THE IMPORTANCE OF LEGAL ACCOUNTABILITY IN NEGLIGENCE AND MENTAL HEALTH CARE

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Legal accountability in mental health care is increasingly gaining recognition in human rights discourse. Negligence is one accountability mechanism that can provide compensation, but has been criticised for failing to deliver justice. The Mental Health and Wellbeing Act 2022 (Vic), along with immunity provisions for clinicians who act in good faith, have shone the spotlight on whether current mechanisms are effective accountability measures. Analysis of authorities suggests that clinicians and health authorities will ordinarily be protected from liability when clinical decisions are made that are consistent with mental health legislation. Yet clinicians often misunderstand the concept of 'duty of care' and use it as an extra-legal power to control. Using a fictional vignette, this article addresses the tensions and dilemmas that exist in tort law and mental health care. Our analysis lends itself to two solutions: the need for effective training and the promise of no-fault insurance schemes.

I INTRODUCTION

Legal accountability in the provision of health and mental care, as in other areas of modern public policy, is increasingly linked to human rights concerns. In human rights discourse, models of legal accountability for human rights abuses emphasise transparency, redress and systemic reform. For example, the United Nations Special Rapporteur on the Right of the Highest Attainable Standard of Health and Mental Health describes accountability as 'an opportunity for rights holders to understand how duty bearers have discharged their duties and claim redress where rights are violated. It also provides an opportunity for duty bearers to explain their actions and make amendments if required.'[1]

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1 Dainius Pūras, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/HRC/35/21 (28 March 2017) 12 [51].

Legal accountability in this model extends far beyond consideration of monetary compensation to the proper functioning of health systems and the protection of human rights. In Australia, mechanisms such as health complaint bodies, ombudsmen, professional regulation, and human rights commissions, contribute to some aspects of accountability. Nevertheless, tort law and the law of negligence remain the principal vehicles for the delivery of monetary compensation for negligent harm. This article outlines the inadequacies of tort law as a vehicle for human rights accountability.

In Australia, the common law of negligence was modified by civil liability reform at the beginning of the 20th century.[2] Perceptions of an 'insurance crisis' led to a review and significant statutory reform by Justice David Ipp ('Ipp reforms'), with new civil liability legislation introduced in six states.[3] These laws differ in detail but have common features. In general, the reforms modified the common law of negligence by introducing a statutory test of causation,[4] restricting recovery for mental harm[5] and limiting damages available for personal injury.[6] The reforms also reintroduced a modified statutory form of the test enunciated in *Bolam v Friern Hospital Management Committee*,[7] which had been rejected by the High Court of Australia in *Rogers v Whitaker* ('*Rogers*'),[8] such that 'peer professional opinion' operates as a *defence* against an action in negligence for harm arising

2 See generally *Review of the Law of Negligence* (Final Report, September 2002) <https://treasury.gov.au/sites/default/files/2019-03/R2002-001_Law_Neg_Final.pdf>.

3 *Civil Liability Act 2002* (NSW) ('*NSW CLA*'); *Civil Liability Act 2003* (Qld) ('*Qld CLA*'); *Civil Liability Act 1936* (SA) ('*SA CLA*'); *Civil Liability Act 2002* (Tas) ('*Tas CLA*'); *Wrongs Act 1958* (Vic) ('*Wrongs Act*'); *Civil Liability Act 2002* (WA) ('*WA CLA*'). For commentary on the reforms, see Harold Luntz, 'Reform of the Law of Negligence: Wrong Questions' (2002) 25(3) *University of New South Wales Law Journal* 836; Peter Cashman, 'Tort Reform and the Medical Indemnity "Crisis"' (2002) 25(3) *University of New South Wales Law Journal* 888; JJ Spigelman, 'Negligence and Insurance Premiums: Recent Changes in Australian Law' (2003) 11(3) *Torts Law Journal* 291; Peter Cane, 'Reforming Tort Law in Australia: A Personal Perspective' (2003) 27(3) *Melbourne University Law Review* 649; Peter Underwood, 'Is Ms Donoghue's Snail in Mortal Peril?' (2004) 12(1) *Torts Law Journal* 39.

4 See, eg, Mirko Bagaric and Sharon Erbacher, 'Causation in Negligence: From Anti-jurisprudence to Principle' (2011) 18(4) *Journal of Law and Medicine* 759, 764; Joanna Manning, 'Factual Causation in Medical Negligence' (2007) 15(3) *Journal of Law and Medicine* 337, 339; Susan Bartie, 'Ambition Versus Judicial Reality: Causation and Remoteness Under Civil Liability Legislation' (2007) 33(2) *University of Western Australia Law Review* 415; Barbara McDonald, 'Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia' (2005) 27(3) *Sydney Law Review* 443. For a contemporary critique, see Tina Popa, 'Criticising Current Causation Principles: Views from Victorian Lawyers on Medical Negligence Legislation' (2017) 25(1) *Journal of Law and Medicine* 150.

5 In this article, we have elected to use the term 'mental harm'. While we acknowledge that the terms 'mental harm' and 'psychiatric harm/injury' are often used interchangeably, we have elected to use the term 'mental harm' as defined in section 67 of the *Wrongs Act* (n 3) to mean 'psychological or psychiatric injury'.

6 John Chu, 'Analysis and Evaluation of Victorian Reform in General Damages for Personal Injury under the Tort of Negligence' (2007) 10(2) *Deakin Law Review* 125, 132 <https://doi.org/10.21153/dlr2007vol12no2art223>; Andrew Field, '"There Must Be a Better Way": Personal Injuries Compensation Since the "Crisis in Insurance"' (2008) 13(1) *Deakin Law Review* 67, 68–98 <https://doi.org/10.21153/dlr2008vol13no1art153>.

7 [1957] 1 WLR 582 ('*Bolam*').

8 (1992) 175 CLR 479 ('*Rogers*').

from diagnosis or treatment.[9] A commonly held assessment of the Ipp reforms is that they have resulted in, as was intended, a significant limitation of negligence litigation in Australia. As Anthony Gray has argued, the limitation of negligence reform in Australia echoes a historical discomfort in law with the notion that public authorities could or should be held liable.[10]

Following the Ipp reforms, courts in three jurisdictions have had the opportunity to consider the application of negligence laws in the context of mental health care and treatment.[11] The High Court ultimately considered the obligation of psychiatrists in *Hunter and New England Local Health District v McKenna* ('*McKenna*'),[12] which was concerned with the question of whether or not a duty of care might be owed to third parties when psychiatrists are considering whether to detain people pursuant to mental health legislation. In a brief judgment, the High Court resolved the question by finding there was no such duty.[13] In finding there was no duty, the Court reiterated the caution that the imposition of a duty would have the perverse consequence of encouraging higher rates of psychiatric detention and treatment.[14] *McKenna* illustrates the public policy tensions that surround questions of duty, liability and accountability in the delivery of mental health care, with the judgment being criticised for missing an opportunity to properly consider the quality of care that should be afforded to mental health patients.[15]

The following vignette assists the reader to understand the context in which the law under discussion is applied in practice. Fictional vignettes, or case studies, are commonly used in legal scholarship to illustrate the disjuncture between law 'on the books' and law in practice.[16] The vignette elucidates the policy tensions which are explored in this article:

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9 Joseph Lee, 'The Standard of Medical Care under the Australian Civil Liability Acts: Ten Years On' (2014) 22(2) *Journal of Law and Medicine* 335, 341–3. See also McDonald (n 4) 443; Loane Skene and Harold Luntz, 'Effects of Tort Law Reform on Medical Liability' (2005) 79(6) *Australian Law Journal* 345, 351.

10 Anthony Gray, 'The Liability of Providers of Mental Health Services in Negligence' (2015) 20(2) *Deakin Law Review* 221 <https://doi.org/10.21153/dlr2015vol20no2art528>.

11 *Presland v Hunter Area Health Service* [2003] NSWSC 754 ('*Presland NSWSC*'); *Adams v New South Wales [No 2]* [2008] NSWSC 1394; *Australian Capital Territory v Crowley* (2012) 7 ACTLR 142 ('*Crowley*'); *Walker v Sydney West Area Health Service* [2007] NSWSC 526 ('*Walker*'); *LC v Australian Capital Territory* [2017] ACTSC 324 ('*LC*'); *Stewart v Hames* [2021] WADC 93.

12 (2014) 253 CLR 270 ('*McKenna*'). In this case, Mr Pettigrove was involuntarily admitted to hospital. Following a psychiatric assessment and an overnight stay, Mr Pettigrove was discharged into his friend Mr Rose's care. Mr Pettigrove subsequently killed Mr Rose and committed suicide. The High Court held the hospital and doctors did not owe Mr Rose's relatives a duty of care because the legislation required least restrictive practice. To impose a duty of care would lead to an inconsistency between the common law and the need to comply with statutory obligations.

13 *McKenna* (n 12) 283 [33], [35] (French CJ, Hayne, Bell, Gageler and Keane JJ).

14 Ibid 232 [31].

15 Ian Freckelton, 'Medical Issues: Legal Liability for Psychiatrists' Decisions about Involuntary Inpatient Status for Mental Health Patients' (2014) 22(2) *Journal of Law and Medicine* 280.

16 See, eg, Chris Maylea, 'The Capacity to Consent to Sex in Mental Health Inpatient Units' (2019) 53(11) *Australian and New Zealand Journal of Psychiatry* 1070 <https://doi.org/10.1177/0004867419850320>; Tim Bunjevac, 'The Rise of Judicial Self-Governance in the New Millennium' (2021) 44(3) *Melbourne University Law Review* 812; Ying Yi Lim et al, 'Medical Negligence Laws and Virtual Reality in Healthcare' (2020) 49(8) *Australian Journal of General Practice* 525 <https://doi.org/10.31128/AJGP-08-19-5036>.

> A young woman, AJ, is experiencing mental distress and calls a dedicated mental health service to discuss her thoughts of suicide. She is advised to attend her local emergency department ('ED'). After waiting five hours, a doctor advises AJ that a mental health clinician will see her soon. An hour later, a psychiatric registrar conducts a short risk assessment of AJ, who informs AJ that they will return soon with a treatment plan.
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> AJ grows tired and overstimulated by the ED environment and asks a nurse if she can leave. The nurse reads an instruction in AJ's medical record from the registrar: 'AJ is a voluntary patient unless she tries to exit the ED.' The nurse tells AJ that if she attempts to leave the ED, security will be called and permitted to use force to restrain her. AJ communicates confusion and fear to the nurse as she thought she was a voluntary patient (not involuntary, as she had been once previously).
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> The nurse approaches the emergency mental health team's office and consults a senior psychiatric nurse. Both nurses attend AJ's cubicle, and the psychiatric nurse tells AJ that it is their duty of care to hold AJ at the ED until staff have deemed it safe for her to leave. AJ states that the ED environment is overstimulating and that the threats of security presence are worsening her distress. AJ asks if she is still a voluntary service user, which the psychiatric nurse confirms. AJ states that she intends to discharge herself.
>
> AJ begins to leave the ED. A code grey is called, and four large male security members meet AJ at her cubicle. AJ is grabbed physically by two security members and forcefully dragged back into the cubicle. AJ resists the security guards and pleads to be let go, as it mimics her past experience of trauma. AJ is then lifted onto the bed and minutes later, chemically restrained[17] by ED staff. Prior to the issuing of restraints, no alternative and less restrictive methods of intervention had been employed. In AJ's medical record, hospital staff justify the use of chemical restraint via a duty of care.
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> When AJ wakes, she is informed by staff that a bed in the hospital's mental health inpatient unit is inappropriate and that she is to be discharged. AJ is instructed to book a GP appointment. AJ advises the nurse that she is feeling traumatised and groggy following the use of restraints, has no means of getting home and would like a taxi voucher to safely discharge. A nurse takes this request to a senior mental health occupational therapist ('OT') who declines it. AJ is instead offered a public transport voucher. The OT states that if AJ does not vacate the ED, she will be escorted out by security. AJ remains in the cubicle and 20 minutes later, a code grey is once again called. AJ is physically restrained by security and forcefully removed from the ED. Security block AJ from re-entering. In AJ's medical record, hospital staff justify the use of physical restraint via a duty of care.[18]

This vignette illustrates the complexities surrounding application of negligence principles in clinical practice, including the misapplication of the 'duty of care' as a power that permits clinicians to act in a way that contradicts mental health legislation. Where clinicians breach their legal obligations, their conduct may result in physical and mental harm to the patient. As a consequence, negligence

17 The term 'chemical restraint' is defined as the 'giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment': *Mental Health and Wellbeing Act 2022* (Vic) s 3 (definition of 'chemical restraint') ('*Mental Health and Wellbeing Act*').

18 This vignette was developed with an emergency department worker and is a fictionalised account of real events.

becomes a powerful vehicle, in theory at least, to allow the injured patient to seek compensation and thus accountability.

Questions about the legal scope of a duty of care have become increasingly important in mental health law, as attempts are made to align mental health legislation with the United Nations *Convention on the Rights of Persons with Disabilities*.[19] Thus, the aim of this article is to explore the contemporary scope of the 'duty of care' following the Ipp reforms and how these principles operate in practice. To achieve this aim, in Part II of this article, we discuss the tort of negligence in light of statutory reforms, examining *McKenna* and subsequent decisions concerning tort principles in mental health care. These cases show that the common law notion of 'duty of care' is clearly conditioned by both civil liability and mental health legislation. In Part III, we examine the notion of 'duty of care' as it is used in policy and practice in mental health care.

We have adopted two research methods in our article: doctrinal analysis and discourse analysis. Doctrinal analysis is used to analyse key cases and legislation, along with secondary sources such as journal articles and reports, to describe, analyse and critique the law and suggest changes.[20] Discourse analysis is a widely accepted tool for social science research.[21] Discourse analysis seeks to analyse and critique the varied ways that discourses develop within and between areas of thought and enquiry.[22] Our analysis indicates that the invocation of a duty of care in day-to-day mental health practice is currently being elevated to an extra-legal standard that is used to justify the detention and treatment of individuals without reference to the checks, balances and limitations that exist in mental health legislation.[23] Part IV of the article outlines two possible responses to the accountability impasse. It is argued that in the first instance, comprehensive legal training is required to improve understanding of the law across the mental health sector. In the longer term, accountability requires the introduction of no-fault compensation schemes in Australia to provide corrective, distributive and restorative justice to those who are harmed by the mental health system.

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19 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

20 See, eg, Ian Dobinson and Francis Johns, 'Legal Research as Qualitative Research' in Mike McConville and Wing Hong Chui (eds), *Research Methods for Law* (Edinburgh University Press, 2nd ed, 2017) 18, 20–2; Jason NE Varuhas, 'Mapping Doctrinal Methods' in Paul Daly and Joe Tomlinson (eds), *Researching Public Law in Common Law Systems* (Edward Elgar Publishing, 2023) 70.

21 See generally Keith Jacobs, 'Discourse Analysis' in Maggie Walter (ed), *Social Research Methods* (Oxford University Press, 4th ed, 2019) 316; Bernadette Vine, *Understanding Discourse Analysis* (Routledge, 1st ed, 2023) 5 <https://doi.org/10.4324/9781003184058>.

22 See generally Jacobs (n 21).

23 See, eg, Scott Lamont, Cameron Stewart and Mary Chiarella, 'The Misuse of "Duty of Care" as Justification for Non-consensual Coercive Treatment' (2020) 70 *International Journal of Law and Psychiatry* 101598:1–4 <https://doi.org/10.1016/j.ijlp.2020.101598>.

II THE LAW OF NEGLIGENCE

It is well recognised that the common law requires a plaintiff to establish they were owed a duty of care,[24] that the duty was breached[25] and that the breach caused the harm suffered.[26] The tort of negligence crystalises when there has been a failure to take reasonable care resulting in harm to an individual or entity.[27] Successful plaintiffs are entitled to compensation. Thus, tort law offers a form of accountability through civil recourse.[28] By correcting the tortfeasor's wrongdoing,[29] it is further supposed that the law exerts a positive normative influence, such that negligent practice will be discouraged.[30]

With respect to negligence in health care, in the earlier seminal decision of *Rogers*, the High Court affirmed that medical doctors owe a duty of care.[31] The Court described the duty as a 'single comprehensive duty' extending to the examination, diagnosis and treatment of patients, including the provision of information.[32] Australian courts have held that a duty of care applies to myriad health care practitioners, such as paramedics,[33] dentists,[34] surgeons[35] and psychiatrists.[36] Other professions have come under less scrutiny, with virtually no Australian case law examining the obligations of, for example, mental health social workers.[37]

Since the civil liability reforms,[38] whether or not a clinician or hospital is found to be negligent will depend first on the assessment of whether there is a duty of care and then on the court's interpretation of the civil liability provisions, especially

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24 See, eg, *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 893 (Lord Diplock); *Gover v South Australia* (1985) 39 SASR 543, 551 (Cox J).

25 See, eg, *Bolam* (n 7) 596 (McNair J); *Rogers* (n 8) 483 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

26 See, eg, *Chappel v Hart* (1998) 195 CLR 232, 242 [23] (McHugh J) ('*Chappel*'); *Bolam* (n 7) 596 (McNair J). While the steps (or elements) of duty, breach and causation or liability are usually treated as three separate stages of enquiry, courts have acknowledged that these considerations are overlapping or commingled in the legal analysis: *Gett v Tabet* (2009) 109 NSWLR 1, 20 [321] (Allsop P, Beazley and Basten JJA).

27 *Donoghue v Stevenson* [1932] AC 562. See also Harold Luntz et al, *Luntz and Hambly's Torts: Cases, Legislation and Commentary* (LexisNexis, 9th ed, 2021) 70–3 [1.5.13]–[1.5.19].

28 See, eg, Jason M Solomon, 'Equal Accountability through Tort Law' (2009) 103(4) *Northwestern University Law Review* 1765.

29 David H Sohn 'Negligence, Genuine Error, and Litigation' (2013) 6 *International Journal of General Medicine* 49, 51 <https://doi.org/10.2147/IJGM.S24256>.

30 Ibid 50–1.

31 *Rogers* (n 8) 483 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

32 Ibid.

33 *Roane-Spray v Queensland* [2016] QDC 348.

34 *Dean v Phung* (2012) Aust Torts Reports ¶82-111.

35 *Hookey v Paterno* (2009) 22 VR 362; *Dixon v Foote* [2012] ACTSC 101.

36 Shrikkanth Rangarajan and Bernadette McSherry, 'To Detain or Not to Detain: A Question of Public Duty?' (2009) 16(2) *Psychiatry, Psychology and Law* 288, 289 <https://doi.org/10.1080/13218710902852867>, citing *Chapman v Hearse* (1961) 106 CLR 112.

37 See Chris Maylea, *Social Work and the Law: A Guide for Ethical Practice* (Macmillan International Higher Education, 2020) 237–8.

38 *NSW CLA* (n 3); *Personal Injuries (Liabilities and Damages) Act 2003* (NT); *Qld CLA* (n 3); *SA CLA* (n 3); *Tas CLA* (n 3); *Wrongs Act* (n 3); *WA CLA* (n 3).

those pertaining to breach[39] and causation.[40] As is discussed below, the questions about whether and in which circumstances a duty is owed, and specifically whether it extends to third parties, have shaped the law pertaining to mental health care.

In general, questions pertaining to the breach of the duty are often at the core of health care negligence claims. With respect to treatment cases, civil liability legislation now outlines the standard of care expected of 'professionals', which includes health care practitioners.[41] These provisions absolve a clinician of liability if they act in a manner that is consistent with how their 'peers' would have acted in the circumstances. Various aspects of these provisions have been subject to interpretation, including: (1) the meaning of 'professional' or 'practising a profession';[42] (2) the term 'peer';[43] (3) the meaning of 'professional practice';[44] (4) the term 'widely accepted', ascertained through clinical practice guidelines and expert evidence;[45] and (5) the term 'competent professional practice'. Additionally, the provision cannot be relied on if the peer professional opinion is 'irrational' or 'unreasonable'.[46]

The New South Wales ('NSW') provisions relating to professional standards were recently considered in *Dean v Pope*,[47] where the plaintiff presented with pain in his right leg. Dr Pope undertook lumbar spine surgery, whereas Mr Dean argued his problems related to the thoracic spine level. Mr Dean argued Dr Pope was negligent in hastily performing the operation without arranging a specialist neurological examination, resulting in physical and psychological harm. At trial, Judge Levy found in favour of Dr Pope, finding that the peer professional opinion defence was satisfied.[48] Mr Dean appealed on that basis that no expert evidence was led pertaining to a particular practice. The issues turned on the interpretation of section 5O of the *Civil Liability Act 2002* (NSW) ('*NSW CLA*'), which requires 'the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice'.[49] Due to the significance of the legal question insofar as it challenged the

39 See, eg, *Wrongs Act* (n 3) s 48. Professional peer practice provisions are also relevant: at ss 57–60.

40 See, eg, ibid s 51.

41 *NSW CLA* (n 3) ss 5O–5P; *Qld CLA* (n 3) s 22; *SA CLA* (n 3) s 41; *Tas CLA* (n 3) s 22; *Wrongs Act* (n 3) ss 59–60; *WA CLA* (n 3) s 5PB.

42 See, eg, *Zhang v Hardas [No 2]* [2018] NSWSC 432, [170] (Leeming JA) (where a chiropractor was held to be 'practising a profession').

43 *Gould v South Western Sydney Local Health District* [2017] NSWDC 67, [617] (Judge Levy) ('*Gould*').

44 *Sparks v Hobson* (2018) 361 ALR 115, 123 [31]–[32] (Basten JA).

45 *Greater Southern Area Health Service v Angus* [2007] NSWSC 1211; *Sydney South West Area Health Services v MD* (2009) 260 ALR 702, 711–12 [34] (Hodgson JA, Allsop P agreeing at 715 [50], Sackville JA agreeing at 717 [58]) ('*MD*'); *Dean v Pope* (2022) 110 NSWLR 398, 443 [233] (Ward P), 446 [255] (Macfarlan JA), 461 [314], 463 [317] (Brereton JA, Meagher JA agreeing at 447 [258], White JA agreeing at 448 [266]) ('*Dean*').

46 *Civil Law (Wrongs) Act 2002* (ACT) s 42 ('*Civil Law (Wrongs) Act*'); *Qld CLA* (n 3) s 22(2); *SA CLA* (n 3) s 41(2); *Tas CLA* (n 3) s 22(2); *Wrongs Act* (n 3) s 59(2); *WA CLA* (n 3) s 5PB(4).

47 *Dean* (n 45).

48 *Dean v Pope* [2021] NSWDC 670.

49 In *McKenna v Hunter and New England Local Health District* (2013) Aust Torts Reports ¶82-158 ('*McKenna Court of Appeal*'), the NSW Court of Appeal held that to establish a peer professional opinion defence, a professional must demonstrate they complied with a particular 'practice', but the High Court did not address this issue on appeal.

correctness of previous decisions of the NSW Court of Appeal, an enlarged five-member bench[50] unanimously held that Dr Pope was not negligent, and that the peer professional opinion defence does not require the existence of a *specific practice* to succeed. Rather, it is sufficient if expert evidence shows that the defendant's conduct is competent.[51]

Once the standard of care has been ascertained, courts must assess whether the clinician is in breach of their duty. At the breach stage, courts are concerned with an enquiry pertaining to foreseeability of risk and how a reasonable person in the defendant's position would respond to that risk.[52] Specifically, civil liability outlines that a defendant is not negligent in failing to take precautions against a risk of harm unless: (a) the risk was foreseeable; (b) the risk was not insignificant; and (c) in the circumstances, a reasonable person in the person's position would have taken those precautions.[53] The court's assessment of what constitutes the standard of peers can be influenced by published standards and guidelines,[54] though in some cases clinical practice manuals may not be determinative.[55]

The third element of negligence, causation, requires the plaintiff to demonstrate that the defendant's breach caused their injury. Australian courts have heard a plethora of cases concerning 'causation' in the health care context, including situations involving failure to warn of the material risks of procedures.[56] Presently, Australian civil liability legislation imposes a two-part test, requiring a plaintiff to show that negligence was a necessary condition of the existence of the harm ('factual causation'), and that it is appropriate for the scope of the negligent person's liability to extend to the harm so caused ('scope of liability').[57] With regard to factual causation, courts have held that it is insufficient that the defendant's negligence simply *increased* the risk of injury. Rather, the negligence must have *caused* or *materially contributed* to the harm.[58] With regard to the scope of liability, the High Court has held that health care practitioners will not be liable for negligence for a practitioner's failure to warn of risks that do not eventuate.[59] In summary, establishing breach and causation are pertinent in negligence cases once a court is satisfied that a duty of care is owed.

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50 *Dean* (n 45) 401 [5] (Ward P).

51 For commentary on the decision, see Sirko Harder, 'The Misunderstanding of *Bolam* and Its Impact on the Australian Civil Liability Reform' (2023) 29(2) *Tort Law Review* 119.

52 *Wyong Shire Council v Shirt* (1980) 146 CLR 40, 47 (Mason J).

53 See, eg, *Wrongs Act* (n 3) s 48(1).

54 *Langley v Glandore Pty Ltd (in liq)* (1997) Aust Torts Reports ¶81-448. See also *Ambulance Service of New South Wales v Worley* [2006] NSWCA 102.

55 *Queensland v Masson* (2020) 381 ALR 560, 578 [79] (Kiefel CJ, Bell and Keane JJ).

56 See, eg, *Chappel* (n 26).

57 See, eg, *Wrongs Act* (n 3) s 51(1). The common law applies in the Northern Territory.

58 *King v Western Sydney Local Health Network* [2013] NSWCA 162, [143]–[156] (Hoeben JA). In this case, the plaintiff was unable to show that the failure of hospital doctors to administer to her a vaccine while 14 weeks pregnant would have prevented her baby being born with Congenital Varicella Syndrome, which inhibits fetal development. Thus, a material increase in risk did not equate to factual causation pursuant to statutory requirements.

59 *Wallace v Kam* (2013) 250 CLR 375. In this case, Mr Wallace initiated proceedings against a neurosurgeon, Dr Kam. Mr Wallace alleged that Dr Kam failed to warn him of two risks associated with spinal surgery: (1) nerve damage from lying too long on the operating table (the less severe risk); and (2) permanent paralysis (the more severe risk). The less severe risk materialised. The High Court refused

In addition to claiming compensation in negligence for physical harm, patients may also claim compensation for negligently occasioned mental harm. Since the introduction of the civil liability reforms, claims for mental harm have been subject to stringent requirements and hurdles, especially for damages for non-economic loss (such as pain and suffering). The civil liability legislation divides claims for mental harm into two categories.[60] The first, consequential mental harm, is defined as harm that is consequential on personal injury. The second, pure mental harm, applies to instances where the plaintiff has not sustained any physical injury but seeks compensation for circumstances that led to a psychiatric illness, such as perceptions of near death or injury. If a patient has experienced a traumatic incident, akin to AJ's experience in our vignette, they may claim for pure mental harm if they have not sustained physical injuries. The Victorian civil liability legislation stipulates:

> A person (the defendant) does not owe a duty to another person (the plaintiff) to take care not to cause the plaintiff pure mental harm unless the defendant foresaw or ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken.[61]

The requirement for a *recognised psychiatric illness* prevents recovery for transient reactions, such as grief and sorrow,[62] and is determined through expert evidence and diagnostic manuals.[63] When assessing 'normal fortitude', the question is not whether the plaintiff was a person of normal fortitude but whether the 'defendant ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness'.[64] However, by virtue of section 72(3) of the *Wrongs Act 1958* (Vic) ('*Wrongs Act*'), if the defendant knows, or ought to know, that the plaintiff is a person of less than normal fortitude, then sections 72(1) and (2) do not prevent a duty being imposed. Thus, the provision acknowledges that the defendant owes a duty of care if they know, or ought to know, of the plaintiff's special vulnerability. This would extend to AJ's circumstances, as she is a patient with apparent vulnerabilities. While the health authority may argue that the first instance of detention is justified, in the second instance, there is arguably no such justification.

The court must also consider various 'circumstances of the case', such as whether the plaintiff suffered the injury because of sudden shock; whether they witnessed a person being killed, injured or put in danger at the scene;[65] the nature of the plaintiff and any person killed, injured or put in danger; and/or whether or

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to impose liability in circumstances where the plaintiff would have been prepared to accept and proceed with the operation, if warned of the more severe risk.

60 See, eg, *Wrongs Act* (n 3) s 67.

61 Ibid s 72. See also *Civil Law (Wrongs) Act* (n 46) s 34; *NSW CLA* (n 3) s 32; *SA CLA* (n 3) s 33; *Tas CLA* (n 3) s 34; *WA CLA* (n 3) s 5S.

62 See *Coates v Government Insurance Office (NSW)* (1995) 36 NSWLR 1, 4 (Gleeson CJ), 12, 14 (Kirby P).

63 The use of the term 'recognised' as opposed to 'recognisable' also suggests that the psychiatric illness must be formally recognised in manuals, such as the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Publishing, 5th ed, 2013).

64 *Wicks v State Rail Authority (NSW)* (2010) 241 CLR 60, 71 [22] (French CJ, Gummow, Hayne, Heydon, Crennan, Kiefel and Bell JJ) ('*Wicks*').

65 For judicial interpretation of 'witnessed at the scene', see *King v Philcox* (2015) 255 CLR 304.

not there was a pre-existing relationship between the plaintiff and defendant.[66] This list is not exhaustive.[67] If the plaintiff is, for instance, the relative of a patient in AJ's position and seeks to recover damages for pure mental harm for their nervous shock arising out of the patient being put in danger, additional obstacles apply.[68]

Recovery of damages is further complicated by restrictions imposed in civil liability legislation. For instance, a court cannot make an award of damages for mental harm unless the plaintiff's harm is a recognised psychiatric illness.[69] Practically, this means that anything falling short of a diagnosis may not qualify.[70] Further, if a plaintiff is seeking damages for non-economic loss, they must show they have sustained a 'significant injury'.[71] This means that the plaintiff's injury must constitute an impairment of 10% or more, per assessment guidelines.[72] Thus, transient injuries are not compensable and the diagnosis must not only be permanent but meet minimum 'whole person percentage' requirements. Since the introduction of the reforms, these provisions were criticised for furthering the divide between physical and mental harm,[73] with these views echoed by Victorian lawyers in subsequent qualitative research.[74]

A Negligence Principles and Mental Health Care

The most significant authority in relation to the provision of mental health care is the High Court's decision in *McKenna*, where the Court held that a hospital and its medical staff *did not* owe a common law duty of care to the relatives of a man killed by a patient. In *McKenna*, Mr Pettigrove was involuntarily admitted to hospital under the *Mental Health Act 1990* (NSW) ('*NSW Mental Health Act*'). Following a psychiatric assessment and an overnight stay, Mr Pettigrove was discharged into his friend Mr Rose's care with the arrangement that Mr Rose would drive Mr Pettigrove to his mother's house and into her care. Mr Pettigrove subsequently killed Mr Rose. The plaintiffs were Mr Rose's relatives, who brought proceedings against the health authority for mental harm they sustained as a result of Mr Rose's death. The trial judge found the hospital did not breach its duty of care by discharging Mr

66 *Wrongs Act* (n 3) s 72(2).

67 See *Wicks* (n 64) 71 [23] (French CJ, Gummow, Hayne, Heydon, Crennan, Kiefel and Bell JJ).

68 *Wrongs Act* (n 3) s 73.

69 Ibid s 75.

70 For an example of a Canadian case where the court was willing to impose liability without a recognised psychiatric illness, see *Saadati v Moorhead* [2017] 1 SCR 543. For commentary on this decision, see Ian Freckelton and Tina Popa, '"Recognisable Psychiatric Injury" and Tortious Compensability for Pure Mental Harm Claims in Negligence: *Saadati v Moorhead* [2017] 1 SCR 543' (2018) 25(5) *Psychiatry, Psychology and Law* 641 <https://doi.org/10.1080/13218719.2018.1525785>.

71 *Wrongs Act* (n 3) s 28LE.

72 Ibid s 28LB(b) (definition of 'threshold level'). Psychiatric injuries are assessed according to the Guide to the Evaluation of Psychiatric Impairment for Clinicians tool: MWN Epstein, G Mendelson and NHM Strauss, 'The Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC)' in Victoria, *Victoria Government Gazette*, No G 30, 27 July 2006, 1564.

73 For commentary, see, eg, Christine Forster and Jeni Engel, 'Reinforcing Historic Distinctions between Mental and Physical Injury: The Impact of the Civil Liability Reforms' (2012) 19(3) *Journal of Law and Medicine* 593, 600–1, 608.

74 Tina Popa, 'Practitioner Perspectives on Continuing Legal Challenges in Mental Harm and Medical Negligence: Time for a No-Fault Approach?' (2017) 25(1) *Tort Law Review* 19.

Pettigrove into Mr Rose's care.[75] The NSW Court of Appeal overturned that decision, finding the hospital owed a common law duty of care to Mr Rose's relatives, that the hospital breached that duty and the breach caused Mr Rose's relatives mental harm.[76] Subsequently, the health authority appealed to the High Court, with the Court tasked with determining whether the health authority owed a duty of care that was breached by discharging Mr Pettigrove into Mr Rose's care.

In *McKenna*, the High Court based its analysis on four examples in *Sullivan v Moody*,[77] which set out the considerations relevant to ascertaining if there is legal duty. While the Court found all to be relevant, the decisive consideration was the inconsistency between finding a duty and the conflicting statutory obligations to provide the care in the least restrictive manner. Determining whether the hospital and its staff owed a duty of care when discharging Mr Pettigrove required consideration of the *NSW Mental Health Act*. The High Court stated: 'Identifying whether there was such a duty (and if there was, its nature and scope) requires consideration of the [*NSW*] *Mental Health Act*. Would a duty of care to the relatives be consistent with the provisions of the *Mental Health Act*?'[78] Their Honours clarified that 'the [*NSW*] *Mental Health Act* prohibited detention, or the continuation of detention, unless the medical superintendent of the hospital formed the opinion that *no* other less restrictive care was appropriate and reasonably available'.[79]

The Court construed that power in the *NSW Mental Health Act* as requiring that the assessor first establish whether the person is 'mentally ill' or 'mentally disordered', and if that is the case then, second, establish whether there is no other care available that is less restrictive than involuntary admission and detention in the hospital.[80] Further, 'if the person was judged to be a mentally ill person, the Act required … that "any restriction on the liberty [of that person] and any interference with their rights, dignity and self-respect [be] kept to the minimum necessary in the circumstances"'.[81]

Ultimately, the High Court found that performance of that statutory obligation would be *inconsistent* with the common law duty of care alleged by the relatives of Mr Rose.[82] Their Honours held that

> [t]he [*NSW*] *Mental Health Act* required … the minimum interference with the liberty of a mentally ill person. It required … that the person be released from detention

75 *Simon v Hunter and New England Local Health District* [2012] NSWDC 19.

76 *McKenna Court of Appeal* (n 49).

77 (2001) 207 CLR 562, 579–80 [50] (Gleeson CJ, Gaudron, McHugh, Hayne and Callinan JJ) ('*Sullivan*'), quoted in *McKenna* (n 12) 278–9 [17] (French CJ, Hayne, Bell, Gageler and Keane JJ).

78 *McKenna* (n 12) 280 [22] (French CJ, Hayne, Bell, Gageler and Keane JJ).

79 Ibid 280–1 [25] (emphasis in original).

80 Ibid 281 [27].

81 Ibid 281 [28].

82 Ibid 281–2 [29]:

> Particularly relevant was the obligation … not to detain or continue to detain a person unless the medical superintendent was of the opinion that no other care of a less restrictive kind was appropriate and reasonably available to the person. Performance of that obligation would not be consistent with a common law duty of care requiring regard to be had to the interests of those, or some of those, with whom the mentally ill person may come in contact when not detained.

> unless the medical superintendent of the hospital formed the opinion that no other care of a less restrictive kind was appropriate and reasonably available to that person.[83]

Thus, as the overarching High Court precedent, *McKenna* demonstrates that the courts are reluctant to impose a duty of care owed to third parties (in this case, Mr Rose's relatives), where imposing a common law duty would conflict with the statutory obligation to be least restrictive with an individual's liberty.

McKenna was decided almost 10 years after the highly publicised decision in *Hunter Area Health Services v Presland* ('*Presland*'),[84] which raised similar questions concerning liability to third parties, and prompted law reform in NSW.[85] In *Presland*, Mr Presland was taken to the hospital by police officers after experiencing hallucinations and violent outbursts. After being discharged, Mr Presland killed his brother's fiancée, Ms Laws. He was subsequently acquitted of the charge of murder because of his mental illness.[86] At first instance, the trial judge highlighted the difficulties and challenges faced by doctors and psychiatrists when exercising statutory decision-making powers, but nevertheless imposed liability on clinicians and awarded damages.[87] On appeal, a majority of the NSW Court of Appeal (Spigelman CJ dissenting) overturned the trial decision. It was not controversial that the defendants owed a duty of care under the common law.[88] However, the Court cautioned against imposing civil liability for a failure to restrain, as such a position may create a bias towards detention and lead to defensive medicine.[89] Despite addressing considerations pertaining to breach and causation, Sheller JA held that public policy considerations ought to take precedence to prevent an individual who had committed an unlawful act from receiving compensation.[90] The Court raised concerns about imposing a common law duty of care on hospitals and psychiatrists out of concerns that it might encourage a 'defensive frame of mind'.[91] Put simply, such an approach might encourage preventative detention,[92] even in circumstances where it is not warranted, and risks generating a 'chilling effect' of a risk of civil liability.[93] The common ground between *McKenna* and *Presland* is that third parties will not be successful in negligence claims arising from the consequences of decisions about discharge from psychiatric facilities.

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83 Ibid 282 [31] (emphasis omitted).

84 (2005) 63 NSWLR 22 ('*Presland*').

85 See generally *Civil Liability Amendment Act 2003* (NSW).

86 The case also concerned whether there was a breach of that duty of care, along with issues of whether the unlawful killing of the victim (Ms Laws) prevented the awarding of damages and whether the award of damages delivered by the trial judge was manifestly excessive.

87 *Presland NSWSC* (n 11). Mr Presland was awarded damages against the hospital and psychiatric registrar for negligently discharging him and failing to restrain and care for him in circumstances where he presented a risk.

88 *Presland* (n 84) 77 [217] (Sheller JA).

89 Ibid 122–3 [388] (Santow JA).

90 Ibid 78–86 [218]–[239] (Sheller JA).

91 Ibid 112 [343] (Santow JA).

92 Kathryn Peterson, 'Where Is the Line to Be Drawn? Medical Negligence and Insanity in *Hunter Area Health Service v Presland*' (2006) 28(1) *Sydney Law Review* 181, 187.

93 *Presland* (n 84) [115].

The *Presland* case led to the introduction of section 43A of the *NSW CLA*, which operates to limit the liability of public authorities. This provision requires the plaintiff to prove that the decision was 'so unreasonable, that no reasonable authority in the position of the defendant could have made such a decision'.[94] Civil liability legislation in NSW and Victoria contains additional provisions regarding claims made against public authorities. Alongside section 43A, sections 42 and 43 of the *NSW CLA* address claims against public authorities for negligence and for breach of statutory duty, respectively. Victoria has equivalent provisions within sections 83 and 84 of the *Wrongs Act*. Since their insertion, judicial consideration of these provisions has been relatively minimal in medical negligence cases and psychiatric cases. An analysis of Victorian cases identified no relevant medical negligence or psychiatric cases that either considered or invoked sections 83 or 84 of the *Wrongs Act*. An analysis of NSW case law identified only four relevant medical negligence or psychiatric cases that considered or invoked sections 42 or 43 of the *NSW CLA*, most notably the *McKenna* decision.[95]

Thus, from 2003, civil liability cases involving mental health care in NSW have required judicial interpretation of this provision. For example, in *Walker v Sydney West Area Health Service* ('*Walker*'),[96] the plaintiff, after being discharged from the psychiatric ward of a hospital, climbed a high tree in his mother's home while in an emotional and intoxicated state. He fell and sustained injuries leading to quadriplegia. The plaintiff pleaded that the defendant was negligent for, inter alia, failing to treat or properly treat him, for discharging him when it was not appropriate and for failing to identify that he was a high-risk mental health client.[97] Simpson J held that the hospital and its staff were not negligent. Her Honour highlighted that pursuant to legislation, the plaintiff could not be involuntarily detained for more than three days and after this time, the hospital staff could apply to a magistrate for an order for involuntary detention.[98] Ultimately, Simpson J found that the defendant was not negligent, and in doing so, took into consideration expert evidence as relevant to the peer professional opinion provisions in the NSW civil liability legislation.[99] Her Honour was satisfied that the medical staff involved acted competently, pursuant to professional practice and in accordance with their statutory obligations.

Subsequent case law demonstrates that where a duty of care is owed, the courts assess liability according to civil liability legislation. For example, in *Smith v Pennington* ('*Pennington*'), following two suicide attempts, the plaintiff was involuntarily detained for three days in hospital.[100] When permitted to leave for four days, the plaintiff attempted suicide again, resulting in extensive brain injuries.

94 *Smith v Pennington* [2015] NSWSC 1168, [243]–[247] (Garling J) ('*Pennington*'). See also *Roads and Maritime Services v Grant* [2015] NSWCA 138, [35]–[37] (Basten JA).

95 Other cases that considered or invoked the NSW provisions varied in degrees of relevance: *Gould* (n 43); *MD* (n 45); *King v Western Sydney Local Health Network* [2011] NSWSC 1025.

96 *Walker* (n 11).

97 Ibid [77] (Simpson J).

98 Ibid [150], [155].

99 Ibid [167].

100 *Pennington* (n 94) [89] (Garling J).

The plaintiff's claim was unsuccessful, and the judgment centred around breach of duty, causation and statutory powers under section 43A of the *NSW CLA*. Garling J held that the health district's decision was not so unreasonable as to amount to a breach of duty of care. However, the hospital staff's failure to warn the plaintiff and his parents about key stressors (alcohol and interactions with his former girlfriend) that would adversely affect him amounted to a breach of duty.[101] Yet, despite this breach of duty, the plaintiff was unable to prove the breach was the cause of the plaintiff's injuries.[102] Ultimately, the plaintiff's claim was unsuccessful.[103]

The NSW appellate courts have tended to find that clinicians owe a duty of care to those who they are assessing for the need for treatment. In *Presland*, which was decided well before *McKenna*, Sheller and Santow JJ (Spigelman CJ dissenting) found there was a general duty of care.[104] Similarly, in both *Walker* and in *Pennington*, the NSW Supreme Court[105] and the NSW Court of Appeal[106] found that duty exists whether or not the consumer is voluntary or is (already) detained under mental health legislation. In both cases: (1) the Court approached the question of negligence through civil liability legislation; (2) the statutory obligations imposed by mental health legislation were relevant to the assessment; and (3) clinicians were found to have owed a duty of care but not to have breached their duty of care.

Conversely in *Australian Capital Territory v Crowley* ('*Crowley*'),[107] the plaintiff was shot in the neck by an Australian Federal Police ('AFP') officer after experiencing a mental health episode, resulting in quadriplegia. He sued the AFP officer, the Commonwealth of Australia and the Australian Capital Territory ('ACT') on behalf of the ACT Mental Health Service ('ACTMHS') for damages stemming from the defendants' alleged negligent acts and omissions. Consistent with the decision in *Stuart v Kirkland-Veenstra*,[108] which considered the exercise of police powers pursuant to section 10 of the *Mental Health Act 1986* (Vic),[109] the ACT Court of Appeal held that police officers *do not* owe a duty of care to a suspect who they are attempting to apprehend for the benefit of public safety and protection.[110] The Court of Appeal stressed the unfeasibility of requiring

101 Ibid [321]–[324].
102 Ibid [415].
103 A subsequent appeal to the NSW Court of Appeal was dismissed: *Smith v South Western Sydney Local Health Network* [2017] NSWCA 123 ('*Smith*').
104 *Presland* (n 84).
105 *Walker* (n 11); *Pennington* (n 94).
106 *Smith* (n 103).
107 *Crowley* (n 11).
108 (2009) 237 CLR 215.
109 Ibid 223 [3] (French CJ). Police officers found Ronald Veenstra sitting in his car, with an apparent intention to commit suicide. After questioning him, police were satisfied he was responsive and rational, and that he intended to return home. Tragically, he subsequently committed suicide. His widow sued the officers and the State of Victoria, alleging that Mr Veenstra ought to have been detained pursuant to section 10 of the *Mental Health Act 1986* (Vic). The High Court held that the officers did not owe Mr Veenstra a common law duty of care to prevent self-harm, holding that imposing such a common law duty would conflict with personal autonomy values. Further, the facts did not give rise to special features of a relationship between the parties (such as control or vulnerability) to impose a duty.
110 *Crowley* (n 11) 192 [287] (Lander, Besanko and Katzmann JJ).

police officers to fulfill a common law duty where that duty would conflict with a statutory duty.[111] Regarding the ACTMHS, the Court of Appeal held it did not fall into the existing physician–patient duty parameters. It held that the ACTMHS did not embark upon treatment and that the mental health officer's attendance at the plaintiff's home for assessment *did not* enliven a duty.[112] The Court explained that such a duty *would* have arisen if the plaintiff was admitted to a health facility or a hospital ED.[113]

By way of contrast, in *LC v Australian Capital Territory* ('*LC*'),[114] the plaintiff's claim was successful. LC was admitted to hospital after a suicide attempt. He subsequently ran away from the emergency ward, was chased by a security guard and jumped off a multistorey car park level, sustaining serious injuries. The plaintiff claimed that staff knew or ought to have known that he was suffering from delusional psychosis and should have taken steps to prevent self-harm. The plaintiff's claim was successful, with Burns J finding the hospital breached its duty by failing to undertake a proper mental health assessment within a four-hour window. This resulted in the plaintiff being admitted voluntarily and thus being free to leave. Burns J accepted that if the plaintiff was admitted involuntarily, his injuries probably would not have occurred, basing his decision largely on the strength and persuasiveness of expert witnesses.[115]

A recent mental health negligence case that considered civil liability was *Stewart v Hames*, which involved 68 claims against 10 defendants.[116] The plaintiff was admitted into hospital and, for part of that stay, was declared an involuntary patient pursuant to the *Mental Health Act 1996* (WA).[117] The plaintiff alleged he was *deliberately*, or alternatively *negligently*, diagnosed with a mental illness.[118] During his stay, the plaintiff sustained an injury when he restrained a co-patient who attacked an elderly patient. The plaintiff subsequently fled from the hospital.[119] After police returned him to hospital, he was reviewed and declared an involuntary patient. He admitted to faking chest pains and a coma to avoid taking medication. Over two days, the plaintiff was forcefully injected with medication. The plaintiff's action was based on 12 grounds,[120] all of which were dismissed. A significant factor in the case related to the plaintiff's credibility, with the trial judge

111 Ibid 192–3 [287], citing *Sullivan* (n 77) 582 [60] (Gleeson CJ, Gaudron, McHugh, Hayne and Callinan JJ).
112 *Crowley* (n 11) 206 [377] (Lander, Besanko and Katzmann JJ).
113 Ibid 206–7 [378].
114 *LC* (n 11).
115 Ibid [57].
116 S*tewart v Hames* [2021] WADC 93, [1] (Bowden DCJ).
117 Ibid [1]–[2].
118 Ibid [3].
119 After fleeing the hospital, the plaintiff was placed on a Form 1 under section 29 of the *Mental Health Act 1996* (WA), which allowed the hospital to detain him: ibid [32].
120 These included fraudulent concealment of falsified medical records, negligence on the basis of occupier liability for an unsafe hospital, deceit, lack of informed consent for admission into the ward, false imprisonment, fraudulently falsifying an involuntary order, assault and battery, medical negligence for misdiagnosis, reprisals as he claimed he was a whistleblower, misfeasance in public office, intentional infliction of emotional distress and, finally, conspiracy: see ibid [47]–[62].

questioning the plaintiff's honesty, truthfulness, reliability and accuracy.[121] Despite being unsuccessful, the case serves as an example of the range of claims that may be brought against hospitals and clinicians, including the torts of negligence and trespass to the person. The key issues stemming from these cases are discussed in the next section.

B Discussion of Key Issues

The preceding analysis indicates that it is clear that hospitals and treating psychiatrists owe patients a duty of care.[122] If a duty of care is owed, the matter will be determined through the lens of civil liability legislation. However, when the legal questions concern foreseeability of risk to *third parties* (as was the case in *Presland*, *McKenna* and *Crowley*), the position in *McKenna* governs the law. *McKenna* asserts that doctors do not have a common law duty to detain patients. Importantly, a unifying theme in the judicial deliberations in *McKenna*, *Presland*, *Walker* and *Crowley* is the concern that imposing civil liability will lead to increased rates of psychiatric detention because clinicians would feel obliged to act defensively despite the obligation to provide the least restrictive care.[123] The case of *LC* provides a rare example of liability being imposed for a failure to detain, though it was a decision of a single judge of the ACT Supreme Court.

The legacy of *McKenna*, however, continues to create difficulties with respect to the conception of a duty of care when clinicians are tasked with assessing the need for treatment. In *Crowley*, the ACT Supreme Court found that no duty of care was owed by the health authority when the clinician was in attendance at the person's home for the purpose of clinical assessment and possible detention. The main consideration of the Court appeared to have been that the health service was offered beyond the hospital, in the person's home. In health systems that explicitly provide a range of services beyond the hospital, understanding *McKenna* as a geographical principle seems out of step with modern mental health care. As with the academic criticisms levelled at *McKenna*, the finding that there is no duty avoids consideration of the quality of the clinical care and leaves an accountability vacuum.[124]

Considered as a whole, the appellate judgments should reassure clinicians that the courts recognise the difficulties involved in exercising powers of detention and are reluctant to find that clinicians and services failed in their duty to provide a reasonable standard of professional care. Notwithstanding this conclusion, clinicians and services should also feel reassured by the public liability provisions in civil liability legislation and immunity provisions in mental health legislation. Public liability provisions, which are included in the civil liability legislation in all states and territories except the Northern Territory ('NT') and South Australia

121 Ibid [616].

122 *Walker* (n 11); *Smith* (n 103); *LC* (n 11).

123 See discussion in Rangarajan and McSherry (n 36) 297–9.

124 Freckelton (n 15). See also David Hirsch, '*McKenna* in the High Court' (2015) 127 *Precedent* 53; Wendy E Bonython and Bruce B Arnold, 'When Statutory Powers Distract: Involuntary Detention and Treatment Laws, and Liability for Harm' (2015) 41(3) *Monash University Law Review* 552.

('SA'), further limit the accountability that is said to accompany tort litigation.[125] These provisions include a test of unreasonableness derived from *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* ('*Wednesbury*') for actions taken against a public authority.[126] The NSW provisions were considered in *Walker*. While it was held that the health authority owed the plaintiff a duty of care, the operation of section 43A removed legal responsibility. Simpson J held that the plaintiff's action cannot succeed unless they establish that the exercise of power was, in the circumstances, so unreasonable that no authority (in this case, the area health service) could properly consider taking that course of action to be a reasonable exercise of the public authority provisions.[127] In addition to section 43A, section 5O of the *NSW CLA*, pertaining to peer professional opinion, was highly relevant to Simpson J's reasoning and ultimate findings.[128] The public authority provisions establish a point of fundamental inequality in the operation of the law. The exercise of compulsory mental health treatment powers in mental health legislation only attaches to designated public hospitals. As Gray explains, the impact of public liability limitations, coupled with the statutory provision reflecting the principle of *Wednesbury* unreasonableness, introduces a double standard of accountability between public and private mental health patients that raises fundamental questions of equity.[129]

Additionally, mental health legislation in all Australian mental health Acts, except SA, include immunity from liability provisions.[130] The common feature of these provisions is that those who undertake action in conformity with legislation will not be held civilly liable if their actions are done in good faith (NSW and Western Australia ('WA')). In the ACT, the good faith actions must be 'honest and without recklessness', in the NT and Tasmania they must be done with 'reasonable care', and in Queensland they must be done 'honestly and without negligence'. In Victoria, the acts must be in good faith and with a reasonable belief in accordance with the Act.[131] In Tasmania, the legislation provides for both civil and criminal immunity.[132] In the ACT,[133] Victoria,[134] Queensland[135] and WA,[136] however, the provisions state that civil liability will attach to the state or territory. The immunity

125 *Civil Law (Wrongs) Act* (n 46) s 111; *NSW CLA* (n 3) ss 43–43A; *Qld CLA* (n 3) s 36; *Tas CLA* (n 3) s 40; *Wrongs Act* (n 3) s 84; *WA CLA* (n 3) s 5X.

126 [1948] 1 KB 223.

127 *Walker* (n 11) [138].

128 Ibid [167].

129 Gray (n 10) 234–6.

130 *Mental Health Act 2015* (ACT) s 265 ('*ACT Mental Health Act*'); *NSW Mental Health Act* s 191; *Mental Health and Related Services Act 1998* (NT) s 164; *Mental Health Act 2016* (Qld) s 797 ('*Qld Mental Health Act*'); *Mental Health Act 2013* (Tas) s 218 ('*Tas Mental Health Act*'); *Mental Health and Wellbeing Act* (n 17) ss 140, 141, 253, 425, 592, 753; *Mental Health Act 2014* (WA) s 583 ('*WA Mental Health Act*').

131 The *Mental Health and Wellbeing Act* (n 17) also provides that the giving of an apology will not be construed as admission of liability: at s 638.

132 *Tas Mental Health Act* (n 130) s 218(3).

133 *ACT Mental Health Act* (n 130) s 265(2).

134 *Mental Health and Wellbeing Act* (n 17) ss 140(2), 141(2), 253(2), 425(2), 592(2), 753(2).

135 *Qld Mental Health Act* (n 130) s 797(2).

136 *WA Mental Health Act* (n 130) s 583(1).

provisions raise important questions about how the interpretation and application will play out in future negligence cases. While it is unclear how the courts will engage with these aspects of mental health legislation, the transference of liability to the state appears to open an avenue of accountability while protecting clinicians from legal action. What is clear is that clinicians will ordinarily be protected if they make decisions that are consistent with mental health legislation.

III HOW THE CONCEPT OF 'DUTY OF CARE' IS RAISED

As is shown above, negligence law works to reinforce the obligation of clinicians to provide mental health care and treatment according to the terms and obligations contained in mental health legislation, and in particular with respect to the obligation to provide care in the least restrictive way.[137] Coupled with the immunity provisions, the overwhelming direction of the law is to limit or remove entirely any civil liability for acts done in good faith under mental health legislation. A central and express objective of the legal framework is to guard against the unnecessary use of civil detention powers to impose treatment. In practice, something quite different is occurring. The term 'duty of care' is increasingly used to invoke a moral or ethical duty to provide treatment. Contrary to its legal roots, 'duty of care' stands as a catch-all for the need to provide access to services, and as a justification for discretionary or policy decisions that overlook the provisions in mental health legislation which protect the rights of consumers and safeguard against the use of unnecessary involuntary treatment. Informal practice interpretations of legal concepts can be difficult to articulate, as they are shared norms that are perpetuated culturally and socially through organisations and interpersonal relationships rather than legislation or case law. However, the informal use of the concept of duty of care in Australian mental health policy and practice is so prevalent that this usage is evident in both official documents and in policy submissions.

We used two approaches to identify the ways in which duty of care was used in policy and practice. First, we conducted a comprehensive online search using the terms 'duty of care', 'mental health' and 'policy'. In addition, we obtained relevant policies from each state and territory government policy website, including chief psychiatrist websites. This search returned 197 relevant policies. This established the policy guidance available to clinicians. Secondly, we searched the submissions and witness statements from the Royal Commission into Victoria's Mental Health System ('Royal Commission') for the phrase 'duty of care'.[138] This provides an indication of how the concept is being used in practice. These documents were analysed using a systematic content analysis using NVivo qualitative analysis

137 *McKenna* (n 12).

138 *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) ('*Royal Commission Final Report*').

software.[139] Relevant documents were double coded by two members of the research team to ensure reliability via crosschecking of results.[140]

As outlined in the introduction, we used discourse analysis to analyse and critique the ways that the concept of 'duty of care' is used. Discourse analysis of texts can involve examples from a wide variety of sources, including government documents, academic articles and books, websites and other online materials found via internet search.[141] Our discourse analysis indicates that the concept of 'duty of care' has three distinct meanings in mental health practice. In the first sense, a duty of care is used as shorthand for a broad ethical and moral responsibility to provide care and treatment for consumers. In the second, it refers to an extra-legal power to detain, forcibly treat, seclude and/or restrain consumers when statutory provisions would not otherwise permit the use of force. The third is an extra-legal power, including a perceived obligation to breach confidentiality. This section details each of these meanings. While the evidence presented here concerns Victorian practice, researchers in NSW have similarly observed the use of 'duty of care' as a reference to an overarching power to restrain and treat against a person's wishes.[142]

A General Responsibility to Care

The phrase 'duty of care' is often used in a non-legal sense to refer to an ethical or moral responsibility to care. For example, Kym Peake, the then-Secretary of the Department of Health and Human Services, wrote in her statement to the Royal Commission that '[m]aking progress in improving the lives of people facing complex social issues requires government to assume a duty of care and stewardship of the services designed to support them'.[143]

Peake uses the phrase 'duty of care' multiple times in this submission, each time suggesting that the government owes a duty to provide services.[144] This notion of 'duty of care' in the passage reflects a moral and/or ethical obligation placed on responsible governments to provide services to the community at large. Similarly, a nurse practitioner described 'duty of care' as a framework of care: 'That's the type of person who already exists within a framework of duty of care because they're receiving a range of services through Package Care, for example.'[145]

In comments to the Royal Commission, a lived experience advocate invoked the idea of 'duty of care' to argue for more asserted action and assistance for child

139 See generally Jennifer Browne et al, 'A Guide to Policy Analysis as a Research Method' (2019) 34(5) *Health Promotion International* 1032 <https://doi.org/10.1093/heapro/day052>.

140 See generally Maria J Mayan, *Essentials of Qualitative Inquiry* (Routledge, 2nd ed, 2023) 187–9.

141 Vine (n 21) 5.

142 Lamont, Stewart and Chiarella (n 23).

143 Kym Lee-Anne Peake, Witness Statement to Royal Commission into Victoria's Mental Health System (24 July 2019) 21 [194] <http://rcvmhs.archive.royalcommission.vic.gov.au/Kym_Peake.pdf>.

144 Ibid 21 [194], 22 [196.2], 23 [202].

145 Transcript of Proceedings, *Royal Commission into Victoria's Mental Health System* (Penny Armytage, Allan Fels, Alex Cockram and Bernadette McSherry, 25 July 2019) 1385 (M R Bush).

carers: 'So it goes that if we are serious about reaching out and helping child carers, we, as the adults in the equation need to assert our duty of care.'[146]

As discussed above, in law, the fact that a duty of care exists does not equate to an obligation to provide treatment, and mental health services and clinicians do not owe a legal duty to provide treatment to all people who require or ask for it. Despite this, a carer described to the Royal Commission how a support worker had told her she could rely on a 'duty of care' when taking her husband to the ED.[147] In evidence, she described how she had attended the ED with her husband, only to be told that there was no bed available:

> [T]hey told us they didn't have a bed for him, and that we should go home'. I decided to take the support worker's advice. I told the worker that because they had admitted [my husband] was suicidal they had admitted duty of care to him, and that they had to admit him to the hospital. Then I left.[148]

These statements about the imperative of a duty of care, in reality, plead for improved access to mental health care and services in an environment where many are not able to access the services they need.

B Duty to Detain, Forcibly Treat, Seclude and/or Restrain

In the clinical context, duty of care is used to invoke a broad power with moral, ethical and legal dimensions that is used to justify forced treatment and detention on a best interest basis. For example, psychiatrist David Copolov argues that the right to life and the right to health underpin the duty to provide treatment:

> If a mental health professional believes their patient with a mental illness is at very high risk for seriously harming themselves or others as a result of that illness, but the patient does not want treatment, then, under most circumstances I consider it to be a degradation of the patient's right to life to and an abrogation of the duty to protect the life of others for whom a clear threat has been posed, to not treat that patient.[149]

This statement describes the duty of care as an overarching ethical obligation to provide psychiatric treatment that transcends the statutory context in which clinicians are required to operate. Similarly, the idea that a duty of care encompasses an overarching duty to treat is reflected in further comments by Peake to the Royal Commission, who suggested that it is necessary to balance 'the principles of choice with duty of care and safety'.[150]

The difficulty with the assumption that it is appropriate to treat people against their will on a best interest basis or to keep them safe ignores the mounting evidence that clinicians' ability to accurately predict future risk of harm to self and others is

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146 Justin Marcus Heazlewood, Witness Statement to Royal Commission into Victoria's Mental Health System (22 April 2020) 14 [72] <http://rcvmhs.archive.royalcommission.vic.gov.au/Heazlewood_Justin.PDF>.

147 Christine Thomas, Witness Statement to Royal Commission into Victoria's Mental Health System (2 July 2019) 2 [12] <http://rcvmhs.archive.royalcommission.vic.gov.au/Christine_Thomas.pdf>.

148 Ibid 2 [13].

149 David Copolov, Witness Statement to Royal Commission into Victoria's Mental Health System (7 July 2020) 87 [268] <http://rcvmhs.archive.royalcommission.vic.gov.au/Copolov_David.pdf>.

150 Kym Lee-Anne Peake, Witness Statement to Royal Commission into Victoria's Mental Health System (4 October 2020) 67 [352(f)] <http://rcvmhs.archive.royalcommission.vic.gov.au/Peake_Kym.pdf>.

very low,[151] such that assessments are inflected with prejudice and discrimination, and that overriding of choice with respect to medical and psychiatric care is intrinsically harmful.[152] Moreover, the invocation of a duty to treat appears to be specific to psychiatric contexts. In other settings, there are no laws that permit the imposition of treatment in this way. Capacious patients in other settings may refuse treatment even when that treatment might save their life.[153]

Turning to the way a duty of care is understood in policy documents, we discovered that a broad duty of care is typically invoked in policy and practice guidelines when there is a perceived 'gap' or absence of legislative power. For example, in the 2014 Victorian Chief Psychiatrist's guidelines on restrictive interventions, it is stated that '[i]n a matter of urgency, restrictive interventions may be applied to any person receiving services in a designated mental health service, regardless of legal status, under duty of care'.[154]

This document is issued under legislative power given to the Chief Psychiatrist under the *Mental Health Act 2014* (Vic) ('*Victorian Mental Health Act*'). Similarly, the Victorian Chief Psychiatrist's High Dependency Unit Guidelines state that people who are not subject to the *Victorian Mental Health Act* may be placed in locked environments under a 'duty of care'[155] References to a duty of care as an alternative basis upon which coercive measures made without reference to statutory obligations also appear in policy documents in the ACT,[156] NSW,[157] Queensland,[158] and Tasmania.[159] While using the term 'duty of care', these documents appear to

151 See, eg, Tonelle Handley et al, 'The Challenges of Predicting Suicidal Thoughts and Behaviours in a Sample of Rural Australians with Depression' (2018) 15(5) *International Journal of Environmental Research and Public Health* 928 <https://doi.org/10.3390/ijerph15050928>; Matthew Michael Large, 'The Role of Prediction in Suicide Prevention' (2018) 20(3) *Dialogues in Clinical Neuroscience* 197 <https://doi.org/10.31887/DCNS.2018.20.3/mlarge>.

152 See, eg, B Christopher Frueh et al, 'Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences within the Psychiatric Setting' (2005) 56(9) *Psychiatric Services* 1123 <https://doi.org/10.1176/appi.ps.56.9.1123>; P Morrison, T Meehan and NJ Stomski, 'Australian Mental Health Staff Response to Antipsychotic Medication Side Effects: The Perceptions of Consumers' (2016) 14(1) *Advances in Mental Health* 4 <https://doi.org/10.1080/18387357.2015.1080651>.

153 See generally *Re JS* [2014] NSWSC 302.

154 Department of Health (Vic), 'Restrictive Interventions in Designated Mental Health Services: Chief Psychiatrist's Guideline' (Guideline, 2014) 4. Note that since 1 April 2024, these guidelines have been replaced: Department of Health (Vic), 'Restrictive Interventions: Chief Psychiatrist's Guideline' (Guideline, April 2024).

155 'High Dependency Unit Guidelines', *Victoria Department of Health* (Web Page, 1 September 2023) <https://www.health.vic.gov.au/practice-and-service-quality/high-dependency-unit-guidelines>.

156 'Confinement, Restraint, Seclusion and Forcible Giving of Medication', *ACT Government* (Web Page) <https://www.act.gov.au/health/providing-health-care-in-the-act/treatment-and-clinical-information/mental-health-treatment-and-care-under-the-act/confinement,-restraint,-seclusion-and-forcible-giving-of-medication>.

157 NSW Health, 'Aggression, Seclusion and Restraint: Preventing, Minimising and Managing Disturbed Behaviour in Mental Health Facilities in NSW' (Guideline, 26 June 2012) 17 <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2012_005.pdf>.

158 Director of Forensic Disability (Qld), 'Use of Reasonable Force' (Guideline, 9 January 2023) 1 <https://www.directorforensicdisability.qld.gov.au/resources/directorforensicdisability/use-reasonable-force-policy.pdf>.

159 Office of the Chief Psychiatrist (Tas), *Mental Health Act 2013: Review of the Act's Operation* (Report, June 2020) 101–2, 108, 167 <https://www.health.tas.gov.au/sites/default/files/2021-12/Mental_Health_

be referring to a different legal concept altogether – the 'doctrine of necessity'. In tort law, the doctrine of necessity is a defence that permits a defendant to escape liability where their actions were necessary to prevent serious harm and they acted reasonably and proportionately to the risk posed in the circumstances.[160]

In the context of health care, the English courts have expanded the defence of necessity to a principle that justifies restraint and the use of force to protect the person but only insofar as the force is a reasonable and necessary response and is in the best interests of the person.[161] Thus, health care practitioners may rely on the defence of necessity to preserve a person's life or health where they are unable to obtain consent.[162] The English courts have held:

> [T]o fall within the principle, not only: (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.[163]

Kim Chandler, Ben White and Lindy Wilmott[164] urge Australian courts not to follow the English courts in elevating necessity from a defence to a justification lest it empower medical professionals with the discretion to detain and restrain individuals who may not have the capacity to consent or the ability to rely on system safeguards.[165] Despite the lack of such endorsement in Australian courts it seems that the defence of necessity is being used in precisely this way under the guise of duty of care.[166] While it is clear that a duty of care is owed to patients, *McKenna* shows that the duty is fundamentally shaped by the relevant statutory framework.

Another way to understand the elevation of duty of care in the guidance and policy documents is to see them as an attempt to fill the uncertainty created by *McKenna* at that liminal point where clinicians must make a decision about whether or not to detain someone for psychiatric treatment. If this is the case, the High Court's conclusion that there was no common law duty has not had the expected effect of encouraging clinicians to engage with the question of least restriction.

Act_Review_-_Outcomes_Report_DoHTasmania.pdf> (referring to the problem of the use of seclusion and restraint being justified by 'duty of care').

160 Carolyn Sappideen, Prue Vines and John Eldridge, *Torts: Commentary and Materials* (Thomson Reuters, 13th ed, 2021) 196.

161 *Re F* [1990] 2 AC 1; *R v Bournewood Community and Mental Health NHS Trust; Ex parte L* [1999] 1 AC 458. Note that in *HL v United Kingdom* [2004] IX Eur Court HR 471, the European Court of Human Rights found that informal detention under the doctrine of necessity did not meet safeguard requirements of article 5 of the *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953).

162 *Re F* (n 161) 73–4 (Lord Goff).

163 Ibid 75.

164 Kim Chandler, Ben White and Lindy Wilmott, 'The Doctrine of Necessity and the Detention and Restraint of People with Intellectual Impairment: Is There Any Justification?' (2016) 23(3) *Psychiatry, Psychology and Law* 361 <https://doi.org/10.1080/13218719.2015.1055853>.

165 Ibid 380.

166 Lamont, Stewart and Chiarella (n 23).

C Duty to Others and to Breach Confidentiality

Despite the clear guidance in *McKenna* that a duty of care is not owed to third parties, policy documents and anecdotal evidence suggest that clinicians and mental health services operate as if such a duty is owed. For example, guidelines by the Victorian Department of Health on Victoria's mental health triage scale indicate that some duty or responsibility extends to carers/family members:

> Where individuals are unable or unwilling to give consent, service providers should observe their legal duty of care and exercise sound judgment in meeting their dual responsibilities to consumers and carers/family members who may be affected by the individual's mental illness.[167]

Similarly, the NorthWestern Mental Health Adult and Youth Inpatient Clinical Risk Assessment and Management form directs clinicians to 'consider duty of care to others at risk'.[168]

The consequence of a widespread assumption that there is a duty owed to third parties is breaches of confidentiality. For example, the Headspace Australia website contains a page titled 'Duty of Care', which suggests that a duty of care encompasses a duty to breach confidentiality to prevent harm to the person or another person.[169] That this occurs in practice is confirmed by a carer who told the Royal Commission that '[t]he interim key clinician told me that, because of their duty of care, they had to call my husband and my workplace to tell them I was a risk to myself'.[170]

Clinicians and mental health services may have an ethical or moral obligation to breach confidentiality. Such obligations may arise in circumstances where a failure to share information could be deemed to be negligent, for example if the withholding of information resulted in a death. In general, however, the sharing of information without consent is only permissible under privacy law or mental health law, and is not governed by negligence law. As with the confusion around the doctrine of necessity, it is not that sharing information is necessarily unlawful, but that it appears that practice and policy approaches to sharing information are undertaken without thought to, or with a misunderstanding of, the law. Often, sharing information will be legally *permitted* but not legally *required*. Applying the wrong legal framework will inevitably lead to legal errors.

IV TORT LAW AND ACCOUNTABILITY

The core claim of tort law is that it provides monetary compensation for harm and exerts a regulatory force which protects society against further acts of negligence.

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167 Department of Health (Vic), 'Statewide Mental Health Triage Scale: Guidelines' (Guideline, 2010) 8 <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/t/triage-guidelines-0510.pdf>.

168 Peter Leonard Burnett, Witness Statement to Royal Commission into Victoria's Mental Health System (11 July 2019) attachment PB–3 <http://rcvmhs.archive.royalcommission.vic.gov.au/Associate_Prof_Peter_Burnett.pdf>.

169 'Duty of Care', *Headspace* (Web Page) <https://headspace.org.au/duty-of-care/>.

170 Rachel Bateman, Witness Statement to Royal Commission into Victoria's Mental Health System (16 June 2020) 6 [30] <http://rcvmhs.archive.royalcommission.vic.gov.au/Bateman_Rachel.pdf>.

There is long-standing recognition that the law of negligence fails to deliver both its corrective justice and normative claims.[171] Negligence litigation is notoriously expensive, difficult to access and has uncertain outcomes that consistently fail to meet the needs of those who claim to be harmed.[172] As the preceeding analysis indicates, the radical limitation of the grounds that must be established to succeed make likelihood of a successful claim in mental health care slim. This means that the possibility of a positive regulatory force being exerted by litigation is similarly limited. Where claims are made, it is likely they will be settled. The Australian Institute of Health and Welfare's 2012–13 report, for example, indicates that only 2.5% of negligence claims are finalised by court decision.[173] Most medical negligence claims are settled prior to trial, often with confidentiality settlements that remove public visibility of the cases and their outcomes.

The established critique of negligence law, especially in the context of health care, is that litigation is associated with perverse consequences. It is argued that because clinicians as a group are professionally and intrinsically motivated to act ethically and to avoid negligent behaviour, the threat of litigation creates fear and anxiety which generates defensive practice and disrupts the physician–patient relationship.[174] With respect to mental health care, the received wisdom is that care must be taken to avoid defensive clinical practice that would result in overuse of psychiatric detention powers.

In reality, the analysis of common practice and attitudes presented in this article shows that clinicians invoke a 'duty of care' to create extra-legal responsibilities and duties that are not grounded in statute law. First, it seems that the general law governing mental health care and treatment is routinely misstated and misunderstood, with the specific obligations contained in mental health legislation either downplayed or ignored. Second, it seems that rather than emphasising the content of statutes, clinical and policy guidance addresses perceived gaps in the legislation. These gaps are filled with statements about moral and ethical obligations to detain and treat. Third, the presence of such duties is justified in terms that suggest a misunderstanding of legal principles such as necessity and privacy, which do have application in mental health law, but not in the sense being claimed. A confused legal environment further muddies the ability of those who are harmed to claim that an action was so unreasonable that no service or clinician would engage in such behaviour.

As is noted at the outset of this article, there are other mechanisms that are supposed to provide some measure of accountability and contribute to the positive

171 McDonald (n 4).

172 See, eg, Michael King and Robert Guthrie, 'Using Alternative Therapeutic Intervention Strategies to Reduce the Costs and Anti-therapeutic Effects of Work Stress and Litigation' (2007) 17(1) *Journal of Judicial Administration* 30; Tina Popa, '"No One Gets Closure in the End": Non-adversarial Justice and Practitioner Insights into the Role of Emotion in Medical Negligence Mediation' (2018) 27(4) *Journal of Judicial Administration* 148.

173 Australian Institute of Health and Welfare, *Australia's Medical Indemnity Claims: 2012–13* (Report, 11 July 2014) 19, 31, 113 <https://www.aihw.gov.au/getmedia/27797a0e-490e-4ef9-bf63-91917fca7208/17533.pdf?v=20230605174701&inline=true>.

174 Sohn (n 29) 49, 51.

regulation of health and mental health systems. It is beyond the scope of this article to provide a full analysis of them, but these structures are criticised for their weak accountability impact. The Australian Health Practitioner Regulation Agency, for example, has been criticised for failing to exert sufficient influence.[175] Similarly, health and mental health complaints bodies and commissions have been criticised for failing to exercise their limited powers or to appropriately respond to complaints about the mental health system.[176] Moreover, despite legislative provisions that require mental health services and clinicians to provide patients with information about the rights and avenues of complaint, such information is, in practice, rarely provided.[177] The point of relevance for the present discussion is that these accountability structures are too weak or poorly implemented to stand as a substitute for the almost complete removal of civil liability mechanisms in mental health care. What can be done to move the limited accountability framework to one that is closely aligned with a notion of human rights accountability?

A Law and Human Rights Training

The analysis of applicable law and jurisprudence in the first section of this article concludes that clinicians and health authorities will ordinarily be protected from liability when clinical decisions are made that are consistent with mental health legislation. Despite this assurance, the commonly repeated claims, that a duty of care denotes a set of extra-legal principles that justify the imposition of care and treatment in ways that are contrary to the content and intent of mental health legislation, is a real concern. It is as if clinicians and others are reaching for outdated common law standards when the correct source of law is legislation, or misunderstand the obligations that arise from human rights standards. This impression is reinforced by empirical studies and professional commentary that indicate a generally low understanding of legislative obligations in the clinical mental health workforce.[178] These findings are understandable to the extent that neither the common law nor statutory frameworks are easy to understand. Statutes

175 Arie Freiberg, 'Regulatory Investigations: Regulators, Regulatees and the Public Interest' (2022) 29(4) *Journal of Law and Medicine* 1026, 1026.

176 See, eg, Terry Carney et al, 'Health Complaints and Regulatory Reform: Implications for Vulnerable Populations?' (2016) 23(3) *Journal of Law and Medicine* 650.

177 Chris Maylea et al, 'Consumers' Experiences of Rights-Based Mental Health Laws: Lessons from Victoria, Australia' (2021) 78 *International Journal of Law and Psychiatry* 101737:1–10 <https://doi.org/10.1016/j.ijlp.2021.101737>.

178 See, eg, *Inquest into the Passing of Mathew James Luttrell* (Coroners Court of Victoria, Coroner Jamieson, 16 May 2023); Maylea et al (n 177); Christopher James Ryan, 'Our Duty to Know and Understand the Law' (2018) 26(5) *Australasian Psychiatry* 453 <https://doi.org/10.1177/1039856218799922>; Martin Humphreys, 'Consultant Psychiatrists' Knowledge of Mental Health Legislation in Scotland' (1998) 38(3) *Medicine, Science and the Law* 237 <https://doi.org/10.1177/002580249803800310>; Ovais Wadoo et al, 'Knowledge of Mental Health Legislation in Junior Doctors Training in Psychiatry' (2011) 35(12) *Psychiatrist* 460 <https://doi.org/10.1192/pb.bp.110.030320>; Geraldine Swift et al, 'Junior Doctors' Experience and Knowledge of Procedures in Compulsory Psychiatric Admissions in Ireland' (2001) 18(1) *Irish Journal of Psychological Medicine* 21 <https://doi.org/10.1017/S0790966700006170>; Jill Peay, Caroline Roberts and Nigel Eastman, 'Legal Knowledge of Mental Health Professionals: Report of a National Survey' [2001] (5) *Journal of Mental Health Law* 44 <https://doi.org/10.19164/ijmhcl.v1i5.363>; Christopher Schofield, 'Mental Health Law Training Should Be Mandatory for All Doctors: Commentary

rarely provide the kind of clarity or simplicity required for effective implementation of new laws into clinical practice. As the Royal Commission noted, the introduction of the *Victorian Mental Health Act*, which brought a new approach to mental health care delivery with the intention of aligning mental health care with human rights standards, was marred by poor implementation and a lack of effective resourcing.[179] With respect to the concept of 'dignity of risk' in the new mental health principles, for example,[180] the President of the Victorian Mental Health Tribunal noted that:

> From my observation they [clinicians] were also provided with little, if any, advice on how less risk averse decision making intersects with their duty of care. They are justifiably concerned that the scrutiny of their decision making will be framed as 'why did you fail to make an accurate prediction about this risk and how to prevent it?' rather than 'was your decision-making process thorough and in accordance with the law?'[181]

Given the importance of mental health legislation in the delivery of care, the failure to equip clinicians with the support they need to fully engage with mental health legislation and other applicable legal principles is a practical problem. From a systems perspective, it seems obvious that effective implementation of innovative legislation requires a fulsome, system-wide analysis of the content and implication of mental health legislation, accompanied by oversight mechanisms that monitor adherence. Nevertheless, there is very little research investigating the most effective way to ensure that the practice of mental health clinicians and services aligns with the legislative frameworks that govern their sector.

B No-Fault Insurance Schemes

On the other hand, there is a need to address the absence of accessible compensation for harm. Internationally, in countries such as Sweden, Denmark and New Zealand, recognition of the limitation of tort law has prompted the creation of no-fault compensation schemes as an alternative mechanism of accountability.[182] No-fault insurance schemes are thought to provide more effective and accessible remedies, while attending to principles of both corrective and distributive justice.[183]

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on … Knowledge of Mental Health Legislation in Junior Doctors Training in Psychiatry' (2011) 35(12) *Psychiatrist* 466, 466–8 <https://doi.org/10.1192/pb.bp.111.035683>.

179 *Royal Commission Final Report* (n 138) vol 4, 23–8.

180 *Mental Health Act 2014* (Vic) s 11(1)(d) ('persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk'); *Mental Health and Wellbeing Act* (n 17) s 23 ('[a] person receiving mental health and wellbeing services has the right to take reasonable risks in order to achieve personal growth, self-esteem and overall quality of life').

181 Matthew Carroll, Witness Statement to Royal Commission into Victoria's Mental Health System (27 April 2020) 6 <http://rcvmhs.archive.royalcommission.vic.gov.au/Carroll_Matthew.pdf>.

182 See, eg, Christopher Hodges and Sonia Macleod, 'New Zealand: The Accident Compensation Scheme' in Sonia Macleod and Christopher Hodges (eds), *Redress Schemes for Personal Injuries* (Hart Publishing, 2017) 33; Thierry Vansweevelt and Britt Weyts (eds), *Compensation Funds in Comparative Perspective* (Intersentia, 2020) <https://doi.org/10.1017/9781839700132>; Kim Watts, *A Comparative Law Analysis of No-Fault Comprehensive Compensation Funds* (Intersentia, 2023) <https://doi.org/10.1017/9781839703492>.

183 Georgina Richardson and Grant Gillett, 'Justice, Restoration and Redress: Error, No-Fault and Tort-Based Systems' (2016) 23(4) *Journal of Law and Medicine* 785.

A compensation fund can be particularly helpful where the tortfeasor cannot be located, is underinsured or – as is the case in health care – the injured patient struggles to establish fault.[184] Unlike principles of corrective justice, which heavily underpin tort law and place a burden on the tortfeasor to 'correct' the wrongdoing, compensation funds are rooted in principles of distributive justice. Such funds pool financial resources from various sources (such as taxes and levies) and then distribute them via an administrative fund based on application processes or merit. Compensation funds often operate on a no-fault basis, meaning the injured person does not need to show the tortfeasor was at fault as they would under a traditional tort model of negligence. Theoretically, benefits of compensation funds are abundant. They are viewed as being administratively more efficient, providing easier and faster access to funds, and eliminating the plaintiff's burden of proof in court litigation to prove causation and fault.[185] However, they have also attracted criticism for being costly and undercompensating injuries. In some instances, research indicates that applicants can find the administrative process burdensome or dehumanising.[186]

As is discussed in the literature, there are numerous compensation funds that aim to respond to patient injuries in health care.[187] Some are comprehensive and wide-ranging, such as the comprehensive no-fault scheme operating in New Zealand.[188] This scheme has attracted much discussion, especially insofar as it compensates treatment injuries.[189] Some commentators contend that the scheme has the potential to meet myriad needs of injured patients and that the scheme is an example of a triple-justice approach (corrective, distributive and restorative) to achieving justice in medical cases.[190] Likewise, France's scheme for medical accidents ('ONIAM') operates a thorough administrative fund for medical accidents, utilising dispute

184 See Thierry Vansweevelt and Britt Weyts, 'An Introduction to Compensation Funds: Current Trends and the Questions We Need to Ask' in Thierry Vansweevelt and Britt Weyts (eds), *Compensation Funds in Comparative Perspective* (Intersentia, 2020) 1, 1–2.

185 Ibid 2.

186 For research studies evaluating schemes, see, eg, Meaghan L O'Donnell et al, 'Compensation Seeking and Disability after Injury: The Role of Compensation-Related Stress and Mental Health' (2015) 76(8) *Journal of Clinical Psychiatry* 1000 <https://doi.org/10.4088/JCP.14m09211>; Genevieve M Grant, 'Claiming Justice in Injury Law' (2015) 41(3) *Monash University Law Review* 618.

187 See, eg, Claire Bright and Christopher Hodges, 'France: The ONIAM Scheme' in Sonia Macleod and Christopher Hodges (eds), *Redress Schemes for Personal Injuries* (Bloomsbury, 2017) 427; Magdalena Tulibacka, 'Polish No-Fault Medical Compensation Scheme' in Sonia Macleod and Christopher Hodges (eds), *Redress Schemes for Personal Injuries* (Bloomsbury, 2017) 437; Christopher Hodges, 'Ireland: The Injuries Board' in Sonia Macleod and Christopher Hodges (eds), *Redress Schemes for Personal Injuries* (Bloomsbury, 2017) 452; Raymond Byrne, 'Ireland: Health Services and Redress for Women Formerly Resident in Magdalen Laundries' in Sonia Macleod and Christopher Hodges (eds), *Redress Schemes for Personal Injuries* (Bloomsbury, 2017) 458; Herbert Woopen and Christopher Hodges, 'Germany' in Sonia Macleod and Christopher Hodges (eds), *Redress Schemes for Personal Injuries* (Bloomsbury, 2017) 469.

188 Kim Watts, 'New Zealand's Universal No-Fault Personal Injury Compensation Fund' in Thierry Vansweevelt and Britt Weyts (eds), *Compensation Funds in Comparative Perspective* (Intersentia, 2020) 89.

189 See, eg, Joanna M Manning, 'Plus ça change, plus c'est la même chose: Negligence and Treatment Injury in New Zealand's Accident Compensation Scheme' (2014) 14(1–2) *Medical Law International* 22 <https://doi.org/10.1177/0968533214544237>; Stephen Todd, 'Treatment Injury in New Zealand' (2011) 86(3) *Chicago-Kent Law Review* 1169.

190 Richardson and Gillett (n 183) 794.

resolution avenues, such as conciliation, to facilitate the amicable resolution of disputes.[191] Similarly, Belgium's Fund for Medical Accidents was introduced and modelled on France's ONIAM to facilitate a dual-track process, allowing an alternative non-litigious avenue for patient injuries while also preserving access to court litigation.[192] Duncan Fairgrieve et al conclude that the hallmarks of best practice schemes are accessibility, transparency, timeliness and adequacy of compensation.[193]

More recently, no-fault schemes have been increasingly adopted to compensate individuals who have sustained injuries because of COVID-19 vaccines.[194] These schemes provide an excellent contemporary site for evaluation of how such schemes might operate to compensate injured patients in other health care contexts. An example is the Australian COVID-19 Vaccine Injury Scheme, which was introduced in December 2021 and is administered by Services Australia.[195] Applicants may seek compensation based on certain eligibility criteria and procedural thresholds, such as medical forms being completed by a doctor. Media reports have criticised the practical application of this scheme as failing to meet the needs of the injured, including allegations of under-compensation and lengthy delays.[196] The criticisms point to the need for greater visibility of the scheme, clearer processes and access to legal support to enable claimants to participate.[197]

In the mental health sector, there are increasing calls for the state to recognise the deep harms caused by restrictive practices and other forms of compulsory treatment in mental health care.[198] A no-fault scheme such as the Australian COVID-19 Vaccine Injury Scheme could be an opportunity to provide a response that brings corrective, distributive and restorative justice. More broadly, an ongoing no-fault scheme could provide an alternative mechanism of accountability that could set a new ethos in the delivery of mental health care and treatment.

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191 Bright and Hodges (n 187).

192 Tina Popa, 'Don't Look for Fault, Find a Remedy! Exploring Alternative Forms of Compensating Medical Injuries in Australia, New Zealand and Belgium' (2019) 27(2) *Tort Law Review* 120.

193 Duncan Fairgrieve et al, 'No-Fault Compensation Schemes for COVID-19 Vaccines: Best Practice Hallmarks' (2023) 44 *Public Health Review* 1605973:1–2, 2 <https://doi.org/10.3389/phrs.2023.1605973>.

194 See, eg, Kim Watts and Tina Popa, 'Injecting Fairness into COVID-19 Vaccine Injury Compensation: No-Fault Solutions' (2021) 12(1) *Journal of European Tort Law* 1.

195 'COVID-19 Vaccine Claims Scheme', *Department of Health and Aged Care* (Web Page, 19 December 2023) <https://www.health.gov.au/our-work/covid-19-vaccine-claims-scheme>.

196 Mary Ward, 'Thousands Left Waiting for Compensation after Claims of COVID-19 Vaccine Injury', *The Sydney Morning Herald* (online, 16 April 2023) <https://www.smh.com.au/national/thousands-left-waiting-for-compensation-after-claims-of-covid-19-vaccine-injury-20230413-p5d03y.html>.

197 Jack Evans, 'The Major Problem with Covid-19 Vaccine Compensation Claims', *News.com.au* (online, 23 October 2022) <https://www.news.com.au/national/the-major-problem-with-covid19-vaccine-compensation-claims/news-story/39b052c5ec6abd11ff933659d309a20f>.

198 See, eg, Simon Katterl, 'Preventing and Responding to Harm: Restorative and Responsive Mental Health Regulation in Victoria' (2023) 58(2) *Australian Journal of Social Issues* 441 <https://doi.org/10.1002/ajs4.242>.

V CONCLUSION

This article outlines some of the dilemmas associated with tort law in the context of mental health care. It has set out the context of the civil liability reforms and discussed their application in the context of mental health care, noting the additional hurdle imposed by the *Wednesbury* unreasonableness criteria in the public authority provisions. It also discusses the burden imposed by the immunity provisions in mental health laws. By considering how the concept of 'duty of care' is used in practice, this article has identified an unexpected consequence associated with the limitation of civil liability. That is, contrary to the courts' assumptions, an increased reliance on the notion of a duty to detain and treat. While dedicated research is necessary to identify the way different conceptions of the law are operationalised in practice, and the various drivers of increasing rates of compulsory care, we argue that the removal of legal accountability has had negative effects on the function of the mental health system. Instead, we argue, systems of broad accountability that deliver corrective, distributive and restorative justice will better protect the human rights of patients and have a positive impact on the quality of care.