Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour

Prepared for the Criminology Research Council

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INDEX

ACKNOWLEDGMENTS .... **IV**
SUMMARY .... **V**
CHAPTER ONE: INTRODUCTION **1**
LEGAL ISSUES 2
ETHICAL ISSUES 4
EMPIRICAL RESEARCH 5
STRUCTURE OF THE REPORT 7
CHAPTER TWO: RISK ASSESSMENT **8**
THE DEVELOPING CONCEPTS OF RISK ASSESSMENT AND RISK MANAGEMENT 8
WHY ASSESS RISK? 10
ETHICAL CONSIDERATIONS 11
RISK PREDICTOR VARIABLES 13
Past Violence 13
Pre-existing Vulnerabilities 14
Social and Interpersonal Factors 15
Mental Illness 16
Substance Abuse 16
State of Mind 17
Situational Triggers 18
Personality Constructs 18
CONCLUSION 20
CHAPTER THREE: RISK ASSESSMENT IN THE FORENSIC CONTEXT **21**
THE CIVIL LAW 21
Involuntary Commitment Legislation 21
Infectious Diseases Legislation 25
Family Law 27
Child Protection Proceedings 28
Occupational Health and Safety 33
THE CRIMINAL LAW 34
Bail Applications 34
Sentencing and Preventive Detention 37
Disposition of Offenders with Mental Disorders 46
Defence of Mental Disorder 46
Hospital Orders 51
Parole 54
CONCLUSION 57

CHAPTER FOUR: CONFIDENTIALITY AND THE PUBLIC INTEREST 59
THE ETHICAL BACKGROUND............60
Absolute Confidentiality............62
Utilitarianism............62
Deontological View............62
Autonomy............63
Privacy Rights............63
Beneficence and Non-maleficence............64
Relative Confidentiality............65
Ethical Justifications............66
THE LEGAL BACKGROUND............67
Disclosure in the Public Interest............68
Disclosure of Past Criminal Activity............68
Disclosure of Threats of Future Criminal Activity............69
The Facts in Smith v Jones............77
Assessing Whether or Not to Breach Confidentiality............78
Problems with the Three-Step Test............79
Legal Requirements for Disclosure and a Public Interest Immunity............81
CONCLUSION............84
CHAPTER FIVE: CONCLUSION............85
REFERENCES............87
APPENDIX A: QUESTIONNAIRE............96
APPENDIX B: RESULTS OF THE QUESTIONNAIRE............103

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The views expressed are the responsibility of the author and are not necessarily those of the Council.

SUMMARY

This Report examines the current legal and ethical background to risk assessment for the purpose of preventing future serious injury to others. It outlines the development of the concepts of risk assessment and risk management and the different ways in which risk can be measured. It now appears that there is some degree of consensus that well-trained mental health professionals should be able to predict a patient's short term potential for violence. The Report also sets out the forensic context for risk assessment and outlines some of the areas of law where mental health professionals may be required to write reports or give evidence concerning risk of harm to others. In the criminal law field, this includes writing reports in relation to the risk of an accused re-offending for the purposes of bail applications, sentencing and preventive detention, the disposition of offenders with mental disorders and parole. The Report then turns to legal and ethical arguments relating to breaching confidentiality when a health professional believes a patient is at risk of harming others. While there are strong ethical justifications for preserving confidentiality, it appears that the majority of health professionals and ethicists view confidentiality as being relative rather than absolute. There is a dearth of case law on the subject in Australia, but the developing common law in England, New Zealand and Canada on the public interest exception to confidentiality has set out some guidelines in the forensic setting that may also be appropriate in the therapeutic context.

CHAPTER ONE: INTRODUCTION

The concept of “risk assessment” is one that is of increasing relevance in the literature dealing with the prevention of criminal behaviour (Brown & Pratt, 2000; Rose, 1998; Pratt, 1997). Risk assessment may be relevant to mental health professionals in the legal context in two ways.

First, in the forensic context, psychiatrists and psychologists may be called upon to assess the risk that their client may be violent in the future. The obvious avenue for this is reports for the purposes of sentencing in the criminal context. For example, section 18B of the *Sentencing Act* 1991 (Vic) enables the imposition of an indefinite sentence where there is “the risk of serious danger to members of the community" and there is “the need to protect members of the community” from this risk. Under that section, the court *must* have regard to “any medical, psychiatric or other relevant report received by it”.

The rise of preventive detention has led to the law requiring assessments of “the kind of crime one might commit in the future” (Pratt, 1997, 171; Freiberg, 2000). It has been argued that, in order to protect society, there will always be the need for the courts to take some account of the risk of future violent behaviour in imposing sentences (Zimring & Hawkins, 1986). Apart from sentencing and preventive detention, other areas of the criminal law that require the assessment of risk include bail applications, the disposition of offenders with mental disorders, hospital orders and parole.

The forensic context of risk assessment also extends beyond the criminal law. In the civil context, a criterion for involuntary admission of a patient common to all Australian jurisdictions is whether or not the person should be detained for “the protection of members of the public”. Risk assessment is also relevant to aspects of family law, public health law, occupational health and safety and child

protection proceedings. The connection between risk assessment and these areas of law is the subject of Chapter Three of this Report.

Secondly, one of the most difficult questions for psychiatrists and psychologists concerns knowing when they should disclose a patient's confidential communication on the basis that the patient may be at risk of harming others. If they breach confidentiality, they may leave themselves open to a legal claim for negligence, breach of contract or breach of confidence by the patient. If the mental health professional does not breach confidentiality, there may be a risk of the patient committing a serious offence, putting other people's lives and well-being at risk.

The aims of this project are thus to:

(1) examine the current legal and ethical background to risk assessment for the purpose of preventing future serious injury to others; and

(2) determine, through empirical work, the main factors that influence mental health professionals' assessment of risk of future serious injury and the main situations when mental health professionals will breach confidentiality because of such a risk.

This Report concentrates on the first aim, while a further Report by Professor Paul Mullen will concentrate on the second aim.

LEGAL ISSUES

Brazier (1987, 49), in writing about the lack of clarity in English laws on confidentiality and disclosure, states that "[d]octors and patients need to know where the law [of confidentiality] stands". There is a wealth of material on the situation in the United States where the Supreme Court of California held in *Tarasoff v Regents of the University of California* 131 Cal Rptr 14 (1976) that a

duty to protect potential victims may override the confidentiality of the relationship between health professional and patient (for example, Appelbaum, Kapen et al,1984; Appelbaum & Appelbaum, 2000; MacKay, 1990). However, there have been relatively few articles exploring the law dealing with breaching confidentiality in the public interest in common law countries such as Australia (MacKay, 1990; Mendelson & Mendelson, 1991).

In England, New Zealand and Canada, the courts have recognised a common law public interest exception to confidentiality (McSherry, 2000, 2001). For example, Bingham LJ of the English Court of Appeal stated in *W v Egdell* [1990] 1 All ER 835 at 848 that "the law treats [confidentiality] not as absolute but as liable to be overridden where there is held to be a stronger public interest in disclosure". It remains unclear what this "public interest" means in a legal context.

The recent Supreme Court of Canada case, *Smith v Jones* (1999) 132 CCC (3d) 225, has significantly broadened the public interest exception to enable disclosure where there is a potential risk to a *class* of victims. Cory J in *Smith v Jones* attempted to be more precise in setting out what needs to be taken into account. He set out three factors to be considered in weighing up breaching confidentiality in the interest of public safety:

> First, is there a clear risk to an identifiable person or group of persons? Second, is there a risk of serious bodily harm or death? Third, is the danger imminent? (at 249)

In Australia, there has been no case that sets out a common law public interest exception to confidentiality. Rather, there seems to be a developing jurisprudence relating to "public immunity" in respect of confidential communications.

The decision in *Smith v Jones* raises a number of issues such as whether or not breaching confidentiality should be mandatory or discretionary and what steps a psychiatrist or psychologist should take in order to warn potential victims.

Further, is reporting concerns to the police sufficient; or is there a duty to locate or contact potential victims? Does a failure to warn potential victims create liability for breach of duty? Does the law of negligence extend beyond the duty of care owed by a health professional to a patient to a general duty of care to third parties to prevent serious crime? What if the psychiatrist or psychologist is overly cautious and needlessly warns third parties - can the patient sue for breach of confidence?

The answers to these legal issues are obviously of great significance to the therapeutic relationship between health professional and patient, and these issues will be explored in Chapter Four.

ETHICAL ISSUES

There are also ethical issues raised in relation to risk assessment and particularly in relation to breaching confidentiality (McSherry, 2000, 2001). The Australian Psychological Society's *Code of Ethics* (1999) permits disclosure of confidential information in circumstances where there is a "clear risk" to others (General Principles III(a)) and the Society's *Guidelines on Confidentiality* (1999, Preamble, Para 4) state that confidentiality is not absolute. The guidelines issued by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) (1999) also permit disclosure at the discretion of the psychiatrist where a patient's intention is "to seriously harm an identified person or group of persons" (Annotation to Principle 4, para 4.6).

There are no examples given of when a person should be considered at risk to others and mental health professionals must therefore decide whether or not to breach confidentiality in the absence of an ethical framework.

In general, the utilitarian or consequentialist rationale for limiting disclosure rests on the presumed importance of the relationship between a health

professional and patient. If confidentiality is not guaranteed there is the possibility that patients will be inhibited in their discussions and unable to receive the full benefit of the therapeutic relationship. Engelhardt (1986), for example, has argued that clients may withhold information if they know it can be disclosed to third parties. This may be particularly salient in circumstances where the client has been referred to a psychiatrist or psychologist as part of the criminal justice system. Such damage to the therapeutic relationship and hindrance to treatment may also be counter-productive to therapeutic prevention of criminal behaviour (Kottow, 1986).

Chapter Four will explore these and other ethical principles that relate to risk assessment and breaching confidentiality.

EMPIRICAL RESEARCH

Assessing the risk of future violence is a notoriously difficult task (Mullen, 1993, 1996). There is a widely held belief in our culture that the mentally ill are predisposed to act in a violent and dangerous manner (Link & Stueve, 1994). There also appears to be a strong community expectation that psychologists and psychiatrists can and should predict criminal dangerousness in those with mental disorders. This applies both to those living in non-institutional settings and those directed to health professionals through the criminal justice system (see, for example, “Carnage in the Community” *The Spectator*, 7 May, 1994).

McMahon (1992) points out the extreme difficulty for health professionals to determine the likelihood of a patient carrying out a lethal threat. It has been suggested that mental health professionals err on the side of caution by identifying a risk of harm in many more situations than is absolutely necessary (Wise, 1978).

A threat to kill may simply be a "cry for help" rather than being accompanied by a genuine intention to carry out the threat (Mangalmurti, 1994).

McMahon and Knowles (1997) found that 87% of psychiatrists and 54% of psychologists whose work involved counselling or clinical work reported dealing with a "dangerous" patient in the course of their professional activities. In addition, criminal lawyers regularly refer patients to psychiatrists and psychologists for assessment for sentencing or trial purposes. While the 1980s saw a wealth of literature concluding that those with mental disorder were not at an increased risk of violent behaviour (Hafner & Boker, 1982), more recent studies have suggested an association between schizophrenia and an increased risk of behaving violently (Mullen, 1996,1997a; 1997b).

While there is a growing body of research examining variables that may have a connection to violence such as unstable family background, age, violent environment and violent peer group (Monahan, 1992; Monahan & Steadman, 1994; Pinard & Pagani, 2001), there has been little empirical evidence carried out as to what factors psychiatrists and psychologists take into account in assessing the risk of future violent behaviour. McMahon and Knowles (1991) found that psychologists placed emphasis on the factors of prior history of violence, psychological disorder, explicit threat, affect, aggressive behaviour and a plan and capacity is assessing that a client is at risk of violent behaviour. In a survey of 262 psychologists and 67 psychiatrists, McMahon and Knowles (1997) found that the profile of the client perceived to be dangerous was a male with secondary or less education. However, in this study, there was considerable variation between other factors that were taken into account. Psychiatrists placed greater emphasis on the current mental state of their client, whereas psychologists indicated that they were more influenced by clients' histories of psychiatric and psychological problems.

As part of this overall project, a questionnaire was developed in consultation with Professor Paul Mullen that adapts and expands on the work by McMahon and Knowles (1991, 1997). The questionnaire is set out in Appendix A. It sets out to explore mental health professional's assessment of the risks of violent behaviour and on what occasions they will breach confidentiality in the public interest. Some of the results of this questionnaire will be set out in Chapters Two and Four. However, further detailed analysis will be carried out separately by Professor Mullen.

STRUCTURE OF THE REPORT

The next chapter examines the concept of risk in the criminal justice and mental health spheres. The chapter looks at the different ways that risk can be measured and defined and sets out some of the results of the questionnaire responses.

Chapter Three sets out the forensic context for risk assessment and outlines some of the areas of law where mental health professionals may be required to write reports or give evidence concerning risk of harm to others.

Chapter Four turns to legal and ethical arguments relating to breaching confidentiality when a health professional believes a patient is at risk of harming others. The conclusion summarises the current state of the law relating to risk assessment and breaching confidentiality and outlines areas for possible future research.

CHAPTER TWO: RISK ASSESSMENT

THE DEVELOPING CONCEPTS OF RISK ASSESSMENT AND RISK MANAGEMENT

The assessment of "risk" is of such significance that is has been viewed as a core organising concept of the Western world in recent years (Morgan, Morgan & Morgan, 1998; Rose, 1998; Gray, Laing & Noaks, 2002). Risk assessment and risk management now occupy a prominent position in virtually all forms of mental health practice (Rose, 1998; Mullen, 2001).

The increased emphasis on risk assessment may be a reflection of the increasing uncertainty of living conditions in 21st century industrial societies. The domain of crime and justice may act as a lightning rod for the expression of anxieties generated by concerns about employment security or personal fulfillment (Morgan, Morgan & Morgan, 1998, 3-4).

Assessing the risk of future violence is a notoriously difficult task (Mullen, 1996). During the early 1980s, research suggested that mental health professionals tended to overpredict violence (McAuley, 1993, 7) and one study concluded that it was rare for psychiatrists to predict future violence with a better than 33% accuracy (Monahan, 1981). During this time, the emphasis was on making clinical assessments of "dangerousness" which did not provide a medical diagnosis, but involved "issues of legal judgment and definition, as well as issues of social policy" (Steadman, 2000, 266).

Between the mid 1980s until the mid to late 1990s, the focus shifted from assessing dangerousness to a focus on statistical or actuarial risk prediction. This shift to risk assessment and risk management has seen the rise of "scientific" literature examining a range of risk factors that have a statistical association to a

future event. The limitations of this approach are that actuarial judgments may ignore individual needs and individual differences, whilst focusing too much on historical variables.

The main benefit of the rise of actuarial instruments to assess risk is that it has altered the focus from concepts of dangerousness to probabilistic thinking and ideas of graduated intervention as opposed to Yes-No, In-Out dichotomies associated with the concept of dangerousness (Steadman, 2000, 266).

Currently, risk assessment involves the consideration of risk factors, harm and likelihood. It combines both clinical and actuarial approaches to form what has been termed “structural clinical judgment” (Heilbrun, Ogloff & Picarello, 1999). Instruments such as the Psychopathy Check-List Revised (PCL-R; Hare, 1991), the Violence Risk Appraisal Guide (VRAG; Quinsey, Harris, Rice & Cormier, 1998) and the Historical/Clinical/Risk-20 (HCR-20; Webster, Douglas, Eaves and Hart, 1997) focus on variables that are said to have been ascertained by actuarial studies. The Macarthur Study of Mental Disorder and Violence has also led to the development of a classification tree model referred to as an “iterative” classification tree (ICT; Monahan, Steadman, Silver et al, 2001). Risk predictor variables will be examined in more detail later in this chapter. However, it is useful to briefly mention the concepts of “risk of harm” and “risk level” in this overview.

Risk of harm generally refers to the amount and type of violence being predicted; and “risk level” refers to the probability of the harm. Steadman (2000, 267-268) writes that risk level should be seen as a continuous probability statement about a person, reflecting that probabilities change over time. Probability of risk in this sense should not be seen as relating to an individual’s traits, but rather be viewed as a product of assessment by the mental health

professional regarding presenting characteristics, history and future interactions with his or her environment.

While Steadman (2000, 268) acknowledges that the research literature has made the shift away from the dichotomous thinking associated with dangerousness, he concedes that "from the judicial perspective, [is it unclear] how much change has really occurred" when it comes to making the final decision. The uses of risk assessment in the forensic context will be examined in the next chapter.

WHY ASSESS RISK?

There is a widely held belief in our culture that mentally impaired people are predisposed to act in a violent and dangerous manner (Mullen, 1996; Appelbaum, 2001) The origins of this belief probably lie in the unease which individuals with serious mental disorders produce in those around them. Their unpredictable and occasionally intrusive behaviour often provokes a reaction of fear. These feelings of fear are readily translated into an attribution of "dangerousness" to the individuals provoking them. The media also plays a large role in exacerbating these existing prejudices, often reporting stories characterising mentally impaired individuals as "convicted killers", "madmen" or "homicidal maniacs". As discussed below, there is a growing body of research which points to a modest, but significant increase in violent behaviour among the mentally ill (Mullen, 1996, 94). However, the overall effect of this increase is small compared to other variables such as substance abuse.

Along with the fear of those with mental disorders comes the expectation that those caring for such individuals will prevent them from acts of harm. As will be explored in the next chapter, mental health professionals are called upon to

assess the risk of violence presented by those with mental disorders in a range of legal areas, from decisions concerning civil detention to determinations related to bail, sentencing, probation and parole. The issue of risk is also a topic of immediate relevance to public policy and health care delivery. Risk management is an essential component of the day-to-day treatment of many patients (Lidz & Mulvey, 1995).

There is also pressure on mental health professionals to take appropriate action to avoid any risk of injury to a third party. In a society where professionals and corporations are increasingly held responsible for the impact of their actions on others, the concept of risk has the ability to shift blame for any adverse actions of their patients or clients. Blame is placed on clinicians who have failed to follow procedure and away from managers who have fulfilled their responsibility by ensuring correct protocols were in place, irrespective of the possibilities of the realistic application of such protocols.

Risk assessment, therefore, seems currently unavoidable, despite the possible policy arguments against the practice. Rose, (1998, 179), for example, refers to psychiatric practice as now being more administrative than therapeutic, because of the emphasis placed on attempting to control the future conduct of problematic persons.

ETHICAL CONSIDERATIONS

While the last two decades have "shown great advances in reshaping the concept of dangerousness", there has been a disappointing lack of improvement in the "abilities of frontline clinical decision makers to make violence risk assessments" (Steadman, 2000, 265).

There is some degree of consensus that well-trained clinicians should be able to predict a patient's short-term potential for violence using assessment techniques analogous to the short-term prediction of suicide risk (Tardiff, 2001, 118). In response to Question 1 of the questionnaire set out in Appendix A (responses are in Appendix B) and answered by 145 mental health professionals in Victoria, 75% of psychologists and 58.8% of psychiatrists indicated that psychiatrists/psychologists predict the likelihood of their client attacking and injuring someone in the future moderately accurately.

Longer-term predictions based on mental health variables become increasingly problematic because the reliability of the patient's clinical state and history increasingly takes second place to factors such as sex, social class, and history of previous violence.

When considering the boundaries that need to be drawn around the practice of risk assessment, Mullen (2001) has set out a list of ethical considerations that should only allow mental health professionals to engage in risk assessment if certain criteria are satisfied. These include:

(1) The existence of a reasonable body of empirical evidence to guide clinical decision making;

(2) Mental health issues are prominent in the individual's clinical make-up and have potential relevance to the probability of the infliction of serious injury on third parties;

(3) Assessment is based on a direct examination of the individual;

(4) The risk is described in terms of probabilities with clear admissions of the fallibility and potential variability in the prediction;

(5) The prediction is formulated to take into account the implications for the patient; and

(6) The predictions are motivated primarily by the intention to provide the patient with better treatment and care.

These ethical considerations may in fact make it difficult for mental health professionals to give evidence in the forensic context, given the adversarial nature of criminal and some civil proceedings. The fifth and sixth points in particular may lead to a questioning of the value of giving evidence in adversarial proceedings. However, the emphasis on describing risk in terms of probabilities with clear admissions of the fallibility and potential variability in risk assessment may aid in challenging outmoded expectations in the legal system concerning the ability of mental health professionals to make risk assessments with 100% accuracy.

RISK PREDICTOR VARIABLES

Mullen (2001) has provided an overview of the types of variables that keep being presented as violence predictors. This section will use Mullen's framework while including references to other research in this area. It will also refer to the results of a questionnaire filled out by 128 psychologists and 17 psychiatrists in Victoria. The questionnaire itself forms Appendix A to this Report and the methodology and results can be found in Appendix B. It should be noted that the sample is small and only gives an indication of attitudes to risk predictor variables. Further detailed analysis of this data will be carried out by Professor Paul Mullen as a separate part of this project.

Past Violence

Currently, it appears that the best predictor of future violence is past violence (Monahan, 1981; Tardiff, 1992). It terms of risk management, obviously mental health professionals need to assess the patient/client's current clinical state rather

than simply relying on past history. Very few people are going to be violent at all times and in all situations.

It is not surprising given the literature on this variable that the results of the questionnaire showed that 93% of psychologists and 100% of psychiatrists ticked “past history of violence” as leading to the prediction of a patient/client as likely to inflict future serious injury to a third party. At the other end of the line, “non-violent convictions” were chosen by only six psychologists and one psychiatrist.

Pre-existing Vulnerabilities

Mullen (2001) includes in this category, being male, anti-social traits, suspiciousness, childhood marred by disorganisation and/or abuse, youth, impulsivity and irritability.

Youth is generally associated with the risk of violence (Swanson, Holzer, Ganju & Jono, 1990) and men commit the majority of violent crimes across different cultures (Marzuk, 1996). However, in the mentally ill, the difference between men and women with regard to violence is far less marked (Binder & McNeill, 1990; Steadman, Monahan, Appelbaum, et al, 1994).

In the questionnaire results, slightly more psychiatrists (41.2%) than psychologists (24.2%) chose “age – under 40” as a predictor variable of violence to a third party. Of psychiatrists, 70.6% chose gender (male patient/client) as a predictor variable, compared to 49.2% of psychologists.

A childhood history of abuse and neglect or harsh and inconsistent parenting has also figured prominently in the literature as a risk factor (Widom, 1989; Faulk, 1994). Early signs of persistent antisocial traits, difficulties in peer relationships, and hostility toward authority figures are also key risk factors for later risk of violence (Farrington, Loeber, Stouthamer-Louber, Vankammen & Schmidt, 1996;

Melton et al., 1997). Not surprisingly, 76.5% of psychiatrists and 57% of psychologists chose “violent home environment as a child” as a predictor variable in the questionnaire results. The percentage fell, however in relation to “unstable family background” (21.9% of psychologists and 23.5% of psychiatrists). Whether or not the patient/client was married did not rate highly (1.6% of psychologists and only one psychiatrist chose being married and 10.9% of psychologists and 11.8% of psychiatrists chose not being married as predictor variables).

Impulsivity was a variable chosen by 88.3% of psychiatrists and 66.4% of psychologists. Threats made in a sustainable state of irritability and arousal also rated highly (68.8% of psychologists and 76.5% of psychiatrists).

Social and Interpersonal Factors

Mullen (2001) includes in this category: poor social networks, lack of education and work skills, itinerant lifestyle, poverty and homelessness. Swanson, Holzer, Ganju & Jono (1990) found that those who were violent were more likely to come from low socio-economic status groups. Similarly, Stueve and Link (1997) suggest that the link between mental illness and violence is stronger amongst those with less education.

Interestingly, lack of education was chosen by only 10.9% of psychologists and 23.5% of psychiatrists as a predictor variable in the results of the questionnaire and low socio-economic status was chosen by even fewer (7.8% of psychologists and 5.9% of psychiatrists). Lack of supportive social networks scored higher (46.9% of psychologists and 41.2% of psychiatrists). Employment and/or residential instability was chosen by 20.3% of psychologists and 29.4% of psychiatrists.

Mental Illness

Mullen (1997, 169) states that the mental illness most consistently associated with the increased risk of violent behaviour is schizophrenia. However, among homicide offenders, the incidence of depression at the time of the offence is relatively high.

The general literature appears to suggest that mental illness, of itself, does not reliably predict violence (Mullen, 1996). However, some *symptoms* of mental illness are related to risk. Mullen (2001) includes in this category: active symptoms, poor compliance with medication and treatment, poor engagement with treatment services, treatment resistance and lack of insight into the illness.

These findings seem to have been reflected in the questionnaire results. While 16.4% of psychologists and 35.3% of psychiatrists chose "primary diagnosis of schizophrenia" as a risk variable, "threats directly related to the patient's delusional preoccupations" was chosen by 65.6% of psychologists and 100% of psychiatrists. Resistance to continuing treatment also rated highly amongst psychiatrists (64.7%), but less so for psychologists (35.9%).

Substance Abuse

The presence of substance abuse is a strong risk factor for violence (McCord, 2001; Mullen, 2001). However, while many studies recognise a link between serious criminality and alcoholism, there is less evidence that alcohol is a direct contributing factor to violence (McCord, 2001). Bean (2001) suggests that setting may be more important than the pharmacology of the substance used. The co-existence of substance abuse with mental illness appears to significantly increase the risks of violent behaviour (Swanson, 1994; Marzuk, 1996; Steadman et al, 1998).

In the questionnaire results, 50% of psychologists and 58.8% of psychiatrists chose history of substance abuse as a predictor of violence to a third party. It may be necessary to specify the types of substances in future questionnaires.

State of Mind

Mullen (2001) refers to the presence of anger or fear, delusions that evoke fear or provoke indignation or produce jealousy, clouding of consciousness or confusion, ideas of influence, and command hallucinations. In the questionnaire results, there seemed to be some discrepancies in relation to the choice of these factors.

62% and a half per cent of psychologists and 58.8% of psychiatrists chose experience of disruption of control over thoughts and actions as a predictor variable while 62.5% of psychologists and 76.5% of psychiatrists chose “general capacity to carry out the violence”. Other variables relating to state of mind did not rate as highly.

For example, 41.2% of psychiatrists and 21.9% of psychologists chose “clouding of consciousness and confusion”, 28.9% of psychologists and 17.6% of psychiatrists chose “emotional blunting” and the choice of “evidence of delusions” was almost equal (41.4% of psychologists and 41.2% psychiatrists). The factor, “high anxiety level” was chosen by 23.4% of psychologists and 11.8% of psychiatrists.

Situational Triggers

Mullen (2001) points out that situational triggers are often ignored by actuarial models. They include loss, demands and expectations, confrontations, ready availability of weapons, and physical illness. Situational variables rated highly in the responses to the questionnaire.

Perhaps not surprisingly, 82% of psychologists and 76.5% of psychiatrists chose “availability of weapons” as a predictor variable in the questionnaire results. The existence of a specific, identifiable victim (78.1% of psychologists and 94.1% of psychiatrists), access to the victim (68% of psychologists and 76.5% of psychiatrists) and the existence of a plan (84.4% psychologists and 100% psychiatrists) all rated highly. Threats made in the context of a dispute which is an ongoing irritant was chosen by 62.5% of psychologists and 82.4% of psychiatrists and threats related to intentions persistent over time was chosen by 72.7% of psychologists and 82.4% of psychiatrists. Threats made with plausibility was chosen by 77.1% of psychologists and 58.8% of psychiatrists. Environmental stressors did not rate as highly (49.2% of psychologists and 41.2% of psychiatrists), perhaps because these were not set out in detail.

Personality Constructs

This is perhaps the most controversial of predictor variables for violence. Psychopathy has been said to be the best predictor of future offending (Hare, 1996; Hart, 1998). Hare (2002, 27) states that psychopathy is “a personality disorder defined by a cluster of interpersonal, affective, and lifestyle characteristics that results in serious, negative consequences for society. Among the most devastating features of the disorder are a callous disregard for the rights of others and a propensity for predatory behaviour and violence”.

There are two main domains of psychopathy: personality characteristics (such as grandiosity, lack or remorse, glibness and superficial charm, lack of empathy, shallow affect and pathological lying) and behavioural characteristics (such as proneness to boredom, poor behavioural controls, impulsivity, irresponsibility and early behavioural problems).

Psychopaths are said to form only a small percentage of those who meet the criteria for antisocial personality disorder in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2002, 4th edition, Text Revision). Personality disorders in the DSM-IV-TR are defined as involving an enduring pattern of inner experience and behaviour that deviates markedly from the individual's culture. The criteria for antisocial behaviour disorder focuses predominantly on behavioural characteristics and includes conduct disorder before the age of 15, plus a range of behaviour traits including irritability and aggression, impulsivity, recklessness, irresponsibility, failure to accept social norms and the lack of remorse. Unsurprisingly, these criteria describe up to 70% of the prison population.

Hare (2002) writes that most psychopaths diagnosed via the Psychopathy Checklist – Revised meet the criteria for antisocial personality disorder, but most offenders with antisocial personality disorder are not psychopaths. His view is that psychopaths make up only about 1% of the general population, but as much as a quarter of the prison population.

The term "psychopath" has been criticised as being a social construct (Ellard, 1996; Cavadino, 1998; McCallum, 2001). Ellard (1996, 62) points out:

If you are a rather disagreeable small-time thief with a bad temper you are likely to be described as suffering from Antisocial Personality Disorder. If without any contrition you waste millions of dollars of other people's money and achieve nothing but notoriety you will be called an entrepeneur. No one reaches for the *DSM-IV*.

Interestingly, less than half of the mental health professionals in the questionnaire results (31.3% of psychologists and 47.1% of psychiatrists) chose a "primary diagnosis of personality disorder" as a predictor variable for future violence to a third party.

CONCLUSION

As Prins (1996) points out, there is no ideal, or even sophisticated, approach available to the assessment of risk. It would seem that risk assessment should vary according to the characteristics of the individual, situation and potential victim involved along with the number of cumulative risk factors experienced by the patient.

The very multiplicity of risk predictor variables indicates that none of them represent the be-all and end-all in relation to risk assessment. Indeed, it is likely that the risk of violence is related to multiple variables, "the effects of which cumulate and perhaps interact to lower the threshold at which an act of aggression will occur" (Appelbaum, 2001, xii).

The combination of statistical tools along with the knowledge of predictor variables may help improve clinical predictions. The questionnaire results seem to indicate that more education is needed in relation to some of the predictor variables such as history of substance abuse and variables dealing with the patient/client's state of mind. It is only through more widespread education on risk models that mental health professionals will ultimately produce more accurate estimates of the risk of violence.

CHAPTER THREE: RISK ASSESSMENT IN THE FORENSIC CONTEXT

This chapter provides an overview of when mental health professionals may be required to provide assessments of risk in the forensic context. In the criminal law field, mental health professionals may also be asked to write reports in relation to the risk of an accused re-offending for the purposes of bail applications, sentencing and preventive detention, the disposition of offenders with mental disorders and parole. There is also a growing need for opinions as to risk in the civil law field. Risk assessment is relevant to the involuntary commitment of those diagnosed with a mental illness or intellectual disability, detention to prevent the spread of infectious diseases, child protection proceedings, workplace occupational health and safety and, more recently, in assessing the risk of child abuse in family law disputes.

This chapter will briefly deal with this civil law context before spending more time examining risk assessment in the criminal law arena. It should be noted that the areas to be examined are not exhaustive, but there may be other areas where risk assessment is relevant, such as licence restoration applications by those convicted of drink driving.

THE CIVIL LAW

Involuntary Commitment Legislation

The process for admitting a person involuntarily to a mental health facility varies within each state and territory. In general, a person may be involuntarily detained if he or she is suffering from a mental illness or mental disorder, is in need of treatment, is refusing or unable to consent to treatment and poses a threat to him or herself or others. The fundamental question which is raised by such legislation is whether or not it is justifiable to detain or treat people without their

consent as there may be a risk of harming others. This question also arises in relation to the compulsory care of those with intellectual disabilities or cognitive impairments whose behaviour is believed to place others at risk. Guardianship laws often provide for guardians to be appointed to consent to the care and treatment of such individuals (Victorian Law Reform Commission, 2002).

In all Australian jurisdictions, the protection from self-harm or the protection of others is a criterion that must be taken into account in terms of civil commitment legislation. Table 1 below sets out the appropriate legislation and requirements in this regard.

TABLE 1: Civil Commitment Legislation

Jurisdiction	**Statutory Provision**	**Criterion**
ACT	*Mental Health (Treatment and Care) Act* 1994 Section 26(1)(b)	Person likely to do serious harm to himself or herself or others
NSW	*Mental Health Act* 1900 Section 9(1)(a) and (b)	Treatment or control of person is necessary for the person's own protection from serious harm; or for the protection of others from serious harm
NT	*Mental Health and Related Services Act* 1998 Sections 14(b)(ii)(A) and (B), 15(c)	Person is likely to cause imminent harm to himself or herself, a particular person or any another person
QLD	*Mental Health Act* 2000 Section 13.	There is a risk that the patient may cause harm to himself or herself or someone else
SA	*Mental Health Act* 1993 Section 12(c)	Person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons

TAS	*Mental Health Act* 1996 Section 24(b) and (c)	Person may be detained if there is a significant risk of harm to the person or others and the detention is necessary to protect that person or others
VIC	*Mental Health Act* 1986 Section 8(1)(c)	Person should be detained for treatment for his or her health or safety…or for the protection of members of the public
WA	*Mental Health Act* 1996 Section 26(1)(b)(i)	Treatment required to be provided in order to protect the health or safety of that person or any other person

Two decisions of the Victorian Mental Health Review Board provide contradictory interpretations as to the meaning of the phrase "protection of members of the public" referred to in section 8(1)(c) of the *Mental Health Act* 1986 (Vic). In *Re the review of MW* (1987) 1 MHRBD (Vic) 14 at 17, the Board took a broad approach to this criterion, stating that it applies when:

> - A person who appears to be suffering from a mental illness, engages in conduct or represents such a burden to care for, that significant injury is likely to be caused to a member or members of the public as a result of that conduct or the giving of the care;
> - Injury includes any significant impairment of mental, physical or emotional health whether permanent or of a temporary nature.
>
> The test is not met by:
> - Mere nuisance or irritation caused to members of the public;
> - Property damage alone.

A later decision adopted a more restricted approach to the interpretation of this criterion. In *Re the review of PB (No 6)* unreported, MHRBD (Vic), 6 January 1999, the Board stated:

> A person should be detained for the protection of members of the public if, by reason of their mental illness, there is *a significant risk in the short or medium term that they will commit an act or omission likely to lead to a significant risk of serious physical harm to another person.* The more serious the type of harm for which the person on the evidence may be responsible, the lower the risk that should be run in respect of their release from detention in order to secure the protection of members of

> the public (see *In the Matters of Major Reviews of Percy, Farrell and RJO* [1988] VSC 70 at paras 56-61 per Eames J). Conversely a very high risk of a relatively minor act of harm occurring to a member of the public, such as indecent exposure, would not generally legitimise the involuntary detention of a person for the protection of members of the public. (Emphasis added)

The first decision takes a broad approach to the concept of injury. The more recent case refers only to the risk of serious physical harm. The second case is probably more persuasive given that O'Bryan J in *Wilson v Mental Health Review Board* [2000] VSC 404 at [30] emphasised that the provisions of the *Mental Health Act* 1986 (Vic) must be interpreted as to least infringe upon patients' rights to liberty. O'Bryan J stated at [30]:

> Because the Act regulates the apprehension, admission and detention of persons in an approved mental health service against their wishes, or understanding, and restricts their freedom in the community, the Act must be interpreted in favour of a person affected by the provisions of the Act. The court should be constrained to interpret the Act in a way that least infringes upon the civil rights of a person because of the stigma surrounding mental illness.

The decisions of the Mental Health Review Board are not binding and the decision in *PB (No 6)* does not address the meaning of "significant risk". The inconsistency in these decisions highlights the need for uniform guidelines as to the meaning of "protection of other persons" as a criterion in civil commitment legislation. Perhaps a starting point could be section 15(1) of the *Mental Health Act* 1990 (Ontario) which enables an assessment to be made where a doctor has reasonable cause to believe that the person:

- Has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
- Has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

- Has shown or is showing a lack of competence to care for him or herself; and

The doctor is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- Serious bodily harm to the person;
- Serious bodily harm to another person; or
- Serious physical impairment of the person.

Confining risk to a serious bodily harm to another person takes the more restrictive approach posed by the Victorian Mental Health Review Board in *Re the review of PB (No 6)*. Giving more detail of the factors to be taken into account in identifying the risk to other persons will obviously aid mental health professionals and review boards working in this area.

Infectious Diseases Legislation

Individuals may also be detained under civil law on the ground that they have an infectious disease and they pose a risk to public health. The Commonwealth and each state and territory have powers to quarantine or isolate individuals in the case of an epidemic. There are also provisions that enable the detention of an individual with an infectious disease in the absence of an epidemic and, in some cases, the provisions deal specifically with individuals with HIV/AIDS.

A number of the provisions are very broad and do not specify time limits on the period of detention. For example, under regulation 7 of the *Public Health (Infectious and Notifiable Diseases) Regulations* (ACT), section 13 of the *Notifible Diseases Act* 1981 (NT) and section 249(6) of the *Health Act* 1911 (WA), a person may be detained by the relevant Medical Officer until release is authorised on the grounds that the person is free from disease or no longer constitutes a danger to the public health.

The provisions in Queensland (*Health Act* 1937), New South Wales (*Public Health Act* 1991), South Australia (*Public and Environmental Health Act* 1987), Victoria (*Health Act* 1958) and Tasmania (*HIV/AIDS Preventive Measures Act* 1993; *Public Health Act* 1997), make it clear that detention is the last resort. Only after measures such as requesting that the person refrain from certain conduct and/or submit to supervision have been taken, can an order for detention be made. In Queensland, South Australia, Tasmania and New South Wales, a court must make or confirm an order for detention. The provisions in New South Wales, Victoria, Tasmania and South Australia also impose time limits on detention, with avenues for renewal of the order. The South Australian and Victorian provisions also include a specific right to appeal against the order for detention.

The challenge for this legislation is to effectively balance the needs of public health against the individual rights of the infected persons. To enable this balance to be struck, it is imperative that decisions as to detention are made on the basis of clearly articulated criteria (which should provide for detention as a remedy of last resort and in cases where the person presents a significant risk to the community), that detention periods be finite in duration and that they are subject to review procedures.

Further, there is a large degree of inconsistency between the different jurisdictions with regard to whether a person is detained under an administrative (ostensibly under executive power) or a judicial order (see also *Chu Kheng Lim v Minister for Immigration* (1992) 176 CLR 1 at 28). Due to the essentially punitive basis of detention of persons with infectious diseases, it is appropriate that the power to detain be exercised judicially or, at very least, subject to judicial merits review (see, for example, the procedure set down in the *HIV/AIDS Preventive Measures Act* 1993 (TAS).

Family Law

Family law matters in which there are allegations of child sexual abuse present grave difficulties for the Family Court of Australia. This can be due to a lack of probative legal evidence arising from an absence of corroboration or clinical reports in relation to the allegation. Many lawyers also believe that in the context of the breakdown of a family relationship there is an increased probability of unfounded allegations of child abuse than is normally the case (Parkinson, 1999; Byrne, 1999). Risk assessment in this area also carries over into the risk of violent conduct towards children (Freckelton, 1995).

In *M v M* (1988) 166 CLR 69, the High Court of Australia laid down the rule that contact should be restricted or denied where it would expose the child to an "unacceptable risk" of sexual abuse, based on the balance of probabilities. For judges trained in the adversarial system, the notion of assessing the possibility of future harm may be difficult where prior sexual abuse has not been proven. There is also an inherent difficulty in obtaining corroborative evidence of sexual abuse.

Before the Family Court can make a finding of sexual abuse, it needs to be satisfied on the civil standard of proof as interpreted by Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362. He stated:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the *reasonable satisfaction of the tribunal*. [Emphasis added]. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.

In this context, the marshalling of precise, impartial and well-substantiated clinical evidence is crucial (Byrne, 1999). However, the standard of proof required means that in most cases, there will be insufficient evidence to justify a finding of

sexual abuse. Justices Fogarty and May noted in *Re C and J* [1996] FLC ¶92-697, 83,334 at 83,334 that the cases which reach the Court are generally ones in which the evidence is most unclear as to whether or not there has been sexual abuse.

Perhaps because of the relatively small amount of cases of alleged sexual abuse that come before the Family Court (Parkinson, 1999), the Court has not laid down any guidelines as to relevant risk factors. Parkinson (1999) has proposed that the Court examine amongst other matters, evidence of heightened risk of abuse. This involves examining the behaviour and attitudes towards the child or other children by the alleged perpetrator such as "grooming" behaviour where the relationship is gradually sexualized, a poor sense of boundaries, inappropriate emotional bonds and isolation. Risk factors of sexual abuse may also overlap with those explored in the literature dealing with child protection proceedings examined in the next section.

Child Protection Proceedings

Risk assessment is a familiar factor in child protection work. It is necessary:

- in order to make a list of priorities in relation to notifications of abuse and neglect;
- in case planning;
- in decisions as to whether to remove a child from his or her home; and
- in determining whether an application should be made for the child to be placed in the care of the state.

Table 2 below sets out the main legislative requirements for determining whether or not a child is considered in need of care and consequently should be placed in the care of the state.

TABLE 2: Child Protection Legislation	
Jurisdiction	**Criterion**
ACT *Children's Services Act* 1986 Section 71	A child is 'in need of care" where: - the child has been physically injured (otherwise than by accident); or - the child has been sexually abused; or - the health of the child has been impaired or there is a likelihood that it will be impaired; or - the child has suffered, or is likely to suffer, psychological damage of such a kind that his or her emotional or intellectual development is or will be endangered; or - the child is engaging in behaviour that is, or is likely to be, harmful to him or her and his or her parents or guardian are unable or unwilling to prevent the child from engaging in that behaviour; or - there is no appropriate person to care for the child; or - there is serious incompatibility between the child and one of his or her parents or between the child and his or her guardian; or - the child is required by law to attend school and is persistently failing to do so and the failure is, or is likely to be, harmful to the child.
NSW *Children and Young Persons (Care and Protection Act)* 1998 Section 23	A child is "at risk of harm" where: - the child's basic physical or psychological needs are not being met or are at risk of not being met; or - the child is not receiving necessary medical care; or - the child has been or is at risk of being physically or sexually abused or ill-treated; or - the child is living in a domestic violence situation which causes them to be at risk of serious physical or psychological harm; or - a parent of caregiver has behaved in such a way that the child or young person has suffered or is at risk of suffering serious psychological harm.
NT *Community Welfare Act* 1983 Section 4(2) and 4(3)	A child is "in need of care" where: - the parents, guardians or the person having the custody of the child have abandoned him and cannot, after reasonable inquiry, be found; or - the parents, guardians or the person having the custody of the child are or is unwilling or unable to maintain the child; or - he has suffered maltreatment; or - he is not subject to effective control and is engaging in conduct which constitutes a serious danger to his health or safety; or - being excused from criminal responsibility under section 38 of the *Criminal Code* he has persistently engaged in conduct which is so harmful or potentially harmful to the general welfare of the community measured by commonly accepted community standards as to warrant appropriate action under this Act for the maintenance of those standards.

	A child has “suffered maltreatment” where: - the child has suffered a physical injury causing temporary or permanent disfigurement or impairment of a bodily function; or - the child has suffered serious emotional or intellectual impairment; or - the child has suffered serious physical impairment evidenced by severe bodily malfunctioning; or - the child has been sexually abused or exploited, or where there is a substantial risk of such abuse or exploitation occurring; or - a female child is at substantial risk of female genital mutilation.
QLD *Child Protection Act* 1999 Section 10	A child “in need of care and protection” is a child who: - has suffered harm, is suffering harm, or is at an unacceptable risk of suffering harm; or - does not have a parent able and willing to protect the child from harm.
SA *Children’s Protection Act* 1993 Section 6(2)	A child “is at risk” where: - the child has been or is being abused or neglected; or - a person with whom the child resides has threatened to kill or injure the child and there is reasonable likelihood of the threat being carried out; or - a person with whom the child resides has killed, abused or neglected some other child or children and there is a reasonable likelihood of the child in question being killed, abused or neglected by that person; or - the guardians of the child are unable to maintain the child, or are unable to exercise adequate supervision and control over the child; or - the guardians of the child are unwilling to maintain the child, or are unwilling to exercise adequate supervision and control over the child; or - the guardians of the child are dead, have abandoned the child, or cannot, after reasonable inquiry, be found; or - the child is of compulsory school age but has been persistently absent from school without satisfactory explanation of the absence; or - the child is under 15 years of age and is of no fixed address.

<table>
<tr>
<td>TAS
Children, Young Persons and Their Families Act 1997

Section 4</td>
<td>A child is at risk if:
- the child has been, is being, or is likely to be, abused or neglected; or
- any person with whom the child resides or who has frequent contact with the child:
• has threatened to kill or abuse or neglect the child and there is a reasonable likelihood of the threat being carried out; or
• has killed or abused or neglected some other child or an adult and there is a reasonable likelihood of the child in question being killed, abused or neglected by that person; or
- the guardians of the child are:
• unable to maintain the child; or
• unable to exercise adequate supervision and control over the child; or
• unwilling to maintain the child; or
• unwilling to exercise adequate supervision and control over the child; or
• dead, have abandoned the child or cannot be found after reasonable inquiry; or
• are unwilling or unable to prevent the child from suffering abuse or neglect; or
- the child is under 16 years of age and does not, without lawful excuse, attend school regularly.</td>
</tr>
<tr>
<td>VIC
Children and Young Person's Act 1989

Section 63</td>
<td>A child is "in need of protection" when:
- the child has been abandoned by his or her parents and after reasonable inquiries the parents cannot be found and no other suitable person can be found to care for the child; or
- the child has suffered, or is likely to suffer, significant harm as a result of physical injury; or
- the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse; or
- the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged; or
- the child's physical development or health has been, or is likely to be, significantly harmed
among other criteria.</td>
</tr>
</table>

WA *Child Welfare Act* 1947 Section 4(1)	A child is "in need of care and protection" if: - the parents of the child are unable or unwilling to care for the child, are dead, or are in the custody of the law; or - the child is under the guardianship or the custody of a person whom the court considers is unfit to have that guardianship or custody; or - the child is not being maintained properly or at all by a near relative, or is deserted; or - the child is ill-treated, or suffers injuries apparently resulting from ill-treatment; or - the child is living under such conditions, or is found in such circumstances, or behaves in such a manner, as to indicate that the mental, physical or moral welfare of the child is likely to be in jeopardy among other criteria.

At least in the United States, there has been a rapid increase in the use of systematic or structured risk assessment systems, aimed at determining the risk of abuse or neglect at some future point (Doueck et al, 1993, p. 442). Whilst the systems enable case workers to more fully articulate the basis for decisions relating to child protection, they need to be used by adequately trained and resourced staff and, where possible, be enshrined in legislation and policy (Doueck et al, 1993, p. 450).

Brown (1999) has provided a useful summary of some of the risk factors that should be taken into account in child protection proceedings such as parental loss, the number of changes in family constellation, parental divorce and separation, and poverty and economic hardship. She also sets out positive factors that may lead to resilience in the face of severely adverse conditions.

Assessment methods need to be viewed from the perspective of the user and with regard to the quality and accuracy of relevant gathered empirical evidence (Murphy-Berman, 1994, pp. 195-197). Child protection assessment methods need to be adequately supported by proactive administrative and supervisory structures and lead to appropriate intervention strategies.

Occupational Health and Safety

Risk assessment is of growing importance in relation to violence in the workplace. The literature dealing with the prevention of such violence deals with the development of pre-employment tests to screen out those who are at risk of violence as well as profiles of existing employees and the measures to deal with violence should it occur: (Mantell &Albrecht, 1994; Chappell & Di Martino, 2000).

Selection and screening processes of potential employees have become the norm in many businesses. However, there are legal constraints set down in privacy guidelines and legislation on the use of screening measures such as criminal background checks and credit checks.

While psychological testing is increasing in relation to the suitability of a potential employee, there are questions concerning the reliability and validity of such tests in relation to assessing the risk of violence (Feliu, 1994; Quirk, 1993). Alcohol and drug screening has also been used in the United States as a method of assessing risk, but other countries such as Canada have opposed this on the basis that such tests are open to serious abuse by employers and constitute an invasion of workers' privacy. Genetic screening has also been mooted as a method of selecting suitable employees, but this brings with it the possibility of direct or indirect discrimination (Mould, 2003).

Chappell and Di Martino (2000) have pointed out that in relation to workplace violence there needs to be an interactive analysis of both individual *and* social risk factors. The situational context in which violence may occur needs to be taken into account as well as focusing on those who may be aggressive (Mayhew, 2002). For example, a person working alone in a small shop or petrol station may be seen as an "easy" target. Certain occupations may also be high risk such as those in the

security and protective services as well as health care and educational sectors (Budd, 1999; Rosen, 2001; Hatch-Maillette et al, 2002).

In relation to individual characteristics, Barling (1996) has suggested that alcohol use, past history of aggression, lack of self-esteem and the use of psychological aggression in the workplace are key predictive factors. Kinney (1996) prefers to stress behavioural patterns. He states (at 305) that the "actual act of making a threat or bizarre patterns of behavior" should immediately result in investigation and action.

Perrone (1999) also points to structural explanations for workplace violence including changes to labour market structures and general levels of social inequality. Obviously any risk management approach to workplace violence must take into account individual, situational as well as structural variables.

THE CRIMINAL LAW

Bail Applications

The granting of bail to accused persons requires a balancing of two concerns. The first concern relates to the hardship of custodial remands, the presumption of innocence and the right of an individual to liberty and security. The second concern is the risk of further offending or absconding whilst on bail.

In general, Australian legislative schemes set out a presumption in favour of bail and view custodial remand as the last resort in the pre-trial context. In the majority of criminal cases, the prosecution has the onus of proving an "unacceptable risk" that the accused will re-offend, abscond or interfere with witnesses in order for bail to be refused.

Concern about offending whilst on bail has, on the other hand, "led to a widening of the traditional grounds on which bail may be refused, in order to permit

the detention of those accused persons thought likely to commit further offences during the pre-trial period" (Raifeartaigh, 1997, p. 1). Thus for serious offences such as murder or drug trafficking, bail will be refused unless the accused can show exceptional circumstances as to why this should not be the case. Bail legislation can create a presumption against bail unless there are unusual circumstances that render negligible the risk that the accused will re-offend, abscond or interfere with witnesses.

Pre-trial preventive detention is therefore an option for serious criminal offences or where there is an unacceptable risk of the person re-offending, absconding or interfering with witnesses.

Table 3 below sets out some of the risk factors that a person granting or refusing bail must consider, in addition to the general consideration of the seriousness of the alleged offence and the likelihood of the accused re-offending, absconding or interfering with witnesses.

TABLE 3: Bail Legislation	
Jurisdiction	**Criterion**
ACT *Bail Act* 1992 Section 22	Protection of the community Physical protection of the defendant from intoxication, injury, use of drugs or other causes
NSW *Bail Act* 1978 Sections 8 and 9	Defendant is accused of a serious offence Defendant is accused of domestic violence, where there has been previous violence against the alleged victim Physical protection of the defendant, including protection from intoxication, injury or use of a drug.

NT *Bail Act* 1982 Section 24	Protection and welfare of the community (in particular, where the alleged offence relates to child welfare or domestic violence, the likelihood of any violence against the child or person protected by the order) Physical protection of the defendant, including protection from intoxication, use of a drug or physical injury
QLD *Bail Act* 1980 Section 16	There is an unacceptable risk that the defendant will commit an offence or endanger the safety or welfare or a person who is claimed to be a victim of the offence The defendant should remain in custody for the defendant's own protection
SA *Bail Act* 1985 Section 10	The need of the defendant for physical protection The need of any victim for physical protection
TAS *Justices Act* 1959 Section 34	Defendant must be admitted to bail unless there is reasonable ground for believing that the granting of bail would not be in the interests of justice Where there has been an application for or breach of a restraint order the protection and welfare of the person for whose benefit the restraint order operates must be considered to be of paramount importance
VIC *Bail Act* 1977 Section 13	Bail may be granted unless the defendant is accused of treason or murder. If the defendant is accused of treason or murder, bail will only be granted in exceptional circumstances
WA *Bail Act* 1982 Section 13, Sch 1 Pt C	Defendant likely to endanger the safety, welfare, or property of any person Defendant is alleged to have committed a crime of such a serious nature as to make the grant of bail inappropriate Protection of the defendant and proper conduct of the trial

In England, recent questions have been raised as to whether or not bail legislation is compatible with Article 5 of the European Convention on Human Rights and Fundamental Freedoms, which guarantees the right of an individual to "liberty and security", subject to certain exemptions (The Law Commission, 1999). The Law Commission found that the presumption that bail will be refused in

serious criminal offences such as murder conflicts with the presumption of innocence and the right to liberty.

The Commission also drew attention to the importance of providing bail decision-makers with appropriate guidance and training in making bail decisions so that they comply with Article 5 of the Convention. It has been suggested that simply ticking a box marked "risk of re-offending" or "risk of absconding" will be insufficient (Editorial, 2000). Detailed reasons for overriding the presumption of innocence and the right to liberty will be necessary. This approach will result in even greater reliance on evidence of risk.

Issues raised in English jurisprudence inevitably have a persuasive value in Australia and as a result it would seem that calls for more detailed reasons for bail decisions will increase in this country. Findings on risk assessment will therefore be of increasing importance in this area of the criminal law.

Sentencing and Preventive Detention

The common law principle of proportionality in sentencing provides that the "type and extent of punishment should be commensurate to the gravity of the harm and the degree of responsibility of the offender" (Fox, 2000, p. 298). The rationale for this principle is to ensure sentences remain commensurate to the seriousness of the offence even where the court takes into account the protection of society.

The High Court has consistently affirmed this principle of proportionality in sentencing. The most notable discussions about the relationship of proportionality and risk can be found in the *Veen* cases: *Veen (No 1)* (1979) 143 CLR 458; *Veen (No 2)* (1988) 164 CLR 465. The majority in *Veen (No 2)* confirmed that proportionality was paramount, but stated that this did not mean that public protection was irrelevant. The majority drew a distinction between merely inflating

a sentence for the purposes of preventive detention, which is not permissible and exercising the sentencing discretion having regard to the protection of society among other factors, which is permissible.

In *Veen (No 1)* Stephens J referred at 464-465 to the difficulties in predicting future violence:

> Predictions as to future violence, even when based upon extensive clinical investigation by teams of experienced psychiatrists, have recently been condemned as prone to very significant degrees of error when matched against actuality.

He went on to say:

> [I]f such, perhaps uncertain, predictions are nevertheless to be employed as aids in sentencing, they should at least be the result of thorough psychiatric investigation and assessment by experts possessing undoubted qualifications for the task.

In *Veen (No 2)*, the majority of the High Court (at 486) noted that it is possible for Parliament to set up a scheme for preventive detention. This is precisely what has happened in recent years with the introduction of legislative provisions that enable indefinite terms of imprisonment on the basis that the offender is a serious danger to the community. Generally, in jurisdictions with provision for indefinite sentencing, a court can order such a sentence on its own initiative, or upon application of the prosecution. The legislation also provides for periodical review of the appropriateness of the sentence. Table 4 below sets out an overview of such legislation.

TABLE 4: Indefinite Sentencing Provisions	
Jurisdiction	**Statutory Provision**
ACT	No equivalent provision
NSW	No equivalent provision. Para 10.8 of a report on sentencing produced by the New South Wales Law Reform Commission(1996) expressed the view that provisions providing for indefinite detention should not be introduced in New South Wales.
NT	*Sentencing Act* 1995 - Section 65 (violent offenders convicted of a crime for which a life sentence may be imposed can be sentenced to an indefinite term of imprisonment by the Supreme Court where the Court considers the prisoner to be a serious danger to the community)
QLD	*Penalties and Sentences Act* 1992 - Section 163 (violent offender who presents a serious danger to the community)
SA	*Criminal Law (Sentencing) Act* 1988 - Part 2, Division 3 – Section 22 (habitual criminal) and Section 23 (offender incapable of controlling sexual instincts)
TAS	*Criminal Code* – Section 392 (dangerous offender) repealed by *Sentencing Act* 1997 Schedule 1 which commenced on 1 August 1998 *Sentencing Act* 1997 - Section 19 (dangerous offender convicted of a violent crime)
VIC	*Sentencing Act* 1991 – Section 18A (offender convicted of a serious offence and high probability that offender is a danger to the community)
WA	*Sentencing Act* 1995 - Section 98 (superior court may impose in cases where if released, the offender would pose a danger to society)

Preventive detention legislation has existed for almost a century. For example, the *Indeterminate Sentences Act* 1907 (Vic) provided for a court to

declare a person an ‘habitual criminal’ and detained at the Governor’s Pleasure. However, while such legislation existed, preventive detention was rarely invoked.

It was not until the 1990s that the issue of preventive detention resurfaced. In Victoria, the government enacted the *Community Protection Act* 1990 which was specifically aimed at the preventive detention of Garry David, who had seriously mutilated his body over 70 times and had threatened to kill the then Victorian Premier John Cain, threatened to poison the city water supply and commit mass murder. The Act empowered the Supreme Court to make an order to detain David for six months for the safety of members of the public. However, David could not be released from a preventive detention order except by further order of the court. A 1991 amendment to the Act enabled the preventive detention order to last for 12 months. Garry David died in Pentridge prison in 1992 and the Act was repealed when indefinite sentencing provisions were enacted in 1993.

The *Community Protection Act* 1994 (NSW) was largely based on the Victorian *Community Protection Act* 1990. The former was aimed at the preventive detention of Gregory Kable who had been sentenced to a minimum of four years imprisonment for pleading guilty to the manslaughter of his wife. During his prison term he wrote a number of threatening letters to his ex-wife’s family and the carers of his two children. He was sentenced to a further year and four months on two counts of threatening murder.

Section 5 of the *Community Protection Act* 1994 (NSW) enabled the Supreme Court to make an order detaining Kable in prison if it was satisfied that he was “more likely than not to commit a serious act of violence”, and that it was considered appropriate for the “protection of a particular person or persons in the community generally” that he be held in custody.

The constitutional validity of this Act was eventually challenged before the High Court. In *Kable v DPP (NSW)* (1996) 189 CLR 51, the majority (Toohey, Gaudron, McHugh and Gummow JJ with Brennan CJ and Dawson J dissenting) held that the Act was incompatible with the principles underlying Chapter III of the Commonwealth Constitution and was therefore invalid. The majority held that the decision to release an offender back into the community is a matter for the executive arm of government to make rather than a court. The provisions in the *Community Protection Act* 1994 (NSW) required the Supreme Court to exercise a non-judicial function and this was incompatible with the court's function as a repository of Commonwealth judicial power under the Constitution.

This decision makes it clear that legislation dealing with the preventive detention of an individual offender will be unconstitutional. But what of general sentencing provisions that enable indefinite detention? Toohey J (at 97) and McHugh J (at 121-122) accepted that State legislatures may enable State courts to impose indefinite sentences upon those found guilty of an offence.

Indefinite detention legislation has created tension between principles of proportionality and questions of risk or public protection. Such legislation has been criticised on the grounds that:

- risk is afforded too much prominence;
- the inclusion in legislation of risk/public protection is often a political response to media and public pressure;
- the legislation fails to define the key terms in a coherent and consistent manner; and
- ill-defined legislative notions of 'risk' cut across notions of proportionality, resulting in conceptual confusion (Morgan, Morgan & Morgan, 1998, pp. 25-26).

A question as to the validity of indefinite detention provisions arose in *R v Moffatt* [1998] 2 VR 229. In June 1996, Geoffrey Moffatt, a 28 year old aboriginal man was sentenced in the County Court of Victoria under section 18A of the *Sentencing Act* 1991 (Vic) to an indefinite sentence. He had pleaded guilty to three counts of rape, an attempted rape, an indecent assault and a range of other offences including false imprisonment, theft, burglary and reckless conduct endangering life. He had a long history of offending from the age of 14, with the offences becoming more serious as time progressed.

On appeal to the Supreme Court of Victoria, defence counsel argued that the implementation of the indefinite sentencing provisions required State court judges to combine the role of imposing an extreme form of punishment with a non-judicial function of "administering" the sentence through the process of periodic review. The Supreme Court rejected this argument and dismissed the accused's application for leave to appeal.

Hayne JA pointed out (at 251) that *Kable's* case had been concerned with legislation that allowed the New South Wales court the power to deprive one specified individual of his liberty based on an assessment of what he *might* do, not what he had done. In comparison, section 18A of the *Sentencing Act* 1991 (Vic) enabled an indefinite sentence to be passed upon an offender *found guilty* of an offence.

The High Court is the case of *McGarry v The Queen* (2001) 207 CLR 121 confirmed that indefinite detention may be legislatively sanctioned, but has signalled that there must be more evidence before the sentencing judge than a risk that the offender will reoffend before an order for indefinite detention can be made.

Michael McGarry was prosecuted on indictment in Western Australia on one count of indecently dealing with a girl under the age of 13 under s 320(4) of the *Criminal Code* (WA). McGarry had seen the complainant's picture in the local paper and obtained her address and telephone number from the telephone directory. He went to her house and knocked on the window to attract her attention. When she came to the window he exposed his penis and masturbated until ejaculation. He then left the premises.

McGarry pleaded guilty to the indictment. The prosecution argued before the sentencing judge that an indefinite period of imprisonment be imposed on the defendant due to his previous convictions of a similar character. McGarry had a lengthy criminal record of sexual offences against young girls spanning a period of approximately 13 years. He had three summary convictions for wilful exposure, for which he received fines and one three month term of imprisonment. In 1991, he was sentenced to seven years and eight months imprisonment on 21 counts of aggravated indecent assault, four counts of aggravated sexual assault and seven counts of willful exposure. The victims of these offences were the daughters of McGarry's then de facto wife. A 1991 psychiatric report noted that "it seems prognosis is very poor and that recidivism is probable". In 1994, McGarry was convicted on two counts of indecently dealing with his biological daughter. He was released on parole in February 1996 and committed the further offence of indecently dealing with the complainant in December 1997.

The trial judge sentenced McGarry to five years imprisonment for the indecent dealing and he then went on to impose an indefinite sentence under section 98 of the *Sentencing Act* 1995 (WA). That section enables indefinite imprisonment where, the court is satisfied "on the balance of probabilities" that

when released from custody, the offender "would be a danger to society or part of it" because of one or more of the following:

> (2)(a) the exceptional seriousness of the offence;
> (b) the risk that the offender will commit other indictable offences;
> (c) the character of the offender and in particular –
>> (i) any psychological, psychiatric or medical condition affecting the offender;
>> (ii) the number and seriousness of other offences of which the offender has been convicted;
>> (iii) the number and seriousness of other offences of which the offender has been convicted;
>
> (d) any other exceptional circumstances.

The trial judge noted the "lack of clear parameters" of section 98, but was persuaded on the balance of probabilities that the order should be made.

A majority of the Criminal Appeal of Western Australia dismissed McGarry's appeal against the indefinite sentence, but concluded that the judge's discretion miscarried in fixing the nominal term of imprisonment. McGarry then appealed to the High Court of Australia. A majority of six judges (one dissenting) upheld McGarry's appeal and found that it was not open to the Court of Criminal appeal to be satisfied on the balance of probabilities that, at the end of his nominal sentence, the defendant, if released, would constitute "a danger to society or part of it". The Court should have passed the sentence that ought to have been passed. The indefinite sentence was therefore set aside.

In their joint judgment, Gleeson CJ, Gaudron, McHugh, Gummow and Hayne JJ noted (at 126) that section 98 "does not oblige a sentencing judge to make an order for indefinite imprisonment in every case in which the conditions specified in that sub-section are met". The sentencing judge retains a discretion at all times.

Their Honours found (at 127) that the trial judge and the majority of the Court of Criminal Appeal failed to identify "the kinds of offending behaviour in which it was probable" that McGarry would engage. The trial judge and Court of Appeal

had based their conclusions on the defendant's criminal record and a "sex offender's treatment report" signed by a social worker and written for the Sex Offenders Treatment Unit of the Ministry of Justice. Gleeson CJ, Gaudron, McHugh, Gummow and Hayne JJ were highly critical of this report. The report concluded that the defendant had a range of entrenched sexually deviant behaviours and had demonstrated that he was dangerous to young female children with whom he had contact. The author, under the heading of risk assessment, asserted that McGarry was at present considered a high risk of re-offending in a sexual manner. The report (at 128) also 'acknowledged that there *may* be some medical means of reducing the risk posed by the defendant and that the defendant had raised this issue himself'. Their Honours highlighted the fact that the report only concluded that the offender was presently a risk of re-offending, rather than forecasting his risk at the time required by section 98(2), that is, the end of the nominal sentence.

Their Honours also considered the difficulties of defining the meaning of "a danger to society or part of it". They acknowledged (at 129) that virtually all criminal conduct could be viewed as harmful to society and noted that the inclusion of sub-sections 98(2)(a)(c) and (d) indicated that more was needed than a risk, even a significant risk, that an offender will re-offend before indefinite detention can be ordered. Their Honours stated (at 130) that the consequences of the commission of predicted future offences must be "grave or serious for society as a whole or for some part of it" before the offender could be reckoned "a danger to society".

Kirby J who agreed with the majority that the appeal should be upheld, emphasised the need to consider the context in which the imposing of an indefinite sentence takes effect. He pointed out (at 141) that prior decisions of the High

Court held that the common law does not sanction preventive detention because it offends against the entrenched principle of proportionality in sentencing. The criminal justice system should therefore treat an indefinite sentence as a serious and extraordinary step that must be based on reports provided by those "with psychiatric, psychological or similar qualifications" (at 144). Kirby J (at 142) also acknowledged the limitations experienced by judicial officers, parole officers and others in predicting dangerousness accurately and estimating what people will do in the future.

The majority of the High Court display a cautious approach to the ordering of indefinite sentences pursuant to section 98 of the *Sentencing Act* 1995 (WA). Callinan J in dissent held that there was sufficient evidence before the trial judge and on appeal for the making of such an order. In relation to the report by a social worker, Callinan J stated (at 156) that a social worker "might be well qualified to form an opinion about the likelihood of recidivism", but it is clear that the majority was of the view that such a report was not sufficient evidence for the making of an order for indefinite detention.

In *R v Moffatt* [1998] 2 VR 229 at 255, Hayne JA observed that "the fundamental proposition [is] that such powers [of indefinite detention] are to be sparingly exercised, and then only in clear cases". This remains the situation following the High Court decision in *McGarry's* case.

Disposition of Offenders with Mental Disorders

Defence of Mental Disorder

The defence of mental disorder or 'insanity' is available in all jurisdictions. However, the consequences of successfully proving the defence vary greatly.

Table 5 following sets out the main provisions that elaborate the defence and its consequences.

TABLE 5: Defence of Mental Disorder	
Jurisdiction and Name of Defence	**Consequences of Defence of Mental Disorder**
ACT Mental impairment *Criminal Code* 1900 (ACT) section 428N.	*Non-serious offence:* When the accused is indicted on a non-serious offence and acquitted on the grounds of mental illness, the court may order the accused submit to the jurisdiction of the Mental Health Tribunal, or make such other orders as it deems appropriate: *Crimes Act* 1900 (ACT) section 428Q *Serious offence:* If the accused is acquitted following indictment for a serious offence involving violence, threatened violence or acts endangering life, the court shall order the accused remain in custody until the Mental Health Tribunal orders otherwise, or order the accused submit to the jurisdiction of the Tribunal to enable the Tribunal to make a 'mental health order': *Crimes Act* 1900 (ACT) section 428R.
CTH Mental Impairment *The Criminal Code* (Cth) section 7.3(1).	Where a person is acquitted due to mental illness, the court may release the person (subject to review by the Attorney-General), subject that person to detention in a hospital or prison, or release that person subject to conditions that he or she undergo treatment or remain in care of a responsible person: *Crimes Act* 1914 (Cth) section 20BJ. In summary proceedings for a federal offence, where it is found that a defendant suffers from a mental illness or intellectual disability, the court may dismiss the charge and discharge the person into the care of a responsible person, on condition that the person attend a place for assessment or treatment or unconditionally: *Crimes Act* 1914 (Cth) section 20BQ.

NSW Mental Illness Common law M'Naghten Rules	*Criminal Proceedings in the District or Supreme Courts:* If an accused is found not guilty by reason of mental illness, the Court must order that the person be detained in such a place and in such a manner as the court thinks fit until released by due process of law: *Mental Health (Criminal Procedure) Act* 1990 (NSW) sections 38 and 39, see also sections 25 and 26. *Summary Proceedings before a Magistrate*: A magistrate is empowered to dismiss charges against a defendant who is developmentally disabled or suffers from a mental illness (and who does not fall within Part 3 of the *Mental Health Act* 1990 (NSW) and discharge the person into the care of a responsible person, on condition that the person attend a place for assessment or treatment or unconditionally: *Mental Health (Criminal Procedure) Act* 1990 (NSW) section 32.
NT Insanity *Criminal Code* (NT) section 35.	If [the jury] find that [the accused] was insane … and say that he is acquitted on account of such insanity the court is required to order him [or her] to be kept in such place and in such manner as the court thinks fit until the Administrator's pleasure is known: *Criminal Code* (NT) section 382
QLD Insanity *Criminal Code* (Qld) section 27	If the accused is acquitted on grounds of insanity, the court is required to order the person to be kept in strict custody, in such a place and in such a manner as the court thinks fit, until the person is dealt with pursuant to *the Mental Health Act* 2000 (Qld): *Criminal Code* (Qld) section 647.
SA Mental Incompetence *Criminal Law Consolidation Act* 1935 (SA) section 269C	If the defendant is found to be mentally incompetent of committing the offence of which he or she is accused, the judge has discretion to release unconditionally or impose a supervision order, commit the defendant to detention, or release the detention on licence with conditions: *Criminal Law Consolidation Act* 1935 (SA) section 269O

TAS Insanity *Criminal Code* (Tas) section 16(1).	On a verdict that a person is not guilty of an offence on the ground of insanity or on a finding being made to that effect, the court must declare that the person is liable to supervision: *Criminal Justice (Mental Impairment) Act* 1999 (Tas) section 21. Section 23 of the same act states that: A court which declares that a defendant is liable to supervision may: (a) release the defendant unconditionally; or (b) make a supervision order releasing the defendant on such conditions as the court thinks fit; or (c) make a community treatment order within the meaning of the *Mental Health Act* 1996 (Tas); or (d) make a continuing treatment order within the meaning of the *Mental Health Act* 1996 (Tas). Section 40 of the *Mental Health Act* 1996 (Tas) states that a community treatment order may only be made if the person has a 'mental illness', which is then defined by section 4 as: (a) serious distortion of perception or thought; or (b) serious impairment or disturbance of the capacity for rational thought; or (c) serious mood disorder; or (d) involuntary behaviour or serious impairment of the capacity to control behaviour.
VIC Mental Impairment *Crimes (Mental Impairment and Unfitness to be Tried) Act* 1997 (Vic) section 20	If the defendant is found not guilty because of mental impairment, the court must declare that the defendant is liable to a supervision order; or order the defendant to be released unconditionally: *Crimes (Mental Impairment and Unfitness to be Tried) Act* 1997 (Vic) section 23. Before a final supervision order is made, the court has a range of dispositional options, including remand in an appropriate place, and any other order the court thinks fit: *Crimes (Mental Impairment and Unfitness to be Tried) Act* 1997 (Vic) section 24(1). Supervision orders can be custodial or non-custodial in nature and are of an indeterminate period, with the option for periodic review: *Crimes (Mental Impairment and Unfitness to be Tried) Act* 1997 (Vic) Part 5.
WA Insanity *Criminal Code* (WA) section 27	If the accused is found not criminally responsible for an offence on grounds of unsoundness of mind, the court may release the defendant unconditionally, make a conditional release order, a community based order or an intensive supervision order, or make a custody order in respect of the defendant: *Criminal Law (Mentally Impaired Defendants) Act* 1996 (WA) section 22(1).

The changes to the law in Victoria in 1997 have led to a growing jurisprudence in this area that is of interest to other jurisdictions. Freckelton (2003,

p. 385) points out that between 1997 and September 2002, there had been in excess of 60 Supreme Court judgments interpreting the Victorian legislation.

Section 35(3) of the *Crimes (Mental Impairment and Unfitness to be Tried) Act* 1997 (Vic) requires the Supreme Court to vary a custodial order to a non-custodial one *unless* this would constitute a risk of serious endangerment to the individual or to members of the community. In 1998, Eames J handed down a decision (*Re Percy, Farrell and RJO,* unreported, [1998] VSC 70) in relation to the standard of proof required in varying a custodial to a non-custodial supervision order. He accepted that the standard for assessing the risk of serious endangerment should be on the balance of probabilities. He also held that a less than 50% chance of violent behavior if the detainee is released might nevertheless support a finding of endangerment to the public. This is a standard that supports a cautious approach to varying custodial supervision orders (McSherry, 1999).

Similarly Hedigan J in *Re GBS* (unreported, [1999] VSC 201) held that a risk of serious harm, even if the risk of the event occurring was less than 50%, could nevertheless amount to a serious endangerment to members of the community.

Freckelton (2003, p. 393) argues that in such cases, there is always a "meaningful risk" of serious endangerment given that supervision order detainees have previously killed and given that most still continue to suffer to some degree from symptoms of the same mental disorder that was present when they killed. He argues that the low standard of proof for risk can lead to conservative and media-conscious decision-making.

It is likely that the continuing jurisprudence in this area of mental health law will have an impact on civil commitment law because of the similarities in the criterion of assessing risk of serious harm.

Hospital Orders

A number of jurisdictions provide for the making of hospital orders, committing a person found guilty of an offence, but whom is also found to be mentally ill or suffering from mental disturbance, to a period of treatment in the hospital system. Hospital orders act as one of the sentencing options open to the court, rather than as an option open to the court upon finding that the accused is not guilty due to his or her mental disposition. However, as will be seen from Table 6 following, there are some areas of overlap between the effect of the different classes of provision (for example, supervision orders that also allow for orders as to treatment).

TABLE 6: Hospital Orders

Jurisdiction	Statutory Provision
ACT	*Crimes Act* 1900 (ACT) – Section 428T – before sentencing the convicted person, the court may order him or her to submit to the jurisdiction of the Mental Health Tribunal, which will assess the person and make recommendations as to how the person should be dealt with. If the Tribunal notifies the court that the convicted person is mentally dysfunctional, the court shall make orders as it considers appropriate (including, if it considers appropriate, an order that the person submit to the jurisdiction of the Tribunal to enable it to make a 'mental health order').
CTH	*Crimes Act* 1914 (Cth) – Section 20BS – where a person is convicted of a federal offence and the court is satisfied that the person is suffering from a mental illness which contributed to the offence, if the appropriate treatment for that person is only available to that person as an inmate of a hospital, the court may make a hospital order, without passing sentence on that person. A hospital order can only be made where the person would have been imprisoned, but for his or her mental illness, and cannot exceed in duration the time that the person would have been imprisoned.

NSW	*Mental Health (Criminal Procedure) Act* 1990 (NSW) – Section 17(3) – As part of the procedure for determining fitness for trial, if the Mental Health Tribunal finds that the defendant is suffering from mental illness or a mental condition for which there is hospital treatment and that the person, although currently unfit for trial, will be fit for trial within a period of 12 months, the court may voluntarily order that the person be detained in a hospital. If that person objects to detention in a hospital, the court may order detention in another place. See also sections 27, 32 and 33. No provisions for post-conviction hospital orders.
NT	*Sentencing Act* (NT) – Section 80 – where a person is found guilty of an offence and the court is satisfied that the person is mentally ill or disturbed, the court may order that the person be detained under an approved treatment facility order. The person is to be detained in accordance with the *Mental Health and Related Services Act* (NT).
QLD	If, in the course of a trial it is alleged that the accused is not 'of sound mind' and the jury subsequently makes this finding, the court must order that the person be detained in strict custody in such a place and in such a manner as the court thinks fit, until the person is dealt with pursuant to *the Mental Health Act* 2000 (Qld): *Criminal Code* (Qld) section 645.
SA	If the defendant is found to be mentally incompetent of committing the offence of which he or she is accused or unfit to stand trial, the judge has discretion to release unconditionally or impose a supervision order, commit the defendant to detention, or release the defendant on licence with conditions: *Criminal Law Consolidation Act* 1935 (SA) section 269O.
TAS	*Sentencing Act* 1997 (Tas) – Section 72 – provides for assessment in an institution of an accused person who is yet to be sentenced, where the detention is necessary for the protection of the person and/or members of the public. Section 75 empowers the court to make continuing care and restriction orders in the case where a defendant is found guilty and is suffering from a mental illness that requires treatment. See also *Criminal Justice (Mental Impairment) Act* 1999 (Tas) – Section 24.

VIC	*Sentencing Act* 1991 (Vic) – Section 93 – where a person is found guilty of an offence and the person appears to be mentally ill and require treatment for the illness for his or her own safety, or the protection of the community, the court may, instead of passing sentence, make a hospital order. A hospital order will require that the person be admitted to and detained in an approved mental health service as an involuntary patient. This section also provides for security hospital orders. A hospital order can only be made where the person would have been imprisoned, but for his or her mental illness, and cannot exceed in duration the time that the person would have been imprisoned. Assessment orders can be made under section 90. Diagnosis, assessment and treatment orders are provided for in section 91.
WA	*Criminal Law (Mentally Impaired Defendants) Act* 1996 (WA) – Section 5(2) – if a judicial officer suspects on reasonable grounds that a person has a mental illness requiring treatment and that treatment is required to protect the health and safety of the defendant or other persons or to protect property from serious damage and the defendant has refused, or cannot consent to, treatment, the court may make a hospital order (maximum period of seven days). See also sections 24 and 25.

There has been some research suggesting that hospital orders are rarely made. For example, Mulvany (1992) found that the two types of hospital orders that exist in Victoria were rarely made, the total being 43 over a five year period between 1987 and 1991 (Mulvany, 1992, p. 71, see also Mulvany, 1995). In Victoria, the difference between a hospital order made under section 93(1)(d) and a hospital security order made under section 93(1)(e) is that a person discharged from a hospital order is discharged into the community, whereas a person discharged from a hospital security order must be returned to prison for the remainder of the specified term: (Fox & Freiberg, 1999, p. 803; see also *Re the appeal of ALB* (1991) 2 MHRBD (Vic) 19). Patients under a hospital security order may be made subject to a restricted community treatment order under section 15A of the *Mental Health Act* 1996 (Vic) as a way of easing them back into the community.

The factors leading to the making of hospital orders are similar to the factors set out in civil commitment legislation and the comments made earlier in relation to that area of the law also apply here.

Parole

Parole is the conditional release of an offender from custody prior to the expiry of his or her sentence to imprisonment. Parole boards exist independently of the courts and corrections departments in each Australian state and territory. Generally, each Board is chaired by a judicial officer and it includes representatives from the medical field as well as the community.

Parole boards have the power to consider many factors, including the risk of re-offending, in deciding whether or not an offender should be released from custody. Table 7 below provides an overview of these factors.

TABLE 7: Parole Provisions	
Jurisdiction	**Statutory Provision**
ACT	*Parole Act* 1976 (ACT) – Section (IA) – when considering whether to grant parole, the Board shall have regard to any concern, of which it is aware, of any victim about the need for protection from violence and harassment by the person.
CTH	*Crimes Act* 1914 (Cth) – Section 19AL – person is to be released at the end of the non-parole period if the Attorney-General considers it appropriate to do so in all the circumstances.
NSW	*Crimes (Administration of Sentences Act* 1999 (NSW) – Section 135 - the Parole Board may not make a parole order for an offender unless it has decided that the release of the offender is appropriate, having regard to the principle that the public interest is of primary importance. In reaching a decision, the Board must consider the circumstances of the defendant, the likely effect on any victim and his or her family, relevant reports and the availability of community support for the person on parole.

NT	*Parole of Prisoners Act* (NT) – Section 5 – Parole Board may release a prisoner who has served his or her minimum sentence at its discretion.
QLD	*Corrective Services Act* 2000 (Qld) – Section 140 – the Corrections Board must decide whether or not to release a person on parole (which is one type of 'post-prison community based release order'). The Act does not seem to provide any 'criteria'.
SA	*Correctional Services Act* 1992 (SA) – Section 67 – in considering whether a person who has been sentenced to life imprisonment or imprisonment of more than five years, the Board must consider: • any relevant sentencing remarks; • the likelihood of compliance with conditions of parole; • where the offence involved violence, the circumstance and gravity of the offence where it may give an indication of likely future conduct; • circumstances of the person if granted parole; • any other relevant material. Where a person is liable for a sentence of less than five years, it seems that the Board is compelled to release him or her on parole at the end of the non-parole period: *Correctional Services Act* 1992 (SA) – Section 66.
TAS	*Corrections Act* 1997 (Tas) – Section 72 – in considering whether to release a prisoner on parole the Board must request from the Secretary the register of victims of the prisoner and write to each victim, informing him or her that the parole of the prisoner is to be considered and inviting submissions within 30 days as to the impact and injuries sustained as a result of the offence. In deciding whether to release a prisoner on parole, the Board is to take into consideration: • the likelihood of reoffending; • protection of the public; • rehabilitation of the offender; • sentencing comments; • likelihood of compliance with parole conditions; • circumstances and gravity of the offence; • behaviour of the prisoner while incarcerated; • relevant reports; • circumstances of the person after release from prison; • the victim's state; • any other matters the Board considers relevant.
VIC	*Corrections Act* 1986 (Vic) – Section 69 – the Board is not to be bound by the rules of natural justice. The Act does not appear to further prescribe any criteria for decision-making as to parole. (however the Adult Parole Board website – located under www.justice.vic.gov.au states that criteria applies very similar in terms to that applying e.g. under the Tasmanian legislation) I cannot find any legislation or regulations that statutorily require the Board to consider these factors.

WA	Sentence Administration Act *1995 (WA) – Section 18 – in assessing whether parole should be granted, the paramount consideration shall be the protection and interest of the community.* *Parole shall only be refused if there are exceptional circumstances, arising from the:* • *nature and circumstances of the offence;* • *degree of risk the person poses to the community and/or any individual;* • *any other relevant information, including reports.* General conditions for granting of parole: http://www.justice.wa.gov.au/displayPage.asp?structureID=69243144&resourceID=49498769

Since the 1990s, actuarial risk assessment instruments have been accepted for use by Parole Boards and probation services, particularly in the United Kingdom. There had been an attempt in 1988 to make Parole Board members take into account statistical indicators as to the likelihood of reoffending (Carlisle, 1988). This was later abandoned, partly because the resources required could not be justified and partly because the scores were rarely given much weight in making the decision whether or not to grant parole (Hood & Shute, 1995). Probation services in the United Kingdom have been required to undertake risk assessments during supervision and the Home Office is currently developing a new assessment instrument for use in prisons and probation (Raynor & Kynch, 2002).

Hood and Shute (2000) studied risk based decision-making in the context of granting or refusing parole. They argue that the Risk of Reconviction instruments developed by Copas, Marshall and Tarling (1996) should be updated and made available to Parole Board members. Raynor and Kynch (2002) assessed two other instruments used in probation services in England and Wales, the Level of Service Inventory-Revised (LSI-R- and Assessment Case management and Evaluation (ACE). Their study assessed over 2,000 offenders using ACE or LSI-R, and found that both assessment instruments are able to predict reconviction at a much higher

than chance level and have good reliability.

While actuarial instruments may provide assistance in certain areas of risk assessment such as decisions relating to parole, as explored in Chapter Two, there is a need to supplement them by other forms of assessment. Raynor and Kynch (2002, p. 57) concluded their study of assessment instruments by stating that their main contribution "would probably be to provide threshold scores and trigger items pointing to the need for further assessment".

CONCLUSION

In this chapter, some of the areas of both civil and criminal law that may require mental health professionals to give assessments of risk have been outlined. It may be that there are other areas emerging where risk assessment will be required. For example, in 2000, JK Mason (2000) coined the term "anticipatory containment" in relation to a proposal by the English Home Office and Department of Health to preemptively detain individuals with "dangerous serious personality disorder", despite having done nothing *objectively* harmful that might otherwise justify criminal detention.

The English proposal has been subject to severe criticism (Mullen, 1999; Prins, 2000; Brookbanks, 2002) and now looks unlikely to go ahead. Herschel Prins (2000) has pointed out that anticipatory containment policies are driven to some degree by a "moral panic" concerning dangerous individuals. He writes (at p. 241) that such panic "has provided a source for political concern and the subsequent somewhat frenetic and ill-considered legislative activity which is best described as 'controlism'". Such controlism is also apparent in the rush to introduce anti-terrorism legislation that will enable governments to detain suspected terrorists for indefinite periods of time.

What is clear from this brief overview of the law is that there is a growing emphasis on risk assessment along with the assumption that mental health professionals are adept at guiding legal decision-makers in this regard.

In the next chapter, another aspect of risk assessment will be explored: the legal, ethical and practical issues concerning disclosure of a patient's confidential communication on the basis that the patient may be at risk of harming others.

CHAPTER FOUR: CONFIDENTIALITY AND THE PUBLIC INTEREST

Confidentiality is often held to be a defining feature of the relationship between patients and health care professionals. However the basis for the obligation of confidentiality has not ever been adequately elucidated. In reality there are diverse practices and a number of exceptions to the general duty to keep patients' information confidential (McMahon, 1999).

One of the most difficult questions for health professionals concerns knowing when they should disclose a patient's confidential communication on the basis that the patient may be at risk of harming others. In England, New Zealand and Canada, the courts have recognised a common law public interest exception to confidentiality. The recent Supreme Court of Canada case, *Smith v Jones* (1999) 132 CCC (3d) 225, has significantly broadened the public interest exception to enable disclosure where there is a potential risk not only to an identifiable person, but also to a *class* of victims.

In Australia, statutory provisions exist that require a health professional to breach confidentiality in circumstances such as reporting child abuse or notifying the authorities of certain infectious diseases (e.g., Holland, 1999; Mendes, 1996; McSherry, 1998). However, a common law public interest exception to confidentiality has yet to develop.

This chapter focuses on the ethical and legal basis for the disclosure of confidential information in the public interest and assesses the test for disclosure set out in *Smith v Jones*. The first part of this chapter deals with the ethical justifications for "absolute" as opposed to "relative" confidentiality. The legal perspective will then be explored.

THE ETHICAL BACKGROUND

Communications between patients and health professionals are generally considered to be confidential. Sometimes the word 'privileged' is used instead of confidential. This is in fact misleading, as privilege is a legal construct. In criminal and coronial proceedings, confidential information between health professionals and patients is not privileged and is not protected from disclosure in the courts. Confidential information is only privileged in relation to civil proceedings in Victoria, Tasmania and the Northern Territory: *Evidence Act* 1958 (Vic) s 28(2); *Evidence Act* 1910 (Tas) ss 87, 94, 96, 101; *Evidence Act* 1939 (NT) ss 9(6), 10, 12. New South Wales has enacted general legislation that may privilege confidential information disclosed in the course of any professional relationship: *Evidence Amendment (Confidential Communications) Act* 1997 (NSW) Div 1A.

The Hippocratic oath, written around 460 BCE, includes the statement "what I may see or hear in the course of treatment I will keep to myself holding such things shameful to be spoken about" (Edelstein, 1987, p. 6). In modern times this has been adapted through guideline 1.3.4 of the Australian Medical Association's (AMA) Code of Ethics (1996). This requires doctors to "[k]eep in confidence information derived from your patient and divulge it only with the patient's permission". Similarly, the ethical guidelines of the Royal Australasian College of Physicians (RACP) state:

> The principle of confidentiality is fundamental to the relationship between doctor and patient. Respect for confidentiality, as with consent, gives expression to the patient's autonomy by acknowledging that it is the patient who controls any information relating to his or her medical condition or treatment. Medical information should not be divulged by a physician except with the consent of the patient (RACP, 1992, pp.16-17).

However, ethical guidelines for health professionals view confidentiality not as "absolute", but rather as "relative" in setting out that confidentiality can be legitimately breached in certain circumstances. The RACP guidelines and the AMA *Code of Ethics* refer respectively to the "overriding public interest" and risk to "the health of others" as justifying a breach of the general rule of confidentiality (AMA, 1996, p. 3, s.1.3(d); RACP, 1992, p. 17).

In relation to mental health professionals, the Australian Psychological Society's Code of Ethics (1999) permits disclosure of confidential information in circumstances where there is a "clear risk" to others (Australian Psychological Society, October 1999, General Principles III (a)) and the Society's Guidelines on Confidentiality clearly state that confidentiality is not absolute (Australian Psychological Society, July 1999, Preamble, Paragraph 4). Similarly, the New Zealand Psychological Society's Code of Ethics (1986) enables disclosure on the grounds of endangerment to others (New Zealand Psychological Society, 1986, paragraph 4.1(d)), though this code is currently being updated. The guidelines issued by the Royal Australian and New Zealand College of Psychiatrists (1999) also permit disclosure at the discretion of the psychiatrist where a patient's intention is "to seriously harm an identified person or group of persons" (Royal Australian and New Zealand College of Psychiatrists, October 1999, Paragraph 4.6).

The importance of confidentiality in relationships between health professionals and their clients has a strong ethical basis. While there are justifications for confidentiality to be absolute, most commentators use ethical principles as a basis for relative confidentiality.

Absolute Confidentiality

There have been a number of ethical arguments put forward to justify confidentiality in the relationship between health professionals and patients.

Utilitarianism

In general, the utilitarian or consequentialist rationale for limiting disclosure rests on the presumed importance of the relationship between a health professional and client. The utilitarian approach aims to identify conduct that will result in the greatest "good" for the greatest number in society. An extreme application of this approach would be that if confidentiality is not guaranteed, clients will be inhibited in their discussions and unable to receive the full benefit of the therapeutic relationship. Thus, Michael Kottow writes:

> [I]f physicians become known as confidence-violators, problem-ridden patients will try to lie, accommodate facts to their advantage or, if this does not work, avoid physicians altogether. Physicians would then be unable to give optimal advice or treatment to the detriment of both the reluctant patients and their threatened environment (M Kottow, 1986, p. 120).

Deontological View

A deontological framework for ethical conduct "holds that the rightness of an action is determined by whether it adheres to an appropriate moral rule, regardless of the consequences" (Ozuna, 1998, p. 8). Thus, according to John King-Farlow and Paul Langham, there is a "universal moral requirement concerning the treatment of other persons" that governs all relationships, not only that between health professional and client (King-Farlow & Langham, 1981, p. 10). That is, there is a general moral duty to avoid passing on someone's remarks said in confidence, whether the recipient of the information is a friend, relative or business colleague.

This general moral duty therefore guides the health professional to keep a patient's confidence.

Autonomy

The ethical principle of autonomy has been interpreted in a number of ways to include self-determination, liberty and free will. In modern bioethics, the principle of autonomy is generally used in the sense that individuals have the right to make their own decisions about their health and be free from interference in this regard. Ian Kerridge, Michael Lowe and John McPhee write:

> This perspective is often referred to as the principle of respect for persons because it promotes the view that the individual is the rightful determiner of his or her own life. Observance of this principle incurs an obligation upon individuals to not constrain [sic] the autonomous actions of others unnecessarily and to treat persons in such a way as to enable them to act autonomously (Kerridge, Lowe & McPhee, 1998, p. 72).

In relation to confidentiality, it can be argued from the principle of autonomy that it should be up to the patient to decide whether or not certain information may be disclosed.

Privacy Rights

The importance of confidentiality has also been justified on the basis of privacy rights (Freedman, 1991, pp. 310-313). Under international law, the right to privacy is protected in the International Covenant on Civil and Political Rights (1966, 999 UNTS 171, Article 17) as well as in instruments such as the European Convention on Human Rights (1950, Eur T S 5, 213 UNTS 221, art 8). The right to respect for private life guaranteed in the European Convention encompasses "the right to establish and to develop relationships with other human beings, especially in the emotional field for the development and fulfilment of one's own personality" (*X v Iceland* App No 6825/74, 1976, p. 87). This broad interpretation of privacy may

therefore support the importance of confidentiality in the health professional-patient relationship.

Beneficence and Non-maleficence

The principle of beneficence is the principle of doing good. It could be argued that the well-being of those seeing health professionals is enhanced if they know their confidences will be kept. That is, confidentiality promotes the disclosure of information that allows the health professional to “do good” by facilitating treatment. Similarly, the principle of non-maleficence or the duty to do no harm sets out an obligation to take steps to prevent harm to an individual which may be caused by breaches to confidentiality (Appelbaum & Appelbaum, 1990).

These ethical principles are not exhaustive. Benjamin Freedman has also analysed the obligation to preserve confidentiality on the basis of commutative and social justice (Freedman, 1991, pp. 313-316). Michael Kottow argues that these ethical principles mean that confidentiality should be absolute (Kottow, 1986, pp. 117-122). He argues that allowing breaches of confidentiality, such as in “the public interest”, will lead to inconsistent decisions and possible abuse of process:

> If public interest demands a catalogue of situations where the physician would be under obligation to inform, medicine becomes subaltern to political design and starts down a treacherous path. Should one prefer to leave the management of confidentiality to the physician’s conscience and moral judgement, public interest would not be relying on a consistent and trustworthy source of information. Fear of either political misuse or personal arbitrariness should make us wary of opening the doors of confidentiality for the sake of public interest (Kottow, 1986, p.120).

While few would argue with the importance of confidentiality, most of the literature on the topic disagrees with Kottow’s position and instead holds that breaches of confidentiality may legitimately occur. The problem lies rather with

defining the circumstances in which confidentiality should be legitimately breached. The next section explores the ethical justifications for relative confidentiality.

Relative Confidentiality

There is some reason to believe that health professionals are in favour of relative confidentiality. In a survey of 23 medical practitioners, 14 of whom were trained in both medicine and law, Roy Beran found that 22 out of the 23 respondents agreed that doctors should have a right to report patients whom they felt posed a risk to the public interest (Beran, 1998, pp. 1-10).

Similarly, Marilyn McMahon and Ann Knowles surveyed Victorian psychologists and psychiatrists about their practices and attitudes toward confidentiality (McMahon & Knowles, 1997, pp. 207-215; McMahon, 1999, pp. 134-161). The results showed that while confidentiality was strongly endorsed by practitioners, most of them believed that some circumstances justified the unauthorised disclosure of confidential information.

In their answers to Question 5 of the questionnaire set out in Appendix B, 44.5% of psychologists and 35.3% of psychiatrists said that they would notify or attempt to notify a potential victim at risk of serious injury from their patient/client. Seventy-five per cent of psychologists and 76.5% of psychiatrists said they would notify the police. This indicates a willingness to breach confidentiality in the public interest. However, in response to Question 6, only 11.7% of psychologists and only one psychiatrist indicated that they would notify a potential victim as their first action.

The answers to Question 8 which sets out a number of situations and asks whether the mental health professional would disclose confidential information indicates a willingness to view confidentiality as relative.

How can the belief in relative confidentiality be ethically justified?

Ethical Justifications

Richard Tur has argued that confidentiality should be relative and it should be left to the health professional to determine whether compelling reasons override the duty to preserve confidentiality (Tur, 1998, pp. 15-28). He argues that there needs to be a middle ground between what he terms “legalism” and “anarchism”.

Legalism requires following a rule without question such as Michael Kottow’s view that confidentiality should be absolute without exception. Tur sees this approach as unrealistic and relying on an “inapt” notion of what a rule is. Nor does he see the opposite extreme of anarchism which “sanctifies the moral conscience of the individual” as being an appropriate approach (Tur, 1998, pp. 22). Rather, Tur argues that maintaining confidentiality is best viewed as an obligation equipped with a liberty.

The principles of beneficence and non-maleficence have been cited as supporting the view that confidentiality is relative (Ozuna, 1998, p. 8). That is beneficence encompasses not only a duty to do the best for the patient, but also a moral duty to the wider community. Similarly, non-maleficence or the duty to do no harm can be viewed as applying to the community at large.

Having recourse to ethical principles results in a tension between an emphasis on responsibility for others and an emphasis on autonomy. This tension is not easy to resolve in the context of confidentiality, particularly as some principles such as beneficence can be used to support either absolute or relative confidentiality.

In considering whether breaching confidentiality is ethically justifiable, the philosophers, Tom Beauchamp and James Childress suggest considering both the probability and the magnitude of the potential harm to be avoided through the disclosure of confidential information (Beauchamp & Childress, 1989, p. 425). They set out the following chart of risk assessment:

Magnitude of Harm

		Major	Minor
Probability of Harm	*High*	1	2
	Low	3	4

If there is a high probability of serious harm as in category 1, the justification for breaching confidentiality is high. Conversely, if there is a low probability of minor harm as in category 4, there is little justification for breaching confidentiality. However, categories 1 and 4 are extremes that provide little cause for reflection. Beauchamp and Childress point out that categories 2 and 3 are complex borderline categories that are the most problematic and where individual practitioners will need to consider carefully the facts of the situation before them.

In developing a public interest exception to confidentiality, the courts have also attempted to provide guidelines for disclosure. These guidelines will be outlined in the following section.

THE LEGAL BACKGROUND

If health professionals breach confidentiality, they may leave themselves open to a legal claim for negligence, breach of contract or breach of confidence by the patient. Because the laws of torts, contracts and equity may be invoked in this manner, the existence of a public interest exception to confidentiality has developed in a haphazard manner.

Disclosure in the Public Interest

Disclosure of Past Criminal Activity

The concept of a public interest exception has developed most fully in cases dealing with the publication of confidential information and in certain cases where one party, usually an employee, is a "whistleblower". For example, there are a number of cases concerning equitable remedies to restrain the publication of confidential information (*Lord Ashburton v Pape*, 1913, p. 475; *Commonwealth v John Fairfax & Sons Ltd*, 1980, p. 50 per Mason J). Those seeking to publish generally rely on the concept of the public interest in the information. In this area, it has been held that it is in the public interest to disclose information about criminal activity as there is no confidence as to the disclosure of "iniquity" (*Francome v Mirror Group Newspapers Ltd*, 1984, p. 895 per Donaldson MR; *Attorney-General (UK) v Heinemann Publishers Australian Pty Ltd*, 1988).

More relevantly, in *R v Lowe* [1997] 2 VR 465, the Court of Appeal of the Supreme Court of Victoria held that evidence given by the accused to "an unqualified and self styled psychotherapist" (at p. 483) concerning the killing of a six year old girl was admissible "in the interests of prosecuting serious crime" (at p. 485). There is, however, no *legal* (as opposed to ethical) duty on mental health professionals to disclose past criminal activity (McMahon, 1999, pp. 152-153).

At common law, there has also developed an obligation to preserve confidences, such as between employer and employee, between spouses, in matters of security and in matters involving defence. Such confidences may be overridden where there is some "iniquity" involved (*Gartside v Outram*, 1856, p. 114 per Wood VC). In the Australian Capital Territory, New South Wales, Queensland and South Australia, there is also legislation aimed at persons who make public

interest disclosures relating to maladministration, corruption or illegal conduct in the public sector (eg., *Public Sector Management Act 1994* (ACT) ss 236-240; *Public Interest Disclosure Act 1994* (ACT); *Protected Disclosures Act 1994* (NSW); *Whistleblowers Protection Act 1994* (Qld); *Criminal Justice Act 1989* (Qld) ss 130, 131; *Whistleblowers Protection Act 1993* (SA)).

Disclosure of Threats of Future Criminal Activity

The concept of a public interest exception to maintaining confidentiality in the health context is not as fully developed. Over twenty years ago, the Supreme Court of California held in *Tarasoff v Regents of the University of California* 17 Cal d 425; 131 Cal Rptr 14, 551 P 2d 334 (1976) that a duty to protect potential victims may override the confidentiality of the relationship between psychologist and patient. *Tarasoff's* case dealt with a situation where the patient had disclosed to a clinical psychologist working at a University student health centre that he was going to kill a woman who could be readily identified. That case gave rise to a wealth of academic literature exploring the ethical and legal issues relating to a duty to protect (Appelbaum et al, 1984; Appelbaum, 1985; MacKay, 1990; Mendelson & Mendelson, 1991; Mangalmurti, 1994). It has not been uniformly followed in the United States and a 1985 addition to the Californian Civil Code has substantially curtailed the scope of the duty (Cal. Civ. Cone, 1988, 43.92(a) and (b)).

It is important to note that English, New Zealand and Canadian courts have shied away from establishing a "duty to protect". The focus instead has been on justifications for breaching confidentiality. In this sense, the courts have accepted confidentiality as being relative. In *W v Egdell* [1990] 1 All ER 835 at 848, Bingham LJ of the English Court of Appeal stated that "the law treats [confidentiality] not as

absolute but as liable to be overridden where there is held to be a stronger public interest in disclosure".

A handful of cases in common law countries deal with disclosure in a health context. Most of these concern disclosure in the forensic arena. However, the New Zealand High Court decision in *Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513 is slightly different in dealing with an appeal in relation to disciplinary proceedings against a medical practitioner. A patient who was a bus driver made a complaint against Dr Duncan for breach of confidence after the latter had revealed to a passenger of the bus and to the local police that his patient had suffered two heart attacks and was, in his opinion, not fit to drive. This disclosure was made after the patient's treating surgeon had signed the necessary certificate enabling the patient to drive.

The complaint led to a finding by the Medical Practitioners Disciplinary Committee of professional misconduct. Instead of appealing to the Medical Council, Dr Duncan made allegations to the media. A Preliminary Proceedings Committee heard further complaints against Dr Duncan and this Committee formulated a charge of disgraceful conduct for an inquiry by the Medical Council. Before this could take place, Dr Duncan instituted proceedings for judicial review in the High Court. Jeffries J dismissed this application for review. In the course of his judgment he stated (at p. 521):

> There may be occasions…when a doctor receives information involving a patient that another's life is immediately endangered and urgent action is required. The doctor must then exercise his [or her] professional judgment based upon the circumstances, and if he [or she] fairly and reasonably believes such a danger exists then he [or she] must act unhesitatingly to prevent injury or loss of life even if there is to be a breach of confidentiality.

Jeffries J approved the Disciplinary Committee's statement that confidential information should only be disclosed in exceptional circumstances,

and then only if the public interest was paramount. On the facts, Jeffries J held that the Disciplinary Committee had been correct in finding that there had not been exceptional circumstances such as to breach confidentiality. Jeffries J held in relation to the Preliminary Proceedings committee appeal that the Committee make an appropriate charge on each separate complaint. The Committee successfully appealed this part of the judgment to the Court of Appeal: [1986] 1 NZLR 513. The Editor's note at the end of the report states that the Medical Council subsequently found Dr Duncan guilty of professional misconduct on a number of grounds, one of which was disclosing confidential information to the national news media.

In a subsequent New Zealand case, Master JCA Thomson signalled a cautious approach to circumstances somewhat similar to *Tarasoff's* case when he struck out a number of claims in negligence for the breach of a common law and statutory duty of care. In that case, *Van de Wetering and Others v Capital Coast Health Limited* (Unreported, 19th May 2000, CP Nos 368/98, 372/98 and 25/99, High Court of New Zealand, Wellington Registry), a man who had been under psychiatric care with the defendant hospital shot and killed four people and wounded another.

At his trial for murder, he was found not guilty on the grounds of insanity. Eight people who had been present at the time of the shooting brought an action against the hospital claiming that the defendant knew or ought to have known that the patient was a danger to the public. As a result, they claimed that the defendant owed a duty to the public to take active steps to protect them from the patient and this duty had been breached. Master Thomson found that there were no tenable courses of action. He stated (at p. 10) that to impose a duty of care on the defendant in such circumstances would create "liability in an

indeterminate amount for an indeterminate time to an indeterminate class". He also considered that policy factors were overwhelmingly against the existence of a general duty of care to the public. He stated (at p. 16):

> A responsible clinician has to be able to focus exclusively on the best interests of the patient. It would impose an intolerable burden on a clinician to be under the constant threat or legal responsibility for the conduct of his/her patients. Otherwise, and plainly contrary to public policy, the clinician will inevitably sublimate or deprioritise the patient's best interests in favour of cautious self-protection.

This case suggests that while a public interest exception to confidentiality may be developing in New Zealand, the courts will shy away from any attempt to impose a *Tarasoff* style duty to protect upon health professionals.

The decision in *Van de Wetering* is similar to that of Gage J in the English decision of *Palmer v Tees Health Authority and another* (1998) 45 BMLR 88. In that case, the mother of a four-year-old girl who had been sexually assaulted and murdered by Shaun Armstrong, a former inpatient at the Hartlepool General Hospital, failed in an action in negligence against the hospital authorities for failing to adequately diagnose and treat Armstrong and for failing to prevent him being released from hospital. The authorities conceded that the injuries to the daughter and the mother's consequent psychiatric illness were foreseeable. However, Gage J found that the nexus between the hospital authorities and the mother was not sufficiently proximate. He found (at p 101) that the "identity of the potential victim or victims who might be at risk whenever and wherever the killer might decide to strike was not known. The risk to [the daughter] was not special or exceptional or distinctive beyond the risk to all young girls."

Both *Van de Wetering* and *Palmer's* case do not refer directly to breaching confidentiality. There are two directly relevant English Court of Appeal decisions on the public interest exception to confidentiality that attempt to identify when

disclosure of confidential information may be justified.

In *W v Egdell and others* [1990] 1 All ER 835, the plaintiff, W, sued a psychiatrist, Dr Egdell, for damages for breach of confidence. W was detained in a secure hospital in the north of England after he had pleaded guilty on the basis of diminished responsibility to the manslaughter of five of his neighbours. He had been diagnosed as suffering from paranoid schizophrenia.

After some years, W sought to be transferred to a regional secure unit as a first stage in a rehabilitation programme. W's solicitors instructed Dr Egdell to examine W and report on his mental state for the purposes of a forthcoming hearing before the Mental Health Review Tribunal. Dr Egdell's report concluded that W had a "seriously abnormal interest in the making of home made bombs" and that W should not be transferred to a regional secure unit.

On the basis of this report, W through his solicitors withdrew his application to the Mental Health Review Tribunal. Not knowing that the application had been withdrawn, Dr Egdell telephoned the Tribunal and asked if they had received a copy of the Report. When they explained that the Report had not been received and the application withdrawn, Dr Egdell contacted W's solicitors asking that his Report be disclosed to the Assistant Medical Director at the secure hospital. When the solicitors declined to do so, Dr Egdell sent a copy of his Report to the Assistant Medical Director and later to the Home Office. W's proceedings against Dr Egdell for breach of confidence were dismissed by Scott J ([1989] 1 All ER 1098). W's subsequent appeal to the Court of Appeal was also dismissed.

The Court held (at p. 848) that in order to disclose confidential communications, it must be shown that:

1. There is a real, immediate and serious risk to public safety;
2. The risk will be substantially reduced by disclosure;

3. The disclosure is no greater than is reasonably necessary to minimise the risk; and
4. The consequent damage to the public interest protected by the duty of confidentiality is outweighed by the public interest in minimising the risk.

The Court thus weighed up two competing public interests, the public interest in maintaining confidentiality in professional relationships and the public interest in preventing harm to the public. It held on the facts that since Dr Egdell had highly relevant information about W's condition, he had been justified in disclosing it to those responsible for making decisions concerning W's future because of its relevance to questions of public safety.

The subsequent decision of the Court of Appeal in *Crozier* (1990) 12 Cr App R (S) 206 followed the guidelines set out in *Egdell's* case. Crozier pleaded guilty to the attempted murder of his sister following a dispute about the administration of a trust fund. Crozier's solicitor instructed a psychiatrist, Dr McDonald to interview Crozier and write a report for the purpose of a sentencing hearing. Dr McDonald formed the opinion that Crozier was suffering from a mental illness and that he presented a continuing danger to his sister and other members of his family. He recommended that he be detained at a maximum security hospital. This report was not given to counsel. Dr McDonald arrived at court to hear the judge imposing a prison sentence. He approached counsel for the Crown and made him aware of the contents of his report. The Crown subsequently applied for a variation of sentence. A hospital order was substituted for the prison sentence and this was appealed by Crozier. One of the grounds for appeal was that Dr McDonald had breached the duty of confidentiality between doctor and client. The Court of

Appeal dismissed Crozier's appeal against sentence. It followed the guidelines set out in *Egdell's* case and stated (at p. 213):

> We believe this too is a case where there was strong public interest in disclosure of Dr. McDonald's views than in the confidence he owed to [Crozier]. We would, accordingly, acquit Dr. McDonald of any impropriety. We think that in a very difficult situation, he acted responsibly and reasonably.

Apart from *R v Lowe* [1997] 2 VR 465 which can be viewed as falling within the disclosure of "iniquity" cases, there are no Australian cases dealing directly with breaching confidentiality in the public interest in the absence of relevant statutory provisions. Where statutory provisions exist, they generally aim to protect confidentiality. For example, in *PQ v Australian Red Cross Society and Others* [1992] 1 VR 19 at 25, McGarvie J considered the operation of section 141(2) of the *Health Services Act* 1988 (Vic). This section precludes health professionals giving any information acquired by reason of their employment in a public hospital that could identify a patient. McGarvie J stated that this section fulfilled "an important social policy" in preserving confidentiality. McGarvie J seems to be emphasising here that confidentiality *should* be preserved wherever possible.

Similarly in the case of *PD v Harvey and Chen,* unreported, 10th June 2003, New South Wales Supreme Court, [2003] NSWSC 487, Cripps AJ held that section 17(2) of the *Public Health Act* 1991 (NSW) requires medical practitioners to take all reasonable steps to prevent disclosure of a patient's HIV status to another person. The decision in *PD's case* focused on the failure to provide adequate pre-test counselling and follow-up procedures once a person is found to be HIV positive. However, it was pointed out in that case that there is an exception to the general rule of protecting confidential information from disclosure. Section 10 of the *Public Health Regulation* 2002 states that information about HIV/AIDS may be disclosed to the Director-General of the Department of Health where the doctor has reasonable

grounds to believe that the patient is behaving in such a way that the health of the public is at risk. Under section 23 of the *Public Health Act* 1991 (NSW), the Chief Health Officer can then take steps to require the patient to undergo treatment and counselling and to refrain from specified conduct.

It seems likely that Australian courts are more likely to set out exceptions to confidentiality rather than develop a legal duty to protect. The High Court in *Sutherland Shire Council v Heyman and Another* (1985) 157 CLR 424 reaffirmed the principle that the common law does not impose a positive duty to rescue, safeguard from or warn another person of a reasonably foreseeable injury.

Despite there being no case in Australia that sets out a *legal* duty to breach confidentiality in the public interest where a patient or client is considering a risk of harming others, the results to the questionnaire set out in Appendix A suggests that mental health professionals believe that such a legal duty exists. In answer to Question Two (set out in Appendix B), the majority of mental health professionals (75.8% of psychologists and 64.7% of psychiatrists) thought there *was* a legal duty in Australia to disclose confidential information to a third party if the psychiatrist/psychologist believes that his or her patient/client is at risk of causing serious injury to a third party. This seems to indicate that more education concerning legal requirements is needed.

Guidelines from the Supreme Court of Canada

The most recent and significant case dealing with the public interest exception to confidentiality is that of the Supreme Court of Canada in *Smith v Jones* (1999) 132 CCC (3d) 225. The Court held that there need not be harm directed against a specific victim for confidentiality to be overridden, it will be enough if a *class* of victims is identified. This case is significant because it broadens the circumstances in

which confidentiality may be breached in the public interest. In addition, Cory J set out a test that may be of use to health professionals in both the forensic and therapeutic contexts, in deciding whether or not to breach confidentiality.

The Facts in Smith v Jones

"Jones" was charged with aggravated sexual assault on a prostitute. His counsel referred him to a psychiatrist, "Dr Smith", for the purpose of preparing a defence or writing a submission for sentencing in the event of a guilty plea. During the interview, Jones told Dr Smith that he had deliberately chosen as his victim a small woman who could be readily overwhelmed. He had planned to rape, kidnap, and kill her and that this would be a "trial run" to see if he could "live with" what he had done. If so, he would carry out further rapes and killings of prostitutes. The next day, Dr Smith telephoned Jones' counsel and said that in his opinion, Jones was a dangerous individual who would, more likely than not, commit future offences unless he received sufficient treatment. Jones subsequently pleaded guilty to aggravated assault. When Dr Smith discovered from Jones' counsel that he would not be called to give evidence, he sought a declaration that he was entitled to disclose the information he had in his possession in the interests of public safety.

The communications between Jones and Dr Smith attracted solicitor-client privilege because the communications were made for the purpose of a possible legal defence or sentencing hearing. The decision is therefore couched in terms of a public interest exception to solicitor-client privilege. Interestingly, solicitor-client privilege was not discussed in the English cases of *Egdell* and *Crozier* although both cases concerned psychiatrists being instructed by solicitors.

The matter was first heard *in camera* before a judge of the British Columbia Supreme Court. The judge ruled that Dr Smith was under a duty to disclose both the

accused's statements and Dr Smith's own opinions regarding Jones' dangerousness to the police and the Crown. The British Columbia Court of Appeal in a further *in camera* hearing allowed Jones' appeal, but only to the extent that the mandatory order was changed to a discretionary one, *permitting* rather than *requiring* Dr Smith to disclose the information to the Crown and police.

Jones then appealed to the Supreme Court of Canada where the proceedings were held in an open court subject to a publication ban. A majority of six judges to three dismissed Jones' appeal on the basis that solicitor-client privilege may be set aside when there is a danger to public safety and death or serious bodily harm is imminent.

Assessing Whether or Not to Breach Confidentiality

Cory J, in delivering the majority judgment, set out a test to guide health professionals in deciding whether or not to breach confidentiality in the public interest.

Cory J in *Smith v Jones* attempted to be more precise in setting out what needs to be taken into account. He set out three factors to be considered in weighing up breaching confidentiality in the interest of public safety:

> First, is there a clear risk to an identifiable person or group of persons? Second, is there a risk of serious bodily harm or death? Third, is the danger imminent? (at p. 249)

Cory J then expanded on each of these factors. In relation to the first factor, Cory J expanded the boundaries of the public interest to include warning a large threatened group providing it is clearly identifiable. In this regard, Cory J referred to the examples of a threat to seriously injure children of five years of age and under, or single women living in apartment buildings.

In relation to the second factor, Cory J again broadened the concept of the public interest by referring to "serious psychological harm" as constituting serious bodily harm.

Finally, in relation to the concept of "imminence", Cory J stated (at p. 251):

> The nature of the threat must be such that it creates a sense of urgency. This sense of urgency may be applicable to some time in the future. Depending on the seriousness and clarity of the threat, it will not always be necessary to impose a particular time limit on the risk. It is sufficient if there is a clear and imminent threat of serious bodily harm to an identifiable group, and if this threat is made in such a manner that a sense of urgency is created.

It is interesting to note that on the facts before the court, the requirement of imminence was arguably not fulfilled. Jones described his plan for his victim as a "trial run", but did not detail how and when he planned to commit further crimes. Smith waited over three months before contacting Jones' counsel to inquire about the proceedings and there was no evidence led as to whether he believed it was probable that Jones would commit a serious attack in the future. Cory J was perhaps referring to this point when he stated that "[d]ifferent weights will be given to each factor in any particular case" (at p. 251). The majority nevertheless held that there was "some evidence of imminence" (at p. 254).

While the case of *Smith v Jones* dealt with a forensic rather than a therapeutic situation and was couched in terms of a public interest exception to solicitor-client privilege, the three-step test may be of use to health professionals in deciding whether or not to breach confidentiality in the public interest. However, there are some difficulties with it.

Problems with the Three-Step Test

An assessment of the three factors of an identifiable person or group, a risk of serious bodily harm or death and imminent danger involves the health professional in

a process of assessing the potential dangerousness of the patient. There appears to be greater community expectations that mental health professionals will be able to predict dangerousness in those with mental disorders who are living in non-institutional settings or who are directed to them through the legal system (eg., "Carnage in the Community", *The Spectator,* 7 May, 1994). Marilyn McMahon and Ann Knowles found in one study that 87% of psychiatrists and 54% of psychologists whose work involved counselling or clinical work reported dealing with a “dangerous” patient in the course of their professional activities (McMahon & Knowles, 1997, pp. 207-215).

However, the process of predicting future dangerousness, or in more recent terms, risk of harm, has been severely criticised (Mullen, 1996; Rose, 1998). Marilyn McMahon has pointed out that it is extremely difficult for health professionals to determine how likely a patient is to carry out a lethal threat (McMahon, 1992, pp. 12–16).

The public interest exception to confidentiality might lead health professionals to err on the side of caution by breaching confidentiality in many more situations than is absolutely necessary (Wise, 1978). A threat to kill may simply be a “cry for help” rather than being accompanied by a genuine intention to carry it out (Mangalmurti, 1994).

A further problem with the decision in *Smith v Jones* is that it is unclear as to whether a health professional *must* breach confidentiality after being satisfied that “the three factors of seriousness, clarity and imminence indicate that the privilege must be maintained” (at p. 251). The majority affirmed the order of the British Columbia Court of Appeal that had *permitted* Dr Smith disclosing the information to the Crown and police. However, in the course of the judgment, Cory J stated:

> If after considering all appropriate factors it is determined that the threat to public safety outweighs the need to preserve solicitor-client privilege, then the

privilege *must* be set aside. [emphasis added] (at p. 251)

This suggests a mandatory requirement for disclosure and is difficult to reconcile with the final order (eg., Freedman, 1991).

Finally, It is unclear what steps a mental health professional need take in order to disclose the information. Cory J stated (at p. 255) that it was not appropriate to set out a procedure but that "it might be appropriate to notify the potential victim or the police or a Crown prosecutor, depending on the specific circumstances".

Legal Requirements for Disclosure and a Public Interest Immunity

Thus far, this chapter has concentrated upon disclosure of confidential information in the public interest. As discussed above, while the area is developing, there is no mandatory legal duty to breach confidentiality where there is a risk of *future* harm in existence in Australia at present.

Mental health professionals may also be asked to breach confidentiality for the purposes of legal proceedings and it is to this type of disclosure that we now turn. Here, there may be a converse public interest in protecting confidential information. The law may instead be developing a "public interest immunity" in relation to records taken during the course of a therapeutic relationship.

Confidentiality of information disclosed by clients to mental health professionals has never been protected at common law from disclosure in courts. However, the courts had discretion in this regard and would not necessarily compel disclosure: *A-G (UK) v Mulholland* [1963] 2 QB 477. This remains the position in relation to criminal proceedings in all states and Territories in Australia. However, a statutory privilege exists in Victoria, Tasmania and the Northern Territory that protects confidential information imparted to a medical practitioners

in relation to civil proceedings: *Evidence Act* 1958 (Vic) s 28(2); *Evidence Act* 1910 (Tas) ss 87, 94, 96 and 101; *Evidence Act* 1939 (NT) ss 9(6), 10, 12. More general legislation exists in New South Wales that may privilege confidential information disclosed in the course of any professional relationship: *Evidence Amendment (Confidential Communications) Act* 1997 (NSW) Div 1A.

In the late 1990s, there was an increasing practice of defence counsel in rape trials seeking access to counselling records made between alleged victims and their therapists: (Bronitt & McSherry, 1997; Cossins & Pilkington, 1996). New South Wales, Victoria and South Australia enacted legislation protecting these confidential communications: *Evidence Act* 1995 (NSW) ss 126A-126F inserted by *Evidence Amendment (Confidential Communications) Act* 1997 (NSW) Div 1A; *Evidence Act* 1929 (SA) ss 67D-67F inserted by *Evidence Act (Confidential Communications) Amendment Act* 1929 (SA); *Evidence Act* 1958 (Vic) ss 32B-32G inserted by *Evidence (Confidential Communications) Act* 1998 (Vic). Mendelson (2002) has pointed out that these provisions have been criticised by the courts as lacking precision in the cases of *R v Young* (1999) 46 NSWLR 681; *R v Norman Lee* [2000] NSWCCA 444; *Atlas v DPP and Ors* [2001] VSC 209 and *Question of Law Reserved* [2000] SASC 205.

At that time also, the police began to apply for search warrants to obtain psychiatric files on accused persons. The legitimacy of such conduct was considered by Cummins J in *Clifford v Victorian Institute of Forensic Mental Health and Anor* unreported, [1999] VSC 359. The facts were that Detective Senior Constable Clifford applied for a search warrant on 27 July 1998 to obtain a psychiatric file which he believed contained an admission by Thien Chi Nguyen who had been charged with the murder of his brother. This application was refused by the Chief Magistrate on the grounds of public interest immunity. The officer took

proceedings in the Supreme Court and Smith J found that the Magistrate was in error and remitted the matter to him to be determined according to law. A warrant was subsequently issued by the Chief Magistrate on 19 October 1998. The material was then placed in a sealed envelope before the Magistrates' Court. On 2 March 1999, the Chief Magistrate then upheld a claim on behalf of the Victorian Institute of Forensic Mental Health of public interest immunity and refused the fruition of the warrant. He ordered the return of the material to the Institute. Detective Senior Constable Clifford then sought judicial review of that order in the Supreme Court.

Cummins J found that "public interest immunity" applied to the material and agreed with the Chief Magistrate in his opinion. In *Sankey v Whitlam and Ors* (1978) 142 CLR 1 at 38, Gibbs ACJ stated:

> The general rule is that the court will not order the production of a document, although relevant and otherwise admissible, if it would be injurious to the public interest to disclose it.

Cummins J stressed the importance of the effective operation of the therapeutic and protective regime established under the *Mental Health Act* 1986 (Vic). He found that it would be injurious to the public interest if the effective operation of that regime were not preserved and that allowing access to confidential documents would undermine that regime. Cummins J distinguished *R v Young* (1999) NSWCCA 166 and *R v Lowe* (1997) 2 VR 465 on the basis that the case before him concerned disclosure to a person in authority at an institution that had a 'governmental function'.

Interestingly, in the answer to Question 7 of the Questionnaire set out in Appendix B, only 31.3% of psychologists and 23.5% of psychiatrists said that they would provide access to confidential documents in response to a search warrant. The percentage was much higher in relation to an order from the County Court or Supreme Court (84.4% of psychologists and 94.1% of psychiatrists).

In summary, if a client has admitted to *past* criminal conduct, then a mental health professional may still be compelled by the courts to disclose this information: *R v Lowe* (1997) 2 VR 465. However, there is no *legal duty* to report to police a client who discloses past criminal offences except in Queensland. In that state, a medical practitioner is guilty of professional misconduct if he or she does not disclose to police any information received concerning an attempted or completed crime, or if he or she attends an injured victim or perpetrator of a criminal act and does not report the incident: *Medical Act* 1939 (Qld) s 35.

If the information deals with possible *future* harm, it would seem that the public interest immunity could very well apply and mental health professionals should not grant access to such files.

CONCLUSION

While there are strong ethical justifications for preserving confidentiality, it appears that the majority of health professionals and ethicists view confidentiality as being relative rather than absolute. The developing common law in England, New Zealand and Canada on the public interest exception to confidentiality has set out some guidelines in the forensic setting that may also be appropriate in the therapeutic context.

An assessment of the three factors of an identifiable person or group, a risk of serious bodily harm or death and imminent danger may aid in deciding whether or not to breach confidentiality. However there are difficulties with the test set out in *Smith v Jones.* It may be that an appropriate legal test in what is an essentially discretionary area is impossible to formulate, but at least *Smith v Jones* may be a step toward greater certainty in a problematic area of professional practice.

CHAPTER FIVE: CONCLUSION

This Report has outlined some of the legal and ethical issues associated with risk assessment and breaching confidentiality in the public interest. While there may be philosophical difficulties with the emphasis placed on risk assessment and management in the therapeutic context, it is clear that risk assessment occupies a prominent position in mental health practice.

There now appears to be some degree of consensus that well-trained mental health professional should be able to predict a patient's short-term potential for violence using assessment techniques analogous to the short-term prediction of suicide risk (Tardiff, 2001, 118). However, as Prins (1996) points out, there is no ideal, or even sophisticated, approach available to the assessment of risk. It would seem that risk assessment should vary according to the characteristics of the individual, situation and potential victim involved along with the number of cumulative risk factors experienced by the patient.

The combination of statistical tools along with the knowledge of predictor variables may help improve clinical predictions. The questionnaire results seem to indicate that more education is needed in relation to some of the predictor variables such as history of substance abuse and variables dealing with the patient/client's state of mind. It is only through more widespread education on risk models that mental health professionals will ultimately produce more accurate estimates of the risk of violence.

Risk assessment may be relevant in civil law areas to the involuntary commitment of those diagnosed with a mental illness or intellectual disability, detention to prevent the spread of infectious diseases, assessing the risk of child abuse in family law matters, child protection proceedings and workplace

occupational health and safety. In the criminal law field, mental health professionals may also be asked to write reports in relation to the risk of an accused re-offending for the purposes of bail applications, sentencing and preventive detention, the disposition of offenders with mental disorders, and parole. It may be that there are other areas emerging where risk assessment will be required.

While there are strong ethical justifications for preserving confidentiality, it appears that the majority of health professionals and ethicists view confidentiality as being relative rather than absolute. The developing common law in England, New Zealand and Canada on the public interest exception to confidentiality has set out some guidelines in the forensic setting that may also be appropriate in the therapeutic context.

This overview of the legal and ethical background to risk assessment for the purpose of preventing future serious injury to others shows that the law in Australia appears to be lagging behind the practice of risk assessment. Perhaps ultimately, legislation clarifying a public interest exception to confidentiality is the best way forward.

The High Court in *McGarry v The Queen* (2001) 207 CLR 121 has set out a cautious approach to risk assessment for the purposes of indefinite detention. Their Honours acknowledged that those with psychiatric or psychological qualifications may assist in risk assessment, but spoke of “grave or serious” risk rather than just “a” risk or “a significant” risk. It may be that such a cautious approach will carry over to other areas of the law such as breaching confidentiality in the public interest, but until there is a specific case before the courts on this, mental health professionals should follow the lead of the developing common law in other countries.

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APPENDIX A: QUESTIONNAIRE

The aim of developing the following questionnaire was to identify the main factors influencing mental health professionals assessment of the risk of future violent behaviour and when they will breach confidentiality. The questionnaire adapts and expands on questions previously researched by McMahon and Knowles (1991, 1995, 1997) to take into account the three-step test dealing with breaching confidentiality set out in *Smith v Jones*. It also poses questions dealing with the legal aspects of breaching confidentiality.

QUESTIONNAIRE

A Criminology Research Council Project

Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour

Age:
Sex:
Qualifications:
Type of practice:
Length of time spent in practice (years):

1. How accurately do you believe psychiatrists/psychologists predict the likelihood of their client attacking and injuring someone in the future?

- ❑ Very accurately
- ❑ Moderately accurately
- ❑ About the same as chance
- ❑ Less than chance.

2. Is there a legal duty in Australia imposed on psychologists/psychiatrists to disclose confidential information to a third party if the psychiatrist/psychologist believes that his or her patient/client is at risk of causing serious injury to a third party?

- ❑ Yes
- ❑ No
- ❑ I Don't Know.

3. Tick which of the following variables in combination would lead you to predict your patient/client as likely to inflict future serious injury to a third party:

- ❑ Past history of violence
- ❑ Existence of a specific, identifiable victim
- ❑ Impulsive nature of the client
- ❑ Male patient/client
- ❑ Primary diagnosis of schizophrenia
- ❑ Primary diagnosis of personality disorder
- ❑ Age – under 40
- ❑ Education - secondary level or less
- ❑ General capacity to carry out the violence
- ❑ Existence of a plan
- ❑ Environmental stressors
- ❑ Resistance to continuing treatment
- ❑ Employment and/or residential instability
- ❑ Unstable family background
- ❑ Violent home environment as child
- ❑ Availability of weapons
- ❑ History of substance abuse
- ❑ Access to victim
- ❑ Clouding of consciousness and confusion
- ❑ Threats made in a sustainable state of irritability and arousal
- ❑ Threats made in the context of dispute which is ongoing irritant
- ❑ Threats related to intentions persistent over time
- ❑ Threats directly related to patient's delusional preoccupations
- ❑ Threats made with plausibility
- ❑ Marital status – married
- ❑ Marital status – not married
- ❑ Non-violent convictions
- ❑ High anxiety level
- ❑ Low socio-economical status
- ❑ Lack of supportive social networks
- ❑ Experience of disruption of control over thoughts and actions
- ❑ Emotional blunting
- ❑ Evidence of delusions

4. Tick which of the following variables in combination would lead you to disclose confidential information regarding your client/patient to a third party:

- ❑ Past history of violence
- ❑ Existence of a specific, identifiable victim
- ❑ Impulsive nature of the client
- ❑ Sex of the patient/client - male
- ❑ Primary diagnosis of schizophrenia
- ❑ Primary diagnosis of personality disorder
- ❑ Age – under 40
- ❑ Education - secondary level or less
- ❑ General capacity to carry out the violence
- ❑ Existence of a plan
- ❑ Environmental stressors
- ❑ Resistance to continuing treatment
- ❑ Employment and/or residential instability
- ❑ Unstable family background
- ❑ Violent home environment as child
- ❑ Availability of weapons
- ❑ History of substance abuse
- ❑ Access to the victim
- ❑ Clouding of consciousness and confusion
- ❑ Threats made in a sustainable state of irritability and arousal
- ❑ Threats made in the context of dispute which is ongoing irritant
- ❑ Threats related to intentions persistent over time
- ❑ Threats directly related to patient's delusional preoccupations
- ❑ Threats made with plausibility
- ❑ Marital status – married
- ❑ Marital status – not married
- ❑ Non-violent convictions
- ❑ High anxiety level
- ❑ Low socio-economical status
- ❑ Lack of supportive social networks
- ❑ Experience of disruption of control over thoughts and actions
- ❑ Emotional blunting
- ❑ Evidence of delusions

5. Which of the following courses of action would you take if you were of the opinion that your client/patient was likely to inflict serious injury to a third party?

- ❑ Talk to the client during treatment
- ❑ Talk to the client during treatment with a view of obtaining client/patient consent to disclose the information
- ❑ Place a note on the client's record
- ❑ Recommend more treatment
- ❑ Notify/attempt to notify the potential victim
- ❑ Inform the police
- ❑ Recommend voluntary hospitalisation
- ❑ Recommend involuntary hospitalisation
- ❑ Decline or terminate treatment
- ❑ Order psychological tests.

6. Indicate which alternative would be your first choice (place a 1 in the box)

- ❑ Talk to the client during treatment
- ❑ Talk to the client during treatment with a view of obtaining client/patient consent to disclose the information
- ❑ Place a note on the client's record
- ❑ Recommend more treatment
- ❑ Notify/attempt to notify the potential victim
- ❑ Inform the police
- ❑ Recommend voluntary hospitalisation
- ❑ Recommend involuntary hospitalisation
- ❑ Decline or terminate treatment
- ❑ Order psychological tests.

7. Would you be prepared to provide access to your professional notes regarding a patient/client to the police in any of the following circumstances?

- ❑ A written request from a police officer
- ❑ Written consent of the patient
- ❑ A search warrant
- ❑ A direct instruction from a magistrate
- ❑ An order from the County Court or the Supreme Court
- ❑ Any other circumstance

  specify____

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8. Tick which of the following situations would lead you to disclose confidential information to a third party:

- ❑ A client/patient discloses that he or she is planning to abuse a child.

A client/patient discloses that he or she is planning to kill:

- ❑ An identifiable individual
- ❑ An identifiable class of individuals
- ❑ A random individual.

A client/patient discloses that he or she is planning to inflict serious injury to:

- ❑ An identifiable individual
- ❑ An identifiable class of individuals
- ❑ A random individual.
- ❑ An HIV positive client/patient discloses that he or she is planning to have unprotected sex with an individual who is unaware of the client's HIV status

A client/patient discloses that he or she is planning to commit a sexual assault on:

- ❑ An identifiable individual
- ❑ An identifiable class of individuals
- ❑ A random individual.

A client/patient discloses that he or she is planning to cause injury to:

- ❑ An identifiable individual
- ❑ An identifiable class of individuals
- ❑ A random individual.

9. Which, if any, of the following would influence your decision when contemplating a breach of confidentiality in regard to the risk of infliction of serious injury to a third party?

- ❑ The risk of personal damage claims
- ❑ The risk of exposing the client to discrimination/prejudice
- ❑ The risk of a complaint being made against you to a registration board or other statutory authority regarding inappropriate standards of behaviour
- ❑ Concerns about undermining the trust of the practitioner/client relationship and the efficacy of the treatment process.

Thank you for completing this questionnaire. Please place it in the stamped addressed envelope provided.

APPENDIX B: RESULTS OF THE QUESTIONNAIRE

The questionnaire set out in Appendix A was sent to 355 psychologists, 62 of whom were listed as members of the Victorian Branch of the College of Forensic Psychologists and 293 whose names were taken randomly from the Victorian yellow pages. Seven envelopes were marked "return to sender" and a further three declined. The questionnaire was also sent to 43 psychiatrists, 36 whose names were taken from the Victorian yellow pages and seven forensic psychiatrists working at the Thomas Embling Hospital in Victoria. Data were obtained from 128 psychologists and 17 psychiatrists.

The questionnaires were mailed out with an accompanying letter indicating that the project was funded by a grant from the Criminology Research Council and had received approval from Monash University's Standing Committee on Ethics in Human Research. The letter included a detachable consent form and two pre-paid addressed return envelopes were included for the questionnaire and consent from. Upon the return of the questionnaire, responses were coded and analysed.

The following pages set out the results from the returned questionnaires. Further analysis of the details will be carried out by Professor Paul Mullen as part of this project.

Question 1: How accurately do you believe psychiatrists/psychologists predict the likelihood of their client attacking and injuring someone in the future?

	INVALID RESPONSE	VERY ACCURATELY	MODERATELY ACCURATELY	ABOUT THE SAME AS CHANCE	LESS THAN CHANCE
PSYCHOLOGISTS N = 128	2 1.6%	2 1.6%	96 75%	24 18.8%	4 3.1%
PSYCHIATRISTS N = 17	1 5.9%		10 58.8%	6 35.3%	

Question 2: Is there a legal duty in Australia imposed on psychologists/psychiatrists to disclose confidential information to a third party if the psychiatrist/psychologist believes that his or her patient/client is at risk of causing serious injury to a third party?

	INVALID RESPONSE	YES	NO	DON'T KNOW
PSYCHOLOGISTS	1 .8%	97 75.8%	22 17.2%	8 6.3%
PSYCHIATRISTS		11 64.7%	4 23.5%	2 11.8%

Question 3: Which variables in combination would lead you to predict your patient/client as likely to inflict future serious injury to a third party?

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Past History of Violence	119	93%	17	100%
Existence of a Specific, Identifiable Victim	100	78.1%	16	94.1%
Impulsive Nature of the Client	85	66.4%	15	88.2%
Male Patient/Client	63	49.2%	12	70.6%
Primary Diagnosis of Schizophrenia	21	16.4%	6	35.3%
Primary Diagnosis of Personality Disorder	40	31.3%	8	47.1%
Age – under 40	31	24.2%	7	41.2%
Education– Secondary Level or Less	14	10.9%	4	23.5%
General Capacity to Carry out the Violence	80	62.5%	13	76.5%
Existence of a Plan	108	84.4%	17	100%
Environmental Stressors	63	49.2%	7	41.2%
Resistance to Continuing Treatment	46	35.9%	11	64.7%
Employment and/or Residential Instability	26	20.3%	5	29.4%
Unstable Family Background	28	21.9%	4	23.5%
Violent Home Environment as Child	73	57%	13	76.5%
Availability of Weapons	105	82%	13	76.5%
History of Substance Abuse	64	50%	10	58.8%
Access to Victim	87	68%	12	70.6%
Clouding of Consciousness and Confusion	28	21.9%	7	41.2%
Threats made in a Sustainable State of Irritability and Arousal	88	68.8%	13	76.5%
Threats made in the Context of Dispute Which is Ongoing Irritant	80	62.5%	14	82.4%
Threats Related to Intentions Persistent Over Time	93	72.7%	14	82.4%

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Threats Directly Related to Patient's Delusional Preoccupations	84	65.6%	17	100%
Threats Made with Plausibility	91	71.1%	10	58.8%
Marital Status – Married	2	1.6%	1	5.9%
Marital Status – Not Married	14	10.9%	2	11.8%
Non-violent Convictions	6	4.7%	1	5.9%
High Anxiety Level	30	23.4%	2	11.8%
Low Socio-Economic Status	10	7.8%	1	5.9%
Lack of Supportive Social Networks	60	46.9%	7	41.2%
Experience of Disruption of Control Over Thoughts and Actions	80	62.5%	10	58.8%
Emotional Blunting	37	28.9%	3	17.6%
Evidence of Delusions	53	41.4%	7	41.2%

Question 4: Which variables in combination would lead you to disclose confidential information regarding your client/patient to a third party?

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Past History of Violence	72	56.3%	9	52.9%
Existence of a Specific, Identifiable Victim	94	73.4%	16	94.1%
Impulsive Nature of the Client	47	36.7%	5	29.4%
Male Patient/Client	16	12.5%	1	5.9%
Primary Diagnosis of Schizophrenia	6	4.7%	1	5.9%
Primary Diagnosis of Personality Disorder	12	9.4%	2	11.8%
Age – under 40	6	4.7%	1	5.9%
Education – Secondary Level or Less	2	1.6%	1	6.3%
General Capacity to Carry out the Violence	61	47.7%	5	29.4%
Existence of a Plan	111	86.7%	15	88.2%
Environmental Stressors	28	21.9%	1	5.9%
Resistance to Continuing Treatment	42	32.8%	6	35.3%

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Employment and/or Residential Instability	4	3.1%	1	5.9%
Unstable Family Background	8	6.3%	1	5.9%
Violent Home Environment as Child	22	17.2%	3	17.6%
Availability of Weapons	87	68%	10	58.8%
History of Substance Abuse	31	24.2%	3	17.6%
Access to Victim	84	65.6%	8	47.1%
Clouding of Consciousness and Confusion	20	15.6%	2	11.8%
Threats made in a Sustainable State of Irritability and Arousal	76	59.4%	9	52.9%
Threats made in the Context of Dispute Which is Ongoing Irritant	67	52.3%	11	64.7%
Threats Related to Intentions Persistent Over Time	81	63.3%	11	64.7%
Threats Directly Related to Patient's Delusional Preoccupations	60	46.9%	15	88.2%
Threats Made with Plausibility	85	66.4%	9	52.9%
Marital Status – Married	2	1.6%	0	0%
Marital Status – Not Married	2	1.6%	0	0%
Non-violent Convictions	3	2.3%	0	0%
High Anxiety Level	20	15.6%	1	5.9%
Low Socio-Economic Status	2	1.6%	1	5.9%
Lack of Supportive Social Networks	18	14.1%	2	11.8%
Experience of Disruption of Control Over Thoughts and Actions	49	38.3%	8	47.1%
Emotional Blunting	27	21.1%	1	5.9%
Evidence of Delusions	28	21.9%	5	29.4%

Question 5: Which course of action would you take if you were of the opinion that your client/patient was likely to inflict serious injury to a third party?

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Talk to the client during treatment	90	70.3%	11	64.7%
Talk to the client during treatment with a view to obtaining client/patient consent to disclose the information	89	69.5%	14	82.4%
Place a note on the client's record	80	62.5%	13	76.5%
Recommend more treatment	61	47.7%	8	47.1%
Notify/attempt to notify the potential victim	57	44.5%	6	35.3%
Inform the police	96	75%	13	76.5%
Recommend voluntary hospitalisation	62	48.4%	12	70.6%
Recommend involuntary hospitalisation	42	32.8%	11	64.7%
Decline or terminate treatment	6	4.7%	0	0%
Order psychological tests	7	5.5%	0	0%
N	128		17	

Question 6: Which would be your first choice of action if you were of the opinion that your client/patient was likely to inflict serious injury to a third party?

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Talk to the client during treatment	35	27.3%	2	11.8%
Talk to the client during treatment with a view to obtaining client/patient consent to disclose the information	49	38.3%	8	47.1%
Place a note on the client's record	0	0%	0	0%
Recommend more treatment	2	1.6%	0	0%
Notifiy/attempt to notify the potential victim	15	11.7%	1	5.9%
Inform the police	17	13.3%	3	17.6%

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Recommend voluntary hospitalisation	7	5.5%	0	0%
Recommend involuntary hospitalisation	2	1.6%	3	17.6%
Decline or terminate treatment	0	0%	0	0%
Order psychological tests	0	0%	0	0%

Question 7: In which circumstances would you be prepared to provide access to your professional notes regarding a patient/client to the police?

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Written request from a police officer	8	6.3%	3	17.6%
Written consent of the patient	97	75.8%	14	82.4%
Search warrant	40	31.3%	4	23.5%
Direct instruction from a magistrate	81	63.3%	9	52.9%
Order from the County Court or Supreme Court	108	84.4%	16	94.1%
Other circumstance	5	3.9%	1	5.9%

Question 8: In which situations would you disclose confidential information to a third party?

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Disclosure of Plan to Abuse a Child	119	93%	16	94.1%
Disclosure of Plan to Kill an Identifiable Individual	123	96.1%	17	100%
Disclosure of Plan to Kill an Identifiable Class of Individuals	105	82%	9	52.9%

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Disclosure of Plan to Kill a Random Individual	92	71.9%	10	58.8%
Disclosure of Plan to Inflict Serious Injury to an Identifiable Individual	119	93%	17	100%
Disclosure of Plan to Inflict Serious Injury to an Identifiable Class of Individuals	95	74.2%	16	41.2%
Disclosure of Plan to Inflict Serious Injury to a Random Individual	80	62.5%	6	35.3%
Disclosure by HIV Positive Client/Patient of Plan to Have Unprotected Sex with Individual unaware of the client's HIV status	76	59.4%	8	47.1%
Disclosure of Plan to Commit a Sexual Assault on an Identifiable Individual	117	91.4%	16	94.1%
Disclosure of Plan to Commit a Sexual Assault on an Identifiable Class of Individuals	79	61.7%	6	35.3%
Disclosure of Plan to Commit a Sexual Assault on a Random Individual	77	60.2%	7	41.2%
Disclosure of Plan to Cause Injury to an Identifiable Individual	104	81.3%	14	82.4%
Disclosure of Plan to Cause Injury to an Identifiable Class of Individuals	74	57.8%	6	35.3%
Disclosure of Plan to Cause Injury to a Random Individual	70	54.7%	7	41.2%

Question 9: What would influence your decision when contemplating a breach of confidentiality in regard to the risk of serious injury to a third party?

ACTIONS	PSYCHOLOGISTS		PSYCHIATRISTS	
Risk of personal damage claims	37	28.9%	7	41.2%
Risk of exposing the client to discrimination/prejudice	43	33.6%	8	47.1%
Risk of a complaint being made against you to a registration board or other statutory authority regarding inappropriate standards of behaviour	43	33.6%	8	47.1%
Concerns about undermining the trust of the practitioner/client relationship and the efficacy of the treatment process.	79	61.7%	13	76.5%