for provision of involuntary treatment, has always had a significant legal component, as has been explained in the historical development of mental health law in Chapter 2.  

The Practice Guide continues:

9.1.2 The Mental Health Act 1996 (MHA 1996) introduced the Mental Health Review Board into legislation, as an independent board to review involuntary status.  

9.1.3 The Mental Health Act 2014 (Act) continues with the concept of a review function but the name has been changed to the Mental Health Tribunal (Tribunal), with a number of new duties and responsibilities in addition to its function of reviewing involuntary status.
Comment: The claimed independence of the Tribunal is questionable, given its close association with the Minister for Mental Health and the MHC. The new legislation does not appear to provide a manifestly independent body of appeal.849

The additional ‘duties and responsibilities’ of the Tribunal outlined in the Act and in the guidelines, represent many new measures which do not address the defects in the operations of the previous MHRB, yet add further demands.

Additional duties placed on the MHT include:

a) Review of involuntary status to determine whether or not an involuntary order should continue (Division 3).

b) Review of involuntary treatment orders with regard to their validity (Division 4).

c) Review the application for the provision of ECT for involuntary patients and all children, voluntary and involuntary, over the age of 14, and either approve or not approve the treatment (Division 6).

d) Review the application for psychosurgery for patients and all children over the age of 16 who provide informed consent, and either approve or not approve the treatment (Division 7).

e) Review orders restricting freedom of communication (Division 9).

f) Review decisions affecting rights (Division 11).

g) Review the admission of long-term voluntary inpatients (Division 5).

h) Review applications in regard to compliance notices for non-clinical matters and decide whether a compliance notice should be made (Division 8).

i) Review the validity of a nominated person to perform that role (Division 10).

In effect the responsibilities of the Tribunal have increased from one central role, viz. reviews of involuntary status, to nine, some of which are potentially very demanding in time, expertise and resources.

849 Hansard Assembly – Thursday 10 April 2014, Mental Health Bill 2013. Consideration in detail: Correspondence from a lawyer to Hon Helen Morton was raised in Parliament which stated; ‘The types of clauses I am advocating would make it clear to consumers, stakeholders, staff of the Tribunal and other public officers employed by the commission, authority or department of the day responsible for mental health that the Tribunal is independent and that the President is responsible for the development, administration and performance of the tribunal. These types of provisions would allow the Tribunal to be more effective and efficient and not beholden to the government department or authority that implements the Mental Health Act.’
8.6 Whether or not an involuntary order should continue

This is the most critical decision for the tribunal and should be the central issue at stake. Other extraneous matters may divert the attention and resources of the tribunal without addressing the fundamental reasons for the hearing, viz. continuation of the detention and treatment. Many of these important but related matters may be better dealt with by current HDWA complaints procedures.\textsuperscript{850}

8.7 Validity of documents

Review of the validity of involuntary treatment orders, introduces a change in the legal duty of the Tribunal which is in sharp contrast with recommendations which led to the establishment of the MHRT system in the UK.

...these review tribunals would not be acting as an appellate court of law to consider whether the patient’s mental condition at the time when the compulsory powers were first used had been accurately diagnosed by the doctors signing the recommendations, or whether there had been sufficient justification for the use of compulsory powers at the time, nor to consider whether there was some technical flaw in the documents purporting to authorise the patient’s admission... The tribunal’s function would be to consider whether the type of care which has been provided by the use of compulsory powers is the most appropriate to his current needs, or whether any alternative form of care might now be more appropriate, or whether he could now be discharged from care altogether.\textsuperscript{851}

8.8 Electroconvulsive treatment reviews (ECT)

The reviews of ECT will introduce an entirely different obligation on the tribunal members, and shift the process from a medical decision-making one, to one requiring a degree of clinical experience not held by either the legal or the community member. It fails to state on what basis these clinical decisions will be made, or indeed whether the decisions will be primarily a checking exercise to ensure the legal requirements have been correctly met.

\textsuperscript{850} Health and Disability Services Complaints Office (HaDSCO).
\textsuperscript{851} Report of the Royal Commission on the Law relating to Mental Illness and Mental deficiency (Cmnd, 169, HMSO 1957) 150-151.
Because the medical member does not have the time allocated, nor in some cases the current experience of ECT technical, safety and procedural requirements, he will, like the other members, be restricted in providing an authoritative view. A tribunal may need to call upon independent psychiatrists with special qualifications and experience in administering ECT, to ensure a balanced and authoritative review. The best interests of patients should be foremost, and personal views of tribunal members as to the value of ECT, should be irrelevant, as would apply in any other medical procedures conducted in hospitals.

8.9 Psychosurgery

The same comments apply in principle to the use of psychosurgery. The usefulness of including these provisions, which relate to surgical procedures not in use in WA over the past 50 years, but adding to the stigmatising character of mental health legislation is debatable, but reflects community concerns. Similarly, the suggestion that newly emerging techniques involving invasive treatment for disorders such as Parkinson’s disease need to be included, is arguable justification. Such procedures would normally be carried out in general hospitals, subject to health service consent requirements and ethical approvals. If additional safeguards were advisable in future, it is hard to see why stigmatising mental health legislation would be needed, unless the patient lacked capacity, in which case guardianship could be applied as is done with other procedures such as sterilisation.

8.10 Reviews of long-term voluntary patients

Under the *Mental Health Act 2014* (WA) a small number of voluntary patients who remain resident in authorised hospitals over six months, will be reviewed by the MHT. The issue of voluntary patients in acute psychiatric hospitals is complex.

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853 *Guardianship and Administration Act 1990*, (WA), Div. 3.
Reference has been made to the difficulty of determining whether such patients are in fact voluntary or merely acquiescing to detention.\textsuperscript{854} In any case, if they are always under staff direction and control and not free to leave, under UK law they would be considered to be deprived of their liberty.\textsuperscript{855}

In old age psychiatry services, some patients with dementia may be so confused and disoriented that they are unaware they have been detained.\textsuperscript{856} Failure to ensure that legally valid measures are in place creates the risk of a tort of trespass being sustained.

Situations in which a person is alone in a room and is unable to leave of his or her own volition are inevitable in authorised hospitals, especially those that cater for older adults.\textsuperscript{857}

The \textit{Mental Health Act 2014} (WA) does not address this issue, and the parliamentary debates infrequently made any reference to older persons. In reply to a question the parliamentary secretary to the Minister for Mental Health confirmed that, ‘If a patient is voluntary, they need to give informed consent for treatment and under emergency conditions it is another scenario’.\textsuperscript{858} A concern remains that psychiatrists are still required to detain elderly patients with dementia, in circumstances which may be contrary to the common law, as was found in England. The ECtHR found violations of the ECHR and imposed financial penalties.\textsuperscript{859}

This cannot occur in WA as the ECHR does not apply, but the fact remains that the same acts are carried out, with the same issues not addressed by government.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{854} Breggin P, Coercion of Voluntary Patients in an Open Hospital, \textit{Archives of General Psychiatry}, 1964; 10 (2):173.
\item \textsuperscript{855} Royal College of Psychiatrists, Mental Capacity Act – Update following \textit{P v Cheshire West and P & Q v Surrey County Council} cases, 3. Members online access, 7 September 2015.
\item \textsuperscript{856} \textit{Meering v Graham White Aviation Co. Ltd.} [1919] 122 Law Times 44.
\item \textsuperscript{857} Parliament of WA, Extract from Hansard [ASSEMBLY — Thursday, 16 October 2014] p7462b-7480a.
\item \textsuperscript{858} Parliament of WA, Hansard, [ASSEMBLY — Thursday 27 February 2014] p 1207b-1227a.
\item \textsuperscript{859} \textit{HL v United Kingdom} Application No. 45508/99, (2005) 40 E.H.R.R. 32.
\end{itemize}
\end{footnotesize}
An additional question must be the rights of any long-term patient to refuse an MHT Review, and what legal authority exists to intrude on the treatment of a voluntary, consenting patient. No such provisions for example apply to private hospitals, non-authorised psychiatric, or otherwise.

### 8.11 MHT constraints

Despite the MHT having some of the features of tribunals, they have previously operated under many serious constraints and resource deficiencies. The *Mental Health Act 2014* (WA) places many new and additional duties on the MHT. There has been no independent examination of the performance of the MHT, to inform the best direction for change. The former MHRB internet information page is still dated 2012, and provides no annual reports from that date onwards. Who is responsible is unclear.\(^{860}\)

### 8.12 Issues which will impact on meeting the new requirements

The *Mental Health Act 2014* (WA) is a substantially enlarged and complex document. Whereas the *Mental Health Act 1962* (WA) extended to only 70 pages, and the *Mental Health Act 1996* (WA) to 118 pages, this new Act has 402 pages. The associated clinical guidelines issued by the CP are another 289 pages and additional reference material is anticipated.\(^{861}\)

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\(^{860}\) “Qui custodes custodiet” or “Who guards the guards?”

The Minister stated; ‘First of all, the review of the Mental Health Act has been going on since about 2004.’ In fact intensive training for clinicians only commenced in 2015. Whereas previously there was no mandated requirement for psychiatrists to undertake mental health law training previously, this is now a requirement. A clinicians e-Learning Package has been produced, comprising 15 modules and taking 3-4 hours to complete.

While the available materials are innovative and commendable, the time allocated to adopt them in culture and practice is debatable.

Legislation by parliament is only one part of the process of bringing change to a system. Even more important is the acculturation of all health professionals and the public generally, to the philosophical and ethics based thinking necessary for effective and fruitful progress. Psychiatry in WA public hospitals is a medical discipline, operating in a social and legal environment. Most patients with mental disorders do not come within the provisions of the Mental Health Act 2014 (WA), but treating clinicians are subject to the common law and tort law in cases of negligence.

The position changes when considering mental health legislation which introduces the power of detaining a person, i.e. restricting, or depriving them of their liberty, and obliging them to accept treatment which they may oppose. New legislation is not simply a matter of directing what must be done under pain of penalties; there must be room for deeper understanding of why a specialised and wholistic approach is expected. While many clinicians have been accustomed to a paternalistic and well-meant view of their role, the changes in societal expectations in recent decades have been substantial.

864 Hansard Assembly Thursday, 13 March 2014, Mental Health Bill 2013: Ms Andrea Mitchell, re; the Objects of the legislation: “We will always rely on common law in these cases. It is no different from any other case; all those things that apply to common law would be used.”
The community at large must also appreciate the moral position behind new directions in mental health care. This cannot be achieved overnight, and undue haste to meet political objectives may be counter-productive. Submissions to the House of Lords Report on implementation of DoLS has highlighted the need for a culture shift in health services thinking rather than reliance on formal legislation and sanctions.

A fundamental change of attitudes among professionals is needed in order to move from protection and paternalism to enablement and empowerment. Professionals need to be aware of their responsibilities under the Act, just as families need to be aware of their rights under it. 865

Newly emerging concerns in mental health service delivery create increased demands on resources, financial and human, as well as taxing the patience and support of families and carers. Drug abuse, with its mix of illegality, criminal and mental health elements, presents problems which are more complex than sometimes appreciated. Tribunals which previously mainly dealt with recoverable or at least treatable mental illnesses, are now faced with people who, on return to a dysfunctional home or community environment, will relapse quickly. Elderly persons are not excluded from this category, and alcohol abuse is a continuing problem. 866

Addressing matters of fairness and procedural justice will rightly involve greater time taken for deliberations by tribunals. As mentioned in chapter 3, the allocation of as many as eight or ten hearings on one day, will be impractical without a considerable change in procedures. Representation by lawyers and other advocates, while eminently desirable, will also add to the length and complexity of hearings, thereby increasing costs. This should be recognised as potentially diverting limited financial resources from provision of quality patient care. More clerical and professional assistance to the tribunals should be a high priority. This will

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be an additional cost but will improve efficiency and reduce failed or deferred hearings due to lack of reports etc.

Involvement by family members, advocates and carers is naturally to be encouraged, but will add considerably to costs and time allocated. This could be reduced if tribunals are provided with detailed and timely reports on social circumstances, and is a service provision issue, best addressed by adequate resources of social work and community care case management staff.

In drawing attention to the need for communication issues to be addressed the Minister indicated that a recourse to a MHT was open to an aggrieved person. This adds yet another supervisory and administrative function for which the tribunal may not have the resources to address and remedy. These are matters of daily health care administration, which the current clinical and administrative provisions in the HDWA, or the Health and Disability Services Complaints Office (HaDSCO) should be equipped to address more effectively.

8.13 Voluntary patients lacking decision-making capacity

8.13.1 State mental health facilities

Under the Mental Health Act 1996 (WA) voluntary patients were not mentioned, or rather were only included by exception, being persons not detained under the Act. The Mental Health Act 2014 (WA) provides a definition, but only by exclusion as not an involuntary patient. The Act includes a provision for review of these patients, but only if they are a long-term inpatient. Long-term inpatients are those who have been in the approved hospital for a continuous period of more than six months. The legislation does not accommodate the legal position of patients lacking capacity and admitted for shorter periods.

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867 Mental Health Act 1996 (WA), Part 3, Division 1, subdivision 2, s 30, Referral of voluntary patients in certain circumstances.
868 Mental Health Act 2014 (WA) Division 5, Review of long-term voluntary patients, s 404-408.
To avoid breaching the obligation to protect the best interests of these patients, it may appear inevitable that a patient in an authorised hospital who lacks decision-making capacity, must be made an involuntary patient, unless there is a legally appointed guardian with authority to consent on behalf of the patient. This may be an undesirable development on several grounds including stigmatisation, distress to family and carers, and needless involvement of guardianship legislation and procedures. It maintains discrimination against authorised mental health facilities providing mental health assessment and treatment to the elderly. This may result from identification of the facility as one linked with asylums and restrictive long term care practices. Contemporary mental health facilities can provide a range of physical and mental health resources for older patients, they should be regarded in the same way as aged care medical facilities in general hospitals, with safeguards applicable to any patient unable to consent to medical treatment.

Steps need to be taken to promote consensual supported decision-making whenever possible. The 2003 Holman review recommended a change to the *Criminal Code 1913* (WA) as follows:

3.9 The Criminal Code 1913 should be amended by inserting a new section immediately after section 337 to read, “A person who exercises duty of care of a person with degenerative brain disease, and as a consequence of their duty of care prevents the person with degenerative brain disease from wandering into an environment where due to their condition they would be at risk of becoming lost or harmed, is not guilty of a misdemeanour under section 337.”

No amendment has been pursued and in theory staff could be found liable. The *Mental Health Act 2014* (WA) has not addressed this issue, but given the complexity and difficulties with the *Mental Capacity Act 2005* and DoLS in the UK, this is perhaps unsurprising. However, there is no excuse for ignoring these issues.

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869 Holman above n332, 3.9, 11.
The case of Westcott v the Minister for Health involving the tort of professional negligence in a public hospital, referred to the Civil Liability Act 2002 (WA) which has the following clauses:

5B. General principles

(1) A person is not liable for harm caused by that person’s fault in failing to take precautions against a risk of harm unless —

(a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known); and

(b) the risk was not insignificant; and

(c) in the circumstances, a reasonable person in the person’s position would have taken those precautions.

(2) In determining whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (amongst other relevant things) —

(a) the probability that the harm would occur if care were not taken;

(b) the likely seriousness of the harm;

(c) the burden of taking precautions to avoid the risk of harm;

(d) the social utility of the activity that creates the risk of harm.

[Section 5B inserted by No. 58 of 2003 s. 8.]

There is a foreseeable risk of harm, if persons in responsible positions of trust are found to have, ‘failed to take precautions’. This failure could include not ensuring lawful procedures were employed when indicated, and paying insufficient attention to risk, in the placement of persons without capacity to consent, in hospitals or aged care facilities.871

870 Westcott v The Minister for Health [2015] WADC 122. Judgement was given against the Minister for a sum of $933,544.87.

871 The Hertfordshire NHS Trust was fined £500,000 when a patient unsuitably placed in a care home killed a care worker. They had failed to carry out a risk assessment. BBC News 21 April, 2009, online.
8.13.2 **Formal detention of voluntary patients**

Under the *Mental Health Act 1996* (WA) provision was made for circumstances where a patient who had agreed to voluntary admission to an authorised hospital, requested discharge and a psychiatrist was not available to examine the person. 872 This Division allowed ‘a senior mental health practitioner’ to detain the patient for six hours.

If a senior mental health practitioner suspects on reasonable grounds that the person should be examined for the purposes of section 29 he or she may in writing order that the person be detained at the hospital for up to 6 hours from the time when the person seeks to be discharged. 873

There was also provision that the psychiatrist who examined the patient was not to be the treating psychiatrist of the patient at that time. 874

The *Mental Health Act 2014* (WA) provision for up to 6 hours’ detention states:

The person in charge of the voluntary inpatient’s ward may make an order for an assessment of the voluntary inpatient by a medical practitioner or authorised mental health practitioner at the authorised hospital if –

(a) the voluntary inpatient wants to leave the authorised hospital against medical advice; and

(b) having regard to the criteria specified in section 25, the person in charge reasonably suspects that the voluntary inpatient is in need of an involuntary treatment order. 875

There is no definition of the ‘person in charge’, but presumably this would be a senior mental health practitioner. This example is mentioned to draw attention to the pre-occupation in WA mental health legislation with the place, *authorised hospital*, and place that is not an *authorised hospital*. The qualifications and training of the professionals should form the basis of detention orders, rather than the building location on a map. 876

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872 Mental Health Act 1996 (WA), Part 3, Div.1, s.30, Referral of voluntary patients in certain circumstances.
873 Ibid, Part 3, Div.1, s.30, (3).
874 Ibid, Part 3, Div.1, s.30, (6).
875 Mental Health Act 2014 (WA), Part 6, Div. 2, s34 (1).
876 See; Government Gazette November 13 2015, 4642-4643, Authorisation of Public Hospitals, Areas bordered red on Plan No A _01_ 4001 R5, 8D St John of God Midland Public Hospital, Mental Health Unit, 4th Floor.
8.14 Capacity and consent

Under section 26 of the *Mental Health Act 1996* (WA), a criterion for involuntary treatment was that ‘the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment’. Holman recommended that refusal should have to be *unreasonable* and this was included in the Bill. As this was thought to give too much scope to psychiatrists deciding what was *unreasonable*, a very late amendment removed this criterion.\(^{877}\)

In its place was substituted that, ‘the person does not have the capacity required by section 18 to make a treatment decision about the provision of treatment to himself or herself’.\(^{878}\) Stakeholders, including the RANZCP supported this very late change, with minimal discussion of potential problems from a shift to capacity based legislation.\(^{879}\) It remains to be seen how well this works in practice, and may be a positive development if training and culture permit. Dawson and Szmukler have recommended abolishing all mental health legislation in favour of a ‘fusion’ with capacity based decision-making procedures, but this may be some way off yet.\(^{880}\)

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\(^{877}\) *Unreasonableness* has a legal meaning. It is said to apply where the decision is so unreasonable that no reasonable bureaucrat similarly placed would have decided the same way: *Associated Provincial Picture Houses Ltd. v Wednesbury* [1948] 1 KB 223. The courts in Australia have restricted use of the expression, *Wednesbury unreasonableness*. The Australian Law Dictionary, (Oxford 2010) 595.


\(^{879}\) House of Lords, Mental Capacity Act 2005: Post legislative scrutiny, Select Committee 2. ‘Our evidence suggests that capacity is not always assumed when it should be. Capacity assessments are not often carried out; when they are, the quality is often poor’.

\(^{880}\) Dawson J, Szmukler G, Fusion of mental health and incapacity legislation; *British Journal Of Psychiatry*, May 2006, 188. ‘Such legislation would reduce unjustified legal discrimination against mentally disordered persons and apply consistent ethical principles across medical law.’
8.15 Reduction of coercion in clinical services

The number of detained patients contacting the CoOV has increased, as can be found in figures from the Annual Report of the Chief Mental Health Advocate.\(^{881}\) A central objective in future clinical care should be systematic efforts to reduce the use of all coercion in psychiatric practice.\(^{882}\) This should move well beyond rather the limited, although essential, preoccupation with the use of chemical and physical restraints in hospitals. An approach involving trained independent negotiators/facilitators suggested by Flood et al, should be explored as an alternative.\(^{883}\) This approach should be less prescriptive than the current MHC directions embodied in the Mental Health Act 2014 (WA) regarding mandatory care plans and punitive measures.

If accepted, the concepts of jointly negotiated and agreed advance care plans in which clinicians and patients are partners in care, could lead to reduced confrontation and be accepted by tribunals, as evidence of adequate care plans. Properly negotiated care planning, using qualified mediators if necessary, could reduce conflicts and the need for more expensive and time-consuming tribunals. Such an approach will require sound policy and procedure documents setting out standards, reinforced with education and enlightened leadership.

Research suggests evidence of benefits where the patient is viewed as a more equal participant in their care planning, and able to negotiate a result in keeping with their wishes and intentions as stated in the UK by Henderson et al:

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We can find no other evidence in the literature that a structured clinical intervention can significantly reduce compulsory psychiatric admission and treatment. This study suggests that the committee reviewing the Mental Health Act 1983 was correct in its assertion that advance agreements can promote more consensual and less coercive care.\textsuperscript{884}

As Szmukler has concluded:

…there are considerable conceptual and practical difficulties in understanding and researching coercion. Nevertheless, it is hugely important to our patients and, indeed, for the status of psychiatry that we do all that is possible to reduce recourse to these measures to a minimum.\textsuperscript{885}

The clear majority of patients attend psychiatrists on a voluntary basis.\textsuperscript{886} More attention should be paid to ways of encouraging maximum voluntary treatment and care.\textsuperscript{887} Reduction of stigma, early community assessment and interventions should be promoted rather than the current preoccupation with coercive legislation and confinement, where possible. Whether acute hospital emergency departments are appropriate for initial psychiatric assessments, or may result in even greater utilisation of coercion and inpatient care should be examined. Research into the extent of unlawful detention in psychiatric and aged care facilities in WA is required, if practice is to change.\textsuperscript{888}

8.16 Summary of changes which should be considered:

1. ‘Voluntary’ patients unable to consent to admission or treatment, should receive special attention from the Mental Health Advocacy Service. The advocacy service staff should ensure that an assessment of decision-making capacity has been documented and the will and wishes of the person respected.\textsuperscript{889}

2. Where decision-making capacity has been recorded as absent or impaired, a review should be undertaken to ensure that the requirements of the \textit{Guardianship and}


\textsuperscript{885} Szmukler G, Compulsion and “coercion” in mental health care, \textit{World Psychiatry} October 2015, 14:3, 261.

\textsuperscript{886} AIHW Mental Health Services in Australia, Table Sum1: Mental health services in Western Australia: Community contacts 844,650 – all mental health related hospital separations 25,252.

\textsuperscript{887} AIHW Mental Health Services in Australia in brief 2013, 13: 50% of all Public Psychiatric Hospital admission are involuntary.

\textsuperscript{888} OPA website: The Office of the Public Advocate works to promote and protect the human rights of more than 65,000 Western Australian adults with decision-making disabilities. Number of people under Guardianship orders 30 June 2015, 1,383. Number of people with dementia in aged care facilities in WA 7,574 of total 13,946 residents. See AIHW, \textit{Dementia in residential aged care}, Table 1, as at 30 June 2012.

\textsuperscript{889} The Act requires that a \textit{youth advocate} with qualifications, training or experience relevant to children and young people is appointed, (Mental Health Act 2014 Part 20, Div. 2, 350, (2). A Seniors Advocate with similar qualifications should equally be a requirement.
Administration Act 1990 Sec 119 (WA), in respect of medical and dental treatment, have been observed. Specifically, this requires ensuring that the person giving authority is one of the categories named in the legislation, as having decision-making authority.

3. Where the Chief Mental Health Advocate (CMHA) is informed that a person with impaired or absent decision-making capacity, may be unable to express a wish to leave a mental health facility, yet not actively attempting to leave, then the CMHA should consider whether a referral to the MHT should be made. Conferring with staff and the person with decision-making authority on behalf of the person, as defined under Guardianship and Administration Act 1990 Sec. 119 (WA) should occur.

4. The Advocacy Service should consider the role of the Independent Mental Capacity Advocate (IMCA), in the UK. Under the Mental Capacity Act 2005 (UK) it is possible to appoint an IMCA who can undertake tasks like that outlined above in 3. Careful selection of experienced and qualified persons would be crucial to success.

5. Legal representation should be provided in all MHT hearings initiated by the advocate, where the patient does not have capacity to consent.

6. Family and carer conferencing post-admission and pre-discharge should be a monitored quality assurance feature of all psychiatry of old age facilities.

7. Where an MHT hearing is to be held there must be significant improvement in compliance with legal and reporting requirements, as well as greater attention to substantive and procedural justice.

Future changes could be introduced incrementally by regulation or administrative measures, rather than rewriting legislation.\footnote{IMCAs are primarily intended to be a safeguard for people who do not have family or friends who can represent them. The MCA identifies this as having no-one other than paid staff with whom “it would be appropriate to consult”. The Code of Practice 10.74 - 10.78 provides more information about how this decision can be made. For example, if someone has limited family contact or if family live some distance away an IMCA can be instructed. Mental Health Regulations 1997 (WA), provide an example of a simple means of updating laws, rather than waiting for rewriting of an entire Act.}
This chapter considered the revised WA legislative measures that regulate detention in mental health hospitals, with comments on their potential to remedy the issues that were raised in preceding chapters. The next chapter has focused on suggestions for changes, that will assist in remedying some of the deficiencies in current legal and clinical practice, in psychiatry and in aged care generally in the whole community.
9 Conclusion and recommendations

This chapter considers measures intended to benefit all persons receiving aged care, inclusive of people undergoing mental health admissions and treatment. Older persons with mental health disorders are often doubly-disadvantaged, having the physical disabilities associated with age and chronic illness, as well as psychological and psychiatric conditions. When providing effective, safe and proportionate responses to their need for health care, discrimination towards the mentally ill should be avoided. Older people with mental health conditions, must be entitled to access the same quality standards and resources as all aged persons, respecting any special needs for management of physical and mental health conditions.

9.1 Challenging detention in aged care facilities

A consequence of dementia and declining physical health may incur necessary placement in residential aged care facilities. Where this has been undertaken in the best interests of the person, by concerned, honest and well-meaning family members the law should be able to keep at a respectful distance, yet be aware of the potential for abuse or deprivation of autonomy and liberty, and must include effective monitoring.

The provision of aged care home facilities in WA is a Commonwealth function, although approvals for admission are managed by State ACAT staff, funded and authorised under delegation, with a potential conflict of interest. Detention in aged care facilities is not granted legal safeguards by Commonwealth or State legal authorities. The only source of authority may be the common law, which has not been tested in this regard in Australia.

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892 At a time now well past, admission to Commonwealth funded nursing homes was restricted if the patient had a significant length of history of psychiatric hospital admission. This led to many bed-ridden patients remaining in mental hospitals well beyond their need for specialist psychiatric care. Striking a happy balance between exclusion and cost-shifting by States is complex.
However, in Britain, the Bournewood decision has affirmed that detention in almost any form, must be accompanied by adequate legal safeguards. Unfortunately, the DoLS measures adopted in the UK have proved ‘unfit for purpose’, have not impacted on abuses which continue, and have tied courts, lawyers, judges, families, and care professionals in knots.

The level and breadth of criticism of the Deprivation of Liberty Safeguards, including from the judiciary, demonstrates that the legislation is not fit for purpose. Better implementation would not be sufficient to address the fundamental problems identified.\(^{893}\)

The challenge remains, in the UK and WA, to meet the need for a balanced legal oversight, with cost-effective protections for the autonomy and safety of individuals in care. A recent editorial suggests that the methods adopted in England, and the legalistic DoLS measures have not helped.\(^{894}\)

All patients admitted to aged care facilities in Australia must be assessed by professional aged care staff under the ACAT procedures. This applies to all private, government funded and non-government or charitable facilities. The *Aged Care Act 1997* (Cth) Part 2.3, deals with approval of care recipients. This information appears at page 88 of the Act, following extensive dealing with approvals of aged care home providers and matters of subsidies etc. There is a new exposure draft on the principles to be applied for approval of care recipients intended for consultation:

6 Residential care

(1) For paragraph 21-2(c) of the Act, a person is eligible to receive residential care only if:

(a) the person is assessed as:

(i) having a condition of frailty or disability requiring continuing personal care; and

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(ii) being incapable of living in the community without support; and

(b) for a person who is not an aged person—there are no other care facilities or care services more appropriate to meet the person’s needs.

(2) In deciding if a person meets the criteria mentioned in subsection (1), the Secretary must consider the person’s medical, physical, psychological and social circumstances, including (if relevant) the following:

(a) evidence of a medical condition, as decided by a suitably qualified medical practitioner;

(b) evidence of absence or loss of physical functions, as established by assessment of capacity to perform daily living tasks;

(c) evidence of absence or loss of cognitive functioning, as established by:

(i) a medical diagnosis of dementia or other condition; or

(ii) assessment of capacity to perform daily living tasks; or

(iii) evidence of behavioural dysfunction;

(d) evidence of absence or loss of social functioning, as established by:

(i) information provided by the person, a carer, family, friends or others; or

(ii) assessment of capacity to perform daily living tasks;

(e) evidence that the person’s life or health would be at significant risk if the person did not receive residential care. 895

The draft principles do not provide guidance as to whether the person assessed has consented to admission to an aged care facility.

By contrast, when dealing with home care there is a requirement that the person, prefers to remain living at home. As a person being considered for residential care is far more likely to have limited capacity to consent, a much stronger requirement indicating the wishes and preferences of the person. The criteria do not promote the person’s ability to express their own views, but are focused on impairments and defects. This appears contrary to the thrust of much work being undertaken to promote participatory decision-making for disabled persons.

9.2 Obtaining consent to aged care facility admission

This should include a mandatory section on consent in the ACAT assessment, with specific measures to ensure mental capacity to decide is present. Where capacity to consent is not present, an additional review should be required. This could take the form of requiring the care home provider to notify the aged care standards monitoring body when routinely detaining a new patient.\footnote{Aged Care Quality Agency, \textit{Assessment module compilation}, June 2014: This compilation addresses a variety of essential matters, but requires a survey of only ‘at least 10\% of care recipients/representatives’. Issues of capacity and consent appear to be included in one obscure reference stating, ‘Management in relation to legal rights such as ability to vote, powers of attorney, guardianships, security of tenure, consent for particular treatments and any special financial arrangements.’ Assessment module 10 Supporting independent lifestyle and preferences. <https://www.aacqa.gov.au/for-providers/Assessmentmodules.pdf>}. 

These care facilities should be monitored to establish that an independent person has authorised detention of any person lacking sufficient decision-making capacity. The detention could be authorised by an aged care ombudsman as in Canada, an approved mediation process or the under the \textit{Guardianship and Administration Act 1990 (WA)}. 

To reduce concerns regarding consent and capacity, ACAT assessments must always be multidisciplinary, must include any available family members, and address comprehensively matters of mental capacity to consent to admission. The principles stated in the \textit{Aged Care Act 1997 (Cth)} should be elevated to requirements, which can only be set aside in exceptional circumstances. Where this occurs, an additional authority must be provided from either a State or Commonwealth judicial or quasi-judicial body. For instance, the ACAT assessment and approval should never be completed by one professional working alone, whether a medical practitioner or other health professional, otherwise the word \textit{Team} in ACAT is misleading.
Requirements to consult with family or relevant carers should be mandatory and documented. Where there is no known family member or suitable person to assist, a guardian or friend ad litem should be appointed, at least for the purposes of helping with an ACAT assessment and approval. The Mental Health Act 2014 (WA) has clear and comprehensive requirements to consult with families and other support persons in the event of involuntary psychiatric admission, and the same standards should be expected in admission to an aged care facility, where detention and deprivation of liberty is proposed.

9.3 The UNCRPD

Commonwealth aged care facility admissions should be consistent with the UNCRPD. Australia is a signatory to this convention and has an obligation to practice as it preaches. There is, however, a thorny legal issue, which is that conventions must be incorporated into domestic law through statute law to have effect, although courts can pay attention to a convention when interpreting domestic laws.

This position was established in Minister for Immigration v Teoh.

Per Mason CJ, Deane, Toohey and Gaudron JJ. Although a Convention ratified by Australia does not become part of Australian law unless its provisions have been validly incorporated into municipal law by statute, the ratification was an adequate foundation for a legitimate expectation, absent statutory or executive indications to the contrary, that administrative decision-makers would act conformably with the Convention. It is not necessary that a person seeking to set up such a legitimate expectation be aware of the Convention or personally entertain the expectation. It is enough that the expectation is reasonable in the sense that there are adequate materials to support it.

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897 Friend ad Litem see, (WA) Rules of the Supreme Court 1971 - Order 70 rule 3. Also in UK, McKenzie Friend, an unpaid adviser in court.
The following observation was included in the decision by the High Court:

Apart from influencing the construction of a statute or subordinate legislation, an international convention may play a part in the development by the courts of the common law. The provisions of an international convention to which Australia is a party, especially one which declares universal fundamental rights, may be used by the courts as a legitimate guide in developing the common law (9). But the courts should act in this fashion with due circumspection when the Parliament itself has not seen fit to incorporate the provisions of a convention into our domestic law.\textsuperscript{899}

In the course of the Teoh judgement reference was also made to the ‘reasonable expectation’ that the principles of an adopted international convention would be upheld in domestic administrative law decision-making.\textsuperscript{900}

The ALRC report on disability makes specific reference to the Commonwealth role in aged care and the case for careful attention to decision-making practices.\textsuperscript{901} The Report affirms the place of supported decision-making in place of substituted decision-making, and proposes making every effort to provide for the ‘will and preferences of the individual’, rather than the more conventional ‘best interests’ approach.\textsuperscript{902} Best interests decisions are based on substituted decisions which are made by others, as opposed to those made in conjunction with the person. This has been described as a ‘paradigm shift’ in disability approaches, and it may be that the practical and legal ramifications of this for all persons making professional decisions in this field have not yet been fully appreciated.

\textsuperscript{899} Ibid, 28.  
\textsuperscript{901} ALRC, Equality, Capacity and Disability in Commonwealth Laws, Final Report, 124, August 2014, 2. 35.  
\textsuperscript{902} Ibid, 2.5.4, 37.
There is some disquiet about the implications of unreservedly adopting the UNCRPD, particularly relating to Article 12. The issue arises from an extreme view emerging from some countries that all forms of substituted decision-making represent unwarranted interference with personal autonomy and must be replaced. However, a balanced view recognises that in certain circumstances, it may deprive a person of rights, to hold that they cannot receive some form of substituted decision-making arrangement, when entirely necessary. As mentioned earlier, the way in which guardianship operated in some countries has been clearly abusive and unjustifiable. See Stanev v Bulgaria. To remedy this by opposing all forms of substituted decision making is equally unhelpful. It should also be recognised that in some cases, disgruntled individuals have felt aggrieved when the results of judicial decisions have caused displeasure. Moves towards greater openness in court proceedings of this kind have been emerging in the UK.

Considering the intentions of the WA Parliament, an obligation to recognise the UNCRPD can be found in the Mental Health Act 2014 (WA) second reading speech, by the Minister for Mental Health who stated:

> The overall purpose of the Bill is to bring mental health legislation into line with current community expectations; to codify good practice from an Australian and International perspective; and to further emphasise the importance of human rights, particularly given that Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities of 2006.

Moving from good intentions to practical application demands more than legislation, and must be accompanied by culture changes, leadership, and careful resource allocation.

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903 Stanev v Bulgaria Application No. 16760/06 ECHR. Accessed online, HUDOC.
9.4 Education

All health staff including psychiatrists and aged care workers should be encouraged to be familiar with current socio-political issues in mental health law. A knowledge of ‘black letter law’, encompassed in legislation is only one part of the requirements to practice safely and effectively.906 What is also essential is background appreciation of the role of law in our society, and its philosophical aspects and ethical elements. In the haste to provide services and meet government objectives this is not always taught and incorporated into practice. Government departments may not have considered fully the genesis of complex rights-based legislation, and the practicality of expecting legislation to satisfy a range of different demands of society. The University of Essex summer schools on autonomy offer an excellent model which could be adopted in Australia.

The Essex Autonomy Project is a research and knowledge-exchange initiative based in the School of Philosophy and Art History at the University of Essex. Our fundamental aim is to clarify the ideal of self-determination in history, theory and practice, both for its own sake, and in order to provide guidance to those who must apply this notion—whether as care workers, as medical practitioners, as legal professionals, or simply as citizens.907

Research should be undertaken in WA to determine the current degree of compliance with legal requirements, like that of the South Australian Office of the Public Advocate.908 This should be undertaken as a quality assurance measure, not as a fault-finding exercise. The aim should be to increase clinical-legal skills and appreciation of the role of law in psychiatry and aged care services.

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906 See above, Chapter 4, Question 22. 196.
907 University of Essex Autonomy Project, <http://autonomy.essex.ac.uk>. The Department of Philosophy at Essex University provides an annual summer school for mental health professionals as well as courses and special teaching in this field. Lecturers were skilled in international and UK mental health law while conveying the relevant philosophical background.
ALRC Recommendation 8-2 must be implemented:

The Australian Government and the Council of Australian Governments (COAG), should develop a national approach to the regulation of restrictive practices in sectors other than disability services, such as aged care and health care.909

A national approach should incorporate common principles of ethics and coercion reduction, consistent with state independence. Some allowance needs to be retained for individual state laws and procedures, consistent with agreed policies and principles. This requires harmonisation of standards, rather than adoption of specific legislation aimed at total uniformity. The Commonwealth Government however should address standards in its own fields, particularly in aged care.

9.5 ACAT assessments

Admission of any person to an aged care facility in Australia requires an ACAT assessment. These assessments typically focus on the care needs of the person, both physical and mental. Before there is any intervention involving an assessment of this nature, with the potential of leading to admission to an aged care facility, the decision-making capacity of the person should be determined. If this reveals that an impairment is present, then as with the mental health path, steps must be taken to ensure that a responsible alternate decision-maker has been directly involved and party to decisions to admit into care.910

9.6 Aged care ombudsman

Some American aged care homes are visited by trained volunteer ombudsmen, providing a consistent review of their allocated facility. A well-managed program could provide improved oversight at a reasonable cost, compared with other ‘hit and run’ reviews by Commonwealth aged care monitoring bodies.


910 See Chapter 7, 7.19, ref 762.
While the two bodies have very different agendas, this model could fill the gap between official reviews, and provide better support to staff as well as to residents.

The country’s Long-Term Care Ombudsman programs were established in each state by the Older Americans Act. The mission of the Long-Term Care Ombudsman Program is to enhance the quality of life, improve the level of care, protect individual rights, and promote the dignity of each senior citizen and/or person with a disability, of any age, housed in a long-term care facility.911

9.7 Community guardians in aged care

The Office of the Public Advocate (WA) has developed a program whereby community volunteers can be trained as guardians and assigned formally to persons in need of decision-making support.912 The program has limited resources at present, and a way of targeting the most appropriate cases should be developed, in cooperation with WASAT. The current program is based on forming a long term supportive relationship with the patient. As this may be less practical in aged care, a system of partnership with an aged care facility could be envisaged. The volunteer could be authorised to visit and familiarise themselves with residents and staff, becoming a contact person if a need was identified.

The Victorian Office of the Public Advocate has a community guardianship program with 900 volunteers.

OPA supports more than 900 volunteers who provide support for people with disability or mental illness across Victoria. OPA’s volunteers are from a variety of backgrounds, age groups, and communities. They work across three programs: Community Visitor Program, Independent Third Persons Program and the Community Guardianship Program. They fulfil their responsibilities with professionalism, compassion, and with the rights of people with disability in mind at all times.913

Examination of literature indicates many jurisdictions are employing volunteer guardians in a variety of roles. While interest is growing, little is known of the effectiveness of this approach. American experience suggests volunteers can generate difficulties unless well trained and supervised. Professional and volunteer relationships are one area of potential problems.

9.8 Community Visiting Scheme

The Commonwealth Government funds several bodies such as Red Cross to provide volunteers who are trained and enabled to visit aged care recipients in their homes or in residential facilities.\textsuperscript{914} While this is a very desirable provision of social support, it is not independent of government, and has no legal support base or mandate to seek out vulnerable persons in aged care facilities who are unable to consent. A program which addresses the issues raised in this thesis could be developed by enhancement of this approach.

9.9 Aged care providers, professionals, and staff

The first issue to be addressed when aged care or mental health providers are requested to assess an individual for hospital or residential should be; what are the person’s own wishes and decisions in this matter?\textsuperscript{915} Persons being assessed should be seen promptly where they are located at the time, and not admitted to hospitals solely for assessment. A multi-disciplinary team approach should be a fixed requirement in all cases, to avoid any suggestion of undue influence, and to support assessment staff in their decisions.

\textsuperscript{914} See Chapter 5, 5.2 Consent.
The next issue should be, can care be provided while keeping the patient at home or in his present location? If not, how best to manage the transition to care. Tackling these takes time, resources, and experienced personnel. Resisting undue pressures from families, carers, other health professionals and local authorities may also require firm action. An agreed culture in society that expects this negotiation to take place at all, is a basic requirement.

Just as we no longer accept the asylum as the answer for social and behaviour problems, we must insist that the aged care facility does not simply take its place.\textsuperscript{916}

If there is no alternative, and the decision is genuinely undertaken in the best interests of the person, issues of facility design and staffing policies have been shown to reduce the requirements for coercion and restraints in aged and mental health care.\textsuperscript{917}

The ALRC Report recommends:

\textit{…that the Australian Government and COAG adopt a similar national approach to the regulation of restrictive practices in other relevant sectors such as aged care and health care.}\textsuperscript{918}

\begin{footnotesize}
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\begin{itemize}
\item \textsuperscript{917} Dementia Services Development Centre, Stirling, Scotland. \texttt{<www.dementia.stir.ac.uk>}. Also \texttt{<www.dementiacentre.com.au>}, Hammond Care.
\item \textsuperscript{918} ALRC Report 124, 2014, 8.4 244.
\end{itemize}
\end{footnotesize}
9.10 Mediation

The use of mediation to resolve disputes, as an alternative to formal legal procedures has emerged as a significant measure in recent decades. This is also known as ADR or alternative/appropriate/additional dispute resolution. There are cost savings to be made and additional benefits through a non-adversarial approach to resolving conflicts in aged care. It is important to note that in a mediated settlement the parties themselves agree to the outcome. It is not one imposed by the mediator.

In 1999 the WA Law Reform Commission released a report which included references to alternative dispute resolution including mediation.919 The report included details of the recommended structure and procedures required for the system to operate effectively and economically. The review recommended the enacting of a Mediation Act to encourage mediation, and ensure confidentiality.920

A 2002 paper by Carroll indicated no progress had been made towards enactment of a Mediation Act.921 An online search of the WA Parliament for Bills related to mediation gave no results.

Elsewhere mediation services have emerged and developed guidelines, training, qualifications and recognition. This is particularly true of Canada, where, as stated on the ADR Institute of Canada website, the following illustrates the role played in cooperation with healthcare services in that country.

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919 Law Reform Commission of WA, Review of the Criminal and Justice System in Western Australia, September 1999.
920 Above, Recommendations, 69.
Since 2006, ADR Ontario has worked with the Ontario Association of Community Care Access Centres, on behalf of the Ministry of Health and Long Term Care, to design and administer a system that would provide Independent Complaint Facilitators (ICF’s) to assist in resolving complaints between Community Care Access Centres and their clients. ADR Ontario regularly appoints ICF’s from a qualified and specially selected roster of its members and administers these cases.\footnote{ADR Institute of Canada, http://adric.ca/services/adr-outsourcing/}.

The Australian Capital Territory (ACT) legislated to place mediation on a sound legal footing by passage of the *Mediation Act 1997* (ACT). This provides for mediation through individuals with appropriate recognised training, and legal protection for both parties.

Carroll, referring to possible WA legislation noted,

> If mediation-specific legislation is introduced it should aim to support the practice of mediation wherever it takes place in Western Australia, including in boards, tribunals and private mediations. This will lead to a greater degree of consistency in the law. Where diversity is required, in terms of process and procedure, regulation and beneficial provisions, this can be achieved in context specific legislation.

### 1.1.1 Mediation providers

A Victorian family mediation service offers the following comments;

Seniors Mediation is a unique type of mediation for elderly people and their families, friends, carers and/or professional service providers. It is a non-adversarial approach to resolving conflict or making important decisions.

Trained FMC Mediators facilitate discussions and decision making with the older person/people and the appropriate parties where decisions need to be made about health, finance and/or care arrangements. Seniors Mediation provides an opportunity for the older person to talk freely (through an advocate or on their own) about their wishes in a supportive environment. This allows them to have a voice in decisions regarding their own care and future. It also helps preserve relationships allowing participants to reach resolution and promote better outcomes for future decision making.\footnote{FMC Mediation and Counselling, http://www.mediation.com.au/how-we-can-help/mediation-dispute-resolution/seniors-mediation/}.

The service mentioned has developed a research program in conjunction with an aged care provider, Benetas.
The House of Lords review of DOLS legislation recommended:

Recommendation 30: We are persuaded that mediation would be beneficial in many more cases prior to initiating proceedings in the Court of Protection. We recommend that consideration be given to making mediation a pre-requisite for launching proceedings, especially in cases concerning property and financial affairs where the costs fall to P.924

The measures employed in guardianship hearings in WA already have much in common with mediation procedures, and mediation is an option offered in some difficult cases. A research trial of professionally managed mediation should be progressed in the mental health field. Mediation has been discussed as a means of making progress towards negotiated settlements in health care, including mental health treatment.

9.11 Statistics and transparency; Aged care facilities and mental health hospitals

The difficulties experienced in documenting the number of persons detained in locked mental health wards in WA has been described in Chapter 7 at par 7.19.1. In the case of older persons, the risk that they may have been subjected to abuse of various overt and subtle characteristics prior to admission, warrants closer attention to legal issues around capacity and consent. Publicly accessible data on the extent of detention in WA mental health Hospitals should be freely available. It should also form the basis of measures to reduce the use of coercion general in health care to the minimum necessary level consistent with best practice. In the absence of accessible data, progress towards best practice cannot be measured.

The position in WA is in contrast with the publicly available statistics on detention under the *Mental Health Act 2007* (UK) which are available on-line. The Health and Social Care Information Centre (UK), provides an Annual Mental Health Bulletin, detailing rates of detention in mental health hospitals. This report included area maps showing highest and lowest levels of use of compulsory powers by health services.\(^\text{925}\)

Equally important is the recognition of the extent of detention in the general aged care field, and the monitoring of restrictive practices such as locked areas. The need for such restrictive practices may be apparent for many individuals, but they must be proportionate to the risks, and not unduly applied to those to whom it need not apply. Reduction in restrictive practices will be challenging to implement, but the very process of seeking alternatives can be rewarding. The decision-making steps taken by patients, families, and health professionals, should be strengthened and supported by full knowledge of the facts surrounding admission into aged care of any category.

\(^{925}\) Health and Social Care Information Centre, at www.hsic.gov.uk, 34.
9.12 Conclusion

The preceding chapters have presented a review of the historical origins of WA mental health law and procedures; problems with current provisions have been reported and views of psychiatrists in both countries sampled. Suggestions have been offered to provide possible remedies. Any new measures should be meticulously assessed to ensure stated aims are achievable, able to be safely implemented and cost effective.

Current flaws in State and Commonwealth safeguarding procedures, relevant to human rights of older persons lacking decision-making capacity, need revision. A survey of psychiatrists in England and WA has shown some evidence of cause for concern regarding these trends in aged care.\textsuperscript{926} To address deficiencies will require significant changes in professional cultures, education, and resourcing, as well as law.

The restrictive practices engaged in psychiatry are subject to extensive statutory regulation, yet detention of voluntary patients in locked authorised, and one non-authorised mental health hospital, continues, despite concerns from the CoOV since at least 1997.\textsuperscript{927} Scope exists in the entire aged care sector to ensure better oversight and protection of vulnerable persons in State and Commonwealth funded aged care facilities. Statutory safeguarding measures must increase their effectiveness, while not adding unduly to costs and intrusion on family responsibilities.\textsuperscript{928}

As Lacey has reported:

\begin{quote}
Until strategies are backed by legislative reform, vulnerable adults will continue to fall through the cracks of existing protective mechanisms and specialist services.\textsuperscript{929}
\end{quote}

\textsuperscript{926} Chapter 4, 4.5 Survey results, Q13, Q 19, Q 20.
\textsuperscript{927} Chapter 5, 5.27, ref. 646.
\textsuperscript{928} OPA Annual Report, 36: Allegations of abuse were a factor in 105 or 25\% of the 423 new guardianship orders appointing the Public Guardian in 2014/15.
Although change in mental health law is a slow and painstaking process, practical implementation of improved and internationally recognised procedures should not to be unreasonably delayed. Webb has also drawn attention to the problem of elder abuse in WA, and the case for considering a legislative approach, despite several difficulties.  

Comparison with measures undertaken in the UK to address similar issues, may be a pointer towards identifying possible remedies, but has not provided a practical and economical solution. Costly and bureaucratic legislative provisions in the UK, have demonstrably failed to ensure comprehensive protection for older persons in that country. Australia has a habit of looking towards the UK for guidance, but in this matter a more independent stance should be adopted. The Chairman of the UK Law Commission has been told by a distinguished group of psychiatrists from the Royal College that their new proposals were:

…bureaucratic and paper driven, excluded families from involvement in decision-making, would draw perhaps 2 million people lacking mental capacity within the legislation’s oversight at huge cost with no obvious advantage in terms of improvement in quality of care and minimal practical safeguards.  

There is a case for improved oversight of procedures which impact on the lives of elderly persons in WA, selectively noting experience elsewhere, and seeking practical, affordable and effective solutions.

Despite a considerable amount of community and professional input to the Mental Health Act 2014(WA), an opportunity has been missed to shift the current focus on coercion, towards negotiated patient autonomy and decision-making.

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931 Note of meeting of members of the Faculty of Old Age Psychiatrists, Monday December 7, 2015 at Law Commission offices, circulated to members by email.
Measures to reduce coercion and promote autonomy in decision making, whether in mental health or aged care facilities, must endeavour to place the person at the centre of decision making.\footnote{MHC (WA) <http://www.mentalhealth.wa.gov.au/mental_illness_and_health/Person_centred_support.aspx>.} This must be more than a slogan, avoiding fads and fallacies.\footnote{Paris J, \textit{Fads and fallacies in psychiatry}, (RCPsych Publications 2013) 106-107.} It needs genuine targeted resourcing, and cultural change from all government bodies and health care professions.

The quest for achieving recognised international best practice should be a journey of discovery, implementation, and continuous re-evaluation. Politicians, clinicians, lawyers, carers, and the community must respect and learn from each other, to make genuine progress.
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10.4 List of conferences/meetings

The following is a list of conferences/meetings attended by the author during the course of his candidacy:

7 October 2011, Royal College of Psychiatrists training MCA 2005 (UK).
July 2011 ANZSHM Society, Brisbane, Oral presentation on History of WA Psychiatry.
8 November 2011, Leeds, Andrew Sims Centre Course, Tony Zigmond, Up on Mental Health Law.
May 15, 2013, Lecture, Prof N Rose, Nottingham.
University of Essex Summer School, Colchester,
June 2014, Shrewsbury, PPS Conference. Lecture presented on critical psychiatry of older persons.
October 14, 2014, address by Tim Wilson, Human Rights Commissioner, (Australia).
October 16, 2014, ARAFMI meeting re; Mentally Impaired Accused Act 1996.
November 3 2014, Mental Health Law Centre, Meredith Blake, Mental Health Bill 2013.
November 17, 2014, Mental Health Act 2014 training session for clinicians. Dr Nathan Gibson.

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21 September 2011, Dr K Samsi, Kings College London. Re; Surveys regarding training for MCA 2005 (UK).
4 October, 2011, Dr J Warner, Chairman Royal College of Psychiatrists Section of Psychiatry of Old Age, regarding survey; see n576, chapter 5, 242.

14 February 2014, Prof Wendy Lacey, Adelaide University Law School, Elder abuse, (telephone).

26 March 2014, Dr John Brayley, Public Advocate, South Australia, in Perth.

24 May 2014, S Boulter, WA Mental Health Law Centre.

9 December, 2015, Gillian Lawson, Acting Public Advocate WA re; Public Guardians.
# Appendices

## 11.1 Table of treaties/conventions

International Covenant on Economic, Social and Cultural Rights (1976)
International Covenant on Civil and Political Rights (1980)

## 11.2 Table of statutes

### 11.2.1.1 UK and England

27 Henry VIII c.46.
*Commissioners in Lunacy Act 1842* (UK).
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11.3 Case law

11.3.1 International

Schloendorff v The Society of New York Hospital (1914) 211 NY 125.
Stanev v Bulgaria Application No. 16760/06 ECHR. Accessed online HUDOC.

11.3.2 UK

Airedale Hospital Trustees v Bland [1992] UKHL.
Anderson v North West Strategic Health Authority [2015] EWHC 3563 (QB).
Bolam v Friern Hospital Management Committee, 1957.
Bolitho v Hackney and City Health Authority, 13, November 1997.
C v Blackburn with Darwen BC (2011 EWHC 3321 (CoP).
CB v Sussex County Council (2010) UKUT 413 (AAC).
Cheshire West and Chester Council v P (by his Litigation Friend The Official Solicitor) [2011 EVCA Civ. 1557.

Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112.


Meering v Graham White Aviation Co. Ltd. [1919] 122

Meering v Graham White Aviation Co. Ltd. [1919] 122.

Mohammed & Ors v Secretary of State for Defence, [2015] EWCA Cw 843.

Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland), [2015] UKSC 11.


R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Secretary of State for Health [2014] EWCA Civ 822.

Re SC v BS Court of Protection, claim 11987961, 2011.

Re. F (Mental Patient: Sterilisation) [1990] 2 A.C. 1).


Regina v. Ashworth Hospital Authority (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz (FC) (Respondent)

Regina v. Ashworth Hospital Authority (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz (FC) (Respondent).

Sidaway v Bethlehem Royal Hospital (1985) par 3,1.

Slater v Baker, (1767) 95 E.R. 860.


11.3.3 Australia


Briginshaw v Briginshaw (1938) 60 CLR 336.

Kracke v Mental Health Review Board & Ors (General) [2009] VCAT 646 (23 April 20

Minister of State for Immigration and Ethnic Affairs v. Ah Hin Teoh, (1995) 183 CLR 273,
Naxakis v Western General Hospital (1999) 197 CLR 269. 20.


Trevorrow v State of South Australia (No 5) [2007] SASC 285.

11.3.4 Western Australia


### 11.4 Tables

#### 11.4.1 List of selected legislation and events: Time line comparison of England and WA

<table>
<thead>
<tr>
<th>England</th>
<th>Comments</th>
<th>WA</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1744 Act for regulating private madhouses</td>
<td></td>
<td>1616</td>
<td>First (Dutch) Europeans to land on West Coast of Aust.</td>
</tr>
<tr>
<td>1828 County Asylums Act (9 Geo. IV, c.40.)</td>
<td>Addressed the need for care and maintenance of pauper and criminal asylums, and building of County asylums</td>
<td>1826</td>
<td>First settlement of Frederictown (Albany, WA)</td>
</tr>
<tr>
<td>1828 Chancery Lunatics Act</td>
<td>Regulations re estates and property of lunatics Holding of Inquisitions on Lunacy</td>
<td>1829</td>
<td>First settlements of Fremantle &amp; Perth WA</td>
</tr>
<tr>
<td>1831</td>
<td></td>
<td></td>
<td>Completion of the first prison, the Roundhouse</td>
</tr>
<tr>
<td>1832 Court of Civil Judicature Act (UK) authorised Governor Stirling to enact local laws.</td>
<td></td>
<td>First mental patient, Dr Langley, detained in a hulk at Fremantle but recovered.</td>
<td></td>
</tr>
<tr>
<td>1833 Chancery lunatics Act</td>
<td>Measures to reduce costs of Writs de Lunatico Inquirendo &amp; proved better care and treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1840 Insane Prisoners Act</td>
<td>Permitted transfer of some prisoners to asylums</td>
<td>English Lunacy Act 1845 applied in WA</td>
<td>1841 Mental patient at Colonial Hospital causes disturbance</td>
</tr>
<tr>
<td>1853 Chancery Lunatics Act</td>
<td>Registrar in Lunacy to attend courts and submit reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1853 Lunatic Asylums Act</td>
<td></td>
<td></td>
<td>Scott’s warehouse Fremantle as asylum</td>
</tr>
<tr>
<td>1862 Criminal lunatic Asylums Act</td>
<td>Transfers both ways between asylums and workhouses</td>
<td>1858 Concerns re “seclusion”</td>
<td>1865 Fremantle asylum opened</td>
</tr>
<tr>
<td>1885 Lunacy Act</td>
<td></td>
<td>1871 Lunacy Act (WA)</td>
<td>Fremantle Asylum “hopelessly overcrowded” (Ellis)</td>
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<tr>
<td>1886 Idiots Act</td>
<td></td>
<td></td>
<td>1883 Asylum transferred from</td>
</tr>
<tr>
<td>England</td>
<td>Comments</td>
<td>WA</td>
<td>Comments</td>
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<tr>
<td>1888 Local Government Act</td>
<td>Gave responsibility for asylums to County &amp; Borough councils</td>
<td></td>
<td>Imperial to Colonial government</td>
</tr>
<tr>
<td>1891 Lunacy Act</td>
<td>Repealed by Mental Health Act 1959</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1899 Elementary Education Act, (Defective and Epileptic Children Act)</td>
<td>Gave responsibility for asylums to County &amp; Borough councils</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1901 Federation of Australia founded</td>
<td>Referred to asylums to County &amp; Borough councils</td>
<td>1903 Local Government Act</td>
<td>Introduced by Dr Montgomery based on UK practice.</td>
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</tr>
<tr>
<td>1908 Lunacy Act</td>
<td>First voluntary boarder admissions to the Maudsley</td>
<td>1903 First patients at Claremont</td>
<td></td>
</tr>
<tr>
<td>1913 Mental Deficiency Act</td>
<td>Board of Control for mental deficiency hospitals</td>
<td>1909 Electric lighting at Claremont</td>
<td></td>
</tr>
<tr>
<td>1915 London County Council (Parks etc.)</td>
<td>First voluntary boarder admissions to the Maudsley</td>
<td>1914 Hein case: Re; incorrectly completed documents.</td>
<td></td>
</tr>
<tr>
<td>1917 Mental Treatment Act</td>
<td>Special provisions for ex-servicemen from WWI</td>
<td>1919 Montessori school at Claremont (operated for 2 years)</td>
<td></td>
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<tr>
<td>1922 Lunacy Act</td>
<td>Master in Lunacy – an office of the Supreme Court</td>
<td>1919 Montessori school at Claremont (operated for 2 years)</td>
<td></td>
</tr>
<tr>
<td>1919 Mental Treatment Act Amendment Act</td>
<td>Special provisions for ex-servicemen from WWI</td>
<td>1915 London County Council (Parks etc.)</td>
<td></td>
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<tr>
<td>1927 Mental Treatment Act Amendment Act</td>
<td>Special provisions for ex-servicemen from WWI</td>
<td>1915 London County Council (Parks etc.)</td>
<td></td>
</tr>
<tr>
<td>1927 Mental Treatment Act Amendment Act</td>
<td>Special provisions for ex-servicemen from WWI</td>
<td>1915 London County Council (Parks etc.)</td>
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<tr>
<td>1941 Mental Treatment Act (War Service Patients) Act</td>
<td>Special provisions for ex-servicemen from WWI</td>
<td>1915 London County Council (Parks etc.)</td>
<td></td>
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<tr>
<td>1949 Mental Institution Benefits (Commonwealth and State Agreement) Act</td>
<td>Special provisions for ex-servicemen from WWI</td>
<td>1915 London County Council (Parks etc.)</td>
<td>Agreement by Commonwealth to provide funds.</td>
</tr>
<tr>
<td>1956 Mental Treatment Act Amendment Act</td>
<td>Special provisions for ex-servicemen from WWI</td>
<td>1915 London County Council (Parks etc.)</td>
<td>Authorised patient transfers between hospitals</td>
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<tr>
<td>England</td>
<td>Comments</td>
<td>WA</td>
<td>Comments</td>
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<tr>
<td>1954 - 1957</td>
<td>Royal Commission (Percy Report)</td>
<td></td>
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<td>1959 Mental Health Act</td>
<td>Abolished all formalities for voluntary admission.</td>
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<td>1961 Suicide Act</td>
<td></td>
<td></td>
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<tr>
<td>1962 Mental Health Act</td>
<td></td>
<td></td>
<td>Boards of Visitors appointed</td>
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<tr>
<td>1963 Convicted Inebriates Rehabilitation Act</td>
<td></td>
<td></td>
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<tr>
<td>1972 Criminal Code Amendments</td>
<td></td>
<td></td>
<td>Attempted suicide law repealed</td>
</tr>
<tr>
<td>1981 Mental Health Act (passed - not proclaimed)</td>
<td></td>
<td></td>
<td>Guardianship legislation proposed</td>
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<tr>
<td>1983 Mental Health Act</td>
<td></td>
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<td>1995 Carers Recognition Act</td>
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<td>1995 Mental Health (Patients in the Community Act)</td>
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<tr>
<td>1996 Mental Health Act</td>
<td></td>
<td></td>
<td>Mental Health Review Board commenced</td>
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<td>2003 Holman Review</td>
<td></td>
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<tr>
<td>2005 Mental Capacity Act</td>
<td>Provides for persons lacking decision making capacity</td>
<td>2004 Carers Recognition Act</td>
<td></td>
</tr>
<tr>
<td>2007 Mental Health Act (+ DOLS)</td>
<td>Revised diagnoses of mental illnesses. DOLS attached to satisfy ECtHR (Bournewood)</td>
<td>2007 Human Rights Bill</td>
<td>Not progressed in WA</td>
</tr>
<tr>
<td>2014 Mental Health Act</td>
<td></td>
<td>2014 Mental Health Act</td>
<td>Commenced November 30, 2015</td>
</tr>
</tbody>
</table>
11.5 Appendix 3: Forms

Participant information form
Participant consent form
Letter of introduction
UWA Ethics Committee final approval form
Dear Doctor,

Participant information sheet for research project;

Does mental health legislation in Western Australia protect the elderly from lack of natural justice and human rights abuse?

Neville Hills is a psychiatrist undertaking a PhD at the University of Western Australia (UWA) Law School. He worked in old age psychiatry in Western Australia from 1978 until 1999, and also as a locum consultant in Old Age Psychiatry at several English hospitals, including the Julian Hospital Norwich, and Carlton Colville, Lowestoft. For the past seven years he was a member of the WA Mental Health Review Board, obtaining experience of legal protection procedures in Western Australia and England.

The purpose of this research project is to compare the opinions of old age psychiatrists in Western Australia with a similar size group in England. Special attention is paid to law and procedures offering protection to elderly persons lacking mental capacity. He is interested in your views of the effectiveness of mental health law in protecting the elderly, and your personal experience of some mental health law topics. He plans to conduct up to 25 email surveys in each country using the Survey Monkey format. Participants may consent or decline after reading the consent page, and responses are encrypted for secure transmission. A series of questions seeking responses to topical issues and a hypothetical case will be used to focus opinions. An opportunity to express a view or comment is included with each question. No identifying data will be retained and no harm is envisaged from participation in this study, which has been approved by the Ethics Committee of UWA. For practical reasons, this is a qualitative ‘convenience’ sample. General themes and impressions will be extracted rather than statistical comparisons.

All data will be retained securely by Neville alone, will not carry identifying information for individuals or service units, and will be erased on completion of the study. It is expected results will be the subject of a presentation at the WPA Vienna Conference in October 2013.

The pressure on your time with similar requests is recognised and your help appreciated. Neville can be contacted by email if there are any questions,

nhills1934@bigpond.com

Yours sincerely,

Daniel Stepniak

Associate Professor
Faculty of Law
M253, The University of Western Australia

35 Stirling Highway, Crawley WA 6009
T +61 8 6488 3565
F +61 8 6488 1045
E daniel.stepniak@uwa.edu.au
www.law.uwa.edu.au
CRICOS Provider Code: 00126G
Research project consent form

Does Mental Health Legislation in Western Australia protect the elderly from human rights abuse and lack of natural justice?

I have read the information provided and any questions have been answered to my satisfaction.

I agree to participate in this research activity, realising that I may withdraw at any time without reason and without prejudice. I understand that if I do choose to withdraw my participation in this research, all record of my involvement will be destroyed.

I am aware that all information provided is treated as strictly confidential and will not be released by the researcher. The only exception is if documents are required by law. I have been advised as to what data is being collected, what the purpose is, and what will be done with the data on completion of the research.

I agree that the research data collected for the study may be published provided my name or other identifying information is not used.

The Human Research Ethics Committee at the University of Western Australia requires that all participants are informed that, if they have any complaint regarding the manner in which a research project is conducted, it may be given to the researcher or, alternatively to the Secretary, Human Research Ethics Committee, Registrar’s Office, University of Western Australia, 35 Stirling Highway, Crawley, WA 6009, (telephone number 6488-3703). All study participants may print and retain copies of the information and consent forms for their records.
Dear old age psychiatrist colleagues,

Does mental health legislation in Western Australia protect the elderly from lack of natural justice and human rights abuse?

Your name and email address have been provided to me on the basis that you may be willing to assist me in my research on mental health law. I am writing to request your assistance in completing a part of my PhD thesis at the University of Western Australia Law School. I have attached the research information and consent forms as is required by the University. The information forms have been signed by my supervisor Associate Professor Daniel Stepniak.

A second email to follow this one will include a multiple choice opinion survey of 25 questions in the Survey Monkey format. Provision is included to consent or decline and to express individual comments.

My premise is that although Western Australian and English mental health laws and procedures have a common historical source, these have diverged significantly. While WA may have pursued a more economical and abbreviated course, this could be at the expense of natural justice and human rights. Your opinion on the value of law in protecting the interests of the elderly will be most helpful.

I do appreciate the many demands on your time and hope you will agree to assist me. I need to collect 50 responses and would appreciate learning of anyone else that could assist. The survey is directed to old age psychiatrists and senior registrars in Norfolk, Suffolk and Cambridgeshire, and to members of the Faculty of Old Age Psychiatry in WA.

Additional comments would be most welcome and will not be identified to individuals or service units.

Kind regards and thanks,

Neville Hills
nhills1934@bigpond
3 Jameson St.                        Home phone WA 9384 2840
Swanbourne Western Australia 6010
Our Ref: RA/4/1/5602

02 August 2013

Associate Professor Daniel Stupnick
Law School
MBEP: M253

Dear Professor Stupnick

HUMAN RESEARCH ETHICS OFFICE – AMENDMENT REQUEST APPROVED

Does mental health legislation in Western Australia protect elderly persons from human rights abuse and lack of natural justice? A comparison with British law and procedures.

Student(s): Neville Francis Hills

I confirm receipt of your correspondence requesting an amendment to the protocol for the above project.

Approval has been granted for the amendment as outlined in your correspondence and attachments (if any) subject to any conditions listed below.

Any conditions of ethics approval that have been imposed are listed hereunder.

1. To change the approved direct interview to online survey due to the difficult of recruiting.

If you have any queries, please contact the HREO at hreo-research@uwa.edu.au.

Please ensure that you quote the file reference RA/4/1/5602 and the associated project title in all future correspondence.

Yours sincerely

Dr Mark Dixon
Associate Director, Research Ethics and Biosafety