51
Forensic psychiatry: The civil practice

updated by

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CONTENTS

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[The next text page is 51-51]

INTRODUCTION

[51.100] Introduction

This chapter is written for those familiar with the law but unfamiliar with psychiatry. It sheds light on the psychiatrist's approach when asked to provide an opinion on matters involving issues such as negligence, decision-making capacity, personal injury and level of impairment, custody disputes, and the right to refuse treatment. The chapter is not concerned with psychiatry practice as it relates to the criminal law, a subject which is discussed in detail in chapter 50, "Forensic psychiatry", and chapter 63, "Sexual abuse of children".

What is a psychiatrist?

[51.110] Training and professional qualifications

First and foremost, a psychiatrist is a doctor. All psychiatrists complete general medical qualifications. Most then work as a junior doctor for at least two years before commencing specialist psychiatry training. Many psychiatrists worked in general practice or another specialty for some years before switching to psychiatry.

This is important because it influences a psychiatrist's view of the world. For most psychiatrists, for most of their professional lives, the people whom they are asked to see are their patients and the aim has been to help those patients to get on with their lives. This is a therapeutic, clinical perspective. In forensic practice, however, the aims are different, but it is hard to entirely step away from a clinical role. Consequently, the traditional patient–doctor dyad can colour a psychiatrist's medicolegal report even when the psychiatrist "knows" that their role is not that of treating psychiatrist.

In Australia and New Zealand, psychiatry training is undertaken over five years. Every six months of those five years, the psychiatry registrar (as trainees are known in Australasia) rotates through different placements in different specialty areas. As with most medical specialties, most of this training takes place in hospitals seeing primarily inpatients. The first year of training is often concerned with psychiatric inpatients in general psychiatric wards, but in the second and third years trainees can undertake a variety of terms, including some in community health centres, private hospitals, and units dealing with particular conditions such as eating disorders or perinatal conditions. During these years, all trainees must undertake six months of child and adolescent psychiatry and six months of consultation–liaison psychiatry (which is described below).

In the fourth and fifth years of training, psychiatry registrars have the option of doing terms focused in subspecialty areas that particularly interest them. Thereafter, the registrar becomes a qualified psychiatrist with a certificate in the subspecialty upon which they focused.

Though all trainees are required to do a formal education course of some kind – often run by local universities in the form of a master's degree – the majority of training is in the form of an apprenticeship, where registrars treat patients under the supervision of qualified psychiatrists.

The training scheme is established, and to some extent regulated, by the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Those who satisfy the College's requirements by way of workplace-based assessments and examinations are awarded a Fellowship of the College, entitling them to the post-nominal FRANZCP. Fellowship of the College or an equivalent overseas qualification allows recognition as specialist psychiatrist in Australia and New Zealand.

Very few psychiatrists take on civil forensic work early in their careers, and the vast majority of psychiatrists will never do any at all. For those who do, many will do no additional training and will learn from peers or from experience. Some varieties of civil practice, such as reports for workers compensation tribunals or motor accident authorities, demand at least a basic level of training in those areas. Usually, these are focused courses conducted over a few days.

Many universities now offer doctors entry to master's-level courses on health law. These tend to be quite broad in their focus, but usually include an introduction to legal reasoning and provide optional units of study in expert opinion and areas relevant to civil forensic practice.

As part of their training, psychiatrists may elect to focus on one or more subspecialty areas. Those who have elected to keep their training broad are known as general adult or generalist psychiatrists. These psychiatrists often work in general psychiatry inpatient settings, in community health centres, or in private practice.

[51.120] Subspecialty areas

There are six broad areas of subspecialty practice. When choosing an expert, it will usually be advisable to select a psychiatrist with subspecialty experience relevant to the particular matter. The six areas are as follows.

(1) **Child and adolescent psychiatry** deals primarily with patients from infancy to young adulthood. Because young people are so entwined within their family of origin, child and adolescent psychiatrists are particularly skilled in working with families. Not surprisingly, child and adolescent psychiatrists are frequently called to provide expertise in custody matters and matters involving juveniles, such as "care and protection".

(2) **Consultation–liaison psychiatry** is the subspecialty which focuses on the interface between psychiatry and general medicine. C–L psychiatrists (as they are often known) work in the emergency departments and general medical wards of general hospitals. Their expertise extends not only to the interactions of medical and psychiatric illnesses, but also to the assessment and management of patients who are suicidal and to determinations of decision-making capacity.

(3) **Old age psychiatry** is self-explanatory, with practitioners of this subspecialty skilled in many of the areas of the consultation–liaison psychiatrist but with a focus on those over 65.

(4) **Addiction psychiatrists** focus on people who are dependent on alcohol or other drugs, or both.

(5) **Psychiatrists who specialise in psychotherapy** focus their expertise on one or more of the talking therapies, such as psychodynamic psychotherapy, interpersonal therapy or cognitive behaviour therapy. It is important to understand, however, that all psychiatrists use these forms of therapy and those psychiatrists who specialise in

psychotherapy continue to prescribe medications when that is appropriate – thus differentiating themselves from psychologists, who are not doctors and who cannot prescribe. (See below on the complementary skills of psychiatrists and psychologists.)

(6) It is also possible to train and take up specialty practice in **forensic psychiatry**, though most psychiatrists who provide reports in the civil realm did not train in forensic psychiatry as registrars. Registrar training in forensic psychiatry is skewed to the criminal jurisdiction and many of the placements are in institutions overseen by the correctional authorities. Many trained forensic psychiatrists take up work in, or are heavily connected to, the prison system, though most also do private work and some of this may be in the civil realm. While a forensic psychiatrist will usually have a great deal of experience in clinical practice in correctional settings, their experience in hospital and community settings can be quite varied. So, again, it is important to match the concerns of the matter with the experience of the expert. (See chapter 50, "Forensic psychiatry", and chapter 63, "Sexual abuse of children", for more detail.)

Psychiatrists who practise in one (or more) of these subspecialties may express that interest by becoming a member of a faculty within the RANZCP. There are six RANZCP faculties, reflecting most of the subspecialty training areas above: Child and Adolescent Psychiatry, Consultation–Liaison Psychiatry, Addiction Psychiatry, Psychiatry of Old Age, Psychotherapy and Forensic Psychiatry. (There is no faculty of adult psychiatry.)

Subspecialty training in psychiatry has only been formalised in Australia since 2003. As a result, many slightly older psychiatrists who practise primarily in a subspecialty area will not have formal subspecialty qualifications and will have learnt their subspecialty on the job. It is also important to understand that the College of Psychiatrists trains all psychiatrists to a level where all are officially qualified to work in all areas of psychiatry. As a consequence, changes in career focus are so common as to be almost the norm. It is not that unusual, for example, for a psychiatrist who did subspecialty training in child and adolescent psychiatry to eventually specialise in general adult or even old age psychiatry. This is relevant because it is likely that, at least as things currently stand, the day-to-day experience of a psychiatrist is going to contribute more to their expertise than any specialist certificate they may have secured as part of their original training.

As their career goes on, many psychiatrists develop a particular interest in some narrow area of clinical practice. Often this will be a particular diagnostic category, such as schizophrenia, eating disorders, post-traumatic stress disorder, mood disorders or postnatal depression. Again, these areas of particular expertise may have little or nothing to do with the psychiatrist's original subspecialty training, and most of this particular expertise will have been gained by years of focused clinical experience in that particular area and by attending conferences and other clinical meetings. The informal nature of the development of expertise in these areas is reflected in a lack of structural recognition of these special interest categories. Often, the only way of discovering who has particular expertise – for example, in eating disorders – is word of mouth. Some psychiatrists who are interested in some of these focused areas of practice may join particular "Sections" of the College. As of 2018, there are 12 such sections, including Child and Adolescent Forensic Psychiatry; Early Career Psychiatrists; Electroconvulsive Therapy and Neurostimulation; History, Philosophy and Ethics of Psychiatry; Leadership and Management; Neuropsychiatry; Perinatal and Infant Psychiatry; Private Practice Psychiatry; Psychiatry of Intellectual and Developmental Disabilities; Rural Psychiatry; Social and Cultural Psychiatry; and Youth Mental Health.

[51.130] Practice types and settings

The majority of Australian psychiatrists, and certainly the vast majority of psychiatrists who do medicolegal work in the civil domain, are in private practice. Essentially, these psychiatrists are small business people, earning most of their income seeing patients with psychiatric

illnesses or other mental health complaints. This clinical work is renumerated by the government through Medicare payments, though most private psychiatrists charge a fee in addition to the amount that can be claimed back from Medicare. Practice arrangements are many and varied. Some psychiatrists sit alone in suburban offices, while many club together in group practices. Some have affiliations to private hospitals and may admit patients to these. Many private psychiatrists have several practice locations, often conducting their civil forensic work out of one particular location. Many attract civil forensic work by signing up to agencies.

One of the factors that acts as a barrier to psychiatrists in private practice providing expert reports is a concern that should they be required to give expert testimony, they may need to cancel an afternoon's or a day's clinical practice at short notice. Not only is this inconvenient for often-fragile patients, but it can significantly impact on the practitioner's small business. Psychiatrists who do a lot of civil work knowing that they may be called to give evidence in a tribunal or court devise ways to minimise this problem.

The other major practice setting for a psychiatrist is public practice. Psychiatrists in public practice work in public hospitals. Public hospital psychiatrists work either in stand-alone psychiatric hospitals (known previously as asylums, which fortunately are becoming rare) or in general medical hospitals which incorporate specialist psychiatric wards or units. These psychiatrists are salaried public servants. Their income tends to be lower than that of their colleagues in private practice, but they would usually say that they have traded that extra income off against what they see as a more interesting work environment that includes not only patient care, but also a significant amount of non-clinical work such as teaching, research, administration or policy development.

There is a considerable cross-over between public and private practice. Many psychiatrists will do a few days each week in public settings and the rest of the week in private rooms.

The third major practice type might be loosely described as academic psychiatry. A relatively small number of psychiatrists are entirely or primarily employed by universities and, though all such people will still do some clinical work, the bulk of their paid hours will be directed to research, teaching and administration associated with that university. These psychiatrists will have titles such as Lecturer, Associate Professor or Professor. They are likely to supplement their university salaries with some private practice.

Numerically, most of the psychiatrists taking up academic roles in Australia are public hospital clinicians who are also doing some teaching and/or research. These psychiatrists have titles that are prefixed by words such as "Clinical", "Adjunct" or "Conjoint" to signify that they are not full-time university academics.

[51.140] Civil forensic psychiatry as a specialty area

The fact that many psychiatrists who do civil forensic work are doing it as a sideline should be welcomed by lawyers seeking an expert. Experts, after all, should first and foremost be experts in the relevant field of clinical psychiatry, and courts and tribunals are often appropriately wary of experts who seem to be experts primarily in being experts. In the United Kingdom, a psychiatrist who worked in a private forensic hospital and who was registered in the field of "Psychiatry of Learning Disabilities" was found to have engaged in professional misconduct when he gave evidence about an ambulance officer's fitness to work in his profession.[1] There have been no similar findings involving Australian psychiatrists, but the subspecialisation of surgeons engaged as experts has been at issue in at least two Australian cases.[2]

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1 *Pool v General Medical Council* [2014] EWHC 3971 (Admin).

2 *Morocz v Marshman* [2015] NSWSC 149; *Tinnock v Murrumbidgee Local Health District (No 3)* [2016] NSWSC 88.

[The next text page is 51-101]

HOW DO PSYCHIATRISTS WORK IN CLINICAL PRACTICE?

[51.200] The patient's history

Like that of any other doctor, a psychiatrist's assessment begins by taking the patient's history. The standard psychiatric history will take the psychiatrist 30 to 40 minutes to complete – sometimes longer.

In clinical practice, the patient has usually been referred with some specific complaint such as depression, flashbacks or anxiety. After collecting some basic demographic information and explaining the purpose of the interview, the psychiatrist will usually focus initially on the presenting symptoms (often abbreviated in their documentation as "PSx"). In this early part of the interview, the psychiatrist will tend to ask the patient open-ended questions, allowing them to tell their own story. As their story progresses, the psychiatrist will begin to form hypotheses as to the possible underlying syndromes that might have caused the presenting symptoms. The bulk of the history and its documentation is often taken up by enquiries to elucidate the nature of the "history of the presenting illness" (HPI). The HPI will detail the onset of the illness, its associated features, any features that are typically present in such an illness but are not present (so-called relevant negatives), and any treatments that the patient has undergone.

With the HPI elicited and documented, the psychiatrist will typically range over a series of other standard areas, each signified by its own subheading and characteristic abbreviation. The order and scope in which these other areas of history are elicited and documented may vary from patient to patient, depending on their particular constellation of symptoms. As a general rule, the psychiatrist will cover the patient's past psychiatric history (PΨHx), past general medical and surgical history (PMHx), family psychiatric and medical history (FΨHx and FMHx), drug and alcohol history (D&A), and forensic history, if relevant (ForHx). The psychiatrist may then enquire about the patient's early years and life course under the heading personal history (PersHx), and their current work and family environment under the heading social history (SocHx). They may also ask the person to describe themselves as a person, trying to elicit something of their personality style prior to the onset of their illness – the premorbid personality (PMP).

Typically, a patient's history is augmented by the testimony of others, be they the patient's partner, relatives or previous clinicians who have provided treatment. These sources of corroborative history are often contacted later and documented separately.

[51.210] The mental state examination

After documenting the history, the psychiatrist will then document a mental state examination (MSE). The MSE is the psychiatric equivalent of the physical examination in general

medicine. (Most psychiatrists do not conduct physical examinations on patients, preferring to rely on findings documented by the general medical doctors who refer the patient. There are – or at least should be, in many cases – some exceptions to this general rule, in areas such as the documentation of a patient's weight or physical side-effects associated with medications that psychiatrists prescribe.)

Like the history, the documentation of the mental state examination is structured and is listed under headings which are sometimes abbreviated. It starts with a description of the patient's appearance and behaviour during the interview. There is then typically a comment on the patient's speech, their predominant facial expression (termed their "affect"), and their self-described mood. There may also be a comment on the rapport established with the patient.

Next, the psychiatrist will make some comment on the patient's "form of thought" – that is, the way that they were able to express their ideas. Many psychiatric disorders are characterised by "formal thought disorder" or a disruption in the patient's form of thought. A range of technical terms may be used to describe abnormalities here, such as loosening of associations, derailment or tangential responses, but a finding of no formal thought disorder is often abbreviated to FTD (where the superscript "o" signifies "no"). Immediately after this, the psychiatrist will comment on the patient's content of thought – essentially, what the patient said. This may include predominant themes, any suicidal ideation (SI), or thoughts of self-harm (TOSH) expressed, or any delusions that were elicited. Next, the MSE will document perceptual abnormalities, where the focus is often hallucinations. If there were no delusions or hallucinations elicited, this is often abbreviated as "no psychotic features".

In cases where it is possible that the patient might suffer some problem with their attention, concentration or memory, the next section of the MSE may contain the results of formal cognitive testing. This may include documenting the results of tests designed to clarify the patient's orientation to time, place and person (OTPP); their ability to immediately recall three to five words and their ability to retain those words for a brief period after distraction; their ability to concentrate on a particular task (such as saying the months of the year in reverse order); and their ability to apply themselves to a task, such as drawing a clock face showing a particular time. Very often, formal cognitive testing is conducted on a standardised form following a standardised regime. There are many of these, but the most commonly used is the Folstein Mini-Mental State Examination.[1] (See chapter 60, "Psychological testing", for a detailed discussion of tests and test batteries.)

The last heading of the MSE is usually "insight", where a comment is made about the patient's own understanding of their symptoms, illnesses and need for treatment.

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1 MF Folstein, SE Folstein and PR McHugh, ""Mini-Mental State": A Practical Method for Grading the Cognitive State of Patients for the Clinician" (1975) 12(3) *Journal of Psychiatric Research* 189.

[51.220] Formulation

With the history and mental state examination completed, the psychiatrist will usually document their formulation of the patient. If you are reading through a psychiatrist's assessment, the formulation (sometimes called the impression) is a good place to start. It should contain a concise statement describing the patient's predicament and how the patient got to be there, pulling together all the relevant elements of the patient's history and mental state examination. Most psychiatrists believe that the ability to create a concise formulation is the quintessential skill of their profession.

[51.230] Diagnosis and differential diagnoses

Following on from the formulation, the next element in psychiatric documentation is the diagnosis. In clinical documentation, this will usually be labelled as a "provisional diagnosis" (PDx) – "provisional" in recognition that the diagnosis may change over time. In reports prepared for civil matters, psychiatrists usually presume that their diagnosis will not change.

Diagnoses are labels that doctors use to succinctly communicate with each other. In psychiatry, they are usually drawn from either the *International Classification of Diseases* (ICD-10)[1] or the American Psychiatric Association's *Diagnostic and Statistical Manual*, now in its fifth edition (DSM-5).[2] In clinical practice, the diagnoses assigned to patients tend to only approximate both the wording and the criteria laid down in these classification systems. For example, the DSM-5 diagnosis "Major Depressive Disorder" may be documented as "Major Depression" and there may be no intention to communicate that the patient's condition has met every one of the DSM's five diagnostic criteria. In contrast, when psychiatrists are writing reports for legal matters, they are more inclined to adhere to the exact wording. If they deviate from the criteria laid down, they will usually explain why.

It is important for lawyers to understand that the categories laid out in the various diagnostic systems do not necessarily describe natural kinds. The aim of the authors of the evolving diagnostic systems is to better describe underlying disease states, but psychiatrists are aware that, ultimately, the diagnoses represent nothing more than shorthand ways of categorising patients. Such categorisation has its uses – most obviously in furthering research – but the limitations of diagnoses are considerable. Unsurprisingly, people are far more varied and complicated than can be successfully categorised by the DSM's 947 pages. It is for this reason that in clinical practice a great deal of weight is placed upon the formulation.

After the provisional diagnosis, the psychiatrist will frequently venture a number of differential diagnoses (DDx). These are alternative or additional diagnoses that may apply to the patient as time passes or as more information comes to hand.

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1 World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders* (1992), which as of 2018 is still widely used.

2 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, 2013).

[51.240] Management

The final section of a psychiatrist's clinical notes will lay out the patient's management plan. This will include a comment as to where the patient will be treated when this is an issue (as it often is when the patient is seen in an emergency department, for example). In these acute settings, such as emergency, whether or not the patient will be treated involuntarily should be documented. In all settings, there will be some comment about the type of treatments that will be used – be they pharmaceuticals, one of the various forms of psychotherapy, or other interventions, such as assisting a patient to find work or housing.

[51.250] Working with psychologists

Psychiatrists frequently work closely with psychologists. To be registered as a psychologist (with general registration) requires the person to have had at least six years of university training and supervised experience. Most commonly, though, psychiatrists will seek out a psychologist with at least another two years of university training and supervised experience who has been able to register as a "psychologist with an area of practice endorsement". By virtue of this additional training, these specialist psychologists can offer skills in assessment and management that will augment the skills of the psychiatrist.

"Clinical psychologists" typically specialise further in the management of particular classes of disorder. While most psychiatrists are, for example, familiar with and able to offer cognitive behavioural therapy, some clinical psychologists may see this as their main therapeutic tool and be able to provide it to a higher standard. "Clinical neuropsychologists" have undergone further training still and have advanced skills in diagnostic assessments targeted at patients

with degenerative brain disease. "Forensic psychologists" use psychological assessment and therapeutic skills in criminal and civil legal contexts in a manner similar to forensic psychiatrists.[1]

1 The Australian Psychological Society website contains more details and outlines other areas of specialist psychological practice: see Australian Psychological Society, "What Is a Psychologist?" (2018): https://www.psychology.org.au/for-the-public/about-psychology/what-is-a-psychologist (viewed 14 June 2018).

[The next text page is 51-151]

COMMONLY ENCOUNTERED ADULT DIAGNOSES – A PRIMER

[51.300] Overview

It is not possible to provide a comprehensive account of all of the various types of psychiatric problems encountered in civil forensic practice, so this section is intended to orientate legal practitioners who have no familiarity with these diagnoses.

[51.310] Neurocognitive disorders

The neurocognitive disorders are a category of disorders introduced in the DSM-5 to cover what were previously called "dementia" (now called "major neurocognitive disorder") and various other conditions that featured cognitive impairments of lesser severity, previously labelled "age-associated cognitive decline" or "mild cognitive impairment". (These are now lumped together as "mild neurocognitive disorders".[1]) Neurocognitive disorders become more common as people age, so that the prevalence of dementia is around 9% by 65 years and may be as high as 30% by 85 years.[2]

The neurocognitive disorders exist along a spectrum of severity, but the key feature of both major and mild neurocognitive disorders is that the person exhibits some decline from a previous level of performance in one or more cognitive domains – such as their ability to attend, reason, remember or learn – and that this decline affects their ability to function in their family, social or work environment.[3] All of the neurocognitive disorders have some underlying cause. The most common underlying causes are Alzheimer's disease or a deterioration of the brain's blood supply called cerebrovascular disease, but many common diseases (for example, hyper- and hypothyroidism) may also affect a patient's cognitive function. Serious cognitive problems may also follow a serious head injury.

While people with severe dementias (major neurocognitive disorders) are easily identified, people with mild or even moderately severe cognitive impairment may function reasonably well in a day-to-day sense, particularly if they live in circumstances where they are faced with few cognitive demands. Often such people are elderly and may be quite frail, so that they no longer go out and engage in activities on their own. Frequently, their families have long ago taken over many of their responsibilities, so they may not notice that their loved one has slowly become less and less able to successfully negotiate cognitive tasks. In these

circumstances, the cognitive impairments may only become apparent with a careful history or detailed testing of the person's cognitive ability. As noted above, most psychiatrists, and indeed most doctors, will conduct brief cognitive screens if they suspect early dementia, but the most sensitive and accurate way to define early cognitive impairment is with formal neuropsychological testing.

Although there are some medications that are able to slow the development of some mild to moderate neurocognitive disorders and a small proportion of dementias are reversible if the underlying cause can be reversed, for the most part treatment is restricted to providing support to the person and their carers.

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1 N Sachs-Ericsson and DG Blazer, "The New DSM-5 Diagnosis of Mild Neurocognitive Disorder and Its Relation to Research in Mild Cognitive Impairment" (2015) 19 *Aging & Mental Health* 2.

2 Australian Institute of Health and Welfare, *Dementia in Australia* (2012).

3 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, 2013), pp 591–643.

Mood disorders

[51.320] Overview

There are two types of serious mood disorder: major depression and bipolar disorder.

[51.330] Major depression

The term "major depression" differentiates this serious depressive syndrome from the normal human sadness that arises when a person suffers some loss. When such normal sadness becomes very severe it is often labelled "adjustment disorder with depressed mood", or "reactive" or "situation" depression. Major depression may begin as normal human sadness, but is eventually manifest as a far more severe, long-lasting and pervasive low mood than occurs as a normal reaction. It is also associated with a range of other symptoms, such as sleep and appetite disturbance, and in its most severe forms hallucinations and delusions that are usually marked by nihilistic themes. As the illness progresses, the person may feel that all hope has slipped away. Without treatment, suicide is a common outcome.[1]

Estimates of the prevalence of major depression vary depending upon how severe a depression must be before it is counted, but it is likely that around one in 20 Australians experiences an episode of moderate to severe major depression each year.[2]

Fortunately, there is a range of treatments that are effective in moderate to severe major depression, including cognitive behavioural therapy and a variety of other talking therapies. The more severe a major depression becomes, the more likely it is that antidepressant medication will be required. When severe major depression fails to respond to medication, or when it is marked by delusions or hallucinations, the treatment of choice is often electroconvulsive therapy (ECT). ECT is effective in the treatment of severe depression and has relatively few side effects, but it is inconvenient to administer, requiring a general anaesthetic, and it is understandably, but unfairly, still seen as frightening by many in the general public. For these reasons, it is very much a second-line treatment for severe depression.

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1 SM Bentley, GL Pagalilauan and SA Simpson, "Major Depression" (2014) 98 *Medical Clinics of North America* 981.

2 Australian Institute of Health and Welfare, "Mental Health Services Australia" (2016): https://mhsa.aihw.gov.au/background/prevalance (viewed 14 June 2018).

[51.340] Bipolar disorder

People who suffer bipolar disorder, previously known as manic-depressive disorder, suffer not only episodes of major depression, but also episodes of pathologically elevated mood called mania.[1] Generally speaking, these are not people who suffer what are typically labelled "mood swings". Outside of episodes of illness, people with bipolar disorder experience the normal ups and downs in their mood, but periodically they suffer discrete episodes of severe depression, largely indistinguishable from those suffered by people with major depression, while at other times they suffer discrete periods of mania. Bipolar disorder is typically diagnosed in young adulthood, but can come on at any age.

When manic, people with bipolar disorder either feel great or, just as commonly, are unusually irritable. They may sleep less and become disinhibited, often violating social mores, engaging in increased sexual activity, and spending to excess. In severe cases, they may suffer delusions or hallucinations, often with grandiose themes. Even brief periods of mania (or hypomania, as it is known when slightly milder) may have severe consequences for affected individuals, as the disinhibition may see them trash longstanding work or marital relationships, or squander life savings. Around 1% of the population suffers from bipolar disorder.

The treatments for bipolar disorder are effective and focus on a range of medications called mood stabilisers, which include lithium and drugs most commonly used in epilepsy or schizophrenia that also have efficacy here.

1 I Grande et al, "Bipolar Disorder" (2016) 387 *Lancet* 1561.

Other commonly encountered diagnoses

[51.350] Schizophrenia and other psychotic disorders

Despite being a relatively common psychiatric condition, suffered by around 0.7% of the general population, schizophrenia is very poorly understood by the lay public. Its most recognised symptoms are hallucinations and delusions, but far less appreciated are the associated cognitive difficulties experienced by sufferers and the so-called negative symptoms which manifest as a loss of the ability to experience emotions and a pervasive apathy. While hallucinations and delusions can be relatively well controlled by medication, in many sufferers the cognitive and negative symptoms are very prominent and far less responsive to treatment. In these individuals, the negative symptoms tend to be the main source of the disability caused by the illness.[1] In men, schizophrenia is typically diagnosed in the late teens or early twenties. In women, onset is typically a decade later. There is, however, wide variation.

It is likely that the syndrome that we call "schizophrenia" is actually a family of illnesses of different underlying pathologies that we currently lump together, as their numerous causes are yet to be elucidated. This is probably one reason for the very varied prognosis seen in those diagnosed with schizophrenia. About one-third of people will only have one episode of illness and then be illness-free; another third will experience an illness that is chronic but relatively well-controlled; and another third will be significantly disabled, around one-third of those severely so. The most common treatments for schizophrenia are a range of antipsychotic medications and rehabilitative efforts focused upon cognitive and negative symptoms.

Hallucinations and delusions also occur in a family of other illnesses known as psychotic disorders that lack the cognitive and negative symptoms of schizophrenia. In delusional disorders, for example, a person may experience a relatively limited range of fixed false beliefs, but otherwise continue to function perfectly well.[2] In one such syndrome, known as delusional infestation, a sufferer's only abnormality will be the abiding conviction that some form of mite has invaded their skin. No amount of professional reassurance will abate this. In

another syndrome, delusional jealousy, a sufferer will become convinced that their partner is unfaithful, despite a lack of any real evidence of infidelity and their partner's denials.

1 MJ Owen, A Sawa and PB Mortensen, "Schizophrenia" (2016) 388 *Lancet* 86.

2 S Opjordsmoen, "Delusional Disorder as a Partial Psychosis" (2014) 40 *Schizophrenia Bulletin* 244.

[51.360] Anxiety disorders

The anxiety disorders are another family of illnesses in which the main feature is one or another variety of intense worry. The four most likely to be encountered in civil forensic practice are generalised anxiety disorder (GAD), panic disorder, obsessive-compulsive disorder (OCD) and phobias. GAD and panic disorder tend to be diagnosed in early adulthood. OCD and phobias frequently begin in early adolescence or childhood.

Persons with GAD experience worry or fearful anticipation in relation to many activities in their daily lives. So intense is this pervasive worry and the other symptoms that go along with it (restlessness, poor concentration, muscle tension, irritability and sleep disturbance) that their work or personal relationships are severely affected.[1]

Persons with panic disorder experience discrete intense episodes of overwhelming anxiety, associated with shortness of breath, chest pain or palpitations, often leading them to be convinced that they are suffering a heart attack.[2] While about one in five individuals suffers a panic attack at some time in their life, those who go on to experience them regularly will often severely restrict their activities in an effort to control the attacks. In the most severe cases, people whose panic disorder are complicated by agoraphobia will refuse to leave their homes, making it very difficult for them to access treatment.

OCD is characterised by an intense anxiety that some misfortune will occur if the sufferer does not engage in a series of rituals. Sufferers may, for example, believe that unless they wash their hands a certain number of times after touching ordinary surfaces, they will contract some infection and pass that on to their loved ones. In this variety of OCD, sufferers may spend hours washing their hands or otherwise "disinfecting" their environments – not only preventing them from engaging in normal activities, but also causing their hands to become inflamed and sore. Unlike people with delusions, people with OCD can, superficially at least, recognise that their concerns have no basis in reality. Nonetheless, their anxiety drives them to adhere to their time-consuming and damaging rituals.[3]

Phobias are broadly defined as an intense irrational fear of certain things or situations. Generally, these are categorised by the thing feared: ornithophobia is the fear of birds, acrophobia is the fear of heights, and so on. Three phobias tend to be categorised separately. The fear of entering crowds or open spaces is called agoraphobia and is almost always a secondary effect of panic disorder. The fear of social situations is termed social anxiety disorder.[4] Blood and injury phobia, also called needle phobia, is also categorised separately, as while most phobias cause the sufferer to become hyperaroused when exposed to the stimulus, sufferers of needle phobia typically faint at the sight of blood.[5] Perhaps surprisingly, certain phobias have been found to constitute disabilities for the purposes of discrimination law.[6] In a famous capacity case, needle phobia was found to render the sufferer incompetent through overbearing her capacity to make a decision.[7]

1 C Gale and O Davidson, "Generalised Anxiety Disorder" (2007) 334 *British Medical Journal* 579.

2 PP Roy-Byrne, MG Craske and MB Stein, "Panic Disorder" (2006) 368 *Lancet* 1023.

3 D Veale and A Roberts, "Obsessive-Compulsive Disorder" (2014) 348 *British Medical Journal* g2183.

4 MB Stein and DJ Stein, "Social Anxiety Disorder" (2008) 371 *Lancet* 1115.

5 I Marks, "Blood-Injury Phobia: A Review" (1988) 145 *American Journal of Psychiatry* 1207.

6 *Sklavos v Australasian College of Dermatologists* (2017) 347 ALR 78; [2017] FCAFC 128. See at [3] for a detailed description of the applicant doctor's specific phobia.

7 *Re MB* [1997] EWCA Civ 3093. See especially at [9], [10], [15] and [26].

[51.370] Post-traumatic stress disorder

The most common psychiatric disorder seen in civil forensic practice is post-traumatic stress disorder (PTSD), which is often attributed to claimants' experiences in their workplace or as part of a motor traffic accident or an assault.

PTSD represents a pathological reaction to some traumatic event. Most commonly, sufferers have directly experienced the event, but the syndrome may develop when a person witnesses traumatic events occurring to others, or even when one learns of a traumatic event that occurred to a close family member or friend. The most dramatic symptoms of PTSD are those associated with reliving the traumatic event, which may take the form of involuntary and intrusive memories, distressing dreams, flashbacks (where the individual feels that the event is occurring again), or intense anxiety associated with cues that symbolise or resemble the original event. In order to avoid these re-experiencing phenomena, sufferers will usually avoid external reminders – a manoeuvre that can be disabling, particularly if the traumatic event was experienced in the workplace and the person is therefore unable to return to work.

Perhaps, though, the most disabling symptoms of PTSD are those least recognised by the public. These are the alterations in cognition and mood that include persistent and exaggerated negative beliefs or expectations of oneself or the world; persistent fear, guilt or shame; a withdrawal from usual social activities; a feeling of detachment or estrangement from others; and a persistent inability to experience happiness, satisfaction or feelings of love. These "negative symptoms" can have devastating effects upon the sufferer's relationships. They are only magnified by alterations in arousal frequently experienced in the syndrome, such as increased irritability, hypervigilance, exaggerated startle response, poor concentration, and sleep disturbance. PTSD is frequently associated with depression and the overuse of drugs or alcohol in efforts to control the debilitating symptoms.[1]

PTSD may be alleviated – at least to some extent – by a range of treatments, including cognitive behavioural therapy and medications, but for many sufferers it remains a chronic and debilitating condition.

The underlying nature of PTSD has recently received some attention in the legal realm as a question arose as to whether it constituted a "bodily injury" for the purposes of the *Civil Aviation (Carriers' Liability) Act 1959* (Cth), which incorporated the 1999 *Convention for the Unification of Certain Rules for International Carriage by Air*, known as the Montreal Convention, into Australian law. At first instance, in a case seeking compensation after a plane was forced to ditch at sea, expert evidence was adduced which convinced the court that PTSD *could be* regarded as a bodily injury.[2] This aspect of the decision was overturned on appeal, but that decision was based on what the Court of Appeal felt was insufficient evidence, not necessarily a disagreement with the underlying argument.[3]

1 A Shalev, I Liberzon and C Marmar, "Post-Traumatic Stress Disorder" (2017) 376 *New England Journal of Medicine* 2459.

2 *Casey v Pel-Air Aviation Pty Ltd* (2015) 89 NSWLR 707; [2015] NSWSC 566.

3 *Pel-Air Aviation Pty Ltd v Casey* (2017) 93 NSWLR 438; [2017] NSWCA 32.

[51.380] Somatic symptom disorder

Although the evolutionary function of pain is to serve as a conscious indicator of bodily damage, it is well known that there is no simple relationship between tissue damage and the experience of pain. It is also known that pain (and other physical symptoms) can arise either

with no apparent underlying physiological change or, more commonly, with an underlying physiological change that does not seem sufficient to explain the physical symptom that the person experiences.

Until recently, psychiatric diagnostic systems dealt with this challenge by positing a range of diagnoses with names such as "somatisation disorder" and "pain disorder" that asked clinicians to make a judgment as to whether or not the symptom experienced could be explained by some underlying physical disease process – that is to say, these diagnoses were, to some extent, diagnoses of exclusion, defined by the absence of an adequate medical explanation for the symptoms experienced.

In its latest iteration, the DSM has moved away from this approach and the equivalent diagnoses now demand a focus on the psychological impact that the bodily symptoms have on the individual, rather than on their cause – that is, how the symptoms affect the individual's life rather than whether or not there is a "medical" explanation for them. As a result, the diagnoses focus on the positive (present) criteria, rather than the negative (absent) features. These criteria are a disproportionate preoccupation with, and cognitive focus on, the physical symptoms; profound and disproportionate emotional distress in relation to the symptoms; and excessive, unsatisfactory and maladaptive behaviours related to the symptoms. This shift in approach assumes that the abnormality lies not in a cryptic psychological mechanism, but rather in the maladaptive and unsatisfactory ways in which the individual reacts to the symptoms and copes with them. It holds that the ultimate source of the somatic symptoms is less able to be discerned and less important than the patient's reaction to the symptoms.[1]

Perhaps unsurprisingly, such a dramatic change in the way that psychiatrists are expected to view the diagnostic interface between the physical disease and the experience of symptoms has resulted in a great deal of controversy.[2] Generally speaking, few have been prepared to defend the old regime of trying to judge what symptoms were based in physical processes, as this had long been recognised as hopelessly unreliable. Instead, dissenters have pointed to the fact that the new diagnoses may be applied to a huge population of patients, many of whom may simply be experiencing normal reactions to pathological bodily processes.

At this point, it seems too early to know what impact, if any, these changes are having on civil forensic practice, where courts frequently seek assistance as to the causative contribution that a bodily injury may make to a plaintiff's subjective experience and functioning.

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1 AJ Barsky, "Assessing the New DSM-5 Diagnosis of Somatic Symptom Disorder" (2016) 78 *Psychosomatic Medicine* 2; SL Kurlansik and MS Maffei, "Somatic Symptom Disorder" (2015) 93 *American Family Physician* 49.

2 R Mayou, "Is the DSM-5 Chapter on Somatic Symptom Disorder Any Better Than DSM-IV Somatoform Disorder?" (2014) 204 *British Journal of Psychiatry* 418.

[The next text page is 51-201]

NEGLIGENCE CASES

[51.400] Overview

While psychiatric expertise may be sought in all manner of negligence matters, perhaps the most common cases involve a health practitioner's alleged act or omission that has been associated with an adverse event, such as suicide or a serious suicide attempt. Psychiatrist experts are often called upon to express an opinion as to the standard of care and, in particular, whether it met the *Bolam* standard.[1]

While it is certainly the case that the variability encountered in presentations and treatment approaches in psychiatry makes the determination of accepted peer professional standards more difficult than it might be in, say, some areas of surgical practice, this is not to imply that the only relevant standard is the unsupported opinion of the expert. Most areas of psychiatric practice are based in a rich empirically derived evidence base that is often used to derive clinical guidelines and reviews that can be regarded as good indicators of peer professional practice at various times. Expert reports should make frequent reference to the literature, reviews or guidelines to support any opinions expressed on peer professional opinion, or should explain why such support is not possible in particular cases.

One area that frequently arises in negligence (and coroner's) cases that concern suicides is the adequacy of a suicide risk assessment. In 2018, it is still common for clinicians seeing mentally ill people to complete a document attesting that the patient represents a high, medium or low suicide risk. This is despite the fact that there is no evidence that any patient characteristic or combination of patient characteristics can be used to usefully divide those presenting in psychiatric crisis into those more or less likely to commit suicide or to seriously harm themselves or others in the future.[2] Unfortunately, many psychiatric experts are apparently unfamiliar with the literature on risk assessment and may express opinions on it based solely on their own experience.

Psychiatric expertise may also play a part in the calculation of damages, particularly to the extent to which damages are based on the anticipated cost of treatment of psychiatric illness.

1 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

2 R Mulder, G Newton-Howes and JW Coid, "The Futility of Risk Prediction in Psychiatry" (2016) 209 *British Journal of Psychiatry* 271; MM Large et al, "Can We Usefully Stratify Patients According to Suicide Risk?" (2017) 359 *British Medical Journal* j4627.

[The next text page is 51-251]

WORKERS COMPENSATION AND MOTOR TRAFFIC ACCIDENT COMPENSATION

[51.500] Overview

Workers compensation and motor traffic accident compensation schemes vary from jurisdiction to jurisdiction. Authorities that administer the formal schemes run courses for psychiatry experts who will be assessing injuries. Assessing psychiatrists must be accredited.

Once a claim for injuries is submitted, a medical assessment is usually undertaken to make a determination of one or more of the following:

- Is there a diagnosable injury?
- What caused the condition?
- If there were other causes of an injury, what proportion is due to the claimed accident or incident?
- What is the severity of the injury for the purpose of compensation?
- What treatment is required? If the injured person is requesting a treatment, is it reasonable and necessary?

A compensable injury is one that meets threshold criteria of having a significant impact on a person's life. Thresholds differ depending on the scheme and are usually determined by assessing the extent of the effect on the injured person's life.

To determine whether a diagnosis can be made, the psychiatrist will take a history of reported symptoms and the history of the injury. The DSM-5 is usually used for diagnostic criteria. In accordance with the DSM, conditions are regarded as clinically significant when they interfere with a person's ability to function or when they cause significant distress.

Having determined the diagnosis, the psychiatrist will consider whether or not it is plausible, from a medical point of view, that the stated mechanism of injury could have caused the symptoms. A history of other stressors, the person's medical and psychiatric history, and consideration of other possible medical causes are required to aid judgment about the medical plausibility of the association between injury and clinical condition. For example, while in most circumstances symptoms consistent with post-traumatic stress disorder after a minor car accident may be implausible, psychiatrists may draw on their expertise to posit that this may not be the case if the person was already vulnerable to the syndrome due to their earlier exposure to a similar severe trauma. Psychiatrists may also gauge the plausibility of a person's apparent cognitive impairment and judge its consistency with the mechanism of injury.

If the stated injury could plausibly cause the medical condition, the psychiatrist then determines if, on the balance of probabilities, it caused the condition, taking into account the person's pre-injury psychiatric condition, the temporal relationship between the injury and the development of symptoms, and other plausible causes of the condition.

The psychiatrist will also need to consider if there was any pre-existing or subsequent psychiatric condition. These factors determine the proportion that can be attributable to the claimed mechanism of injury. A person who has a chronic major depression may claim that it has been exacerbated after a motor accident or workplace injury. The psychiatrist assesses the possibility that the injury has been exacerbated and estimates the proportion of the current clinical presentation that is actually due to the injury that is being assessed. The assessment of this proportion may be by estimate or by fixed amount, depending upon the relevant scheme. In the assessment of workers compensation in New South Wales, for example, 10% of an impairment can be deducted if there is a pre-existing psychiatric condition.[1]

The psychiatrist's assessment of the severity of the injury is important, as most compensation schemes have a threshold of severity for which compensation is payable. In order to standardise assessment, the schemes produce guides for the assessment of the severity of impairment. Most of these guides translate impairment into a percentage impairment, known as "whole person impairment" (WPI).

In order to be assessed, the injury must be permanent or stable. The definition of permanent varies according to the scheme. In some schemes, determination includes consideration of the duration of the impairment and whether the person has undertaken all reasonable rehabilitative treatment.[2] In other schemes, a condition is considered permanent if it is unlikely to change by more than a small percentage in the next year. If the condition is not stable or permanent, assessment of the degree of impairment is deferred.[3]

Criteria for the assessment of severity also vary from scheme to scheme. The psychiatrist will take into account how the person is able to manage daily stresses and the person's functioning, not just the reported symptoms. The injured person's level of pain may or may not be included in the assessment, depending on the scheme. In some schemes, secondary psychiatric injury (for instance, an emotional reaction to a physical injury) is excluded from assessment.

If the injury has resulted in more than one psychiatric condition, the WPI comprises the effect of the totality of the conditions on the person's functioning such that a single WPI is calculated. However, when assessing injuries for military compensation, if the conditions are distinct, then the injuries are assessed separately for the purposes of WPI.

It is critical that the psychiatrist assess only the impairment due to the psychiatric injury and not other injuries. This will frequently lead to a report in which the psychiatrist may opine that the person is fit to undertake some form of work when the person is clearly physically incapable of doing so, or the converse.

The psychiatrist can also assist when the insurer or injured person wishes to establish if the injured person's request for treatment is reasonable and if it is necessary. In this case, the psychiatrist should determine if the condition is caused by the claimed injury and, if so, if the treatment conforms to recognised guidelines or established clinical practice. For instance, a person may request psychological therapy for a claimed post-traumatic stress disorder, but the psychiatrist may instead diagnose an Adjustment Disorder as a reaction to pain and limited function. In this case, the psychiatrist would conclude that trauma-focused therapy was not reasonable or necessary.

Requests for approval of a range of therapies that provide temporary relief or improvement of mood may not be an effective treatment backed by research. The psychiatrist will also consider a reasonable duration of therapy and whether pharmacological agents might be of benefit.

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1 State Insurance Regulatory Authority, *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (4th ed, NSW Government, 2016).

2 See, for example, Comcare, *Guide to the Assessment of the Degree of Permanent Impairment* (Edition 2.1).

3 See, for example, State Insurance Regulatory Authority, *Motor Accidents Permanent Impairment Guidelines* (NSW Government, 2018).

[The next text page is 51-301]

CAPACITY, GUARDIANSHIP AND TESTAMENTARY CAPACITY

General principles

[51.600] Overview

Capacity is the ability to make decisions. The area of capacity assessment and its application in both medical and legal practice presents a range of opportunities for the actualisation of human rights[1] – namely, by maximising autonomy in decision-making while safeguarding against undue influence and abuse. Specifically, autonomy can be maximised when capacity assessors and their instructing legal professionals alike are mindful of restricting interference with decision-making, while at the same time identifying abuse.[2] Obligations in regards to the latter, particularly elder abuse, have recently been articulated by the Australian Law Reform Commission.[3]

Accordingly, capacity should not be conceptualised as a global construct, but rather in reference to specific decisions, tasks or domains,[4] and instructions. Accordingly, assessments should be restricted to the specific legal question at hand. A statement in a medical report that a person "lacks capacity" is meaningless without reference to the specific decisions for which the person lacks capacity. Further, the capacity task is different for each domain or decision and, as such, capacity cannot be extrapolated from one decision to another (for example, from testamentary capacity to appointing an attorney under a power of attorney). In a similar vein, it is not helpful to ask a doctor who saw a patient for other reasons (for example, for a surgical or ophthalmological review), and did not put their mind to the specific capacity task in question, to opine on capacity. Finally, capacity can vary even within a capacity task. Not all decisions are the same. Some are more complex, depending on the decision or situation at hand. It is, therefore, ill-advised to state that a person lacks capacity to "appoint a guardian" or make "a will", rather than to "appoint their daughter as guardian with decisions over health" or make "this will" – that is, the will in question.

An important starting point in capacity assessment is the presumption of capacity for all adults.[5] A valid "trigger" must exist to rebut this presumption of capacity. This means that nothing can be assumed about a person's capacity on the basis of diagnosis alone, including diagnoses of mental illness, cognitive impairment (including dementia and delirium), or intellectual disability. The role of the capacity assessor is to sort out which decisions the person

is capable (or not) of making, but only in areas under due enquiry. Capacity assessment, often perceived by the person being assessed as intrusive and offensive, must be justified.

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1 *Convention on the Rights of Persons with Disabilities*: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html (viewed 14 June 2018).

2 C Peisah, "Capacity Assessment", in H Chiu and K Shulman (eds), *Mental Health and Illness of the Elderly*, Mental Health and Illness Worldwide series (Springer, 2017); see also chapter 1 in N O'Neill and C Peisah, *Capacity and the Law* (2nd ed, Australasian Legal Information Institute, 2017): http://austlii.community/wiki/Books/CapacityAndTheLaw (viewed 14 June 2018).

3 Australian Law Reform Commission, *Elder Abuse – A National Legal Response*, Report No 131: https://www.alrc.gov.au/publications/elder-abuse-report (viewed 14 June 2018).

4 C Peisah, O Forlenza and E Chiu, "Ethics, Capacity, and Decision-Making in the Practice of Old Age Psychiatry: An Emerging Dialogue" (2009) 22 *Current Opinion in Psychiatry* 519.

5 *Re MB* [1997] EWCA Civ 3093.

[51.610] Undue influence

As stated above, a valid "trigger" must exist to rebut the presumption of capacity, a valid such trigger being the question of undue influence or abuse. Arising out of late-19th-century English case law in relation to testamentary undue influence,[1] the concept has been increasingly applied to all capacity determinations.[2] The screening for it is now considered an obligation of lawyers and doctors alike[3] and is considered long overdue.[4] Undue influence can occur in all circumstances where one person can benefit from the decision-making of another, commonly in the procurement of legal documents that favour, advantage or give power to the "influencer".[5]

Developed in the context of will-making,[6] the following risk factors for undue influence have been identified and apply equally to other types of undue influence:

- relationship risk factors:
  - anyone in a position of trust or upon whom a testator is dependent for emotional or physical needs;
- social or environmental risk factors:
  - isolation and sequestration of the person;
  - change in family relationships/dynamics;
  - recent bereavement; and
  - family conflict;
- psychological and physical risk factors:
  - physical disability;
  - non-specific psychological factors, such as deathbed wills, sexual bargaining, serious medical illness with dependency, and regression;
  - personality disorders;
  - substance abuse; and
  - mental disorders, including dementia, delirium, mood and paranoid disorders; and

- legal risk factors:
  - beneficiary instigates or procures the will or document;
  - contents of the will include unnatural provisions;
  - contents favour the beneficiary or "influencer";
  - contents are not in keeping with previous wishes;
  - other documents have changed at the same time – longstanding patterns of formalised trust (such as power of attorney or guardianship) are changed in proximity to the time the will or other document is changed; and
  - inter vivos gifting to the "influencer".

In regard to document procurement, an important screening question is to consider who the client is. It is ill-advised to take instructions from a third party on behalf of another, whether it be a friend, son or daughter. If a person requires somebody else to give instructions on their behalf, then the lawyer must consider carefully if indeed the client is capable of giving instructions.

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1 *Wingrove v Wingrove* (1885) 11 PD 81 at 83.

2 See chapter 2 in N O'Neill and C Peisah, *Capacity and the Law* (2nd ed, Australasian Legal Information Institute, 2017): http://austlii.community/wiki/Books/CapacityAndTheLaw (viewed 14 June 2018).

3 General Purpose Standing Committee No 2, Legislative Council, Parliament of New South Wales, *Elder Abuse in New South Wales* (2016) https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6063/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf (viewed 14 June 2018).

4 New South Wales Law Reform Commission, *Wills – Execution and Revocation*, Report 47 (1986), [8.34]: http://www.lawreform.justice.nsw.gov.au/Documents/Publications/Reports/Report-47.pdf (viewed 14 June 2018). See also R Kerridge, "Wills Made in Suspicious Circumstances: The Problem of the Vulnerable Testator" (2000) 59(2) *Cambridge Law Journal* 310, p 328; P Ridge, "Equitable Undue Influence and Wills" (2004) 120 *Law Quarterly Review* 617.

5 Until *Nicholson v Knaggs* [2009] VSC 64 at [584], the standard of proof for undue influence had not been met in an Australian court. For other examples of cases where the issue of undue influence has since been successfully raised, see *Petrovski v Nasev* [2011] NSWSC 1275 at [276]; *Dickman v Holley* [2013] NSWSC 18; *Brown v Wade* [2010] WASC 367.

6 C Peisah et al, "The Wills of Older People: Risk Factors for Undue Influence" (2009) 21 *International Psychogeriatrics* 7.

Testamentary capacity

[51.620] Overview

Testamentary capacity refers to the capacity to make a will. Clinicians are commonly asked to do assessments of testamentary capacity for testators who are contemplating making, or who have recently made, a will (contemporaneous assessment), and for deceased testators whose testamentary capacity has been challenged retrospectively (retrospective assessment).[1]

The test for testamentary capacity is defined according to an English case of 1870, *Banks v Goodfellow*,[2] in which the court laid out four broad criteria to be satisfied, namely:

- "understand the nature of the act [of making a will] and its effects";

- "understand the extent of the property of which he is disposing";
- "be able to comprehend and appreciate the claims to which he ought to give effect"; and
- "that no disorder of mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties – that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made".

Although this doctrine has endured for nearly 150 years, its applicability to the modern environmental context of testamentary capacity has been questioned.[3] Shulman et al[4] have proposed that these traditional *Banks v Goodfellow* criteria be updated and attuned to advances in neuroscience. Most relevantly, the prevalence of cognitive disorders (over "insane delusions" due to schizophrenia suffered by John Banks in 1863) among modern testators has necessitated modified criteria, including rationale for any dramatic changes or significant deviations from the pattern identified in prior wills or previously expressed wishes regarding the disposition of assets.[5]

Guides for performing both contemporaneous and retrospective assessments of testamentary capacity,[6] as well as testamentary capacity and the deathbed,[7] the suicide note,[8] delirium[9] and the lucid interval[10] have all been addressed.

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1 See chapter 4 in N O'Neill and C Peisah, *Capacity and the Law* (2nd ed, Australasian Legal Information Institute, 2017): http://austlii.community/wiki/Books/CapacityAndTheLaw (viewed 14 June 2018). See also C Peisah and K Shulman, "Testamentary Capacity", in G Demakis (ed), *Civil Capacities in Clinical Neuropsychology: Research Findings and Practical Applications* (Oxford University Press, 2011); M Frost, S Lawson and R Jacoby, *Testamentary Capacity: Law, Practice, and Medicine* (Oxford University Press, 2015).

2 *Banks v Goodfellow* (1870) LR 5 QB 549.

3 K Purser, "Assessing Testamentary Capacity in the 21st Century: Is *Banks v Goodfellow* Still Relevant?" (2015) 38 *University of New South Wales Law Journal* 854.

4 KI Shulman et al, "*Banks v Goodfellow* (1870): Time to Update the Test for Testamentary Capacity" (2017) 95 *Canadian Bar Journal* 251.

5 KI Shulman et al, "*Banks v Goodfellow* (1870): Time to Update the Test for Testamentary Capacity" (2017) 95 *Canadian Bar Journal* 251.

6 C Peisah, "Reflections on Changes in Defining Testamentary Capacity" (2005) 17 *International Psychogeriatrics* 709; KI Shulman, CA Cohen and I Hull, "Psychiatric Issues in Retrospective Challenges of Testamentary Capacity" (2005) 20 *International Journal of Geriatric Psychiatry* 63; KI Shulman et al, "Assessment of Testamentary Capacity and Vulnerability to Undue Influence" (2007) 164 *American Journal of Psychiatry* 722; KI Shulman et al, "Contemporaneous Assessment of Testamentary Capacity" (2009) 21 *International Psychogeriatrics* 433.

7 C Peisah et al, "Deathbed Wills: Assessing Testamentary Capacity in the Dying Patient" (2014) 26 *International Psychogeriatrics* 209.

8 M Sinyor et al, "Last Wills and Testaments in a Large Sample of Suicide Notes: Implications for Testamentary Capacity" (2015) 206 *British Journal of Psychiatry* 72.

9 B Liptzin et al, "Testamentary Capacity and Delirium" (2010) 22 *International Psychogeriatrics* 950.

10 KI Shulman et al, "Cognitive Fluctuations and the Lucid Interval in Dementia: Implications for Testamentary Capacity" (2015) 43 *Journal of the American Academy of Psychiatry and the Law* 287.

[51.630] Capacity and planning ahead tools – enduring guardianship and enduring powers of attorney

In order to promote decision-making autonomy, people are encouraged to plan ahead to appoint an enduring guardian (EG) or enduring power of attorney (EPOA) to make medical,

personal or financial decisions, depending on the state or territory. The tests are found in statutory and common law,[1] depending on the jurisdiction,[2] the diversity of authority underlining the importance of providing experts with the relevant criteria when seeking expertise on these matters.

Notwithstanding this diversity, the following useful frame for assessment of the capacity to appoint an EG or an EPOA has been developed:

(1) The "why" of the appointment: Who has initiated the appointment? Is there a valid trigger to rebut the presumption of capacity? Is there already a valid document in place? Has it been revoked? Is the appointment in the best interests of the donor or someone else?

(2) The "what" of the appointment: Does the person understand when it is explained to them:

    (a) that they are authorising someone to look after/assume authority of their medical/personal/financial affairs;

    (b) the nature and extent of what they are authorising the attorney/guardian to do;

    (c) the sort of things the attorney/guardian can do without reference to them;

    (d) that the guardian/attorney can make decisions about their medical/personal/financial affairs which they themselves would otherwise make;

    (e) when the authority will begin; and

    (f) that they can revoke the EG/EPOA while they have the capacity to do so.

(3) The "who" of the appointment:

    (a) Why has the person been selected for appointment?

    (b) Has the person executed any EG/EPOA previously? If so, how frequently have there been changes (that is, revocations and new appointments) and can the person recall making these?

    (c) Have they considered the trustworthiness and wisdom of the person they are appointing?

    (d) Is this appointment in keeping with previous appointments (for example, has someone else been consistently appointed in the past)?

    (e) What is the history of the relationship between the person and the attorney/guardian, and has there been any radical change in that relationship coinciding with the onset or course of dementia?

(4) The "freedom" of the appointment:

    (a) Has all the relevant information been given to the person in a way they can understand?

    (b) Is the person making the appointment freely and voluntarily, and not being unduly influenced or "schooled" to make the appointment?

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1 For Australian common law examples of tests for financial powers of attorney, see *Ranclaud v Cabban* [1988] NSW ConvR 55-385; [1988] ANZ ConvR 134; *Szozda v Szozda* [2010] NSWSC 804; *Ghosn v Principle Focus*

Pty Ltd [2008] VSC 574; *Scott v Scott* (2012) 7 ASTLR 299; [2012] NSWSC 1541.

2 See chapters 9 and 10 in N O'Neill and C Peisah, *Capacity and the Law* (2nd ed, Australasian Legal Information Institute, 2017): http://austlii.community/wiki/Books/CapacityAndTheLaw (viewed 14 June 2018).

[51.640] Guardianship and administration

In Australia, applications for guardianship and administration orders are made both to tribunals and to the Supreme Court. While the most common functions given to guardians relate to decisions about accommodation, health care, medical and dental consent, and service provision, a wide range of other personal decision-making functions, including access decisions, can be given.

Assessments for the purposes of the appointment of a guardian should follow the appropriate State or Territory-based legislation in regards to the criteria for making an order,[1] which, notwithstanding variations, are based on the presence of (i) disability, (ii) incapacity and (iii) a demonstrated need for a decision to be made. The existence of all three criteria is an important safeguard to promote human rights – that is, neither disability per se, nor disability with incapacity per se, is sufficient to warrant an application for guardianship. There must, as well, be a need for a guardian. A decision must be pending and there must be a real risk associated with, or a failure of, current informal arrangements. Australian tribunals do not make "just-in-case" orders.

A standard template for assessment for the purpose of a guardianship application is as follows:

(1) Is there an appropriate trigger for an assessment and application? Are there already sufficient substitute decision-making arrangements in place (for example, enduring guardianship, or medical or personal EPOA)? Do decisions need to be made (for example, there is no need for an accommodation order if the person is already settled in a nursing home)?

(2) Does the person have a disability?

(3) Is the person unable, by reason of that disability, to make decisions about matters relating to their person or circumstances, such as lifestyle, health and welfare. Specifically, does the person's disability impact on their decision-making about:

    (a) where the person should live;

    (b) with whom the person should live;

    (c) whether the person should be permitted to work (for example, in Victoria);

    (d) what health care they should receive; and

    (e) to whom they should have access.

(4) Is there a need, and/or is it in the best interests of the person, for an order to be made? What is the current situation regarding the practicability of services being provided without the need for an order? Is there risk? What are the consequences of making/not making an order?

(5) What are the person's wishes? What are the wishes of close family members/carers? Is there a dispute?

(6) Do you have any input into who should be guardian, including knowledge of personal history and family relationships, keeping in mind the aim of preserving family relationships and cultural and linguistic environments?

Concerns about a person's decision-making in relation to their financial affairs may trigger a financial capacity assessment. This assessment guides the decisions of others about whether they need to begin using a financial EPOA or, where no EPOA exists, to apply to the relevant tribunal or guardianship board for an administration or financial management order.

A suggested outline for assessment of the ability to manage financial affairs includes the following:[2]

(1) What is the trigger for the report? Who initiated the assessment and why? Concerns regarding financial abuse or self-neglect with failure to pay for basic care or utilities may be valid triggers.

(2) Is there a diagnosis or disability? Unlike Australian guardianship legislation, administration law does not always require the presence of a disability for the appointment of a financial manager/administrator. However, a prudent assessor would describe the diagnosis, its severity, and the basis for the diagnosis, with results of neuropsychological testing being helpful if available, but neither necessary nor mandatory for a capacity assessment.

(3) Specific functional testing of financial capacity: Although a plethora of instruments has been developed,[3] there is no gold single standard instrument. Rather, these scales provide more of a guide to the domains that should be considered, such as basic monetary skills; financial conceptual knowledge; cash transactions; chequebook management; bank statement management; financial judgment, including vulnerability to fraud and abuse; bill payment; knowledge of personal assets/estate arrangements; and investment decision-making.[4] It is important that the assessor is provided with corroborative information regarding assets, income, and bill payment to check the veracity of responses.

(4) Need and/or best interests: Can they afford food and can they pay crucial utility bills? Are there risk factors for undue influence (that is, risk of exploitation or dissipation of the estate by others) or evidence of financial abuse? If they are unfamiliar with their financial affairs or have never managed their own affairs, are there appropriate alternative or informal arrangements already in place and working (for example, a family member looking after affairs, an EPOA, or an accountant)?

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1 Chapters 6 and 7 in N O'Neill and C Peisah, *Capacity and the Law* (2nd ed, Australasian Legal Information Institute, 2017): http://austlii.community/wiki/Books/CapacityAndTheLaw (viewed 14 June 2018).

2 Chapter 8 in N O'Neill and C Peisah, *Capacity and the Law* (2nd ed, Australasian Legal Information Institute, 2017): http://austlii.community/wiki/Books/CapacityAndTheLaw (viewed 14 June 2018).

3 LB Sousa et al, "Financial and Testamentary Capacity Evaluations: Procedures and Assessment Instruments underneath a Functional Approach" (2014) 26 *International Psychogeriatrics* 217.

4 DC Marson et al, "Assessing Financial Capacity in Patients with Alzheimer Disease: A Conceptual Model and Prototype Instrument" (2000) 57 *Archives of Neurology* 877; MM Kershaw and LS Webber, "Assessment of Financial Competence" (2008) 15 *Psychiatry, Psychology and Law* 40.

[The next text page is 51-351]

CIVIL CHILD AND FAMILY MATTERS

[51.700] Overview

When issues relating to children are considered in the Family Law Courts, the guiding principle is the best interests of the child.[1] This is a different perspective compared with many other legal proceedings. Here, the goal is not so much to weigh up the merits of either side but to find a path through the complexities that will best serve the needs of a particular child. All too often, there are difficulties on both sides so the final outcome may be not the best but "the least detrimental alternative".[2]

Mostly, these are matters relating to parenting arrangements after the breakdown of the parental relationship. Less often, the conflict might be between parents and grandparents and occasionally it involves other parties connected to the child – for example, a foster parent or a sperm donor. The court is concerned with the capacity of the parties to provide for the needs of the child, including emotional and intellectual needs. Here, the child and family psychiatrist can assist the court by undertaking an assessment of the child and the respective adults, as individuals and also in terms of their attachment relationships, understanding that secure, stable and nurturing bonds with committed and responsive caregivers are fundamental to a child's development and well-being. Assessment of the child will include particularities of gender, aptitudes, interests, vulnerabilities and perhaps special needs, such as medical problems or learning difficulties. Psychological assessment may be required for more precise assessments, such as where there are issues of cognitive development.

There are specialised instruments for measuring attachment, but for practical purposes the skilled clinician can provide an adequate assessment.[3] In general terms, the attachment relationship is assessed as secure or insecure. This requires careful observation of the child and the child's primary caregivers, including their interactions and behaviours. For example: can the child separate at an age-appropriate level? Who does the child turn to for assistance or reassurance? How well does a parent respond to non-verbal cues? With toddlers and preschool children, observations of their play reveal a lot about their feelings; older children may be able to provide that information in a regular verbal interview.

In regard to assessment of the adults, beyond the capacity to meet the child's basic needs, parenting involves commitment, investment, sensitivity and the capacity for bonding. Sound mental health is also important, but here the traditional psychiatric assessment may not be as relevant as in other contexts. Sometimes a parent who has no psychiatric disorder is not well equipped to parent a particular child, while a parent with a diagnosable psychiatric condition may turn out to be the better option. A person with a serious mental illness who is committed to and receiving good clinical care may retain good parenting capacity, whereas some disturbances of personality, while they would not qualify as mental disorder, may constitute deficits in parenting. Antisocial behaviour is an example; even if it is not at a level to qualify for a diagnosis of antisocial personality disorder, it may still pose a risk of harm to children. Similarly, lack of empathy is a narcissistic personality trait that may not in itself constitute personality disorder, yet it seriously detracts from parenting capacity.

Attachment is not simply reflective of time spent with the child. A child may be as strongly attached to a parent who is working full-time away from home as the child is to a parent who is a full-time homemaker. This is an important issue, since so often parents in family law disputes will vie for equal time.

Without doubt, the most difficult issues to be assessed in Family Court matters are those of family violence and allegations of sexual abuse. These are problems that occur "behind closed doors" and so they are difficult to substantiate, but the standard of proof required in these proceedings is evidence of an "unacceptable risk" of harm to the child.[4]

Family violence is a major public health problem globally.[5] Children growing up in violent households are more likely to suffer neglect and all forms of abuse – physical, sexual and emotional. These adversities cause developmental damage and lead to mental health issues that continue into adult life and beyond, since violence is transmitted into the next generation. Children suffer such harm whether they are direct victims of violence or witness to it.[6] Perpetrators who are violent towards their partners are more likely to abuse or be violent towards their children,[7] so any consideration that "he only beats his wife; he has never hurt the children" offers no safety. Similarly, pet abuse is correlated with family violence, so it too is a warning signal.[8]

Where there is independent evidence of family violence – such as police intervention, previous restraining orders, or a victim requiring medical treatment – the perpetrator's future contact with children may need to be restricted or at least supervised. Whether this might be subject to some form of therapeutic intervention is a difficult question. Drug and/or alcohol abuse are common background factors in family violence and there is little prospect of controlling or preventing family violence if substance abuse issues are not dealt with first.[9] However, to date the evidence for the effectiveness of therapeutic interventions is "weak"[10] and rates of re-victimisation post-treatment are "alarmingly high".[11]

Allegations of sexual abuse are difficult to assess. Historically, women complainants have been regarded with suspicion by legal and medical professionals. While there are some cases of false claims, the weight of evidence indicates that this is not common. False allegations may apply in only 10–12% of cases.[12] The statistics are similar in cases of sexual assault of adult women, with around 10% or less making false allegations.[13] In the case of a child making an unprompted disclosure, it is particularly dangerous to dismiss this as manipulation, fantasy or deception. The available evidence suggests that, absent prompting or coaching, children rarely make false allegations of sexual abuse.[14]

When the court finds that there is an unacceptable risk of harm from a parent, the parent's contact with the children is likely to be restricted. Perhaps supervision of contact will be required, or in very high-risk cases there may be no provision for contact at all. Some experts argue that where sexual harm has been substantiated, even supervised contact is potentially harmful,[15] while others fear that an absent parent may become an idealised figure.[16] In these potentially very high-risk situations, there may be interim orders suspending contact with a parent. With very young children, there is then a need for urgent resolution since prolonged separation from a parent will undermine the strength of the bond. If some years pass before there is a finding of no unacceptable risk, it may be impossible to rehabilitate that parent–child relationship.

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1 *Family Law Act 1975* (Cth) s 60CA.

2 J Goldstein, *The Best Interests of the Child: The Least Detrimental Alternative* (Simon and Schuster, 1996).

3 JA Crowell, "Assessment of Attachment Security in a Clinical Setting: Observations of Parents and Children" (2003) 24 *Journal of Developmental & Behavioural Pediatrics* 199.

4 *Family Law Act 1975* (Cth) s 60CG.

5 C Garcia-Moreno et al, "Prevalence of Intimate Partner Violence: Findings from the WHO Multi-Country Study

on Women's Health and Domestic Violence" (2006) 368 *Lancet* 1260.

6 K Richards, "Children's Exposure to Domestic Violence in Australia" (2011) 419 *Trends & Issues in Crime and Criminal Justice* 1.

7 J Stanley and C Goddard, "The Association between Child Abuse and Other Family Violence" (1993) 46 *Australian Social Work* 3.

8 AM Volant et al, "The Relationship between Domestic Violence and Animal Abuse: An Australian Study" (2008) 23 *Journal of Interpersonal Violence* 1277.

9 C Easton, S Swan and R Sinha, "Motivation to Change Substance Use among Offenders of Domestic Violence" (2000) 19 *Journal of Substance Abuse Treatment* 1.

10 L Tarzia et al, "Interventions in Health Settings for Male Perpetrators or Victims of Intimate Partner Violence" (2017) *Trauma Violence Abuse* (published online ahead of print).

11 CI Eckhardt et al, "The Effectiveness of Intervention Programs for Perpetrators and Victims of Intimate Partner Violence" (2013) 4 *Partner Abuse* 196.

12 A Green, "Factors Contributing to False Allegations of Child Sexual Abuse in Custody Disputes" (1991) 15 *Child & Youth Services* 177; AE Smit, MV Antokolskaia and CCJH Bijleveld, "Between Scylla and Charybdis: A Literature Review of Sexual Abuse Allegations in Divorce Proceedings" (2015) 6 *Psychology* 1373; N Trocmé and N Bala, "False Allegations of Abuse and Neglect When Parents Separate" (2005) 29 *Child Abuse & Neglect* 1333.

13 D Lisak et al, "False Allegations of Sexual Assault: An Analysis of Ten Years of Reported Cases" (2010) 16 *Violence against Women* 1318; C Spohn, C While and K Tellis, "Unfounding Sexual Assault: Examining the Decision to Unfound and Identifying False Reports" (2014) 48 *Law & Society Review* 161.

14 E Jones and P Parkinson, "Child Sexual Abuse, Access and the Wishes of Children" (1995) 24 *International Journal of Law and the Family* 54; RK Oates et al, "Erroneous Concerns about Child Sexual Abuse" (2000) 24 *Child Abuse & Neglect* 149; K Saywitz, GS Foodman and J Myers, "Can Children Provide Accurate Eyewitness Reports?" (1990) 9 *Violence Update* 3.

15 E Jones and P Parkinson, "Child Sexual Abuse, Access and the Wishes of Children" (1995) 24 *International Journal of Law and the Family* 54; DP Jones and JM McGraw, "Reliable and Fictitious Accounts of Sexual Abuse to Children" (1987) 1 *Journal of Interpersonal Violence* 27.

16 RB Straus, "Supervised Visitation and Family Violence" (1995) 29(2) *Family Law Quarterly* 229.

[The next text page is 51-401]

OTHER ISSUES AT THE INTERFACE OF PSYCHIATRY AND CIVIL PRACTICE

[51.800] Civil detention under mental health legislation

Until recently, the law surrounding compulsory detention and treatment for mental illness was similar in all Australian jurisdictions. However, since 2013, as all jurisdictions (bar the Northern Territory) have reformed their laws, primarily to bring them into compliance with Australia's ratification of the United Nations *Convention on the Rights of Persons with Disabilities*, there has been considerable divergence in the legislative regimes.[1] Nonetheless, broadly speaking, all jurisdictions require that for a person to be detained and/or to receive psychiatric treatment, there must be reasonable grounds for believing that three criteria apply. First, the person must suffer a "mental illness" or "mental disorder", as variously defined. Second, the person (or others) must be deemed to need protection from some form of serious harm. Third, that involuntary treatment (and detention) must be the least restrictive avenue reasonably available to deliver safe and effective care.

The post-2013 reforms have seen the introduction of a fourth element that takes account of the person's decision-making capacity. In Queensland, South Australia, Tasmania and Western Australia, this fourth involuntary treatment criterion was added, requiring that before treatment could be applied without consent the person had to lack decision-making capacity with respect to their decision to refuse that treatment. The Australian Capital Territory, New South Wales and Victoria all raised the importance of a person's decision-making capacity when considering involuntary treatment, but stopped short of prohibiting involuntary treatment of those who competently refused it.

For psychiatrists to impose involuntary treatment, a judgment must be made that the mentally ill person meets the treatment criteria and, after a period ranging between days and weeks (depending on the jurisdiction), a tribunal must affirm the psychiatrist's judgment or the involuntary treatment cannot continue. Patients may have legal representation at the tribunal hearings and evidence from independent psychiatrists may be adduced to aid the tribunal in its deliberations. These tribunals also consider applications brought by psychiatrists for treatment with psychosurgery (in jurisdictions where that is permitted) and electroconvulsive therapy.

1 S Callaghan and CJ Ryan, "An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law" (2016) 39 *University of New South Wales Law Journal* 596.

[51.810] Termination of pregnancy

The laws concerning the termination of pregnancy differ markedly from jurisdiction to jurisdiction across Australia. In most cases, psychiatrists will have little or no role in the assessment of women requesting a termination. However, from time to time, a question may be

raised over the woman's decision-making capacity and in those rare instances psychiatrists may be able to provide expert evidence relevant to that issue. In New South Wales and Queensland, abortion remains a crime,[1] but in both jurisdictions a common law defence exists based in necessity[2] and in Queensland there is also a statutory defence.[3] Though psychiatrists are rarely asked to consult in routine cases, in cases of late termination or other cases where there is concern that the lawfulness of the procedure may later be called into question, a psychiatric report can be obtained to provide evidence that, to quote from the Levine ruling, continuing the pregnancy "would result in a serious danger to [the woman's] physical or mental health".[4]

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1 *Crimes Act 1900* (NSW) ss 83, 84; *Criminal Code* (Qld) ss 224 – 226.

2 *R v Wald* [1971] 3 DCR (NSW) 25; *CES v Superclinics (Australia) Pty Ltd* [1995] NSWSC 103; *R v Bayliss* [1986] 9 Qld Lawyer Rep 8.

3 *Criminal Code* (Qld) s 282.

4 *R v Wald* [1971] 3 DCR (NSW) 25 at 29 (Levine J).

[51.820] Physician-assisted suicide and euthanasia

Around the world, more and jurisdictions are providing a legal avenue by which people suffering from severe or terminal illnesses may seek assistance from doctors to end their lives at a time of their choosing. As of mid-2018, Victoria is the only Australian jurisdiction to have legalised physician-assisted suicide.[1]

In most assisted dying legislation, there is a requirement for some assertion to be given that the person requesting death retains decision-making capacity. Where this is in doubt, psychiatrists may be asked to make this judgment. The new Victorian legislation is similar. It requires any coordinating medical practitioner, who is unable to determine whether the person requesting assistance in dying has decision-making capacity, to refer the person "to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness".[2]

If asked to engage a health practitioner for the purposes of compliance with the procedures of an assisted dying Act with regard to capacity assessment, lawyers should ideally engage a health practitioner with training and expertise in the assessment of capacity and undue influence.

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1 *Voluntary Assisted Dying Act 2017* (Vic).

2 *Voluntary Assisted Dying Act 2017* (Vic) s 18(1).

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[The next text page is 53-1]